

# 2011

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# Table of Contents Volume 2

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## Dental Benefits, Practice and Health

- 3000 Council on Dental Benefit Programs: Claim Adjudication and Reimbursement for Dental Procedures (Res. 1)
- 3001 Council on Dental Benefit Programs: Definitions of Usual and Customary Fees (Res. 2)
- 3003 Council on Dental Benefit Programs: Statement on Determination of Customary Fees by Third Parties (Res. 3)
- 3005 Council on Dental Benefit Programs: Limitations in Benefits by Dental Insurance Companies (Res. 4)
- 3007 Council on Dental Benefit Programs: Definitions of Fraudulent and Abusive Practices in Dental Benefit Plans and Claims (Res. 5)
- 3011 Council on Access, Prevention and Interprofessional Relations Supplemental Report 1: Leading Community Efforts to Improve Oral Health (Res. 18)
- 3013 Report 3 of the Board of Trustees: Rescission of Policy, "Availability of Survey Results" (Res. 19)
- 3015 Council on Access, Prevention and Interprofessional Relations Supplemental Report 2: Update on Council Activities
- 3020 Council on Access, Prevention and Interprofessional Relations Supplemental Report 2: Rescission of Policy, "American Dental Association Dental Health Program for Children" (Res. 35)
- 3029 Council on Dental Practice Supplemental Report 2: Development of a Policy Statement on Comparative Effectiveness Research (Res. 36)
- 3040 Eighth Trustee District: ADA Scientific Review of Alternative Dental Workforce Models (Res. 41)
- 3041 Board of Trustees: Substitute Resolution (Res. 41B)
- 3042 Fourteenth Trustee District: Developing the Native American Dental Workforce (Res. 50)
- 3044 Fourteenth Trustee District: Policy on Native American Workforce (Res. 51)
- 3046 Council on Access, Prevention and Interprofessional Relations Supplemental Report 3: Update on the Community Dental Health Coordinator Pilot Program
- 3057 Council on Dental Practice Supplemental Report 1: Response to Resolution 110H-2010—Advocating for Victims of Addictive Disease
- 3062 Report 8 of the Board of Trustees: Dental Workforce Model: 2009-2030
- 3086 Fourteenth Trustee District: Learning the Lessons of Contract Analysis (Res. 60)
- 3087 Fourteenth Trustee District: Practical Development of Teledentistry (Res. 61)
- 3089 Fourteenth Trustee District: Developing CDHC Practice Models (Res. 65)
- 3090 Eleventh Trustee District: ADA Alternate Proposal to the Midlevel Provider Pilot Project (Res. 76)

## Dental Education, Science and Related Matters

- 4000 Council on Dental Education and Licensure: Amendment of the Policy, "Comprehensive Study of Dental Specialty Education and Practice" (Res. 6)
- 4001 Council on Dental Education and Licensure: Rescission of the Policy, "Periodic Review of Specialty Education and Practice" (Res. 7)
- 4002 Council on Dental Education and Licensure: Amendment of the Policy Statement on Continuing Dental Education (Res. 8)

## TABLE OF CONTENTS

4005	Council on Scientific Affairs: Rescission of Policy on Use of Approved Materials in New Techniques and Products (Res. 13)
4006	Report of the CODA Monitoring Committee: Activities Update
4009	Report of the CODA Monitoring Committee: Monitoring of Accreditation Matters on Behalf of the ADA (Res. 39)
4010	Commission on Dental Accreditation Supplemental Report 1: Progress on Implementation of Recommendations in the 2008 Report of the Task Force on CODA
4024	Commission on Dental Accreditation Supplemental Report 1: Funding Support for CODA Strategic Planning Efforts (Res. 40)
4025	Council on ADA Sessions: Request for Postponement of the Proposed CERP Eligibility Criteria (Res. 47)
4027	Eighth Trustee District: Recognition of Specialty Groups (Res. 48)
4028	Board of Trustees: Substitute Resolution (Res. 48B)
4029	Report 12 of the Board of Trustees: Accreditation Standards for Dental Therapy Programs (Res. 53)
4031	Commission on Dental Accreditation Supplemental Report 3: Informational Report on Developing Accreditation Standards for Dental Therapy Programs
4037	Council on Scientific Affairs Supplemental Report 1: Update on Response to Assignments From the 2010 House of Delegates and Other Matters
4040	Commission on Dental Accreditation Supplemental Report 2: Update on International Accreditation
4052	Report 10 of the Board of Trustees: Status of Resolution 51H-2009: ADA Library on the Web
4056	Report of the Workgroup on Resolution 42H-2010: RFP Process for Portfolio-Style Clinical Examination
4076	Fourteenth Trustee District: Deflating the Dental Education Bubble (Res. 66)
4078	Fourteenth Trustee District: Reassessing Standards for Accreditation (Res. 58)
4080	Fourteenth Trustee District: Investigation of Expanding the Scope of Dentistry (Res. 59)
4081	Board of Trustees: Proposal to Realign Oversight of the Association's Evidence-Based Dentistry Activities (Res. 67)
4084	Eighth, Ninth and Eleventh Trustee Districts: Reinstitution of the Subscription to the Cochrane Library (Res. 69)
4086	Ninth Trustee District: Autonomy of the ADA Editor (Res. 72)
4087	Eleventh Trustee District: Substitute Resolution (41BS-1)
4088	Sixteenth Trustee District: <i>Professional Products Review Study</i> (Res. 81)

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## Dental Benefits, Practice and Health



Resolution No. 1 New ☒ Substitute ☐ Amendment ☐Report: NA Date Submitted: July 2011Submitted By: Council on Dental Benefit ProgramsReference Committee: Dental Benefits, Practice and HealthTotal Net Financial Implication: None Net Dues Impact: \$Amount One-time \$ Amount On-going \$ADA Strategic Plan Goal: Members (Required)**CLAIM ADJUDICATION AND REIMBURSEMENT  
FOR DENTAL PROCEDURES****Background:** (*Reports:58*)

**Non-Orthodontic Procedures Subject to Orthodontic Lifetime Maximums:** The Council discussed a dental office's concerns over a carrier's adjudication of extractions necessary for orthodontic treatment. Basically, the carrier considered the extractions (D7140) as part of the orthodontic lifetime maximum and applied the allowance for these procedures to the orthodontic lifetime maximum and not the plan's annual maximum. Thus, there were fewer dollars available in the orthodontic lifetime maximum for the patient and the claim was paid at a lower percentage (50% instead of 80%). The Council believes that third-party payers and administrators should not intentionally change a procedure code's category of service in order to reduce available reimbursement amounts that are subject to benefit plan limitations and exclusions.

There is no current ADA policy that addresses this issue. The Council, therefore, recommends adoption of the following resolution. This resolution supports the ADA strategic plan goal to support member success.

**Resolution**

**1. Resolved,** that claim adjudication and reimbursement be guided by a procedure code's category of service as specified in the *Code on Dental Procedures and Nomenclature*.

**BOARD RECOMMENDATION: Vote Yes.****BOARD VOTE: UNANIMOUS. (BOARD OF TRUSTEES CONSENT CALENDAR ACTION—NO BOARD DISCUSSION)**





Resolution No. 2 New ☒ Substitute ☐ Amendment ☐Report: NA Date Submitted: July 2011Submitted By: Council on Dental Benefit ProgramsReference Committee: Dental Benefits, Practice and HealthTotal Net Financial Implication: None Net Dues Impact: \$Amount One-time \$ Amount On-going \$ADA Strategic Plan Goal: Members (Required)**DEFINITIONS OF USUAL AND CUSTOMARY FEES****Background:** (*Reports:58*)

**Definitions of Usual and Customary Fees:** The Council reviewed the ADA policy on Definitions of Usual and Customary Fees (*Trans.2010:545*) with a goal of amending the policy to be consistent with other policies that contain language referencing fees and maximum allowable/maximum plan benefits, and felt that the term “customary fee” should be replaced with the term “maximum plan benefit.” The Council believes the term “customary” is misleading, as a “customary fee” is arbitrarily determined by individual insurance companies using proprietary information and algorithms. The Council, therefore, recommends adoption of the following resolution. This resolution supports the ADA strategic plan goal to support member success.

**Resolution**

**2. Resolved,** that the ADA policy, Definitions of Usual and Customary Fees (*Trans.2010:545*), be amended as follows (additions are shown by underscoring; deletions are shown by strikethroughs):

**Definitions of “Usual fee” and “Maximum Plan Benefit ~~Customary~~” Fees**

**Resolved,** that the following definitions of “usual fee” and “maximum plan benefit ~~customary~~” fees be adopted:

*Usual fee* is the fee which an individual dentist most frequently charges for a specific dental procedure independent of any contractual agreement.

It is always appropriate to modify this fee based on the nature and severity of the condition being treated and by any medical or dental complications or unusual circumstances.

*Maximum plan benefit ~~Customary fee~~* is the fee level determined by the administrator of a dental benefit plan for a specific dental procedure. This may vary widely by geographic region or by benefit plans within a region.

and be it further

**Resolved,** that the use of the terms “customary” or “UCR” to justify denial of a claim or communicate with patients or dental benefit plan purchasers is inappropriate due to the arbitrary and prejudicial manner in which it can be designated, and be it further

1       **Resolved**, that the ADA should communicate these definitions to insurance regulators, consumer  
2       advocacy groups, and dental benefits administrators to encourage the proper use of these terms,  
3       and be it further

4       ~~**Resolved**, that the Definitions of Usual, Customary and Reasonable Fees (*Trans. 1987:501*) be~~  
5       ~~rescinded.~~

6       **BOARD RECOMMENDATION: Vote Yes.**

7       **BOARD VOTE: UNANIMOUS. (BOARD OF TRUSTEES CONSENT CALENDAR ACTION—NO BOARD**  
8       **DISCUSSION)**

Resolution No. 3 New ☒ Substitute ☐ Amendment ☐Report: NA Date Submitted: July 2011Submitted By: Council on Dental Benefit ProgramsReference Committee: Dental Benefits, Practice and HealthTotal Net Financial Implication: None Net Dues Impact: \$Amount One-time \$ Amount On-going \$ADA Strategic Plan Goal: Members (Required)**STATEMENT ON DETERMINATION OF CUSTOMARY FEES  
BY THIRD PARTIES****Background:** (*Reports:59*)

**Statement on Determination of Customary Fees by Third Parties:** The Council reviewed the ADA policy on Statement on Determination of Customary Fees by Third Parties (*Trans.*1991:633; 2010:545), as amended by Resolution 1H-2010. Based on recent activities concerning terminology relating to “customary fees” the Council reviewed existing ADA policies that make reference to this term and recommends substituting the term “maximum plan benefit” for the term “customary fee.” The Council believes the term “customary” is misleading, as a “customary fee” is arbitrarily determined by individual insurance companies using proprietary information and algorithms. The Council, therefore, recommends adoption of the following resolution. This resolution supports the ADA Strategic Plan Goal to Support Member Success.

**Resolution**

**3. Resolved,** that the Statement on Determination of Customary Fees by Third Parties (*Trans.*1991:633; 2010:545) be amended by deleting the word “customary” (except in the title of the Statement to facilitate search capabilities) and adding the words “Maximum Plan Benefit” (additions are shown by underscoring; deletions are shown by strikethroughs), and be it further

**Resolved,** that appropriate agencies of the ADA take action to encourage the adoption of these guidelines at both the state and federal level.

**Statement on Determination of Maximum Plan Benefit (Customary)  
Fees by Third Parties**

The legitimate interests of insured patients are best served by use of precise, accurate and publicly announced methodologies for determining ranges of fees for all dental services.

Therefore, policy-makers should develop guidelines for regulations which:

- Establish standard terminology for identifying benefits in policies, Explanation of Benefits and other descriptive materials
- Establish a standard screen setting method (such as percentile) and/or require a policy statement, which describes the overall percentage of services (percentile) the policy should allow in full
- Require disclosure regarding the average percentage of claim dollars submitted anticipated to be allowed

- Require disclosure describing the frequency of updates and/or the basis for screen development
- Require disclosure describing how region and specialty were considered in setting the Maximum Plan Benefit Customary Fee Screens
- Require carriers to use sufficient data when determining Maximum Plan Benefit Customary Fee Screens (whether from claims experience or other sources)
- Require carriers to demonstrate how they have set their screens and how they have determined if sufficient data were employed

**BOARD RECOMMENDATION: Vote Yes.**

**BOARD VOTE: UNANIMOUS. (BOARD OF TRUSTEES CONSENT CALENDAR ACTION—NO BOARD DISCUSSION)**

Resolution No. 4 New ☒ Substitute ☐ Amendment ☐Report: NA Date Submitted: July 2011Submitted By: Council on Dental Benefit ProgramsReference Committee: Dental Benefits, Practice and HealthTotal Net Financial Implication: None Net Dues Impact: \$Amount One-time \$ Amount On-going \$ADA Strategic Plan Goal: Members (Required)

1                   **LIMITATIONS IN BENEFITS BY DENTAL INSURANCE COMPANIES**

2    **Background:** (*Reports:60*)

3    **Limitations in Benefits by Dental Insurance Companies:** The Council reviewed the ADA policy on  
4    Limitations in Benefits by Dental Insurance Companies (*Trans.*1997:679). Using the term “maximum plan  
5    benefit” is consistent with recent changes to existing ADA policy and the Council recommends that this term  
6    replace “maximum plan allowance.” The Council, therefore, recommends adoption of the following resolution.  
7    This resolution supports the ADA Strategic Plan Goal to Support Member Success.

8                   **Resolution**

9    **4. Resolved,** that the policy, Limitations in Benefits by Dental Insurance Companies (*Trans.*1997:680), be  
10   amended in the first resolving clause by replacing the term “maximum plan allowance” with the term  
11   “maximum plan benefit” (additions are shown by underscoring; deletions are shown by strikethroughs):

12               **Resolved,** that since the term “usual, customary and reasonable” is often misunderstood by  
13   patients and tends to raise distrust of the dentist in the patient’s mind by suggesting the dentist’s  
14   fees are excessive, the American Dental Association urges all third-party payers employing this  
15   terminology to substitute the term “maximum plan benefit” ~~“maximum plan allowance”~~ in all patient  
16   communications and explanations of benefits, and be it further

17   **BOARD RECOMMENDATION: Vote Yes.**

18   **BOARD VOTE: UNANIMOUS. (BOARD OF TRUSTEES CONSENT CALENDAR ACTION—NO BOARD**  
19   **DISCUSSION)**

WORKSHEET ADDENDUM

COUNCIL ON DENTAL BENEFIT PROGRAMS

POLICY TO BE AMENDED

**Limitations in Benefits by Dental Insurance Companies (1997:680)** (additions are shown by underscoring; deletions are shown by strikethroughs)

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**Resolved**, that since the term “usual, customary and reasonable” is often misunderstood by patients and tends to raise distrust of the dentist in the patient’s mind by suggesting the dentist’s fees are excessive, the American Dental Association urges all third-party payers employing this terminology to substitute the term “maximum plan benefit” ~~“maximum plan allowance”~~ in all patient communications and explanations of benefits, and be it further

**Resolved**, that appropriate agencies of the American Dental Association and constituent dental societies urge purchasers of dental benefit plans to eliminate pre-existing condition clauses from their contracts, and be it further

**Resolved**, that appropriate agencies of the American Dental Association urge purchasers of dental benefit plans to increase yearly maximum benefits to be consistent with cost-of-living increases, and be it further

**Resolved**, that appropriate agencies of the American Dental Association notify all providers of dental benefits of these new policies, and be it further

**Resolved**, that the American Dental Association seek legislation and/or regulations to accomplish these goals, and be it further

**Resolved**, that constituent dental societies be urged to seek legislation or regulation in their individual states to accomplish these same requirements.

Resolution No. 5 New ☒ Substitute ☐ Amendment ☐Report: NA Date Submitted: July 2011Submitted By: Council on Dental Benefit ProgramsReference Committee: Dental Benefits, Practice and HealthTotal Net Financial Implication: None Net Dues Impact: \$Amount One-time \$ Amount On-going \$ADA Strategic Plan Goal: Members (Required)**DEFINITIONS OF FRAUDULENT AND ABUSIVE PRACTICES  
IN DENTAL BENEFIT PLANS AND CLAIMS****Background:** (*Reports:60*)

**Definitions of Fraudulent and Abusive Practices in Dental Benefit Plans and Claims:** The Council reviewed the ADA policy on Definitions of Fraudulent and Abusive Practices in Dental Benefit Plans and Claims (*Trans.*1998:701; 2001:428; 2010:548), as amended by Resolution 2H-2010. Based on recent activities concerning terminology relating to “customary fees” the Council reviewed existing ADA policies that make reference to this term and recommends substituting the term “maximum plan benefit” for the term “customary fee.” The Council believes the term “customary” is misleading, as a “customary fee” is arbitrarily determined by individual insurance companies using proprietary information and algorithms. The Council, therefore, recommends adoption of the following resolution. This resolution supports the ADA Strategic Plan Goal to Support Member Success.

**Resolution**

**5. Resolved,** that the Definitions of Fraudulent and Abusive Practices in Dental Benefit Plans and Claims (*Trans.*1998:701; 2001:428; 2010:548) be amended in the second paragraph under the definition of “Inappropriate Fee Discounting Practices” by deleting the word “customary” and inserting in its place the words “maximum plan benefit” (additions are shown by underscoring; deletions are shown by strikethroughs):

**Inappropriate Fee Discounting Practices:**

Intentionally engaging in practices which would force a dentist, who does not have a participating provider agreement, to accept discounted fees or be bound by the terms and conditions set forth in the participating provider contract.

Some examples of inappropriate fee discounting practices include, but are not limited to: issuing reimbursement checks which, upon signing, result in the dentist accepting the amount as payment in full; using claim forms which, upon signing, require the dentist to accept the terms of the plan’s contract; issuing insurance cards which state that the submittal of a claim by a dentist means that he or she accepts all terms and conditions set forth in the participating provider contract; and

1 sending communications to patients of nonparticipating dentists which state that he or she is not  
2 responsible for any amount above maximum plan benefit ~~customary~~ fees as established by the  
3 plan.

4 **BOARD RECOMMENDATION: Vote Yes.**

5 **BOARD VOTE: UNANIMOUS. (BOARD OF TRUSTEES CONSENT CALENDAR ACTION—NO BOARD**  
6 **DISCUSSION)**

7 H:\2011 Annual Session\File 06 Resolution 05.doc



## 1 WORKSHEET ADDENDUM

## 2 COUNCIL ON DENTAL BENEFIT PROGRAMS

## 3 POLICY TO BE AMENDED

4 **Fraudulent and Abusive Practices in Dental Benefits Plans and Claims (1998:701; 2001:428; 2010:548)**  
5 (additions are shown by underscoring; deletions are shown by strikethroughs)

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6 **Resolved**, that the following definitions related to potentially fraudulent and abusive practices committed by  
7 third-party payers administering dental benefits be adopted.

8 **Claims Payment Fraud:** The intentional manipulation or alteration of facts or procedure codes submitted  
9 by a treating dentist resulting in a lower payment to the beneficiary and/or treating dentist than would have  
10 been paid if the manipulation had not occurred.

11 **Bad Faith Insurance Practices:** The failure to deal with a beneficiary of a dental benefit plan fairly and in  
12 good faith; or an activity which impairs the right of the beneficiary to receive the appropriate benefit of a  
13 dental benefits plan or to receive them in a timely manner.

14 Some examples of potential bad faith insurance practices include, but are not limited to: evaluating claims  
15 based on standards which are significantly at variance with the standards of the community; failure to  
16 properly investigate a claim for care; and unreasonably and purposely delaying and/or withholding payment  
17 of a claim.

18 **Inappropriate Fee Discounting Practices:** Intentionally engaging in practices which would force a dentist,  
19 who does not have a participating provider agreement, to accept discounted fees or be bound by the terms  
20 and conditions set forth in the participating provider contract.

21 Some examples of inappropriate fee discounting practices include, but are not limited to: issuing  
22 reimbursement checks which, upon signing, result in the dentist accepting the amount as payment in full;  
23 using claim forms which, upon signing, require the dentist to accept the terms of the plan's contract; issuing  
24 insurance cards which state that the submittal of a claim by a dentist means that he or she accepts all terms  
25 and conditions set forth in the participating provider contract; and sending communications to patients of  
26 nonparticipating dentists which state that he or she is not responsible for any amount above maximum plan  
27 benefit ~~customary~~ fees as established by the plan.

28 **Downcoding:** A practice of third-party payers in which the benefit code has been changed to a less  
29 complex and/or lower cost procedure than was reported except where delineated in contract agreements.

30 **Bundling of Procedures:** The systematic combining of distinct dental procedures by third-party payers that  
31 results in a reduced benefit for the patient/beneficiary.

32 and be it further  
33

34 **Resolved**, that the following definitions related to potentially fraudulent and abusive practices by a dentist  
35 who is submitting claims to a third-party carrier be adopted.

36 **Claims Reporting Fraud:** The intentional misrepresentation of material facts concerning treatment  
37 provided and/or charges made, in that this misrepresentation would cause a higher payment.

- 1     **Overcoding:** Reporting a more complex and/or higher cost procedure than was actually performed.
- 2     **Unbundling of Procedures:** The separating of a dental procedure into component parts with each part
- 3     having a charge so that the cumulative charge of the components is greater than the total charge to
- 4     patients who are not beneficiaries of a dental benefit plan for the same procedure.

Resolution No. 18 New ☒ Substitute ☐ Amendment ☐Report: CAPIR Supplemental Report 1 Date Submitted: July 2011Submitted By: Council on Access, Prevention and Interprofessional RelationsReference Committee: Dental Benefits, Practice and HealthTotal Net Financial Implication: None Net Dues Impact: \$Amount One-time \$ Amount On-going \$ADA Strategic Plan Goal: Public Health (Required)

**COUNCIL ON ACCESS, PREVENTION AND INTERPROFESSIONAL RELATIONS  
SUPPLEMENTAL REPORT 1 TO THE HOUSE OF DELEGATES: LEADING COMMUNITY  
EFFORTS TO IMPROVE ORAL HEALTH**

**Background:** The *ADA Principles of Ethics and Code of Professional Conduct (Code)* states that individual dentists “have an obligation to use their skills, knowledge and experience for the improvement of the dental health of the public and are encouraged to be leaders in their community.”<sup>i</sup> The *Code* goes on to say that “each dentist should share in providing advocacy to and care of the underserved,” and that “each dentist meet this goal subject to individual circumstance.”<sup>ii</sup>

Dentists demonstrate their commitment to provide care to underserved populations through participation in national programs such as the ADA’s Give Kids A Smile Program, the ever-expanding number of Mission of Mercy projects and their historic commitment to the Dental Lifeline Network’s Donated Dental Services Program. Dentists participate in a plethora of constituent and component programs focused on improving access to care for underserved populations that are too numerous to catalogue. The Council recognizes and commends member dentists for the many hours they donate to support these efforts.

At the same time, one of the four goals of the *ADA Strategic Plan 2011- 2014* calls for the ADA to “be the trusted resource for oral health information that will help people be good stewards of their own oral health.”<sup>iii</sup> The Strategic Plan states that a shared responsibility exists in order to attain this goal and that the “individual and the dental professional understand their unique roles and responsibilities in managing an individual’s, or a community’s state of oral health.” The Council believes that this goal may best be advanced by dentists serving as oral health care leaders in their communities. In doing so, dentists will be in the best position to make oral health an integral part of the collective effort focused on improving the overall health of their communities.

The Council believes that dentists must be present and assume leadership roles when policies and programs are being developed that impact community health at the local level. Only by doing so can they assure that such programs reflect the knowledge and experience of practicing dentists. This is of utmost importance in the current shifting health care environment. It is incumbent upon dentists to assure that oral health is acknowledged as an integral component to an interdisciplinary approach to improving population health.

This requires dentists to establish strong working relationships with others who impact the health of the community in which they live and practice. Engagement in such will familiarize dentists with the ever-growing cultural, political and socio-economic diversity that exists within their community. The dentist will develop a shared understanding with other community leaders about internal and external factors impacting the community’s health.

Dentists will be sought out to serve as key informants, advisors, consultants and community leaders as strategies are developed by the “various communities of interest which serve, support or impact the health care environment and delivery of oral health care.”<sup>iv</sup> Differences of opinion will inevitably surface and agreement with everyone engaged in the discussion may not be reached; yet shared solutions and common ground to address the needs of the community will emerge.

This proactive strategy will afford dentists the opportunity to influence the decision-making processes when discussions are being held at the community level on how best to integrate and promote oral health or provide oral health services within a medical home, health home, safety net clinic, school, a facility serving the developmentally disabled or a nursing home. There are a variety of mechanisms for engaging in these grassroots efforts including, but not limited to, serving as volunteer leaders of boards of local health departments and federally qualified health centers, school health advisory councils, nursing home advisory committees, Head Start Health Service Advisory Committees, local health partnerships and local oral health coalitions. By having dentists engaged in these grassroots, broad-based community efforts, the Council believes that collective efforts will be more effective, more likely to achieve their intended outcomes and less likely to result in unintended consequences that may have minimal impact on improving the oral health of the public.

Therefore, in that improving oral health is an integral component of community efforts to improve overall health, the Council recommends the adoption of the following resolution.

#### **Resolution**

**18. Resolved**, that the American Dental Association encourages active participation by member dentists as leaders in grassroots community efforts that impact the oral health of the public.

**BOARD RECOMMENDATION: Vote Yes.**

**BOARD VOTE: UNANIMOUS. (BOARD OF TRUSTEES CONSENT CALENDAR ACTION—NO BOARD DISCUSSION)**

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<sup>i</sup> American Dental Association’s Principles of Ethics and Code of Professional Conduct, Section 3.A. Community Service.  
[http://www.ada.org/sections/about/pdfs/ada\\_code.pdf](http://www.ada.org/sections/about/pdfs/ada_code.pdf)

<sup>ii</sup> American Dental Association’s Principles of Ethics and Code of Professional Conduct, Preamble.

<sup>iii</sup> American Dental Association’s Strategic Plan: 2011- 2014

[https://www.ada.org/members/sections/about/doc\\_strategic\\_2011.pdf](https://www.ada.org/members/sections/about/doc_strategic_2011.pdf)

<sup>iv</sup> Ibid., Introduction to the American Dental Association Strategic Plan 2011 – 2014

Resolution No. 19 New ☒ Substitute ☐ Amendment ☐  
 Report: Board Report 3 Date Submitted: July 2011  
 Submitted By: Board of Trustees  
 Reference Committee: Dental Benefits, Practice and Health  
 Total Net Financial Implication: None Net Dues Impact: \$  
 Amount One-time \$ Amount On-going \$67,000 (Estimated Revenue)<sup>1</sup>  
 ADA Strategic Plan Goal: Members, Financial (Required)

**REPORT 3 OF THE BOARD OF TRUSTEES TO THE HOUSE OF DELEGATES: RESCISSION OF  
POLICY, "AVAILABILITY OF SURVEY RESULTS"**

**Background:** In 2008, the House of Delegates adopted Resolution 80H (*Trans.*2008:471), which reads as follows:

**80H-2008. Resolved,** that all appropriate Survey Center results be published in the "MEMBERS ONLY" section of the ADA website and there be no cost associated with this information for members of the ADA.

Reports currently available free of charge to ADA members on ADA.org ([www.ADA.org/freereports](http://www.ADA.org/freereports)) include all of the Survey of Dental Practice reports (2008-09 plus the specialist-specific reports from 2006); Survey of Dental Fees (2009); Survey of Dental Services Rendered (2005-06); Distribution of Dentists (2007-09); Survey of Dental Graduates (2008-09); Survey of New Dentists (2008); Survey on Retirement and Investment (2010); Survey of Current Issues in Dentistry (2007); Technology Survey (2006); Survey on the Use of Dental Labs (2008); and the most current issues of the Survey of Dental Education; Survey of Advanced Dental Education; Survey of Allied Dental Education and all reports from the Survey of Economic Confidence since its inception in third quarter, 2008.

When survey reports were made available free to members, this led to a significant increase in the number of reports accessed by members. Total quantity increased from 1,420 reports sold in 2008 to 22,730 reports downloaded for free in 2009. Clearly, making the reports free led to a substantial increase in quantity of reports accessed by members. It also led to a significant decrease in non-dues revenues for the ADA. Sales revenue from survey reports decreased by over \$200,000 between 2008 and 2009 (Table 1).

**Rationale for Rescission of Resolution 80H-2008:** First and most important, despite being free of charge, only a very small portion of members access these free reports. For example, the single most accessed free report (Survey of Dental Fees) had a market share of 1.8% of members in 2010 (i.e., 2,915 free downloads). The market share was 6.4% for the top-ten most accessed free survey reports combined and 15.2% for all HPRC free survey reports combined. These data indicate clearly that only a small portion of members are benefiting from free survey reports. Therefore, the Board believes a user fee is appropriate.

Second, given the ADA's financial situation, there is a need to increase non-dues revenues. HPRC has tremendous potential for generating non-dues revenues with unique data sets and analytic expertise. Under new leadership since March 2011, HPRC is in the process of developing a medium-term strategy for generating non-dues revenue. As an immediate measure, however, no longer providing full survey reports free to members will help restore some lost revenues. A conservative estimate of an additional \$67,000 in revenue for 2012 is expected if survey reports are no longer free (one-third of the annual lost revenue).

Table 1. HPRC Survey Reports Sales, 2006-2010

	Reports Downloaded (Free to Members)	Reports Sold	Total Sales and Downloads	Total Sales Revenue
2006	-	2,209	2,209	\$225,451
2007	-	2,033	2,033	\$224,281
2008	-	1,420	1,420	\$275,443
2009	22,730	665	23,395	\$73,831
2010	23,599	635	24,234	\$97,111

**Guiding Principles for Pricing Strategy:** If Resolution 19-2011 is adopted, the immediate next step by the Board will be to develop a pricing strategy. The following principles shall be used to develop a pricing strategy:

- Executive summaries or 'highlights' of all reports will be free to members.
- Dentists who reply to an ADA survey will be provided a free copy of the full report when it becomes available upon request. This is expected to improve survey response rates which have been declining.
- Members will receive a discount. For reports that are currently not free, members receive a 50% discount off of the market price. The appropriate price differential will need to be further investigated, but there is a desire to increase the member discount to more than 50%. Subscriptions will also be considered where reports are bundled into a series with a single discounted fee. Pricing for commercial entities will also need to be further investigated.
- Prices will be the same for downloadable and hardcopy reports. This is consistent with current practice for similar products (research reports).

For these reasons, the Board recommends adoption of the following resolution.

#### Resolution

**19. Resolved,** that Resolution 80H-2008 (*Trans.*2008:471), Availability of Survey Results, be rescinded, and be it further

**Resolved,** that executive summaries of survey reports be made available at no cost as a member benefit.

**BOARD RECOMMENDATION: Vote Yes.**

**BOARD VOTE: UNANIMOUS. (BOARD OF TRUSTEES CONSENT CALENDAR ACTION—NO BOARD DISCUSSION)**

<sup>1</sup>This amount is already reflected in the 2012 Health Policy Resources Center budget; thus, if Resolution 19 is not adopted, there would be a negative impact of \$67,000 to adjust within the budget.

Resolution No. 35 New ☒ Substitute ☐ Amendment ☐Report: CAPIR Supplemental Report 2 Date Submitted: September 2011Submitted By: Council on Access, Prevention and Interprofessional RelationsReference Committee: Dental Benefits, Practice and HealthTotal Net Financial Implication: None Net Dues Impact: \$Amount One-time \$ Amount On-going \$ADA Strategic Plan Goal: Collaboration (Required)**COUNCIL ON ACCESS, PREVENTION AND INTERPROFESSIONAL RELATIONS  
SUPPLEMENTAL REPORT 2 TO THE HOUSE OF DELEGATES: UPDATE ON COUNCIL ACTIVITIES**

The following information is provided to update the House of Delegates on activities that have occurred since the preparation of the 2011 Annual Report of the Council on Access, Prevention and Interprofessional Relations (CAPIR). The Council met on June 23-25, 2011, at the ADA Headquarters Building in Chicago.

**Update on the Post-Access to Dental Care Summit Activities:** On May 18, 2011, at ADA Headquarters in Chicago, the final meeting of the Coordination and Communication (C&C) Workgroup was held, concurrent with the first formal meeting of the U.S. National Oral Health Alliance (Alliance). During that meeting, a motion was made to disband the C&C Workgroup, as its purpose to establish a sustainable infrastructure for advancing the aims and spirit of the Access to Dental Care Summit had been accomplished in the U.S. National Oral Health Alliance.

The U.S. National Oral Health Alliance is an outgrowth of the Access to Dental Care Summit and seeks to provide a sustainable infrastructure for seeking and promoting common ground. Its predecessor, the C&C Workgroup, emphasized the importance of continuous communication to increase familiarity and build trust among such diverse stakeholders as private practice dentists, nonprofits, corporations and government agencies. It took several years of regular meetings to build up enough experience among these stakeholders for them to recognize and appreciate the common motivation behind their different efforts. With time, they saw that their own interests would be treated fairly, and that decisions would be made on the basis of objective evidence and common ground. It will take time to assure partners that their interests will be treated fairly and solutions to the problem of access to care for underserved populations will not favor the priorities of one organization over another.

In developing the Alliance, the founding Board gave careful consideration to the name. An alliance describes a partnership of persons, states or organizations. Each partner preserves its own identity and lends its expertise to issues the alliance has adopted as common to all. The U.S. National Oral Health Alliance similarly seeks partners who commit to responding to its purpose question: *What are we going to do, in the short and long term, both individually and collectively, to assure optimal oral health through prevention and treatment for underserved people.* This was also the question used for the 2009 Access to Dental Care Summit convened by the ADA.

The vision of the Alliance is a shared vision of optimal oral health for all. Its mission is to provide the platform for a diverse network of stakeholders to forge common ground in order to harness opportunities and create viable solutions for improved oral health through prevention and treatment for vulnerable populations across our country. The core principles of the Alliance include trust-building, shared leadership without expectation of ownership, and diverse and effective partnerships. Its values include integrity and transparency, respectful relationships, creativity and innovation, comprehensive approaches and forward-looking solutions. The

1 working norms of the Alliance are to honor differences of perspective, build an atmosphere of trust and  
2 openness, always strive for "common ground," encourage dialogue and active listening, consistently seek to  
3 clarify and understand other points of view, thoroughly explore an issue before assuming knowledge, and  
4 promote mutually reinforcing activities and collective impact.

5  
6 The participants agreed that in the traditional sense, the Alliance would not be a membership organization,  
7 nor would it focus on making decisions or creating policy. Rather, it should be an organization of "partners"  
8 who share a common vision, mission, and values, and who together convene and engage in multi-stakeholder  
9 discussions to envision and harness opportunities by continuing to find common ground for improving oral  
10 health. Toward this end, the Alliance would engage individual and organizational partners in a series of  
11 colloquia held in different regions of the country. Each colloquium would build on the approach, underlying  
12 principles, and groundwork begun at the original 2009 Access to Dental Care Summit in order to deepen and  
13 widen the discourse among diverse stakeholders about the challenges and opportunities for improving oral  
14 health.

15  
16 **Follow-Up to the 2010 Medicaid Provider Symposium:** CAPIR is in the process of officially creating a  
17 Medicaid Provider Advisory Committee (MPAC) to provide guidance and offer direction to the Council and the  
18 ADA on matters of provider participation in Medicaid. As of August 15, an informal group has met twice and  
19 provided input to Council on Government Affairs regarding the increasing Medicaid Integrity investigations of  
20 dental providers.

21  
22 **Medicaid/SCHIP Dental Association (MSDA):** This inaugural MSDA Oral Health Symposium marked the  
23 first time that MSDA has brought together a diverse group of oral health stakeholders, who are critical to  
24 supporting and strengthening the health and oral health care system for Medicaid and Children's Health  
25 Insurance Program (CHIP) beneficiaries. Its goal was to increase collaboration, cooperation and  
26 communication among these partners, including state and federal Medicaid/CHIP programs. The ADA had a  
27 strong presence at the Symposium, including two plenary speakers and a facilitator from the Association.  
28 The recommendation provided and the presentations shared during this symposium can be found at  
29 <http://www.medicaidental.org/events/2011Sessions.html>. The ADA is represented on the MSDA Best  
30 Practices and Data committees. MSDA has invited organized dentistry representation to broaden the  
31 perspective of these committees and align similar efforts in order to maximize resources and avoid  
32 redundancy.

33  
34 **HRSA/ADA Collaboration:** The continuing fiscal challenges within the federal government, as evidenced by  
35 the year-long continuing resolution freezing 2011 funding at 2010 levels and the prolonged debate over the  
36 federal debt ceiling, has hindered much progress on collaboration. Funds to support an interdisciplinary  
37 planning group to convene an implementation conference on national perinatal oral health best practices have  
38 been designated and the project is moving forward.

39  
40 **CDC-Sponsored State Dental Director Workshop:** Dr. William Calnon, ADA president-elect, presented the  
41 ADA perspective as part of a panel of speakers addressing health literacy in dentistry. Ms. Judy Sherman,  
42 CGA staff, provided an update on the ADA's advocacy efforts. The ADA, along with representatives of  
43 ASTDD, Pew, Children's Dental Health Project, and the DentaQuest Foundation, met with Dr. Tom Freiden,  
44 director of the CDC, to discuss areas for collaboration in the future.

45  
46 **Public Health Advisory Committee (PHAC):** A Dental Public Health Orientation module for the ADA Board  
47 of Trustees was developed by the PHAC and will serve as a valuable resource in educating all Council and  
48 Committee volunteers about dental public health and its integral relationship to the profession.

49  
50 **ASTDD State Oral Health Program Review:** CAPIR participated as part of an ASTDD team reviewing  
51 Alaska's state oral health program. Program reviews are designed to assist state health department oral  
52 health programs in assessing their current program goals, objectives and key program activities and building  
53 their capacity to promote and maintain oral health in the state.



**Barriers to Oral Health Care Series Paper II—The Tattered Safety Net:** The Division of Communications has completed the second in the “Barriers to Oral Health” series, entitled “The Tattered Safety Net.” This paper explores the diverse elements that compose the nation’s oral health safety net, describing their components and their functions, strengths and weaknesses, and the ways in which they can be improved. CAPIR played a key role in providing content expertise.

**CDC/ADA Collaboration on Emergency Department (ED) Use for Oral Health:** Work continues on several related projects including: literature review to identify potential surveillance measures for oral health that are based on ED data; review of national and state data sets assessing the impact of differences or changes in Medicaid adult dental benefits; preparation of a white paper reporting population-based rates of utilization, repeat visits, and expected source of payment utilizing [BioSense](#)/North Carolina data; and ADA paper reporting on national ED trends is under review for publication. On a related issue, there is interest in expressing support for CDC or other guidelines for prescribing opioid narcotics in EDs, especially with respect to dental pain.

**Organization for Safety and Asepsis Procedures:** In June, OSAP invited CAPIR to speak at its 2011 annual symposium on patient safety and quality of care with a focus on root cause analysis and finding solutions towards quality improvement. The presentation, entitled, *Headlines to Frontlines: Managing Risk* included information on breaches in infection control making current news headlines and reported violations in dental practices from the State of Maryland, a brief introduction to Root Cause Analysis, a process to identify the cause of problems, and resources and tools to address quality of care and patient safety.

**American Medical Association:** CAPIR volunteers and staff attended the annual and interim sessions of the American Medical Association. In June, Dr. David Whiston, ADA liaison to the AMA and staff were in attendance at the AMA House of Delegates. Three resolutions were debated on issues of particular interest to the dental profession: 1. Sweetened soft drinks (Resolution 417); 2. The safety of bottled water (Resolution 420); and, 3. The Council on Science and Public Health Report 5 on Bisphenol A.

Resolution 417 on sweetened soft drinks was referred with a report expected at the next meeting of the AMA House of Delegates. Testimony was presented regarding the complexity of taxing sweetened soft drinks including concerns with taxation having a defined outcome, use of tax revenues to be defined (for e.g., targeted at combating obesity), the issue of artificial sweeteners included in the resolution title, and the concern that sweetened beverages, such as *Pedialyte*, have therapeutic benefit. There is an opportunity for the ADA to discuss the caries issue that is not included in this resolution as it currently is written. CAPIR will work with the Divisions of Science and Government and Public Affairs to determine if any further discussion with the AMA is warranted. Resolution 420 on the safety of bottled water was referred on consent. According to the Reference Committee report, there was testimony in support of adoption of the resolution, especially the second resolve calling for a timely study of various public health concerns that have arisen regarding the drinking of bottled water. The Reference Committee felt an immediate call to action was not appropriate “considering the paucity of knowledge surrounding fluoridation levels in bottled water.” The Council on Science and Public Health will be preparing a report.

Regarding a report on Bisphenol A, the AMA House approved the report on consent. The report reviewed the exposure to, and regulation of, BPA. The report recommends the AMA recognize BPA as an endocrine disrupter demonstrating epigenetic influences. The focus of the AMA action is specific to only baby bottles, and infant feeding cups and the linings of infant formula cans, and encourages industry actions to stop producing BPA-containing baby bottles and infant feeding cups. The AMA acknowledges that a better understanding of the routes and extent of human exposure are needed. CAPIR will continue to monitor these issues.

**American Academy of Pediatrics (AAP):** CAPIR participates on the AAP Executive Committee of the Section on Pediatric Dentistry and Oral Health (SOPDOH), now known as the Section on Oral Health

(SOOH). In July 2011, AAP launched a risk assessment tool and tutorial on its web site: <http://www.aap.org/ORALHEALTH/RiskAssessmentTool.html>. The tool was developed for pediatricians to provide an oral health risk assessment during visits. The tool encourages establishment of a dental home by 12 months of age, and identifies infants who may need fluoride varnish or supplements.

**The Joint Commission:** Key issues of interest to the ADA in recent months include:

- *The Primary Medical Home:* TJC has developed standards for the primary medical home. According to TJC, a Primary Care Home is a model of care whereby services are provided to patients by a primary care practitioner or team that increases access to its services, tracks and coordinates a patient's care delivered by other practitioners and facilities, uses evidence based treatment protocols, and focuses more on patient and family education and self-management. The Primary Care Home option will help accredited organizations to increase patient satisfaction, improve patient outcomes and reduce the overall costs to the health care system. <sup>TJC website</sup>
- *Requirement for the flu vaccine:* TJC's position is to improve current immunization rates; however, a mandate for health care centers to require immunization is not evidence-based, may be overly burdensome and impacts legal and ethical issues.
- *Telemedicine:* The Centers for Medicare & Medicaid Services (CMS) recently released a new rule on telemedicine credentialing and privileging requirements effective on July 5, 2011. The new rule removes unnecessary burdens to allow the use of telemedicine for medically necessary interventions. CMS upholds the current TJC practice of allowing the hospital to utilize information provided by the distant-site hospital when credentialing and privileging practitioners. By increasing flexibility to hospitals and lessening the regulatory burden, it is expected this will have a positive impact on care for patients in rural areas.
- *Speak Up™ Videos:* TJC recently released several animated Speak Up™ videos that address how patients can advocate for their own health by "speaking up". The videos released to date provide information on how to prevent the spread of infection, how to prevent errors in one's care, how to take medication safely, and how to reduce the risk for falls. [Free downloadable copies](#) of the new Speak Up videos are available in both English and Spanish for use on closed circuit television and other uses. From TJC's on-line newsletter, "The entertaining 60-second videos are produced by The Joint Commission to encourage patients to speak up and be active participants in their health care. They are intended as public service announcements and are now airing on The Joint Commission's [YouTube channel](#), on The Joint Commission [website](#), and in other venues."

**International Conference on Indigenous Child Health:** CAPIR volunteers and staff attended this international meeting designed to focus on innovative clinical care models and community-based public health approaches for children and youth in Indigenous communities in the U.S., Canada and (to a much smaller extent) internationally. CAPIR was invited to host an educational session about "Early Childhood Caries among American Indian and Alaska Native Children: Results of a Consensus Conference."

**Indian Health Service Dental Updates Conference:** The Council was invited to participate in the annual Indian Health Service (IHS) Dental Updates Conference. Dr. Monica Hebl attended the July 18-21, in Albuquerque. This conference is the primary source of continuing dental education (CDE) for IHS/tribal dental personnel. In addition to clinical CDE, the meeting also included information about the IHS early childhood caries initiative, alternative medicine, and cultural issues.

**Institute for Healthcare Advancement Annual Health Literacy Course:** CAPIR was invited to give a poster presentation, "Use of Communication Techniques by Dentists in the United States: Results of a National Survey," during the IHA Health Literacy Conference., May 4-6, 2011 in Irvine, CA. This meeting brings together clinicians, educators, researchers, policymakers, and others who have developed best

practices to face the limited health literacy challenge. Participants discussed programs and solutions to improve health communication, review programs of critical importance to improving health literacy, and teach attendees skills to better serve the public.

**National Rural Health Association:** CAPIR gave a presentation, "National Plans to Improve Health Literacy," during the NRHA annual meeting, May 3-6, 2011 in Austin, TX. The session focused on the federal and ADA/CAPIR action plans to address health literacy. The NRHA Annual Rural Health Conference is the nation's largest rural health conference, created for those with an interest in rural health care, including rural health practitioners, hospital administrators, clinic directors and lay health workers, social workers, state and federal health employees, academics, community members and others.

**American Public Health Association:** The Council has been invited to organize and moderate a panel presentation, "Building Capacity for Statewide Initiatives to Improve Health Literacy," during the APHA annual meeting, October 29-November 2, 2011, in Washington, D.C. This session will include representatives from Missouri, Minnesota and Maryland and focus on the development, implementation and maintenance of statewide initiatives to improve health literacy, including conducting needs assessment, engaging stakeholders and developing resources.

**Geriatrics and Special Needs Populations:** In continuing the Council's efforts to implement Resolution 5H-2006 (*Trans* 206:617) the following actions have occurred:

1. **How-to Guide for the Use of Incurred Medical Expense (IME):** How-to information about using the IME mechanism was disseminated widely in September through various electronic messaging systems and posting on ADA.org. The suggested guidelines are targeted to dentists, state and county Medicaid caseworkers, and nursing home residents/their representatives. The IME mechanism allows nursing facility residents enrolled in Medicaid to pay for medically necessary dental care that is NOT covered by the state's adult Medicaid program using their SSI or other income.
2. **Overcoming Obstacles to Oral Health: A Training Program for Caregivers of People with Disabilities and Frail Elders 5th Edition** was made available through the ADA catalog in September 2011. The Pacific Center for Special Care at the University of the Pacific, Arthur A. Dugoni School of Dentistry, with input from national experts (including ADA's National Elder Care Advisory Committee), created a unique training program which provides resources and information for direct caregivers and the professionals training direct caregivers about oral health for people with disabilities and frail elders. The training program is designed to engage two different audiences - Direct Caregivers and facility administrators and/or trainers in long-term facilities. The direct caregiver training materials are designed to engage direct caregivers in maintaining oral health of people for whom they are caring. The materials were created to be understood by a caregiver with a 6th grade education or equivalent. The material for administrators and trainers provides suggestions for facility administrators, directors, supervisors and trainers about how to create and implement an oral health program in an organization. The program consists of two discs: a CD and DVD. Some unique characteristics of this training program are that it uses a combination of oral health prevention, dental information and behavioral approaches that benefit caregivers of both frail elders and people with disabilities.
3. **Proceedings from the National Coalition Consensus Conference: Oral Health Needs of Vulnerable Older Adults and Persons With Disabilities (NCCC):** Proceedings from this conference, including recommendations generated by attendees were widely disseminated during the last quarter of 2011 through various ADA electronic media and can be found on the ADA website. CAPIR continues to seek funding for publication of a Special Supplement of *JADA* containing the five papers prepared for the Conference as well as the summary of recommendations.

The Council has expressed concerns regarding the impact of budget reductions on the programs, activities of CAPIR, and has made several recommendations to the Board of Trustees for improving the process through greater engagement of Council leadership in the budget development process.

**The American Dental Association Dental Health Program for Children:** Resolution 4H-2010 (*Trans.*2010:552) calls for the appropriate ADA agency (CAPIR) to study the policy and report to the 2011 House of Delegates. The impetus for the policy, “American Dental Association Health Program for Children” (*Trans.*1966:179, 306; 1967:336; 2010:552), was to provide guidance to the federal government for the establishment of an organized dental health education, preventive dentistry and dental care program for all children, particularly the needy and underprivileged. The policy did serve its purpose as it led to the establishment of the federal Early Periodic Screening, Diagnosis and Treatment (EPSDT) program in 1967, which was designed to ensure that children enrolled in Medicaid receive comprehensive services. In light of that establishment as well as the current health care reform and Essential Oral Health Care Act, it appears the policy is no longer needed and the Council recommends the adoption of the following resolution.

**35. Resolved,** that the policy, “American Dental Association Dental Health Program for Children,” (*Trans.*1966:179, 306; 1967:336; 2010:552) be rescinded.

**BOARD VOTE: UNANIMOUS. (BOARD OF TRUSTEES CONSENT CALENDAR ACTION—NO BOARD DISCUSSION.)**

WORKSHEET ADDENDUM

COUNCIL ON ACCESS, PREVENTION AND INTERPROFESSIONAL RELATIONS

POLICY TO BE RESCINDED

**The American Dental Association Dental Health Program for Children (1966:179, 306; 1967:336; 2010:552)**

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**Objective:** The objective of the American Dental Association Dental Health Program for Children should be to make the benefits of an organized program of dental health education, preventive dentistry and dental care available to all children, particularly the needy and underprivileged.

This objective should be attained by the application of the following principles.

1. All dental services should be provided which are necessary to prevent disease and to restore and maintain oral health.
2. It is the duty of the dental profession, through dental associations, in consultation with the proper public health agency, to plan and evaluate dental programs which may be established.
3. There should be full cooperation between representative members of the dental profession and the private and public agencies at the local, state and national levels in the planning, operation and financing of such programs.
4. The scope of the local program should be determined at the community level and should be based on the general standards which have been established through the state and national programs.
5. The use of all preventive measures should be encouraged and an incentive program for the intensive promotion of the fluoridation of public water supplies should be established.
6. Increased support should be provided for research in all procedures and programs for improving the dental health of children.
7. All preschool and school children, through the age of 18 years, should be included in the program and existing resources should be made available on a priority basis to the younger age groups.
8. The initial program in each community should be expanded on a planned and systematic basis to include additional age groups of the school population as rapidly as experience and resources permit.
9. The dental health education components of all local, state and national programs should be expanded.
10. Every individual should be encouraged to develop increasing responsibility for his own dental health and parents should be motivated to full responsibility for the dental health of their children.
11. The services of private practitioners and of all existing resources and facilities should be utilized fully in the operation of the program.
12. The right of freedom of choice by both the patient and the practitioner should be preserved.
13. The highest quality of dental services should be available to all.
14. The opportunities for the basic and continued education of dentists and dental auxiliaries should be expanded as needed in order to ensure an adequate supply of qualified personnel for the program.
15. The use of voluntary prepayment and postpayment programs for the purchase of dental care for children should be expanded.
16. Priority consideration should be given to reimbursement for professional services on the "full fee" basis.
17. Fiscal responsibility for the dental care of nonindigent children and families must continue to lie with the individual, the family and private and voluntary agencies.
18. The terms indigent and dentally indigent, for the purposes of this program, should be defined by appropriate state agencies in accordance with existing state laws and regulations in full consultation with representatives of the dental profession.

### Dimensions of Problem

The present and potential size of a Dental Health Program for Children can be measured by the number of children and their dental needs. The present utilization of dentists' services is also an index of major unmet dental needs in the child population.

**Population:** The child population is expected to increase steadily despite recent decreases in the birth rate. Projections by the U.S. Bureau of the Census in 1966, indicate that the preschool population, now about 24.5 million, will increase by 1985 almost 50% or by 12 million children. The school-age population of 49.5 million (25% of the total population) will increase by the same date by almost 30%, or 13 million. The total number of children under age 19 will increase from 74 million to about 98 million by 1985.

In the total child population there are approximately 7 million children on public assistance. This subgroup will probably increase faster than the total child population because the birth rate is relatively higher in the indigent segment of the population. Implementation of existing legislation for indigent children by all of the states could increase the number of children receiving some form of public assistance health care to 15 million by 1970.

**Disease:** The prevalence of dental disease in children is nearly universal. By age two, 50% of children have decayed teeth. The average child on entering school has three decayed teeth. By age 15, the average child has 11 teeth decayed, missing or filled. The average Selective Service recruit has three missing and seven decayed teeth.

Selected surveys show the incidence of one new cavity per year in children aged 6 to 11 years, and one and one-half cavities per year in children aged 12 to 15 years. In fluoride areas, the incidence of caries declines by about 60%, a sizable reduction in the dental needs of a community.

Large-scale studies indicate that up to 50% of children would benefit from orthodontic treatment.

Gingivitis occurs in a major portion of the child population. This condition can lead to progressive periodontal disease, a major cause of the loss of teeth in adults. Cleft palate, with or without cleft lip, occurs about once in every 700 births.

**Utilization:** About one-half of all children in the United States under 15 have never been to a dentist. This percentage is higher for children in rural areas.

The utilization of dentists' services is related to family income, the educational level of the parents, the availability of dental service, the effectiveness of dental health education and the degree to which a dental program has been organized. Although family income may not be the principal reason that more children are not receiving dental care, 66% of the children in families with incomes under \$4,000 have never been to a dentist, compared to 40% in families with incomes of \$4,000 or more.

The utilization of dentists' services can be increased in organized programs by removing or reducing financial barriers as demonstrated by the experience of dental prepayment programs. In one program which used the recall system, utilization was increased to 70%. In other programs, an effective system of dental health education also increased utilization significantly.

### Manpower Resources

A Dental Health Program for Children should be geared realistically to existing dental manpower resources and planning should be initiated immediately to expand those resources in a measure commensurate with the anticipated growth of the program. In general, the manpower problem is accentuated by the distribution of dental personnel in certain areas and by the known shortage in rural areas.

The dentist population is not expected to increase in proportion to the projected increase in the child population and to the anticipated increase in demand under an organized program of dental health for children. Since 1930 the population per dentist has increased by 25% and this increase is expected to continue. This disparity between dental manpower and population will be a major factor in the development of a Dental Health Program for Children.

**Dental Practitioners:** In 1965, 88,500 dentists were actively engaged in private practice. Of these, 95% accept children in their practices. There are approximately 1,200 dentists who limit their practice to pedodontics and approximately 3,500 who limit their practice to orthodontics.

In a recent survey, 40.3% of dentists replying indicated they are so busy that they must either turn new patients away or work longer hours than desirable; 36.8% reported that they had enough patients. Only 22.9% stated that they could take more patients; this group consisted largely of recent graduates, older dentists and dentists in certain large cities with a low population per dentist.

This statement of dentists' patient load is based on the present utilization of dentists' services by less than half the population during the course of a year.

The existing workforce, then, should be amplified in both numbers and productivity if there is to be sufficient manpower to cope with the demands of a Dental Health Program for Children. This can be done by: (1) increasing the number of practicing dentists; (2) providing increased instruction for professional personnel in the dental care for children at the undergraduate, graduate and postgraduate level; (3) increasing the number of continuing education courses devoted to the care of children; (4) increasing the number of training programs for auxiliary personnel; and (5) expanding efforts to achieve more effective utilization of auxiliary personnel.

**Dental Administrators:** The Dental Health Program for Children will create a significant demand for trained dental administrators. There will be a need for personnel to organize and administer state, community and area-wide programs of education, prevention and care. While dentists and hygienists trained in public health are qualified to fill these positions, public health personnel already is in short supply and there is not enough staff to administer existing public health programs adequately.

It will be necessary, therefore, to recruit and train more personnel in dental public health to meet the expanded responsibilities placed on official health agencies by a Dental Health Program for Children. In addition, university-based training programs should be developed to prepare dental and related personnel for the organizational, supervisory and administrative responsibilities to be assumed by community and area program directors.

**Dental Auxiliaries:** In addition to the expansion of educational programs for both dental and auxiliary personnel, it is essential for dental societies to join with dental schools in assuming aggressive leadership in determining the nature and extent of additional functions which can be delegated to auxiliary personnel.

**Distribution of Personnel:** A realistic assessment of manpower resources demands consideration of the distribution of dental and auxiliary personnel. Immediate consideration should also be given to the distribution of dental personnel within the individual states.

### The Recommended Program

**Initial Stages:** While the establishment of a Dental Health Program for Children appears to be a shared objective of the public and of the dental profession, realism and prudence dictate that it be initiated on a carefully considered basis which would be useful in predicting its future operation and results. The mere provision of the massive funding necessary to establish the program is not sufficient to ensure its success nor would a vast initial expenditure be justified in terms of the nation's economy or the productive expenditure of tax funds without preliminary planning.

The complex problems of administration at local, state and national levels, the available supply of dental personnel and its distribution throughout the country, the provisions for adequate financing and the solution of many other problems involved in providing dental services on an unprecedented basis—all dictate a provisional approach to the total program.

It is recommended, therefore, that the program be initiated with a series of pilot or exploratory programs designed to provide the actuarial and operational experience necessary to expand the program successfully on a nationwide scale. Such programs, adapted to the needs of individual communities and designed to provide essential information, can be supported through Project Grants which are authorized under existing law. New legislation and support will undoubtedly be needed to assure the achievement of the total objective of the program.

The programs in this initial phase should be carefully designed to provide data which would fill the gaps in existing knowledge in such areas as: the cost and effectiveness of expanding treatment programs by the addition of age groups on a planned and progressive bases; the determination of the initial and maintenance costs of dental care for children under a variety of conditions; the variations in programs which might be required in fluoridated and nonfluoridated areas; the patterns of administration at local and state levels; the production of more dental personnel and the retraining of existing personnel to meet the needs of a children's program; the role of dental hygienists and dental assistants in staffing a dental health program for children; the reaction of individual dentists, dental societies and state boards of dental examiners to expanding the role of selected auxiliaries to enlarge the manpower resources; the practicality of applying the principles of dental prepayment to purchase dental care for children of indigent and nonindigent families; the coordination of the public and private segments of a community in a comprehensive dental care program for children.

While there should be no artificial limitation on the number of pilot or exploratory programs, it is recommended that at least 40 be developed in order to encompass the investigation of the problems which have been identified.

Some of the programs already in existence and those which could be developed in the near future should constitute the core of the needed exploratory program. Thus existing resources could be enlisted in designing the total program which might be envisioned at the end of a five-year period. After such initial programs are identified, there should be a critical analysis to determine whether all visible research needs are being satisfied. The programs should be evaluated periodically and the results made available to all interested in the development of a Dental Health Program for Children.

A program of dental health for children should be comprehensive so as to meet the total dental health needs of every child. The program should include, but not be limited to, the following elements.

**Preventive Program:** There are available preventive techniques of demonstrated effectiveness for the prevention of dental diseases. These should be employed in their full range, and all dentists should be made aware of the benefits to be realized from their application in communities and to the individual patient.

*Fluoridation of Communal Water Supplies.* Every program should have the benefit of fluoridation of the communal water supply to reduce dental caries by approximately 60%. When there is no communal water supply, the alternative uses of fluorides should be programmed. State action, when necessary, should be sought to require the fluoridation of all community water supplies. Federal and state support should be provided for all communities in the form of incentives to foster the fluoridation of the water supply. These incentives may take the form of a subsidy for the purchase of equipment and supplies and the employment of personnel for the fluoridation program.

*Topical Agents.* Where the fluoridation of communal water supplies is not feasible, provision should be made for the topical application of fluorides, or other anticariogenic agents, by dentists in private practice or on a public health basis.

*Dietary Fluoride Supplements.* Provision should be made, when necessary, for the use of dietary fluoride supplements either through public health programs or on the prescription of a physician or dentist.

*Anticariogenic Dentifrices.* The use of anticariogenic dentifrices on a public health or individual basis should be encouraged.

*Control of the Consumption of Sweets.* Educational campaigns should be conducted to reduce the frequency of consumption of sweets in the diets of all children. Special attention should be given to the elimination of the sale of sweets in schools.

*Toothbrushing Instruction.* Toothbrushing instruction and oral prophylaxis at regular intervals starting at three years of age, should be encouraged.

*Malocclusion.* Carious teeth should be restored to maintain normal occlusion; spaces resulting from the early loss of primary teeth should be maintained; and deleterious oral habits should be discouraged.



1 *Patient Education.* Provision should be made for a comprehensive and continuing program of patient  
2 education in all treatment programs.

3 **Treatment Services:** The program should provide all indicated treatment services which are necessary to  
4 restore and maintain the dental and total health of the child patient. All programs should be designed to  
5 include:

- 6 • Complete examination and diagnosis including radiographs.
- 7 • Elimination of pain and infection.
- 8 • Treatment of injuries.
- 9 • Elimination of diseases of bone and soft tissues.
- 10 • Treatment of anomalies.
- 11 • Restoration of carious or fractured teeth.
- 12 • Maintenance or recovery of space when this service will have an effect on occlusion.
- 13 • Replacement of missing permanent teeth.
- 14 • Treatment of malocclusions with priority provided for interceptive service and disfiguring or  
15 handicapping malocclusions.

16 **Dental Health Education:** This program should be designed to encourage the appreciation of dental health  
17 and the practice of proper oral hygiene. Dental health education for parents, children and personnel working  
18 with children should be an essential component of all programs.

19 **Research:** Research of all types, especially in the social sciences and in administration, should be supported  
20 in larger measure in order to improve the dental health of children.

21 **Evaluation of Program:** An integral part of all dental programs for children should be the establishment of  
22 procedures for the continuing evaluation of the results of the program in terms of the individual patient, the  
23 community, the state and the nation.

#### 24 **Administration**

25 The administration of a Dental Health Program for Children should be based on full cooperation among the  
26 dental profession, the public and private agencies.

27 Governmental health agencies have traditionally relied on advisory committees composed of  
28 nongovernmental experts and the lay public to assist in establishing policies and guidelines relating to the  
29 planning and operation of a publicly funded program. The use of advisory committees at national, state and  
30 local levels to assist governmental agencies in managing program responsibilities for a Dental Health  
31 Program for Children is essential.

32 The use of private agencies to share in the administration and operation of governmental health care  
33 programs has also had a history of success. In the administration of grants for dental treatment programs,  
34 provision should be made for the use of an intermediary, such as the dental service corporation or the  
35 commercial insurance company. Voluntary prepayment organizations are now acting as fiscal intermediaries  
36 for such long-standing programs as the Dependents' Medical Care and the Federal Employees' Health  
37 Benefits Programs. Congress has also recognized the desirability of continuing this system of sharing  
38 administration in the new Title XVIII of the Social Security Act. Guidelines for Title XIX of the same Act give  
39 assurance that this principle will be applied to the newly expanded program for public assistance recipients.  
40 The use of private, voluntary prepayment organizations in the administration and operation of the American  
41 Dental Association Dental Health Program for Children should be specified in the enabling legislation and in  
42 guidelines for the program.

43 **National Level:** At the national level, where ultimate responsibility and authority for the approval of publicly  
44 funded plans lie, the program should be administered by the Secretary of the Department of Health,  
45 Education and Welfare, through the Division of Dental Health of the Public Health Service. The Secretary and  
46 the Division of Dental Health should have advice and assistance from an interagency committee, including

representation from the Office of Education, all Department of Health, Education and Welfare agencies with dental programs, and from other agencies, such as the Department of Defense and the Office of Economic Opportunity, which have significant dental interests.

A national advisory committee should be established to assist the Secretary in the administration of publicly funded elements of the program. The committee should be composed of dentists and members of the lay public.

**State Level:** At the state level, responsibility for approving publicly funded programs developed at the local level and for their statewide administration should be vested in the state health department, through its division of dental health. Collaboration with the department of welfare, the department of education and other state agencies with dental interests should be sought as needed. Fiscal administration of the program should be assigned, by contract, to a private, voluntary prepayment organization.

There should be a state dental advisory committee, composed of representatives of the dental profession and the lay public, to assist state health department officials.

**Local Level:** At the local level, the public funded elements of the program should be administered by an agency recognized by the state health department.

There should be a local advisory dental committee, composed of representatives of the dental profession and the lay public, to assist the agency recognized by the state health department.

### Financing the Program

**Present Funding:** In the development of a Dental Health Program for Children, cost will be one of the significant factors. It has been increasingly apparent that the contribution of the private sector must be augmented by governmental assistance. The traditional method for sharing costs between federal and state governments is the grant-in-aid mechanism which has been in successful operation for many years. Limited funds are available at the present time to initiate the dental program, although it must be recognized that new legislation will be essential both to provide the additional funds needed for a total program and to provide one channel for funds which are now disbursed by many agencies of the federal government.

The Department of Health, Education and Welfare now channels funds for dental programs of some type through the following seven agencies: Children's Bureau, Welfare Administration; Bureau of Family Services, Welfare Administration; Division of Community Health Services, Bureau of State Services, Public Health Service; Division of Indian Health, Bureau of Medical Services, Public Health Service; Division of Dental Health, Bureau of State Services, Public Health Service; Division of Hospital and Medical Facilities, Bureau of Medical Services, Public Health Service and Division of Plans and Supplementary Centers, Office of Education. In addition, the independent Office of Economic Opportunity provides funds for dental programs through its Community Action Program which includes Project Head Start.

It should be clear that no federal funds are available for dental programs for the children of nonindigent or non-medically indigent families, except for certain dependents of federal employees. Funding of a dental health program for nonindigent children must be derived from the private sector of the economy—on a voluntary basis.

**Cost of the Program:** It is not possible to determine with precision the cost of a Dental Health Program for Children since so many variables and unknown factors are involved. If the 15 million children who will be eligible for dental care under existing legislation were to receive it, the national cost would be at least a half billion dollars for the first year. It is not likely, nor perhaps desirable, that funding of this order should be authorized for it would place an overwhelming burden upon existing dental manpower and facilities before pilot and exploratory programs had revealed more effective and economical methods for the expenditure of funds. At the outset, therefore, the estimated total cost of the program should be reduced to one that is more manageable within the nation's economy and to provide for the period of experimentation and development that will be necessary to ensure a productive expenditure of funds as the program matures.

**Pilot or Exploratory Programs:** Federal funds should be made available for the pilot or exploratory programs without matching by the states when this is indicated in order to secure essential information for the development of the program.

**Future Program:** For programs beyond the pilot or exploratory stage, provision should be made for federal grants on a matching basis. The matching should be designed to take into consideration the size of the problem in a given state, the economic status of the state and other variables which traditionally apply to matching programs. It is desirable that a uniform method of allocating grants be devised for the dental program to replace the heterogeneous methods which are now used by various agencies.

**Financing Dental Care for Indigent Children:** Project and formula grants are presently available to the states—and not fully utilized—for the provision of dental care for indigent and dentally indigent children. The extension of these grants to all of the states will provide interim funding until new legislation as previously recommended places the program on a permanent basis.

**Financing Dental Care for Nonindigent Children:** Federal financing for nonindigent children is not available under existing legislation. No legislation should be sought to provide federal funds for the dental care of nonindigent children.

Dental care should be extended to nonindigent children as a responsibility of the private and voluntary sectors of society. Coverage of dental prepayment plans should be extended to children and individual insurance coverage for children and families should be made available. Incentives, such as income tax credits, should be made available to parents to encourage the purchase of dental care for their children. Other incentive measures should be established to stimulate prepayment agencies to experiment in the development of new methods of providing coverage to children in segments of the population not presently eligible for existing plans.

### New Legislative Authority

New federal legislation will eventually be needed if there is to be an orderly development of a Dental Health Program for Children. Even though existing law provides a large measure of authority to finance dental care costs of several million indigent and dentally indigent children, the system for allocating these federal funds does not adequately assure that resulting programs will have professional guidance or standards to achieve the quality of care available from private dental practitioners today. Equally objectionable is the system's inflexibility. Title XIX of the Social Security Act, for example, is designed to provide comprehensive care to all needy and near needy persons. But there is no way under Title XIX for a state to concentrate its dental resources upon children; nor is there provision for designing an orderly plan that will permit the states to enlarge programs by age groups, an approach that is essential under existing limitations of both manpower and funds.

Legislation should be sought first to provide federal project grants for pilot programs in at least 40 communities throughout the country. After a sufficient time has elapsed to evaluate the pilot programs, a permanent legislative design should be fashioned to provide the states the opportunity to bring all children within the Dental Health Program for Children, with provision for appropriate cost sharing by federal, state and local governments and private and voluntary agencies.

### Conclusion

The American Dental Association, on the basis of its unique competence in the field of dentistry and under its obligation to foster the improvement of personal and national health, recommends a national dental health program for the children of the United States. Such a program has been the objective of the Association and of the dental profession for many years.

Strong national attitudes predict that such a program can now be initiated with new potential for adequate funding. Legislation is already in existence to provide much of the administration and support which will be needed to initiate the program. The program should be started by the selection of a number of communities which will establish pilot or exploratory programs to provide the professional, administrative, statistical and

1 other data which are needed to guide the national program in its future development. Funding will be largely  
2 on the traditional grant-in-aid basis and responsibility for the planning and operation of the program will rest  
3 heavily at state and local levels. The advice of the dental profession will be made continuously available  
4 through the establishment of advisory councils at all levels. The  
5 community should have the responsibility for the essential design of its program in order to meet local needs  
6 and conditions.

7 All dental services should be provided under the program which are necessary to prevent disease and to  
8 restore and maintain oral health. The program must ensure the provision of the highest quality of dental care  
9 and special emphasis must be placed on preventive services. All preschool and school children through the  
10 age of 18 should eventually be included in a national program. There should be a continuing, organized  
11 program of dental health and patient education.

12 Existing facilities and resources, especially those of private practice, should be fully utilized and plans  
13 should be developed to provide an adequate supply of well qualified dental personnel for the program.

14 State and local health departments should have a major role in the administration of the program.  
15 Administration at the national level should be coordinated through an interagency committee with  
16 representation from all federal agencies having a role in the dental program.

17 The translation of this program into reality in the predictable future will require a new awareness on the part  
18 of many agencies and individuals of the value of dental health services to the individual child, the community,  
19 state and nation. Dentists and dental societies must apply their professional knowledge and leadership  
20 effectively by cooperation with the administering agencies at all levels. Only a full partnership of the  
21 profession and those administering the program can convert the Dental Health Program for Children to a  
22 national asset that will bring returns for many years to come in terms of a healthier and stronger nation.

Resolution No. 36 New ☒ Substitute ☐ Amendment ☐Report: CDP Supplemental Report 2 Date Submitted: September 2011Submitted By: Council on Dental PracticeReference Committee: Dental Benefits, Practice and HealthTotal Net Financial Implication: None Net Dues Impact: \$Amount One-time \$ Amount On-going \$ADA Strategic Plan Goal: Members (Required)**COUNCIL ON DENTAL PRACTICE SUPPLEMENTAL REPORT 2 TO THE HOUSE OF DELEGATES:  
DEVELOPMENT OF A POLICY STATEMENT ON COMPARATIVE EFFECTIVENESS RESEARCH**

**Introduction:** In April 2010, the Board of Trustees directed the Council on Dental Practice to lead an interagency workgroup to direct ADA activities in the area of comparative effectiveness research.

**B-25-2010. Resolved,** that because of the complex and far-reaching goals established for comparative effectiveness research (CER), the Council on Dental Practice be the primary agency for an inter-Council committee to examine, evaluate and make recommendations to the appropriate ADA agencies on the Association's activities in this area.

**Background:** Dentists have used professional judgment to balance individual patient treatment decisions derived from published studies, evidence-based reviews, anecdotal case reporting by colleagues or personal experience. Occasionally, an available study may appear pertinent to a patient's treatment but the population studied may be different from the individual patient in important demographic areas. Epidemiologic studies have helped to understand population differences, but individual patients are not populations. Determination of an individual's outcome from a proposed treatment is at the core of CER, which is more precisely known as patient-centered outcomes research (PCOR).

The American Recovery and Reinvestment Act (ARRA) incorporated several provisions to expand the knowledge base of CER/PCOR because of its potential to inform practice, improve care and influence costs. As part of health care reform, CER/PCOR is overseen at a new agency, the Patient Centered Research Outcomes Institute (PCORI). PCORI's focus is on alternative ways to treat conditions, information gathering and dissemination. Its role in decision-making or best practices is uncertain at this time.

Many concerns related to CER/PCOR have been raised. These include the possibility that improvements in dental care through new or improved therapeutic devices, pharmaceuticals, or procedures may be limited; misuse of CER/PCOR findings may limit insurance coverage policy or coverage decisions; and/or use of CER/PCOR findings as a basis for determining a standard of care.

**Process:** The Council appointed five members to form a Subcommittee on Comparative Effectiveness Research (SCER): Dr. Steve O. Glenn, Dr. Jonathan B. Knapp, Dr. Kevin D. Sessa, Dr. Brendan P. Dowd and Dr. Jamie L. Sledd met March 1, 2011, to plan initial activities. Because the work of several ADA councils could be impacted by CER/PCOR, the SCER was expanded to include Dr. Herbert Ray, Council on Government Affairs (CGA), Dr. Mark Jurkovich, Council on Dental Benefit Programs (CDBP), Dr. Brian Scott, Council on Access, Prevention and Interprofessional Relations (CAPIR), Dr. John Burgess and Dr. G. Garo Chalian, Council on Scientific Affairs (CSA). These additional members assure broadly diversified viewpoints as the SCER's work progresses.

Prior to formation of the expanded SCER, CGA had communicated to CDP the urgency for developing basic ADA policy in this area. Policy was needed to help guide ADA responses to legislative activity concerning CER/PCOR. The SCER's first priority became development of Association policy in CER/PCOR.

The Subcommittee studied the definitions of CER developed by various government entities, policy of other associations regarding CER and background information available which included a preliminary report to the Council on CER from Dr. Albert Guay, ADA's chief policy advisor (see Appendix). Each Subcommittee member shared the concerns of their Councils. A smaller group volunteered to draft ADA policy, which was vetted through the entire Subcommittee and each of the involved Councils. The Council, therefore, recommends adoption of the following resolution.

#### Resolution

**36. Resolved**, that the Policy Statement on Comparative Effectiveness Research (Patient-Centered Outcomes Research) be adopted.

#### **POLICY STATEMENT ON COMPARATIVE EFFECTIVENESS RESEARCH (PATIENT-CENTERED OUTCOMES RESEARCH)**

The American Dental Association (ADA) has a long history of identifying and supporting scientific advances in dentistry. Through rigorous scientific enquiry and knowledge sharing, the ADA supports advancements in dental research that improve the health of all Americans.

As an organization with a strong belief in evidence-based dentistry and improving patient outcomes, the ADA supports comparative effectiveness research and patient-centered outcomes research (CER and PCOR) as methodologies that can lead to improved clinical outcomes, higher quality and increased patient satisfaction. Concurrently, such research should be designed to address important variables that may impact outcomes, such as patient subpopulations, to help address biological variability and individual patient needs.

Through the 2010 Patient Protection and Affordable Care Act, Congress has established an independent, non-profit organization to conduct this research. This organization, the Patient-Centered Outcomes Research Institute (PCORI), is in the process of obtaining public input and feedback prior to adoption of priorities, agendas, methodological standards, peer review processes or dissemination strategies.

Therefore, the ADA urges PCORI or other CER/PCOR entities to incorporate the following principles when evaluating diagnostic or treatment modalities pertaining to the provision of oral health care.

#### *1. CER/PCOR Must be Well Designed.*

Objective, independent researchers should conduct thorough, rigorous and scientifically valid research with specific outcome measures. Actual, potential and perceived conflicts of interest must be disclosed.

Protocols must be developed to ensure sound, reliable and reproducible research. Additionally, all efforts must be made to eliminate the introduction of bias into research protocols, literature reviews and clinical summaries.

Patient safety, confidentiality of personal health information and data security must be assured. Institutional review boards (IRBs) must be used to consider whether any risk to patients is balanced by potential research gains. It is essential to obtain informed consent from patients participating in CER and PCOR studies.

CER and PCOR must stratify studies to specific populations by race, gender, ethnicity, age, economic status, geography or any other relevant variable to assure the applicability of the study.

Long-term and short-term studies should be performed and adequately funded. Periodic reevaluation must be done to determine the efficacy of oral health related to CER/PCOR.

2. CER AND PCOR Process Must be Open and Transparent.

Setting research priorities, developing research techniques and selecting investigators must be accomplished using an open, transparent process. As the experts in oral health delivery, dentists and/or dental researchers must have central roles in these processes.

3. CER/PCOR Should Not Limit Innovative Treatments or Diagnostics.

CER/PCOR should not act to limit the continued development of innovative therapeutic or diagnostic modalities which may not initially produce marked clinical superiority but which demonstrate the potential for improved outcomes.

4. The Doctor/Patient Relationship Must be Maintained.

The unique dentist/patient relationship and patient autonomy are overriding principles that must be included when assessing CER/PCOR information. CER/PCOR should not be used to mandate or predetermine a course of treatment for an individual patient, nor should it be used to determine a standard of care.

5. CER/PCOR Should be Widely Disseminated.

Balanced, clear, accurate, effective and timely communication of results, written with the audience in mind, should be made. Study results should include any limitations of the study. PCORI or other CER/ PCOR research entities should work with the ADA to disseminate results to the profession.

6. CER/PCOR Should not be Payment Driven.

PCORI or other CER/PCOR entities should not make recommendations on payment or coverage decisions. The primary purpose and focus of research designed and/or supported by PCORI or other CER and PCOR entities should be the improvement of patient outcomes, quality of care and/or quality of life.

**BOARD RECOMMENDATION: Vote Yes.**

**BOARD VOTE: UNANIMOUS. (BOARD OF TRUSTEES CONSENT CALENDAR ACTION—NO BOARD DISCUSSION.)**

## Appendix

Council on Dental Practice  
October 2009

Comparative Effectiveness Research  
Emerging Issues

**REPORT OF THE CHIEF POLICY ADVISOR and the  
SENIOR VICE-PRESIDENT, DENTAL PRACTICE AND PROFESSIONAL AFFAIRS:  
COMPARATIVE EFFECTIVENESS RESEARCH**

**Background:** The American Recovery and Reinvestment Act of 2009 (ARRA), Public Law 111-5, established the Federal Coordinating Council for Comparative Effectiveness Research (the Council) and made \$ 1.1 billion available to the Department of Health and Human Services (HHS) for comparative effectiveness research (CER). That allocation was divided between three HHS agencies; \$300 million to the Agency for Healthcare Research and Quality (AHRQ), \$400 million to the National Institutes for Health (NIH) and \$400 million to the Office of the Secretary (OS) of HHS.

The Council is made up entirely of senior federal officials who have the responsibility for Federal health programs. Half of the members must be physicians or have experience and expertise in health-related research. Besides the Department of HHS, members come from the Department of Veterans' Affairs, Department of Defense, Office of Minority Health, Office on Disability, community health centers, mental health workers, workers in the fields of HIV and other infectious diseases, preventive health workers and others. The Council is charged with coordinating CER and related health services research across the Federal Government, advise the President and the Congress on addressing the infrastructure needs within the government for CER and Federal expenditures for CER.<sup>1</sup>

**What is Comparative Effectiveness Research?**

The Council established a definition of CER from several existing definitions:<sup>2</sup>

*"Comparative effectiveness research is the conduct and synthesis of research comparing the benefits and harms of different interventions and strategies to prevent, diagnose, treat and monitor health conditions in "real world" settings. The purpose of this research is to improve health outcomes by developing and disseminating evidence-based information to patients, clinicians, and other decision-makers, responding to their expressed needs, about which interventions are most effective for which patients under specific circumstances.*

- To provide this information, comparative effectiveness research must assess a comparative array of health-related outcomes for diverse patient populations and sub-groups.*
- Defined interventions compared may include medications, procedures, medical and assistive devices and technologies, diagnostic testing, behavioral change, and delivery system strategies.*
- This research necessitates the development, expansion, and use of a variety of data sources and methods to assess comparative effectiveness and actively disseminate the results."*

**The Rationale for Expanding Comparative Effectiveness Research**

Each day clinicians and patients must make important health care decisions, often without adequate information related specifically to them and their unique situation because of a lack or dearth of relevant information comparing the treatment options available to them. There is an amazing amount of information available because of the spectacular achievements in medical science, but sometimes it is unclear which treatment has the best outcome for specific types of patients, especially the elderly, racial and ethnic minorities and those with several complicating co-morbidities.

The purpose of CER is to provide information for clinicians and patients to use to choose the treatment options that fit the individual patient's condition, needs and preferences. It aims to provide better answers



than “we don’t really know” to questions aimed at determining which of several options available would be the best to select. We need information to deliver the right treatment to the right patient at the right time. In order to accomplish this goal, CER must be patient-centered, beyond being disease-centered.<sup>3</sup>

There is concern that past research in this area has not been conducted in a “real world” environment, considering average populations and not the significant differences that occur in patients seen every day. The findings do not take into consideration ethnic and racial minority groups, socio-economic and educational variations among individual patients, etc., rendering the information gathered of less value across the patient spectrum. CER should be expanded to address the needs of sub-groups of the population that have traditionally been underrepresented in medical research.<sup>4</sup> In the past, CER has been heavily focused on pharmacologic therapy rather than the complete array of treatment modalities.

#### **CER Differs From...**

**...efficacy research**, such as drug trials for the U.S. Food and Drug Administration (FDA) which are generally done to determine whether a new drug is efficacious under ideal circumstances compared to a placebo. CER takes into consideration the other-than-ideal circumstances encountered in daily practice and compares the new drug, device or procedure to the others that are currently be employed therapeutically, rather than to a placebo. The randomized controlled trials (RCT) that are the hallmark of efficacy research are insufficient for CER; comparisons other than to placebos must be made and the samples constructed must be representative of those patients commonly seen in daily practice.<sup>5</sup>

**...evidence based dentistry (EBD)**, since most EBD studies or systematic reviews are primarily efficacy studies, with the limitations listed above. Results may not be generalizable to all situations. These studies are usually disease-centered rather than patient-centered.

**...Pay-for-Performance (P4P)**, which is a financial or reputational incentive system designed to influence doctors’ behavior in prescribing treatment. Levels of performance are rewarded/penalized according to established quality measures and targets. It is not a comparative research activity.<sup>6</sup>

#### **Prioritization of Comparative Effectiveness Research**

With the great amount of CER that needs to be done, it became important that prioritization criteria be established to guide the effective use of resources allocated to this research.<sup>7</sup> The Council established Minimum Threshold Criteria, i.e., criteria that must be met before any proposal can be considered:

- Must be included within statutory limits of the ARRA and the Federal Coordinating Council definition of CER
- Must have the potential to inform decision-making by patients, clinicians and other stakeholders
- Must be responsive to the expressed needs of patients, clinicians and other stakeholders
- Must be a feasible research topic, including the time necessary to complete the research.

Prioritization criteria for scientifically meritorious research were also established:

- The potential impact of the project, based on: the prevalence of the condition, the burden of the disease, the variability of outcomes, costs, and the potential for increased patient benefit or decreased harm
- The potential to evaluate comparative effectiveness in diverse populations and patient sub-groups and engage communities in research
- The uncertainty within the clinical and public health communities regarding management decisions and variability in practice
- Whether it addresses a need or gap unlikely to be addressed by other organizations
- The potential for multiplicative effect, e.g. lays the foundation for future CER such as data infrastructure and methods development and training, or generates additional investment outside government.

Certain populations and sub-groups have been identified as being generally under-represented in medical research and designated as priorities for CER so that information gathered can be directly applied to them. Health disparities compared to the general population that exist and persist for these groups should be reduced. These groups include racial and ethnic minorities, the elderly, individuals with disabilities, people with mental illness, children, people of low socio-economic status, veterans and members of the military and individuals with multiple chronic conditions.<sup>8</sup> Generalizations that are drawn from CER that fail to consider population sub-groups and individual differences may have limited applicability.

With the advent and movement towards personalized medicine, CER has an important part to play in the design of individualized treatment, along with genomics and molecular medicine. Treatment can be designed to recognize and take into account individual patient variability.<sup>9</sup>

## National Priority Research Projects

In the ARRA, the Institute of Medicine (IOM) was asked to recommend national priorities for research questions to be addressed by CER.<sup>10</sup> An IOM committee solicited recommendations from stakeholders and the public and received input from direct mail, a public hearing and a web-based questionnaire and winnowed down the suggested 2600 potential topics to 100 priority projects that comprised a “balanced portfolio of research topics that, collectively, address broad societal needs.”<sup>11</sup> The list is divided into quartiles according to priority.

About half of the 100 recommended priority projects compare some aspect of the health care delivery system, as opposed to specific therapies.<sup>12</sup> The IOM reasoned that the early investment in CER should focus on the “how and where” services are provided, rather than which services are provided. One third of the remaining priorities address racial and ethnic disparities and one fifth deal with patients’ functional limitations and disabilities. Cardiovascular and peripheral vascular disease ranked second to the health care delivery system, followed by psychiatric disorders. Six recommended primary projects relate to cancer.

Two direct dental projects are identified in the initial 100 recommended priority projects.<sup>13</sup>

- In the first quartile, **Compare the effectiveness of the various delivery models (e.g., primary care, dental offices, schools, mobile vans) in preventing dental caries in children.**
- In the third quartile, **Compare the clinical and cost-effectiveness of surgical care and a medical model of prevention and care in managing periodontal disease to increase tooth longevity and reduce systemic secondary effects in other organ systems.**

In addition to those recommended dental topics, several others that do not mention dentistry directly will have a significant bearing on dental care delivery. Of the 29 research areas included in the priority list, oral health ranks 23<sup>rd</sup>.

## What Comparative Effectiveness Research is Not

Some concern has been voiced that CER will be used to determine standards of care, payment schedules, eligibility for benefits determinations and/or rationing of care. The ARRA clearly states in Section 804(g)(1&2), page 73;

*(1) COVERAGE-Nothing in this section shall be construed to permit the Council to mandate coverage, reimbursement, or other policies for any public or private payer.*

*(2) REPORTS AND RECOMMENDATIONS-None of the reports submitted under this section or recommendations made by the Council shall be construed as mandates or clinical guidelines for payment, coverage, or treatment.*<sup>14</sup>

The Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA) called government attention to the need to gather comparative effectiveness information, primarily concerning

1 pharmaceuticals, but also medical devices and health care and disseminate that information, with the  
2 goal of moderating costs. The Department of HHS was not allowed to use any effectiveness information  
3 in negotiating prices or benefit limitations.<sup>15</sup> Cost effectiveness was not considered in MMA analyses.

4 Although the government, under ARRA, is also precluded from issuing mandates or establishing clinical  
5 guidelines through the Council, non-governmental organizations (such as private payers) have no such  
6 prohibitions. A large majority of California-based health care organizations surveyed believe that cost  
7 effectiveness factors should be considered in determining insurance coverage decisions.<sup>16</sup>

## 8 **Effectiveness Review In Foreign Nations**

9 It is not uncommon in nations that have a national health care system to conduct effectiveness studies to  
10 be used to influence health care in their land.<sup>17</sup>

- 11 • Australia—A Pharmaceutical Benefits Advisory Committee (PBAC), after study of a drugs  
12 clinical and cost effectiveness, recommends to the Minister of Health whether a drug should be  
13 listed in the national formulary. The decision cannot be appealed and is made public without any  
14 rationale for the decision.
- 15 • Canada—Applications for review of new drug coverage are reviewed by the Common Drug  
16 Review (CDR), which is made up of an advisory committee of experts. The decision of the CDR  
17 is made public without either the data or the rationale for the decision.
- 18 • Germany—The Institute for Quality and Efficiency (IQWiG) is responsible for evaluating the use,  
19 quality and efficiency of drugs and services. It also evaluates guidelines for clinical practice. A  
20 Federal Institute for Drugs and Medical Devices (BfArM) authorizes pharmaceuticals and  
21 reimbursement for them.
- 22 • United Kingdom—The U.K. National Institute for Health and Clinical Excellence (NICE) reviews  
23 all types of medical technologies (including pharmaceuticals) that have a significant health or  
24 fiscal impact, or are controversial. NICE was established to: develop and disseminate best  
25 practices standards to reduce variations in practice across the UK; encourage the rapid spread  
26 of medical innovations; and, maximize the health benefits in the National Health Service for the  
27 money expended.<sup>18</sup>
- 28 • Denmark—The Danish Center for Evaluation and Health Technology Assessment (DACEHTA)  
29 makes prioritized resource allocation decisions "...in order to neutralize "expensive" healthcare  
30 technologies..."<sup>19</sup>
- 31 • France—The government controls the construction of hospitals and their budgets, the purchase  
32 of medical equipment, hospital rates and the price of drugs, and the number of pharmacies per  
33 capita in France. The French High Health Authority has been designed to stipulate the benefits  
34 for medicines and set reimbursement levels.

## 35 **Association Statements On Comparative Effectiveness Research**

36 The Council on Scientific Affairs (CSA) at its July 8-10, 2009 meeting adopted the following resolution:

37 **Resolved**, that the CSA supports the following related to comparative effectiveness research  
38 (CER) as defined by the Institute of Medicine generally, and specifically under the American  
39 Recovery and Reinvestment Act of 2009:

- 40 • CER that is intended to compare the clinical effectiveness, risks, and benefits of two or more  
41 health care approaches used to treat, diagnose, or prevent illness or injury in patients, *and* is  
42 designed to identify effective treatment alternatives in patient sub-populations to address patient  
43 variability and individual patient needs;
- 44 • CER that studies dental/oral conditions, diseases and therapies, and that meets the criteria  
45 above;
- 46 • Participation of organized dentistry in the scientific, clinical and policy aspects of CER and  
47 translation/application of the research results;

- Open access of all CER studies, reports and publications.

The Council on Dental Practice (CDP) comments that, “informing patients of treatment options is critical to practicing dentists and, when well done, CER could aid dentists with critical decision making.” The Council on Dental Benefit Programs (CDBP) postulates that “CER would potentially inform coverage decisions and performance measures.” The Council on Access, Prevention and Interprofessional Relations (CAPIR) admonishes that “Dental representation is needed to ensure the research agenda reflects the needs of the profession.”

### The Priority Dental Research Subjects

The highest priority direct dental project, namely, **Compare the effectiveness of the various delivery models (e.g., primary care, dental offices, schools, mobile vans) in preventing dental caries in children** is clearly a delivery system investigation. It is not a study of the relative effectiveness of the various methodologies for preventing dental caries in children, but rather where and/or by whom the therapy is administered. It is not known whether there are existing data available currently to answer that question. If there are, a systematic review could be done; if not, a prospective study would be needed. Such a prospective study would take many years to conduct.

The other priority direct dental project, i.e., **Compare the clinical and cost effectiveness of surgical care and a medical model of prevention and care in managing periodontal disease to increase tooth longevity and reduce systemic secondary effects in other organ systems** is both a study of clinical effectiveness and cost efficiency. It is not known whether there are existing data available currently to answer that question. If there are, a systematic review could be done; if not, a prospective study would be needed. Such a prospective study would take many years to conduct..

### Potential Implications for Dental Practice

**Effectiveness**—In its purest form, CER could provide clinicians credible, science-based information that could assist clinicians decide which interventions work best to treat specific individuals, or population sub-groups for a given medical or dental condition. Specific samples will have to be assembled to gather such information. Varying interventions by procedures used, medications prescribed, medical devices employed, diagnostic tests performed, behavioral changes recommended and the nature of the delivery system within which treatment was provided can be evaluated as to the outcome of care rendered. Variations that may be, at least, partially responsible for the health care disparities observed among different population groups, may become evident.

**Cost**—The consideration of the cost for care is included in several of the IOM priority projects listed,. Including the two direct dental projects. When cost comparisons become an integral part of the analysis of the effectiveness of various interventions, questions naturally arise concerning the true motivation for the comparison and how those comparisons will affect treatment decisions. The Federal Coordinating Council's Report to the President and the Congress remarks that in gathering data, “Several respondents expressed concern that CER could be used to restrict access to care, to deny coverage, or to reduce payments for interventions, thus undermining physician/patient decision-making and limiting patient access to treatment options.”<sup>20</sup> Reimbursement plans that restrict, reduce or deny payment for services provided on the basis of CER will have a major disruptive effect on several aspects of dental practice.

**Relative Value**—When both clinical and cost comparisons are incorporated into CER, there is an attempt to quantify relative value of interventions beyond the ability of the intervention to affect the condition being treated. The Federal Coordinating Council's Report states that, “CER can improve quality, safety and the value of care delivery while improving patient satisfaction.”<sup>21</sup> Those who propose that the relative value of various interventions should be assessed, “...because of escalating costs and limited funding, we need mechanisms to differentiate medical treatments with high value and those with little

1 incremental value. Without a method to objectively analyze the relative value of treatments, the costs of  
2 medical care will continue to rise to unaffordable levels.”<sup>22</sup> Some of the IOM priority projects clearly  
3 indicate that cost considerations are integral to CER, e.g., ***Compare the effectiveness (including***  
4 ***survival, hospitalization, quality of life and costs) of renal replacement therapies...***”

## 5 IOM Priorities

6 Direct Dental Projects—Only two projects directly mention dentistry. The project to study the prevention  
7 of dental caries in children addresses the issue of how and where caries preventive care is provided for  
8 children is unrelated to the actual care provided. It is a systems and cost study that does not consider  
9 the actual care provided. The project is to study the clinical and cost effectiveness of two models of  
10 periodontal care in increasing tooth longevity and reducing secondary systemic effects (unspecified). It is  
11 a clear example of the linkage of costs to effectiveness and illustrates the complexity of some of the  
12 proposed CER by linking these two disparate factors.

13 Non-direct Dental Projects—Several other projects address issues that are very relevant to dental care  
14 even though they address issues that are applicable to health care in general, e.g., managing chronic  
15 disease, care in rural settings, telemedicine, using the Internet, remote patient monitoring and several  
16 others. Some projects are aimed specifically at the health insurance industry, for example:

- 17 • **Compare the effectiveness of coordinated care (supported by reimbursement**
- 18 **innovations) and usual care in long-term and end-of life care of the elderly.**
- 19 • **Compare the effectiveness of different benefit design, utilization management, and**
- 20 **cost-sharing strategies in improving health care access and quality in patients with**
- 21 **chronic diseases (e.g., cancer, diabetes, heart disease).**

22 Several private sector entities have attempted to assess comparative effectiveness as part of their  
23 coverage decision making process. One of the pioneers in these efforts is the Technology Evaluation  
24 Center (TEC) established by the Blue Cross/ Blue Shield Association in 1985. Its technology  
25 assessments rely on comprehensive reviews of existing clinical evidence and focus on clinical  
26 effectiveness and appropriateness of a specific medical procedure, device or drug.<sup>23</sup>

## 27 Observations

28 The law and the accompanying IOM priorities listing describe an endeavor that is as much a  
29 sociological as a medical enterprise because of its concern with categories of minority groups that  
30 have traditionally been under-represented in medical research. “Generalized” research does not  
31 always answer effectiveness questions for special sub-groups within our population. Studies of the  
32 effectiveness of therapies specifically within population sub-groups will be a tool to gather information to  
33 reduce the disparities in health status between minorities and the general population.

34 The greater part of the CER priorities are in reality not traditional efficacy studies of therapies, but health  
35 systems research. It will need to employ different methodologies than those employed in the “medical  
36 science” community, combining sociology, human behavior, and health care systems with clinical science.  
37 Dr. Jack Wennberg, a pioneer in medical practice variations states, “The research to address  
38 unwarranted variation in the frequency of use of supply-sensitive care for the chronically ill must be  
39 radically different from research that is primarily focused on comparing alternative treatment options.”<sup>24</sup>  
40 Dr. Mark McClennan, former Director of the FDA and CMS Administrator, observes that, “Where we  
41 really need better evidence ...is on evaluating different styles of medical practice, not just head-to-head  
42 comparisons of particular treatments.”<sup>25</sup>

43 The Association does not have an agency that considers dental care systems. Questions in that area are  
44 dealt with by several agencies on an *ad hoc* basis. Consideration should be given to the establishment of  
45 a multi-agency group, housed in the appropriate agency, to consider dental care systems issues.

1 The issue of cost is an important component in much of the discussion about comparative effectiveness.  
2 Although not directly addressed, except for Federal programs as noted, it is hard to imagine that in other  
3 settings, cost will not be a factor in evaluating effectiveness. There are two schools of thought on that  
4 subject: CER should be concerned solely with therapeutic effectiveness with no relation to cost; and,  
5 relative cost speaks to efficiency as an integral part of effectiveness. Where can cost considerations lead  
6 us? What would payers, for example, do about a drug that is 20% less effective than an alternate drug but  
7 costs 50% less? That is the subjective unknown.

8 CER is only partially science based and includes various subjective components. Its conclusions will have  
9 broad effects on the practice of dentistry beyond clinical implications. Accordingly, the Association's  
10 response to this endeavor must also go beyond solely scientific considerations.

11 **Recommendation:** CDP will likely be assigned lead responsibility for CER.

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Resolution No. 41 New ☒ Substitute ☐ Amendment ☐Report: NA Date Submitted: September 2011Submitted By: Eighth Trustee DistrictReference Committee: Dental Benefits, Practice and HealthTotal Net Financial Implication: \$40,000 (41 and 41B) Net Dues Impact: \$0.37

Amount One-time \$ Amount On-going \$

ADA Strategic Plan Goal: Members (Required)**1 ADA SCIENTIFIC REVIEW OF ALTERNATIVE DENTAL WORKFORCE MODELS**

2 The following resolution was submitted by the Eighth Trustee District and transmitted on August 30, 2011 by  
3 Mr. Greg Johnson, executive director, Illinois State Dental Society.

4 **Background:** The American Dental Association and its member dentists have come under criticism by a  
5 number of foundations, including the Kellogg and Pew Foundations, and from within our profession by the  
6 American Association of Public Health Dentistry (AAPHD) regarding the nation's "access to care" problem for  
7 the underserved. The Kellogg and Pew Foundations and the AAPHD are advocating for changes to the  
8 dental care delivery model by inclusion of a dental mid-level therapist. These foundations have already  
9 targeted vulnerable states where they are beginning to institute these changes and are looking to pass  
10 legislation that will incorporate these changes into law.

11 The past two years, member dentists have provided testimony at the ADA House of Delegates Reference  
12 Committees that identify weaknesses in ADA policy. These weak points could be strengthened by allowing  
13 constituent dental societies the opportunity to better advocate against outside forces that are attempting to  
14 alter the political climate and modify laws governing the current dental model with the dentist as the head of  
15 the dental team, supported by dental hygienists and dental assistants.

16 During this time, we find that Canada is struggling with its alternative dental provider pathway due to funding  
17 constraints as its current central government is attempting to defer these programs to provincial responsibility.  
18 In addition, by report, the New Zealand dental therapist program is perceived to be fraught with problems and  
19 flaws. However, as a scientific organization, the ADA has not developed any report or study that would  
20 provide concrete scientific data that could be shared with the state constituent societies and their members.

21 On the surface, the Kellogg and Pew Reports contain citations, yet the ADA responses do not include  
22 citations and any ADA statements on mid-level providers appear to be based on opinion rather than scientific  
23 analysis and fact.

24 With the need to collate and analyze what facts are available, dentistry is at an important crossroads. We  
25 need to develop scientific criteria for analyzing the claims that have been put forth about these alternative  
26 provider models having improved the access to care problem, and determine whether these claims are also  
27 an extension of longstanding differences with outside groups regarding "scope of practice" issues. If we  
28 answer these questions, we as a profession will have done our due diligence using science to support our  
29 position of the dentist as the only individual who should be providing irreversible and/or surgical services for  
30 patient care.

**Resolution**

**41. Resolved**, that the American Dental Association, through its appropriate councils including the Council on Scientific Affairs and Council on Dental Practice, conduct a systematic scientific review of the available literature on alternative dental workforce models, which are in development or are already developed in this country and around the world and issue a report evaluating the information, and be it further

**Resolved**, that the information from this research be reported to the 2012 ADA House of Delegates.

**BOARD COMMENT:** The Board agrees that concrete and verifiable information on many aspects of new dental workforce models, both in the United States and in other countries, would be beneficial. The Board believes that a more focused review of non-dentists in countries similar to the United States, answering specific research questions as indicated by systematic review protocols would be the most appropriate manner in which to proceed.

The Board, therefore, recommends adoption of the following substitute resolution.

**41B. Resolved**, that the American Dental Association, through the appropriate ADA agencies, conduct a systematic scientific review of the literature (excluding other studies authorized by the House of Delegates) on workforce models where non-dentists diagnose patients, formulate treatment plans and or provide irreversible or surgical dental procedures, which are in development or are already developed in this country or similarly developed countries worldwide and issue a report evaluating the information, and be it further

**Resolved**, that the information from this research be reported to the 2012 ADA House of Delegates.

**BOARD RECOMMENDATION: Vote Yes on the Substitute.**

**BOARD VOTE: UNANIMOUS.**

Resolution No. 50 New ☒ Substitute ☐ Amendment ☐Report: NA Date Submitted: September 2011Submitted By: Fourteenth Trustee DistrictReference Committee: Dental Benefits, Practice and HealthTotal Net Financial Implication: None Net Dues Impact: \$Amount One-time \$ Amount On-going \$ADA Strategic Plan Goal: Public Health (Required)1 **DEVELOPING THE NATIVE AMERICAN DENTAL WORKFORCE**

2 The following resolution was submitted by the Fourteenth Trustee District and transmitted on September 15,  
3 2011, by Dr. Bryan J. Shanahan, president, Arizona Dental Association.

4 **Background:** The Native American Oral Health Care Project is a collaboration of four state dental  
5 associations (Arizona, New Mexico, North Dakota and South Dakota) made possible by the State Public  
6 Affairs (SPA) program. During the last two years, this project working with CAPIR, Native American  
7 consultants and talking directly with tribal leaders and policy-makers, has allowed the participants and the  
8 ADA to better understand the needs and desires of many in Native American communities. Consistent with  
9 SPA goals, ADA resources have aided with immediate local issues, but the goal is to better equip the  
10 Association and other constituent dental societies with resources to proactively address issues. An issue that  
11 was identified with national implications is the severe lack of Native American dentists practicing or entering  
12 the profession.

13 This is an urgent, but multi-faceted problem which will require the efforts of many, including tribal  
14 communities, educational institutions and organized dentistry. Currently many of these entities lack the  
15 resources or coordination to achieve their respective oral health goals, but the Association can utilize what it  
16 has learned to facilitate and harmonize the efforts and turn good dialog into action.

17 Model programs for integrating Native American students into the professions have been successful in  
18 engineering and medicine. Dental programs like the Jesuit Dental School Recruitment Collaborative  
19 (Creighton, Marquette, Gonzaga and the Robert Wood Johnson Foundation) have functioned successfully on  
20 a small scale. Taking the lessons of these successful efforts to the broader community will be a starting point  
21 for future efforts.

22 The *Pathways Into Health* website describes the organization as “ a grassroots collaboration of more than 150  
23 organizations (including the ADA) . . . dedicated to improving the health, health care, and health care  
24 education of American Indians and Alaska Natives in this country. [They] are combining the expertise,  
25 resources, and strength of Tribes and Native American Organizations, tribal colleges, prominent universities,  
26 the Indian Health Service and American Indian and Alaska Native Communities that work together to solve a  
27 major problem that exists today.” Their annual gathering presents an opportunity to get many stakeholders  
28 together in the same place.

29 **Resolution**

30 **50. Resolved**, that the participants of the Native American Oral Health Care Project, be urged, with the  
31 help of the Council on Access, Prevention and Interprofessional Relations, Council on Dental Education

and Licensure and the Department of State Government Affairs, to build upon existing educational programs, develop coalitions, and be it further

**Resolved**, that the American Dental Association, through the Native American Oral Health Care Project, convene a meeting of stakeholders during the spring 2012 *Pathways Into Health* annual conference to recruit participants in the coalition, and be it further

**Resolved**, that the coalition be asked to consider at least the following objectives:

- Inform and educate young Native American students about oral health care careers and encourage these students to consider careers in dentistry, dental hygiene, dental assisting, community dental health coordination or dental technology.
- Recruit, support and mentor Native American students to promote access to education, inspire academic excellence, encourage successful completion of necessary academic programs and ensure the attainment of necessary degrees.
- Train and develop a highly skilled and competent Native American oral health workforce.
- Develop partnerships to provide financial sustainability for ongoing workforce development activities.

and be it further

**Resolved**, that the Native American Oral Health Care Project be asked to prepare a report on its activities including an action plan with recommendations for consideration at the June 2012 meeting of the Board of Trustees.

**BOARD COMMENT:** The Board fully supports the aims of the resolution and believes that it can be achieved within existing resources.

**BOARD RECOMMENDATION: Vote Yes.**

**BOARD VOTE: UNANIMOUS.**

Resolution No. 51 New ☒ Substitute ☐ Amendment ☐  
Report: NA Date Submitted: September 2011  
Submitted By: Fourteenth Trustee District  
Reference Committee: Dental Benefits, Practice and Health  
Total Net Financial Implication: None Net Dues Impact: \$  
Amount One-time \$ Amount On-going \$  
ADA Strategic Plan Goal: Public Health (Required)

## POLICY ON NATIVE AMERICAN WORKFORCE

The following resolution was submitted by the Fourteenth Trustee District and transmitted on September 15, 2011, by Dr. Bryan J. Shanahan, president, Arizona Dental Association.

**Background:** American Indians are among the most underserved populations in the United States when it comes to oral health care. Geographic isolation, low population densities, high levels of unemployment and poverty make it difficult to create sustainable economies of scale for the provision of oral health services. This is complicated by the fact that the Indian Health Service (IHS) operates on a budget that is 25% of what is needed for the population it serves. The results are devastating: 1) Early Childhood Caries (ECC) is 400% higher among Native American children than the national average; 2) untreated periodontal disease is complicating the treatment of diabetes and heart disease, which are chronic among Native American adult populations; 3) one in four Native elders is without natural teeth; and 20% of those do not have dentures.

According to the Society of American Indian Dentists, there are approximately 400 dentists employed by IHS and 150 dentists employed by Tribal health programs. Unfortunately, of these 550 dentists, fewer than 80 are known to be American Indian, and only 170 Native American dentists are known to be practicing nationally. It can be further noted that if the dentist-to-patient ratio of the American Indian population were the same as that of the non-Indian population, there would have to be 3,200 Native American dentists. These statistics reveal the enormity of the education and workforce challenge facing Indian country.

Having dentists, hygienists, community dental health coordinators, assistants and administrative staff that are tribal members provides community leadership, improves the connection between dental clinics and the tribal communities they serve, and links appropriate services and delivery methods to identified community needs.

Native American leaders and communities are looking for solutions. The American Dental Association's ongoing efforts should be to assist them in addressing these needs and allow them to harness the resources of organized dentistry to improve their success. In doing so, we will not only be improving the oral health of a significant American population, but also making it less likely that they will be tempted by alternative providers and relegated to a lower tier of care.

## Resolution

**51. Resolved**, that the American Dental Association supports efforts by Native American communities to build capacity and improve the availability of community-based oral health services, and be it further

**Resolved**, that the ADA nationally advocate for a larger and more diverse Native American dental workforce by promoting awareness of Native American oral health issues, enlisting useful partnerships and being a resource to tribes and organizations that recruit, support and promote dental education for Native Americans, and be it further

1       **Resolved**, that Native American communities and populations be urged to build upon existing  
2       educational programs with local constituent and component dental societies to improve access to dental  
3       education resources for Native Americans in their areas and to improve cultural understanding and  
4       awareness of need.

5       **BOARD RECOMMENDATION: Vote Yes.**

6       **BOARD VOTE: UNANIMOUS.**

7  
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Resolution No. None New ☐ Substitute ☐ Amendment ☐Report: CAPIR Supplemental Report 3 Date Submitted: September 2011Submitted By: Council on Access, Prevention and Interprofessional RelationsReference Committee: Dental Benefits, Practice and HealthTotal Net Financial Implication: None Net Dues Impact: \$Amount One-time \$ Amount On-going \$ADA Strategic Plan Goal: Public Health (Required)

**COUNCIL ON ACCESS, PREVENTION AND INTERPROFESSIONAL RELATIONS**  
**SUPPLEMENTAL REPORT 3 TO THE HOUSE OF DELEGATES: UPDATE ON THE COMMUNITY**  
**DENTAL HEALTH COORDINATOR PILOT PROGRAM**

**Brief Summary:** This informational report provides an update on activities related to the Community Dental Health Coordinator (CDHC) Pilot Program since the transmittal of the Council on Access, Prevention and Interprofessional Relations' (CAPIR) Supplemental Report 4 to the 2010 House of Delegates (HOD). A chronology of the development of the CDHC project may be found in Appendix 1.

**2011 Update:** In December 2010, the Board of Trustees received a report from CAPIR on the CDHC Pilot Program highlighting some of the following key issues: the need to formalize a process for evaluating students who have academic performance issues; the re-examination of the admission criteria and the selection process for Cohort 3; the importance of program directors and Rio Salado College representatives to work collaboratively towards fostering the success of the training program and the status of the UCLA site.

In April 2011, the Board of Trustees received an updated report addressing the relocation of the American Indian site to Arizona School of Dentistry and Oral Health (ASDOH), the training of the last cohort of students and the restructure of the evaluation component of the program.

The latest report received by the Board in June 2011 described the training of the last cohort of students and the evaluation component of the program. Additionally, the report contained a financial update and a request for additional funding to support the project.

A significant amount of time was also devoted to the CDHC project by the Council at its January and June meetings. A transition plan at the conclusion of the pilot project was the topic of discussion at the most recent meeting.

**Current Status Report:** In light of the Council's continuing efforts to monitor, evaluate and improve the CDHC pilot project during the implementation phase, major issues are highlighted below.

The CDHC Workgroup continues to meet on a regular basis via conference call. The most recent call was held on June 15, 2011; the Workgroup also met face to face on June 23-24 during the Council meeting. The Education Subcommittee, Evaluation Subcommittee, Sustainability Subcommittee and Communication Subcommittee along with ADA staff continue to meet to support the Workgroup. A summary of major issues being address by these groups is provided below.

**Field Report:** The first cohort of students enrolled in the CDHC Pilot Program has completed the program: five students from the University of Oklahoma (OU) and five from the University of California at Los Angeles (UCLA); one student from each of these location did not complete the program due to personal reasons.

On October 23, 2010, ADA staff and Rio Salado College (RSC) staff took part in the program completion and recognition ceremony held at OU. A story describing the ceremony has been published in the *ADA News* see: <http://www.ada.org/news/5064.aspx>.

In March 2010, a new cohort of 18 students at these universities and also at Temple University in Philadelphia (six from each participating institution) began training as part of the second cohort of CDHC trainees. Of the initial 18 students who were selected for Cohort 2, eight students completed the didactic element of their training. The other students left the program for academic performance issues or personal reasons. The remaining eight trainees are currently in their internship and are involved in a series of activities as documented in Appendices 2 and 3).

On March 28-30, 2011, a kick off meeting for Cohort 3 trainees took place at Rio Salado College in Tempe, AZ (Appendix 4). At that time, a new group of 20 students (six from Temple, eight from the University of Oklahoma and six from ASDOH) began training as part of the last cohort in the CDHC Pilot Program. This event presented an opportunity to orient the new students to their online courses at Rio Salado College and receive laptops.

A panel discussion with CDHCs from Cohort 1 and Cohort 2 trainees present at the meeting allowed these to share their experiences as they work in their communities. A SWOT analysis (Strengths, Weaknesses, Opportunities and Threats) was conducted with these students and is appended to this report (Appendix 5). In addition, pilot program directors and clinic representatives in attendance discussed lessons learned during the previous two phases of the pilot program. This event was featured in the April 18, 2011, edition of the *ADA News* (see: <http://www.ada.org/news/5691.aspx>).

Following the kick off meeting, in order to enhance communication between Oklahoma-based community dental health coordinators, interns and trainees who are associated with the CDHC pilot training program, the Oklahoma site directors and staff developed an informative electronic newsletter (Appendix 6).

**American Indian Pilot Site:** At its December 2010 meeting, the Board of Trustees decided to end the relationship with UCLA as a part of the CDHC Program by adopting the following resolution.

**B-226-2010. Resolved,** that efforts be made for UCLA and the ADA to mutually agree that UCLA will no longer participate as a pilot site for training Community Dental Health Coordinator (CDHC) Program participants, and be it further

**Resolved,** that if such agreement cannot be achieved, that the decision be made unilaterally by the ADA that UCLA no longer serve as a pilot program training site for the CDHC Program and that a termination letter be executed to this effect, and be it further

**Resolved,** that the CDHC Program be consolidated so that the University of Oklahoma and Temple University serve as the primary training institutions for the third cohort of students, with the University of Oklahoma assuming responsibility for training both rural and Native American participants.

In early 2011, with the agreement of the Board of Trustees, UCLA and ADA mutually agreed to end UCLA's participation in the CDHC pilot program. Due to the fact the University of Oklahoma was not able to expand their program, and, in light of a need maintain a focus on American Indian populations, the ADA began discussions with A.T. Still University's Arizona School of Dentistry and Oral Health (ASDOH) to investigate the possibility of starting a CDHC training program in Mesa, AZ. ASDOH expressed enthusiasm for this opportunity. Those discussions highlighted the institution's numerous ties to the American Indian community which would make it uniquely appropriate for the CDHC students. More specifically, the school has the nation's largest contingent of tribally enrolled American Indian dental students and boasts a 100% graduation rate for those students. Also, according to ASDOH's dean, ASDOH's American Indian graduates practice in



American Indian communities. An additional positive factor is that Dr. George Blue Spruce, the nation's first American Indian dentist and a former U.S. assistant surgeon general, is ASDOH's assistant dean for Indian Affairs. These conversations were later followed by an in-person meeting in Arizona to further discuss the CDHC project. As a result, ADA, ASDOH and Rio Salado staff drafted a plan to ensure the success of ASDOH as a training site. Rio Salado College offered to provide administrative support to ASDOH and this offer was well received by ASDOH and the CDHC Workgroup.

Soon thereafter, these discussions were formalized via an executed contract making ASDOH the new pilot training program for the American Indian site. A joint ASDOH-ADA statement announcing this new partnership was released in March 2011. Please see: <http://www.ada.org/5580.aspx>

**Education:** The Education Committee continues to meet regularly to evaluate the courses already completed by the students and, as a group, come to consensus on necessary curriculum changes. Reviewing and revising the community health worker component of the curriculum is the Committee's highest priority. On February 3-4, 2011, a subcommittee of the Education Committee met with Rio Salado College staff and Mr. Donald Proulx, associate director, University of Arizona Area Health Education Center (AHEC) and an expert in Community Health Worker training. Recognizing that the Rio Salado College's course offerings for community health workers, as offered to Cohort 2 CDHC students, did not best fulfill the needs of the pilot program, the subcommittee worked to create three new customized courses, i.e., Dental Advocacy and Outreach, Oral Health Communication, and Dental Health Legal and Ethical Issues, tailored specifically to the CDHC program. The subcommittee met again in Tempe, AZ, during the Third Cohort Kick-off Session, March 29-30, 2011, to further develop the three new courses. Consulting agreements were entered into between the ADA and Ms. Marsha Beatty, Oklahoma CDHC pilot program co-director and Ms. Sydney Sevier, Oklahoma CDHC pilot program assistant to complete the technical revisions to the new course content.

The subcommittee has cross-referenced the new courses with the ADA's original CDHC competencies (formerly known as Modules 1-6), to ensure that all foundation knowledge and skills areas are included. A timetable for developing the lessons and learning activities to complement each new course has also been established. The new courses will be ready for the third cohort of CDHC students in September 2011.

Additional responsibilities for the Education Committee will include evaluation of content and student performance as Cohort 3 students complete the curriculum. The Education Committee also will consider and recommend integrated sequencing of the dental and community health worker courses for future implementation by educational institutions.

**Evaluation:** As described in previous reports to the HOD, evaluating the CDHC program has been an iterative process. The Evaluation Committee and project staff continue to work on designing and implementing a comprehensive evaluation of the CDHC project (see Appendix 7). Early in 2011, a written evaluation plan was developed that describes the evaluation, identifies resources, indicators and a timeline for the work. The evaluation of the CDHC project will have two components. The first is a structure and process evaluation and the second is an evaluation of access to care and patient outcomes that result from the CDHC working in a clinic.

The structure and process evaluation will examine the success of the following CDHC training components: 1) Recruitment; 2) Curriculum, didactic and clinical; 3) Employment; 4) Internships; and 5) Clinic management of the new CDHC. Data collection will be both qualitative and quantitative. Qualitative data will consist of interviews with staff and students including clinical evaluations and exit interviews. Quantitative data will include, but not be limited to: calculation of the rate of program attrition, time spent accessing the Rio Salado online system and test scores. The structure and process evaluation will cover all three CDHC cohorts. The objective of the structure and process evaluation is to improve the CDHC program and provide a comprehensive curriculum for CDHC training. The work involved in implementing the structure and process evaluation will be coordinated jointly by the CDHC Evaluation and Education Committees and will begin in the fourth quarter of 2011 (see Appendix 8).

1 The goal of the CDHC patient access and outcome evaluation is to assess the impact of the CDHC on patient  
2 access to dental care and health outcomes. The objective is to learn how to best deploy CDHCs to improve  
3 patient access across a range of community settings and access to care barriers. The design of the  
4 evaluation is clinic driven and uses patient access or outcomes goals that have been targeted by the clinic  
5 leadership for intervention by the CDHC. The basic evaluation scenario assumes a clinic will identify a patient  
6 access barrier or problem that can be addressed by utilization of the CDHC taking into account available time  
7 and scope of practice as dictated by each state dental practice act. The clinic will implement this scenario with  
8 a goal setting process that includes clinic priorities and the core competencies of the CDHC. The clinic will  
9 define metrics to analyze the improvement in access during the time period when the CDHC is working  
10 compared to the prior time period. The goals selected will need to be realistic and feasible to implement.

11 Essentially, the evaluation will be based on a compilation of case studies that reflect the impact of the specific  
12 intervention without a control group experimental design. Across the set of case studies a picture of how to  
13 best use the CDHC to address those patient access and outcome challenges typically encountered by clinics  
14 will emerge (see Appendix 9).

15 The patient access and outcome evaluation will accomplish two things: 1) evaluate the success or failure of  
16 CDHCs in helping clinics improve patient access and outcomes; and 2) provide examples of how the CDHC  
17 can be deployed in the workforce to improve patient access and outcomes across a wide range of problems  
18 and conditions. It is anticipated that this information will prove very useful to other clinics that are considering  
19 the addition of a CDHC to the dental team.

20 The data collection requirements for the project call for patient encounter data to be collected from each clinic  
21 to analyze the results for each patient access goal chosen by the clinic for the case study. The data will be  
22 collected from the clinic patient management system or collected from dental records manually including  
23 forms developed specific to the pilot program. Currently several patient management systems are in use at  
24 the participating clinics: Dentrix Enterprise, Eaglesoft, and E-Clinical. Data captured for the evaluation  
25 project will be stored in a secure relational database being developed by the Department of Information  
26 Technology and CDHC project staff at the ADA. The new database will be called the CDHC National Data  
27 Repository. All data for the project to perform the analysis of CDHC clinic case study results will be filed in  
28 this database. Appendix 10 provides a diagram of the process for data collection.

29 Stored data will be fully encrypted and sent via secure connections to the ADA. In addition, access to the  
30 system will be restricted to limited staff with security passwords. To facilitate the development of the  
31 computer methods that will be used to collect the clinic data, a test version of the Dentrix Enterprise software  
32 has been sent to the ADA for staff to begin developing the model and common metrics. In addition, data  
33 collection forms or surveys are currently under development to obtain baseline data about the operation of  
34 each clinic and information about the community where the clinic is located. The data collected will be used  
35 to understand and interpret the results of clinic case studies as part of the evaluation research. As ADA staff  
36 will be accessing patient data, a security and privacy program was put in place.

37 At this time, four clinics have been identified to work with the ADA on the process and outcomes evaluation.  
38 Three of the four clinics are located in Oklahoma; one is in Wisconsin. The CDHCs involved are all Cohort 1  
39 graduates from the Universities of Oklahoma and California, respectively. Additional clinics will be added  
40 from those staffed by Cohort 2 CDHCs in the months ahead. The four clinics participating in the first phase of  
41 the evaluation have been contacted by ADA project staff to discuss potential patient access goals to  
42 implement during the study period (see Appendix 11).

43 The metrics developed will provide a case study specific to each clinic that will investigate the success or  
44 failure of the clinic in achieving their respective goals. During the course of participating in the case study,  
45 CDHC project staff may offer assistance to the clinic to include, but not be limited to: 1) drafting data  
46 collection forms and rules; 2) exporting data from clinic computer systems; and 3) providing data collection  
47 training or advice. The case study report will follow a prescribed outline.

The clinics will be given the opportunity to review and participate in the interpretation of case study results, as is appropriate. Each clinic will also receive a final report with recommendations for their use in evaluating their own progress, and, for use in future patient access improvement activities. A second case study report will be prepared which will present the aggregate case study results with summary analysis. Individual clinics will not be identified in this report which will be disseminated to ADA senior management, the members of CAPIR and other internal and external stakeholders.

The CDHC Evaluation Committee has oversight for the automation of the CDHC workflow in practice management software. Henry Schein has offered to automate the CDHC workflow using its Dentrax Enterprise software system. Staff from the evaluation project negotiated with the Dentrax Enterprise development group to perform the work. However, before the Dentrax development group will begin the work they need to be provided with a detailed specification for the new module. Staff working on the CDHC evaluation began working with the ADA's Information Technology staff to create the necessary specification during July. After the specification is completed, a formal agreement can be entered into with the Dentrax development group for the programming of the new CDHC workflow module. Once completed, the module would be added to the Dentrax Enterprise system at CDHC clinics that use the software.

The CDHC Evaluation Committee remains an invaluable source of guidance for this project. The Committee continues to meet monthly via conference calls to discuss the status of the project and any key issues. ADA staff also provide bi-weekly update reports. A representative from the A.T. Still School of Dentistry will be appointed to join the Committee.

**Sustainability:** The Sustainability Committee continues to meet and discuss key concerns regarding the future of the CDHC program as follows:

- The Department of State Government Affairs staff continues to monitor state Medicaid practice regulations, which may require revision to allow appropriate procedures to be done by CDHCs in public health settings with indirect supervision. Reimbursement remains a key concern with procedures that can be provided by the CDHC. Recently, New Mexico passed a new law that authorizes the state dental board to certify CDHCs to provide educational, preventive and limited palliative care and assessment services. CDHCs will work under the general supervision of a licensed dentist in settings outside of traditional dental office and dental clinics.
- In Oklahoma and Pennsylvania, there continue to be challenges by organized dental hygiene groups to the CDHC training program. Efforts to collaborate and develop partnerships with other interested stakeholders should be pursued before proposals are brought before legislative bodies.
- CAPIR staff and volunteers have been discussing with the Council on Dental Benefit Programs' Subcommittee on the Code a consideration to add a code for case management. This would emphasize the importance of patient navigation as a principal duty of the CDHC. This code would be beneficial to *promotoras* and community health workers already working in the community. There is no guarantee that such a code would be recognized as reimbursable; however, establishment of such a code is a first step.
- Outside of the equipment and software support of Henry Schein, ADA's corporate area continues to pursue additional funding in support of the CDHC Program. The Committee recommends that individual states should continue to seek corporate funding to support the implementation of the Program in their respective areas.
- There was a possibility of pursuing one or more of the demonstration projects for alternative workforce models authorized within HRSA under the healthcare reform legislation, but these projects have not been appropriated at this time. The ADA chose to advocate against this particular appropriation

1 due to the possibility of it supporting a mid-level provider demonstration project. Funding has and will  
2 continue to follow ADA policy.

3 ADA staff continues to develop the pro forma model to provide a cost-benefit analysis for the training of the  
4 CDHC and deployment into the dental workforce. Cohort 1 data, analyzed as part of the overall CDHC  
5 evaluation, will provide essential information regarding the use of the CDHC in a dental practice. The model  
6 will analyze the cost of education versus the projected revenue based on claims data for allowable  
7 procedures the CDHC has done.

8  
9 For the cost analysis, data will include, but is not limited to, the cost of the CDHC training (tuition, equipment  
10 and travel expenses), the opportunity cost (i.e., lost earnings during training if applicable, the operational  
11 costs for facilities [i.e., overhead] and the practice model [number of dentists and allied professionals]). To  
12 project revenue, assumptions will be made as to the number of hours the CDHC is in the office versus in the  
13 field on a weekly basis. The types of procedures the CDHC performs (workflow) and frequency of services  
14 will also be projected.

15  
16 As there are several practice models under evaluation in geographically diverse areas, the pro forma model  
17 must address confounding variables such as payer mix, access to care barriers, wage rates and disease  
18 burden. Key to understanding the pro forma is the inherent value of CDHCs as a community health worker  
19 with dental knowledge. This individual contributes to programmatic success (efficiency, effectiveness and  
20 productivity); however, these services are generally not directly billable. This value-added component will be  
21 captured via proxy metrics as it is considered a strong determinant in demonstrating the successful viability of  
22 oral health programs utilizing CDHCs.

23 In developing the pro forma, volunteers and staff on the Sustainability Committee are aware of concerns  
24 about the efficient use of existing highly trained dental team members being trained as CDHCs, such as  
25 expanded function dental assistants and dental hygienists. Though cross-training is encouraged, the  
26 question is whether it is cost-effective and efficient to have these procedure-based team members providing  
27 prevention information and patient navigation resources in the community. Is the model more appropriately  
28 designed to primarily train high school graduates or dental assistants as CDHCs? Where does teledentistry  
29 fit into the equation?

30 The pro forma is expected to be completed in late October 2011.

31 **Financial Update:** Based on a projected cost of \$8.5 million dollars, the House of Delegates authorized a  
32 total of \$7 million dollars for the CDHC Pilot Program. As of June 30, 2011, the project has incurred  
33 expenses totaling \$4,541,078. The 2011 expenses reported on the dashboard include pending and paid  
34 expenses not yet posted. The remaining funds include \$100,000 in funding obtained through a grant from the  
35 American Dental Association Foundation in 2011.

36 To date, the Board of Trustees has appropriated \$5,365,092 from the Reserve Fund for the project, with a  
37 balance of \$1,634,908 authorized by the House of Delegates to fund the program. In June 2011, to ensure  
38 continued financial viability of the pilot program, CAPIR requested the Board of Trustees to appropriate  
39 additional funds of \$1,000,000 for 2011 from reserves for the CDHC program. The total funds appropriated  
40 reported above includes this \$1,000,000 that was approved by the Board. A request for 2012 funds will be  
41 made in December 2011 based upon actual expenses.

42 Expenses to date for 2011 include Cohort 3 payments (Temple, Oklahoma and Arizona); payments to Rio  
43 Salado College; and the final payment to UCLA. Projected total program costs are approximately  
44 \$6,446,782. Approximately \$865,000 of expenses have been off-set by a donation from Henry Schein to pay  
45 for equipment for some of the students. The program will require additional funds to be allocated in 2012 for  
46 completion of the final phase of the program.

Appendix 12 provides a detailed summary and a dashboard of the current financial status. Total expense summaries are graphed according to the specific ADA accounts used by the Accounting Department to track expenses for the program. Pilot site summaries reflect expenses paid directly to the pilot sites and do not include ADA administrative support expenses. The 2011 projections have been adjusted to reflect actual incurred expenses in 2010 and expected expenses for 2011-13 based on the timing of the respective cohort training sessions beginning with didactic studies and followed by the internship.

**Communication:** The Communication Committee has been meeting monthly in order to address continuing communications needs as well as to anticipate and input to the communications impact of the evolution of the program. Significant time has been devoted to the sensitive communications issues and needs surrounding the transition from UCLA to ASDOH. Specific communication was successfully developed and distributed. All CDHC ambassador materials have been updated; however the use of ambassadors as presenters to meetings and caucuses has not been pursued further at this time. The Committee continues to keep all website material current as well. Of significance is the initiation of the development of a position paper on the CDHC resulting from Council action.

**CDHC Post Pilot Transition Planning:** A transition plan at the conclusion of the pilot project was the topic of discussion at the June CAPIR Council meeting. In September 2012, the final cohort of CDHCs will have completed their training and in 2013 the formal evaluation of the pilot program is expected to be completed. Assuming that the pilot will demonstrate success, a process for educating and training vibrant new members of the dental team will be ready for nationwide implementation on a state by state basis.

A few considerations which need to be addressed are the transition process from a pilot program to adopting the CDHC training by various institutions and how to best assist states that desire to include CDHCs as part of their dental team workforce in order to establish organizational infrastructure at the state level to implement CDHC training programs.

For the pilot program there have been three core partners: 1) the ADA as funder, provider of the curriculum, and evaluator; 2) dental schools; and 3) an on-line curriculum provider. During the pilot phase of the program there were no tuition costs for students who enrolled in the program, dollars were provided to the training institutions to implement the pilot, equipment was provided at no cost to clinical sites engaged in the program, and funds were provided to supplant the salaries of students enrolled in the program. Furthermore the ADA did not have direct relationships with the clinical sites where the students were being trained. Recruiting students into the program was the responsibility of the University pilot programs.

Establishing CDHC training programs at the state level will require a significant commitment of time and resources by both the ADA and the local stakeholders.

**The Role of Constituent Societies:** In the spring of 2011, New Mexico became the first state to formally authorize the Community Dental Health Coordinator through its dental practice act. The revision of the dental practice act authorizes the state dental board to certify CDHCs to provide educational, preventive and limited palliative care and assessment services. Based on the ADA model, CDHCs will work under the general supervision of a licensed dentist in settings outside of traditional dental offices and dental clinics.

Each constituent dental society faces unique political circumstances. Some may wish to follow in the footsteps of New Mexico; others may be reluctant to pursue changes to the state's dental practice act and/or rules and to recognize this new member of the dental team. For that reason, it seems prudent that the CDHC curriculum be licensed at first to institutions in those states whose dental societies support the expansion of the dental team to include CDHCs. Support from the constituent society is also important because the society will likely need to take an active role, in partnership with the institution requesting a license, to obtain any regulatory or legislative approval needed to launch the CDHC in that state.

**Licensing the Curriculum:** One of the first steps that will be required will be licensing the curriculum to institutions of higher education that sponsor dental, allied dental or advanced dental education programs accredited by the Commission on Dental Accreditation in states in which the constituent dental society supports the recognition of CDHCs.

**Ownership of CDHC Curriculum:** At the completion of the pilot program, it is anticipated that the ADA will own or otherwise have the right to the entire CDHC curriculum. As a result, the Association will be free to license the curriculum to any entity and on any terms it sees fit. Currently, the Division of Legal Affairs has a template license available to state societies who would like to initiate CDHC training programs before the pilot project has been completed.

**Cost of Licenses:** It is important to the success of the CDHC concept that as many institutions as possible become licensees and institute CDHC programs. For that reason it would seem important that a nominal licensing fee be applied. The cost should be sufficient to recoup expenses associated with the transfer of the curriculum to the school.

**Potential Licensees:** At this point in time potential licensees fall into several categories: existing licensees, high priority opportunities and other schools:

- *Existing Licensees.* At present, the following schools have licenses to use the CDHC curriculum as part of the CDHC pilot program: University of Oklahoma College of Dentistry, Temple University Kornberg School of Dentistry, A.T. Still University's Arizona School of Dental and Oral Health, with Rio Salado College as the on-line provider of the training. It is important that these schools be permitted to build on the work done by them to date and continue operating CDHC programs without interruption. Not only will this take advantage of the existing momentum within these particular institutions, it will also provide an existing base from which to expand the CDHC concept to other schools.
- *High Priority Opportunities.* Tribal colleges present a unique opportunity to overcome barriers to access to care and to continue to demonstrate the value of the CDHC. Tribal colleges in general are important stakeholders because they serve an important intermediary role between American Indian students, the tribal community, regional academic institutions and the tribal/regional economy. Special efforts should be made to seek out appropriate tribal colleges as CDHC licensees. It should be noted in certain states where there may be a desire to implement CDHC training programs, there may be no dental schools or tribal colleges that operate dental assisting programs. Although there are tribal colleges with nursing programs, they currently do not have the staff or facilities to host CDHC training programs. In assessing tribal colleges as potential licensees, the costs of building out the necessary infrastructure and capacity must be taken into consideration.
- *Other Schools.* Over time, the ADA should encourage more schools to establish a CDHC program and, therefore, the Association will need to develop a plan to communicate the opportunity to do so.

**When Licenses Should Be Available:** It may be prudent to delay the grant of CDHC licenses until after the evaluation portion of the pilot program is complete. Nevertheless, for the reasons stated above with respect to existing licensees, Oklahoma, Temple, Arizona and Rio Salado College should be permitted to continue to operate CDHC programs without interruption. In addition, the pressing need for solutions to barriers to care within portions of the American Indian community tribal colleges should be allowed to seek licenses to the CDHC curriculum before completion of the evaluation phase.

**Modifications to Curriculum:** Unique circumstances may warrant modifications to the current curriculum and licensees should be able to do so with ADA approval. Examples of such circumstances might include opposition to particular aspects of the CDHC scope of practice in a particular state. This approach has the potential to lead to CDHCs with different training and capacities in different parts of the country. While this

may not be ideal, similar conditions exist for other members of the dental team, including hygienists and assistants. The license agreements from the ADA should provide the Association with rights to approve any proposed substantial modifications to the curriculum and the right to be informed in advance of any other modifications to the CDHC curriculum to assure that the programs operating under license meet the standards and guidelines for the CDHC position adopted by the ADA.

This is critical if the intent going forward is to assure that CDHC training programs are eligible for accreditation by the Commission on Dental Accreditation. As stated in the Principles and Criteria established by CODA and appended to this report (Appendix 5) CODA “seeks to ensure the quality of the education programs, for the benefit and protection of both the public and students.”

**Marketing of the CDHC Program and License Opportunities:** The American Association of Public Health Dentistry recently published a series of papers that highlight curriculum guidelines for the training of dental therapists: <http://onlinelibrary.wiley.com/doi/10.1111/jphd.2011.71.issue-s2/issuetoc>. The AAPHD papers cover principles upon which a dental therapy program should be based; recommended length of training; competencies required for graduates; and general curriculum content.

It would be prudent for the ADA to develop a similar paper or commentary to submit to the *Journal of Public Health Dentistry* and other appropriate media to inform the larger community that the CDHC program has already established principles upon which a CDHC program should be based; recommended length of training; competencies required for graduates; and general curriculum content.

The ADA also needs to develop a communications plan, explaining how it will reach out to potential licensees, so that they are aware of the potential opportunity. Because constituent society support for the program in each society’s state is essential, the communications plan needs to call for the involvement of the constituent society in identifying potential schools and in marketing the opportunity.

**Reaching out to the Indian Health Service (IHS), Tribal Communities, Federally Qualified Health Centers and the Community Health Worker Community:** There is a need to educate federally qualified health centers as well as IHS and tribal 638 dental directors, CEOs and COOs about the inherent value of CDHCs as valuable members of the facility team. Similar to the value of a front desk person who is critical for programmatic success, CDHCs have the potential to increase facility efficiency, effectiveness, productivity and outreach to the community. Recent presentations to various communities including IHS Area Dental Officers and participants in a New Hampshire Oral Health Workforce meeting have resulted in greater appreciation of the role CDHCs can play in improving community oral health.

**Reaching out to Philanthropic and Governmental Organizations:** Beyond the pilot phase there will clearly have to be another layer of funders to ensure sufficient resources are available to implement programs at the state level. In all likelihood there will have to be multiple funders ranging from federal programs and foundations, corporate/industry sponsors and private donors.

With the above mentioned background CAPIR voted unanimously to adopt the following resolutions at its June 2011 meeting:

**Resolved,** that the appropriate agencies identify states interested in initiating CDHC training programs, and be it further

**Resolved,** that staff immediately contact current pilot program sites to assess their interest in continuing the program.

**Resolved**, that appropriate ADA agencies develop a monograph describing how the CDHC program has already established principles upon which a CDHC program should be based, recommended length of training, competencies required for graduates, and general curriculum content.

**Resolved**, that the Association shall develop a licensing plan for the CDHC curriculum for states interested in initiating CDHC training programs, and be it further

**Resolved**, that as part of the licensing plan, the ADA offer licenses to the CDHC curriculum to institutions sponsoring CODA-accredited dental, allied dental and advanced dental education programs, or other institutions as approved by the ADA; and be it further

**Resolved**, to address the pressing need for solutions to barriers to care within portions of the American Indian community the licensing plan should permit tribal colleges to seek licenses to the CDHC curriculum before completion of the evaluation phase, and be it further

**Resolved**, that if other educational training programs request licenses before the evaluation phase of the CDHC pilot program is complete that those requests be considered on a case by case basis, and be it further

**Resolved**, that the licenses shall permit, with ADA permission, modifications to the CDHC curriculum, and be it further

**Resolved**, that the Association should initially establish a nominal licensing fee, and be it further

**Resolved**, that CAPIR seek guidance from leadership on the role ADA will play in how best to implement CDHCs as viable members of the dental team and on how best to provide technical assistance to states wishing to implement a CDHC training program before and after completion of the pilot program.

**Summary:** Ten of the 12 Cohort 1 students enrolled in the CDHC pilot project completed the program. Eight of the 18 Cohort 2 students have completed their online didactic training and are currently in their internship. Mutual agreement has been reached to dissolve the UCLA/ADA relationship and ASDOH has been selected as the new American Indian training site. The community health worker portion of the curriculum is currently being revamped and Cohort 3 students are expected to benefit from this change. A process and structure evaluation is being finalized and contacts have been made with clinics selected to participate in this evaluation. A transition plan is underway.

### **Resolutions**

This report is information and no resolutions are presented.

**BOARD RECOMMENDATION: Vote Yes to Transmit.**

**BOARD VOTE: UNANIMOUS.**



### **Index of Appendix Material\***

1	Appendix 1	Chronology of the Development of the CDHC Project
2	Appendix 2	CDHC Internship Report—Temple University
3	Appendix 3	Oklahoma CDHC Update July 2011
4	Appendix 4	CDHC Cohort 3 Orientation and Kick-Off Information Session, March 28-30, 2011
5	Appendix 5	SWOT (Strengths, Weaknesses, Opportunities and Threats) Analysis
6	Appendix 6	Oklahoma CDHC Newsletter
7	Appendix 7	Evaluation Plan—CDHC Pilot Program
8	Appendix 8	Structure and Process Evaluation Design
9	Appendix 9	CDHC Case Study Report Outline
10	Appendix 10	CDHC Evaluation Field Data Collection and ADA CDHC Data Repository Process
11	Appendix 11	CDHC Clinic Access Evaluation Sites—Summer 2011
12	Appendix 12	Detailed Expenses—2011

**\*Note:** Due to the number and size of the attachments, these documents can be found on ADA Connect, House of Delegates Community (<http://connect.ada.org>) and ADA.org, House of Delegates Page (<https://www.ada.org/members/2011hodreports.aspx>)



Resolution No. None New ☐ Substitute ☐ Amendment ☐Report: CDP Supplemental Report 1 Date Submitted: September 2011Submitted By: Council on Dental PracticeReference Committee: Dental Benefits, Practice and HealthTotal Net Financial Implication: None Net Dues Impact: \$Amount One-time \$ Amount On-going \$ADA Strategic Plan Goal: Members (Required)

**COUNCIL ON DENTAL PRACTICE SUPPLEMENTAL REPORT 1  
TO THE HOUSE OF DELEGATES: RESPONSE TO RESOLUTION 110H-2010—ADVOCATING FOR  
VICTIMS OF ADDICTIVE DISEASE**

**Background:** The 2010 House of Delegates adopted Resolution 110H-2010 (*Trans.*2010:564), which directed the Council on Dental Practice (CDP) to develop an action plan to communicate the value and importance of safe, confidential treatment and monitoring for dental team members suffering from addiction. The resolution reads as follows:

**110H-2010. Resolved,** that the Council on Dental Practice, through its Dentist Well-being Advisory Committee, develop strategies to communicate the value and importance of safe, confidential treatment and monitoring for dental team members suffering from addiction, and be it further

**Resolved,** that the Council on Dental Practice assign a task force to consider addiction issues that will include up to four members of the Council and four representatives from constituent society well-being committees selected by the chair of the Council, and be it further

**Resolved,** that the Council, with the assistance of its Dentist Well-Being Committee, recommend an action plan to include:

- Promoting the availability of intervention programs in all constituent jurisdictions
- development of materials and protocols to support state and constituent-sponsored programs
- building appropriate connections within the broader medical community
- advocacy communication with policy decision-makers at both national and state levels
- communication about the availability of services within the profession
- re-evaluation of the action plan on an ongoing basis

and be it further

**Resolved,** that a report and action plan with recommendations be given to the 2011 House of Delegates.

In November 2010, the CDP appointed a Well-being Task Force consisting of four members selected from the Council and four representatives and one consultant selected from the constituent dental society dentist well-being committees to develop a response to Resolution 110H-2010.

The following individuals were selected to serve on the Task Force : Dr. Judee Tippet-Whyte, CDP Dentist Well-Being Advisory Committee (DWAC); Dr. Lee Gardner, CDP DWAC; Dr. Christopher Larsen, CDP Ergonomic and Disability Support Advisory Committee (EDSAC); Dr. Roger Newman, CDP EDSAC; Dr. Brett Kessler, Colorado Dental Association Concerned Colorado Dentists and DWAC; Dr. Wayne McElhiney, Tennessee Dental Association Concerned Dental Professionals; Dr. Curtis Vixie, California Dental Association Well-Being Program; and Dr. Robert Herzog, New York State Dental Association Peer Assistance Program. Dr. Jerry Gropper, Professional Recovery Network and DWAC, was selected to serve as the consultant to the Task Force.

**Initial Survey and Results:** The Task Force developed and conducted a survey (see Appendix 1) to identify the strengths, weaknesses, needs and wants of the constituent dentist well-being programs (CDWPs). Collaborating with the ADA Survey Center, the Task Force developed an online survey that was distributed to all constituent dental society executive directors and all CDWP staff in the 45 states with active programs.

After reviewing the results (see Appendix 2) of the survey, the Task Force determined that many of the survey questions were not answered adequately. Concerns were raised that the survey had not been distributed to the most knowledgeable staff members in the CDWPs. To address this issue, each Task Force member contacted an average six dental society executive directors to identify the most appropriate person to answer future surveys. Accordingly, the Task Force intends to reissue a follow-up survey in the first year of the multi-year action plan.

**Action Plan:** The Task Force developed a three-year plan for the Council's consideration as follows.

*2011-12.* The primary focus of the first year of the action plan will be on developing grassroots promotions of well-being programs and resources to distribute to ADA members, as well as the constituent dental society executive directors. This will be accomplished through a variety of action steps:

1. Reissue a follow-up survey to each of the CDWP directors to obtain an accurate picture of the current status of the CDWPs.
  - a. From the survey, identify the strengths and weaknesses of each CDWP and use this information as a foundation to develop resources to enhance or improve CDWPs.
2. Promote the awareness of the ADA and the CDWPs and the member value they provide to dentists in the various states.
  - a. Develop an advertising template that can be formatted by the CDWPs to advertise their programs in constituent dental society communications (e.g., newsletters, brochures, websites and presentations).
  - b. Develop educational sessions for the ADA annual session examining impairment issues.
  - c. Expand impairment information presented in dental schools by enhancing slides provided to the ADA's Success Program.
  - d. Collaborate with the New Dentist Committee to educate new dentists on impairment resources available to help dentists affected with addiction.
  - e. Utilize a variety of ADA communications channels to publicize the actions of the Task Force in order to raise awareness of CDWPs.

A secondary activity will be to develop advocacy to address the ADA's role in legislative efforts to counteract the actions of the [Citizen Advocacy Center \(CAC\)](#). Since 1987, the CAC has been focused on

the accountability of health professional oversight bodies, including state dental boards. The CAC has developed research, training and networking opportunities for health care regulatory, credentialing, and governing boards and the public that undermine well-being programs for health professionals. Unfortunately, the CAC is in favor of enforcing strict regulations on impaired dental professionals that may threaten a dentist's ability to recover from an addiction and to continue his or her professional career.

This activity will be accomplished by:

1. Developing advocacy and legislative efforts that support the personalized and positive impacts of well-being programs and the anonymity of health professionals in recovery.
  - a. Collaborate with the ADA Council on Government Affairs to develop talking points that support ADA member dentists.
  - b. Communicate with the constituent dental society executive directors and the CDWP directors to monitor and report CAC activities within their states.

*2012-13.* The Task Force determined the focus of the second year of the action plan will be to increase publicity and availability of resources resulting from its advocacy and awareness efforts and to create a coalition of national health care professional organizations to share information related to well-being activities.

The following course of action is planned for the second year:

1. Build on the first year efforts to increase publicity, availability of resources and heightened awareness of well-being programs.
2. Continue to develop and disseminate a positive advocacy message related to CDWPs.
3. Develop resources to increase the collaboration efforts between and effectiveness of CDWPs and the ADA.
  - a. Update the [\*2004 Handbook for Dentist Well-Being Programs\*](#) and distribute the *Handbook* to the CDWPs and/or constituent dental societies interested in developing a dentist well-being program.
  - b. Develop a secure discussion community on ADA Connect for CDWP directors to open dialogues, share information and distribute resources.
4. Develop a coalition of health care organizations and share information with key partners who also support impairment issues on behalf of their members (e.g., American Medical Association, American Nurses Association and the American Academy of Addiction Psychiatry).
5. Contribute to the planning and support the ADA 2013 Conference on Dentist Health and Wellness, incorporating a significant impairment learning track into the conference agenda.

*2013-14.* The Task Force determined that the third year of the action plan should be focused on the evaluation of the implementation of the first two years. Collaborative efforts to promote well-being programs to dentists should be refined and renewed during this year.

1 **Resolutions**

2 This report is informational and no resolutions are presented.

3 **BOARD RECOMMENDATION: Vote Yes to Transmit.**

4

5 **BOARD VOTE: UNANIMOUS. (BOARD OF TRUSTEES CONSENT CALENDAR ACTION—NO**  
6 **BOARD DISCUSSION.)**

7

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**1 Index of Appendix Material\***

- 2 Appendix 1 2011 Constituent Dental Society Well-Being Committee Survey
- 3 Appendix 2 2011 Constituent Dental Society Well-Being Committee Survey—Overall Summary

**\*Note:** Due to the size of the attachments, these documents can be found on ADA Connect, House of Delegates Community (<http://connect.ada.org>) and ADA.org, House of Delegates Page (<https://www.ada.org/members/2011hodreports.aspx>)





Resolution No. None New ☐ Substitute ☐ Amendment ☐Report: Board Report 8 Date Submitted: September 2011Submitted By: Board of TrusteesReference Committee: Dental Benefits, Practice and HealthTotal Net Financial Implication: None Net Dues Impact: \$Amount One-time \$ Amount On-going \$ADA Strategic Plan Goal: Members (Required)**REPORT 8 OF THE BOARD OF TRUSTEES TO THE HOUSE OF DELEGATES:  
DENTAL WORKFORCE MODEL: 2009-2030**

**Executive Summary:** This is an annual report prepared in response to the 1981 House of Delegates adopted Resolution 124H (*Trans.*1981:571) directing that the Board of Trustees examine and report, on a continuous basis, the rate of growth in the number of licensed dentists.

**Background:** The Dental Workforce Model (DWM) was developed by RRC, Inc. (an economics/consulting firm in Bryan, TX) for the ADA's Health Policy Resources Center with significant extensions to the original work.<sup>1</sup> The primary source of data for the DWM is the House-mandated census survey, *Distribution of Dentists in the United States by Region and State*. A second source of statistics on the profession's demographics is the *Survey of Dental Education*. Below are a few highlights from the 2011 DWM report. The appendix contains the full report prepared for the ADA by Donald R. House, Ph.D.

**Projected Number of Professionally Active Dentists and Active Private Practitioners:** The number of both professionally active dentists<sup>2</sup> and active private practitioners<sup>3</sup> is expected to increase over the projection period. The number of professionally active dentists increased 20.2% between 1993 and 2009. Between 2009 and 2030, the number of professionally active dentists is projected to increase 8.9%, reaching 202,913. The number of active private practitioners increased 19.9% between 1993 and 2009. Between 2009 and 2030, the number of active private practitioners is projected to increase 10.7%, reaching 189,343. The number of professionally active dentists and active private practitioners per 1,000 U.S. population have been fairly stable—although both are projected to decline in the coming years. However, increases in productivity of dental practices in the future may permit the capacity of the delivery system to be maintained or to expand.

<sup>1</sup> An important part of this work is documented in: Nash KD, House DR. The dental school applicant pool and the rate of return to dentistry. *J Am Dent Assoc* 1982;105(2):271-5.

<sup>2</sup> Professionally active dentists are those whose primary and/or secondary occupation is private practice (full- or part-time), dental school faculty/staff member, armed forces, other federal services, state or local government employee, hospital staff dentist, graduate student/intern/resident, other health/dental organization staff member.

<sup>3</sup> Active private practitioners are a subset of professionally active dentist category and are defined as dentists whose primary and/or secondary occupation is private practice (full- or part-time).

Table 1: Census Counts and Projections, 1993-2030

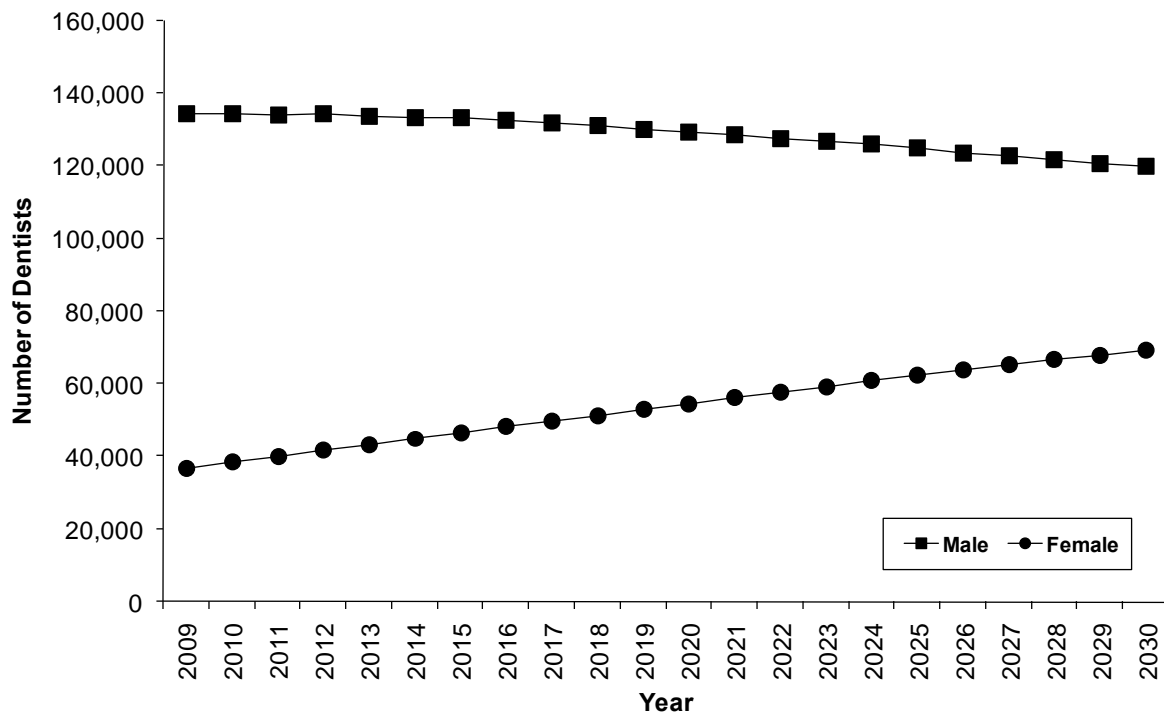
Year	Professionally Active Dentists	Active Private Practitioners	Applicants to Dental School	Applicants per Admission	U.S. Resident Population (in thousands)	Professionally Active Dentists per 1,000 U.S. Resident Population	Active Private Practitioners per 1,000 U.S. Resident Population
1993	155,087	142,603	6,761	1.649	259,919	0.60	0.55
1994	157,228	144,581	7,713	1.872	263,126	0.60	0.55
1995	158,641	146,089	7,996	1.887	266,278	0.60	0.55
1996	160,388	147,247	8,598	2.021	269,394	0.60	0.55
1997	160,781	147,778	9,829	2.261	272,647	0.59	0.54
1998	163,291	151,309	9,447	2.213	275,854	0.59	0.55
1999	164,664	152,151	9,010	2.089	279,040	0.59	0.55
2000	166,383	152,798	7,770	1.796	282,172	0.59	0.54
2001	168,556	155,716	7,412	1.682	285,082	0.59	0.55
2002	169,894	156,921	7,538	1.695	287,804	0.59	0.55
2003	173,574	160,184	8,176	1.770	290,326	0.60	0.55
2004	175,709	162,184	9,433	2.045	293,046	0.60	0.55
2005	176,634	162,180	10,731	2.289	295,753	0.60	0.55
2006	179,594	164,864	12,463	2.633	298,593	0.60	0.55
2007	181,725	166,837	13,742	2.881	301,580	0.60	0.55
2008	181,774	167,769	12,178	2.476	304,375	0.60	0.55
2009	186,415 <sup>4</sup>	171,110 <sup>4</sup>	12,202	2.398	307,007	0.61	0.56
2015	193,456	179,836	12,477	2.175	325,540	0.59	0.55
2020	197,654	183,960	12,200	2.022	341,387	0.58	0.54
2025	201,115	187,262	12,755	2.054	357,452	0.56	0.52
2030	202,913	189,343	13,560	2.098	373,504	0.54	0.51

Source: American Dental Association, Health Policy Resources Center, 2011 ADA Dental Workforce Model: 2009-2030.

<sup>4</sup> The 2009 numbers for professionally active dentists and active private practitioners were revised after the *Distribution of Dentists in the United States by Region and State, 2009* was published. The numbers in this table are the correct numbers for 2009.

**Female Dentists:** Female dentists are joining the profession in steadily increasing numbers. Judging by the recent increasing percentages of females in dental school enrollments, it is fair to say that the ratio of male to female dentists has yet to stabilize, unlike that of the medical<sup>5</sup> profession. Based on ADA's *Distribution of Dentists in the United States by Region and State*, the percentage of professionally active female dentists has increased from 21.4% in 2008 to 22.1% in 2009. The number of female dental graduates in 2009 reached 2,251; representing 46.2% of the graduating class. As graduating classes continue to move into the profession, women will continue to form an ever-increasing portion of practicing dentists through the foreseeable future.

**Figure 1: Projected Number of Active Private Practitioners, by Gender, 2009-2030**

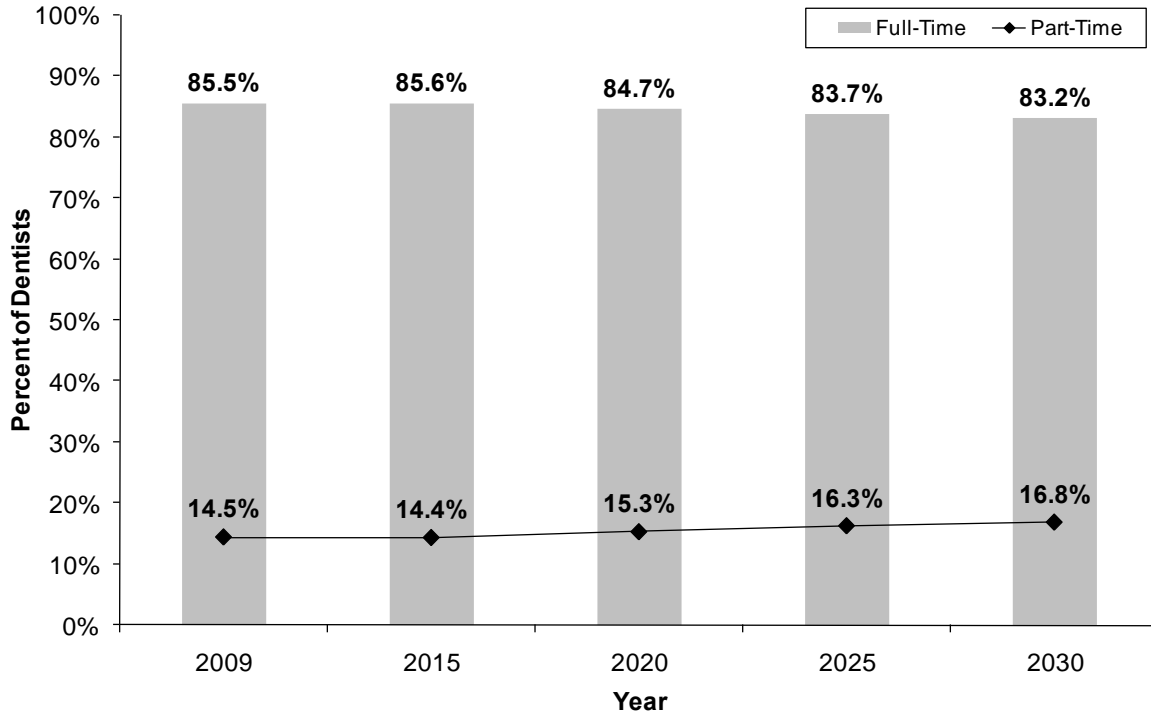


Source: American Dental Association, Health Policy Resources Center, 2011 ADA Dental Workforce Model: 2009-2030.

**Part-Time Active Private Practitioners:** In 2009, 14.5% of active private practitioners were part-time. As shown in Figure 2, the percent of part-time active private practitioners is expected to follow a general trend of increase over the course of the projection period—from 14.5% in 2009 to 16.8% in 2030.

<sup>5</sup> For a data on medical school enrollments go to: <http://www.aamc.org/data/facts/charts1982to2010.pdf>.

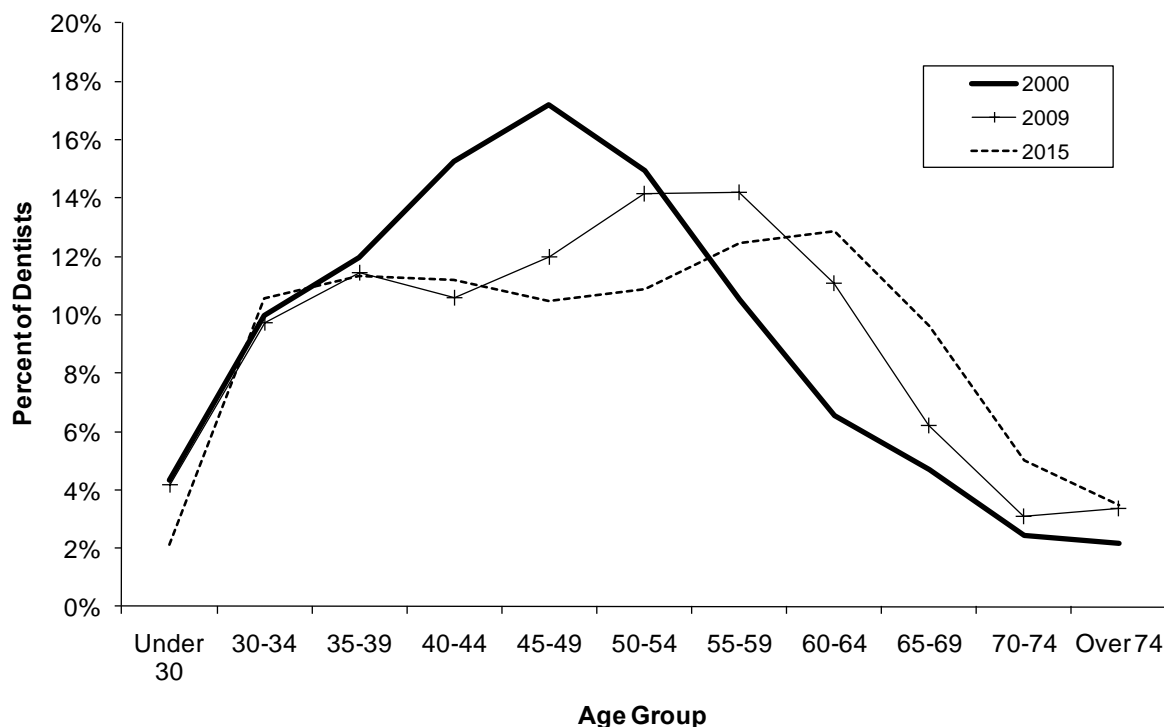
**Figure 2: Percentage Distribution of Active Private Practitioners, by Full-Time and Part-Time Status, 2009-2030**



Source: American Dental Association, Health Policy Resources Center, 2011 ADA Dental Workforce Model: 2009-2030.

**Age Distribution of Professionally Active Dentists:** As shown in Figure 3, the upward age shift that had been predicted over the last few years has begun. In 2000, for example, there was a significant peak in the age distribution among the 45-49 age group (17.2% of professionally active dentists); by 2009, the peak (14.2%) in age distribution occurs among the 55-59 age group. By 2015, the age distribution will be flatter and more diffuse with significantly more dentists in higher age groups—the largest distribution of 12.9% occurring among the 60-64 age group.

**Figure 3: Percentage Age Distribution of Professionally Active Dentists in 2000, 2009 and the Projected Distribution in 2015**



Source: American Dental Association, Health Policy Resources Center, *2011 ADA Dental Workforce Model: 2009-2030*.

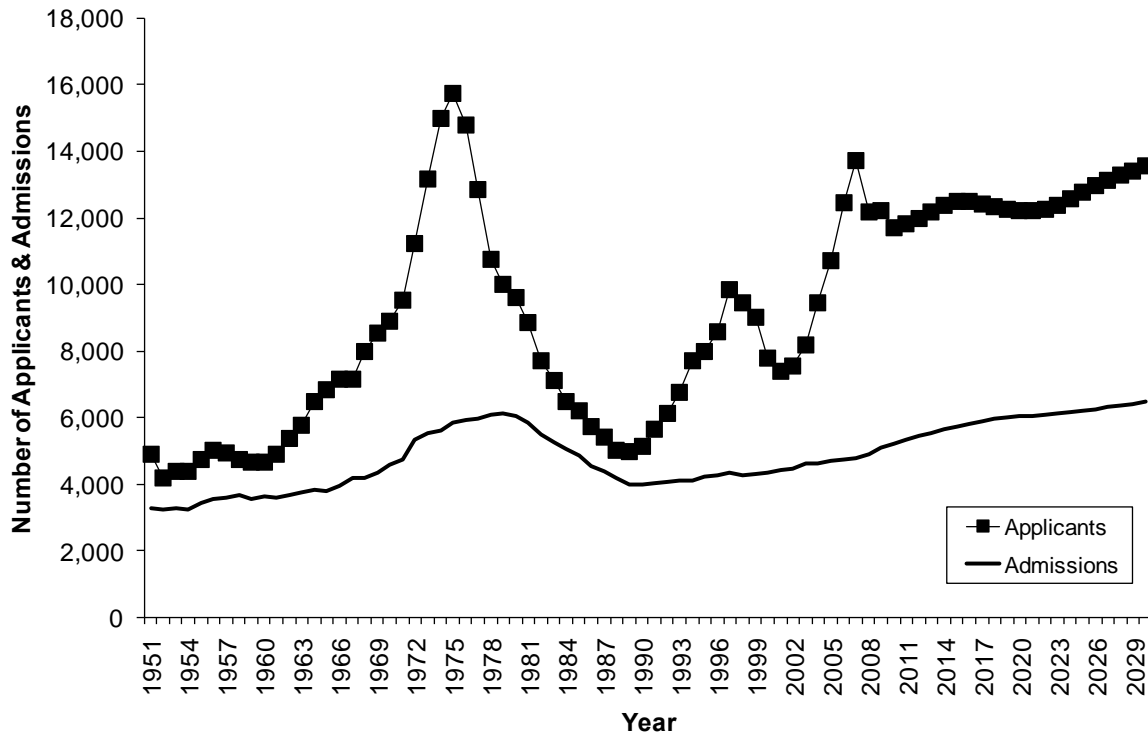
**Dental School Applicants:** There were 12,202 applicants in 2009, up from 12,178 in 2008—an increase of 0.2%. The number of applicants dropped each year between 1997 and 2001. Since 2001, however, the number of applicants increased each year until 2007—then dropping in 2008. In general, the number of applicants is projected to continue upward over the next ten years. This upward trend is heavily influenced by two major factors: the projected increase in the U.S. population 22-26 years of age until the year 2015, and the continued increase in dental income relative to the income of other professionals<sup>6</sup> with a bachelor's degree or higher. After the year 2016, the number of applicants is projected to decline. This decline corresponds to the Census Bureau's projected decline for the U.S. population aged 22-26 during this same period.

**Dental School Admissions:** The number of first-year enrollments increased 3.5% from 4,918 in 2008 to 5,089 in 2009. Enrollments in U.S. dental schools have responded to the trends in applicants with some delays as institutions adjust to large shifts in demand for dental education. Hence, it follows that the

<sup>6</sup> There is recent evidence that the net incomes of dentists, adjusted for inflation, have decreased. This recent decline may be part of another temporary cycle which should be discounted in projections of applicants. Yet, if this is the beginning of a longer trend that outpaces any decline in the incomes of college graduates, it will affect applicants negatively. At this point, it is too early to incorporate this recent evidence into the projections.

enrollments are not very responsive in the short-run, as one would expect. The long-run trend in enrollment shows a moderate, but direct response to the size of the applicant pool.

**Figure 4: Actual and Projected Dental School Applicants and Admissions, 1951-2030**



Source: American Dental Association, Health Policy Resources Center, *2011 ADA Dental Workforce Model: 2009-2030*.

**Sensitivity Analysis:** The projection of professionally active dentists depends, among other factors, on the assumed rate of return to dental education. The sensitivity analysis suggests that an increase in the rate of return positively affects the size of the dental workforce within approximately six years. When examining the impact of a reduction in the rate of return, the results are found to have similar downward effects. (The Appendix of the attached full report contains a complete analysis that explores the impact of changes in the rate of return on future applicants, graduates, professionally active dentists and active private practitioners.)

### Resolutions

This report is informational and no resolutions are presented.

**BOARD RECOMMENDATION: Vote Yes to Transmit.**

**BOARD VOTE: UNANIMOUS. (BOARD OF TRUSTEES CONSENT CALENDAR ACTION—NO BOARD DISCUSSION.)**

## Appendix

**2011 American Dental Association Dental Workforce Model: 2009-2030**

**Overview:** The Dental Workforce Model (DWM) performs long-term projection of the U.S. dental workforce using statistical transition models for retirements, occupation change, location choice, specialty education and death. Additional allocation models distribute new dental school graduates into dental occupations, locations and specialty programs. The DWM was developed for the ADA's Health Policy Resources Center<sup>7</sup> with significant extensions to the original work.

The DWM was extended in 1993 by using more sophisticated statistical methods to handle the new rotating panel method used for the ADA census of dentists, the *Distribution of Dentists in the United States by Region and State* (DOD). An improved accounting of net foreign dentist immigration was also implemented. The DWM also projects the number and gender of dental school graduates based on: relative lifetime earnings of dentists (vis-à-vis that of other college graduates), dental education costs and financial support available in dental schools. The theory is that the number of dental graduates is very well explained by the rate of return to dentistry, which is the relative expected financial reward from dental education (net of the cost of schooling) and availability of financial support while in school.

It should be noted that the dental workforce projections apply only to dentists within the United States, not U.S. territories. Also, the projections assume that there will be no major structural change in the economy, technology, politics, or the delivery mechanisms and organization of the dental care industry. In particular, no major component of the dental care sector is expected to be nationalized over the horizon of the projections. However, while some technological change can be expected, if it is of a similar impact to the changes over the past 20-30 years it will not substantially affect the projections.

The growth of managed care may have some effects on the dental care marketplace. However, these effects are not expected to create major changes in the delivery of dentistry over the next decade. Despite the large number of participating dentists, managed care patients currently make up a relatively small portion of the patient base. Further, there is no compelling economic argument for dentistry to move significantly toward managed care at the levels found in general medicine. Dentistry as a whole currently practices preventive care to a larger extent than any other segment of the health care industry, and dental costs are much more predictable and limited than major medical costs. Unless these market structure changes are much more rapid and dramatic than they have been in the past ten years, the overall pattern of the projections will not be affected.

Note that the projections in this report do not include the impact of new dental schools coming on board. However, the number of universities offering dental school programs has remained relatively stable over time. The history of dental schools has been marked by a period of slow, consistent growth from 1950-78; a plateau period from 1978-85, which represented both its most stable period and the period in which the number of dental schools open was at its peak; a period of general decline from 1986-2001; and, the more modern period, 2002 to the present, which is experiencing a period of growth.

Recently, there have been a number of new dental schools that have opened—including Midwestern University in Glendale, Arizona and Western University of Health Sciences in Pomona, California. These schools opened in 2008 and 2009, respectively. Additionally, there are a number of new programs under development. They include Eastern Carolina University in North Carolina, Midwestern University in Illinois, the University of Southern Nevada in Nevada and Lake Erie Dental School in Florida. All are scheduled to open in the fall of 2011 with the exception of Lake Erie Dental School—expected to open in the fall of 2012.

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<sup>7</sup> An important part of this work is documented in: Nash KD, House DR. The dental school applicant pool and the rate of return to dentistry. *J Am Dent Assoc* 1982;105(2):271-5.

Proposals, in various stages, are also currently under consideration for Texas Tech University in El Paso as well as the University of Arkansas in Little Rock and the University of New England in Portland, ME. In addition, the University of Utah is in the very early stages of planning a dental school; conditioned on improvements in the state's financial standing.

Although the DWM does not consider the number of dental schools that are in the planning stage, it does utilize three more granular aggregated measures collected from all open universities; the number of net applicants, the number of admissions and the number of graduates. Changes in the rate of return to dentistry, the relative expected financial reward from dental education, is a significant underlying factor that triggers change in the applicant pool. And, depending on the direction of the change, dental schools respond by opening or closing and/or expanding or contracting ongoing programs.

Using the current estimates from the models for dental workforce projections, selected results and remarks about future trends in applicants, admissions, dental school graduates, as well as the number of professionally active dentists<sup>8</sup> and active private practitioners<sup>9</sup> are provided below.

**Applicants, Admissions and Graduates:** The 2009 projections of applications, admissions and dental school graduates are in line with the 2008 projections. Note that the projections published in this report are influenced by changes in population projections of the U.S. Census Bureau. A graph of the current Census projections of the U.S. population aged 22-26 years is presented in Figure 1.

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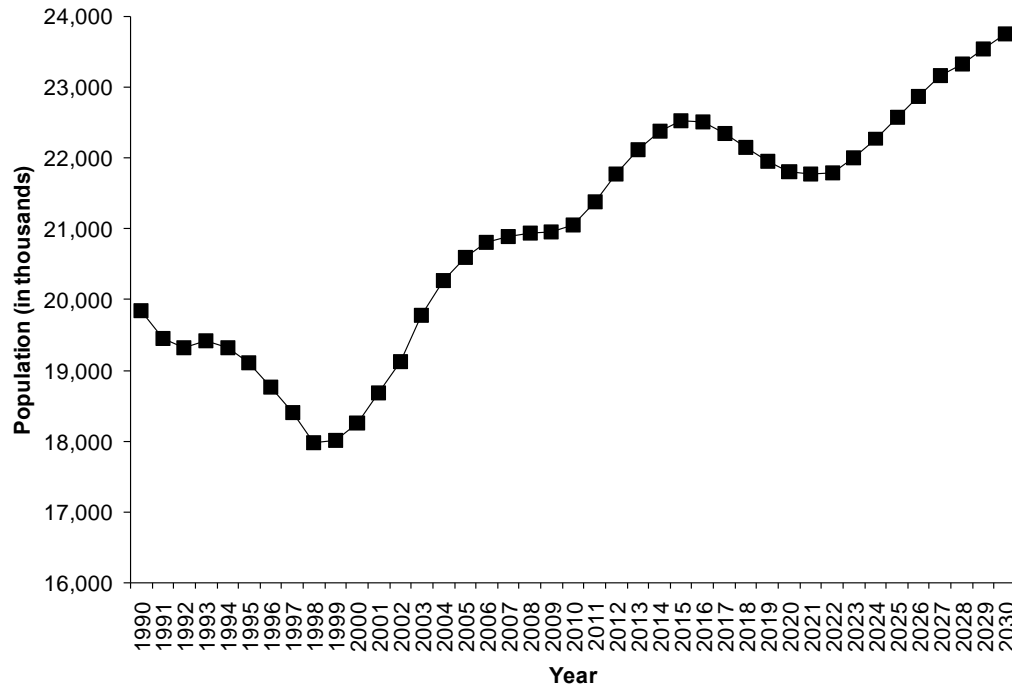
<sup>8</sup> Professionally active dentists are those whose primary and/or secondary occupation is private practice (full- or part-time), dental school faculty/staff member, armed forces, other federal services, state or local government employee, hospital staff dentist, graduate student/intern/resident, other health/dental organization staff member.

<sup>9</sup> Active private practitioners are a subset of professionally active dentist category and are defined as dentists whose primary and/or secondary occupation is private practice (full- or part-time).



1

**Figure 1: Current Census Projections of the Population Aged 22-26 Years  
(Time-Adjusted from 20-24 Age Group Projections)**



Source: U.S. Census Bureau, International Data Base, Table 094: Midyear Population, by Age and Sex, available at: <http://www.census.gov/ipc/www/idb/groups.php>. Last Revised: December 2010, accessed 4 April 2011. (Since the Census Bureau provides projections for the age cohort 20-24, the time-adjustment was done by RRC, Inc.)

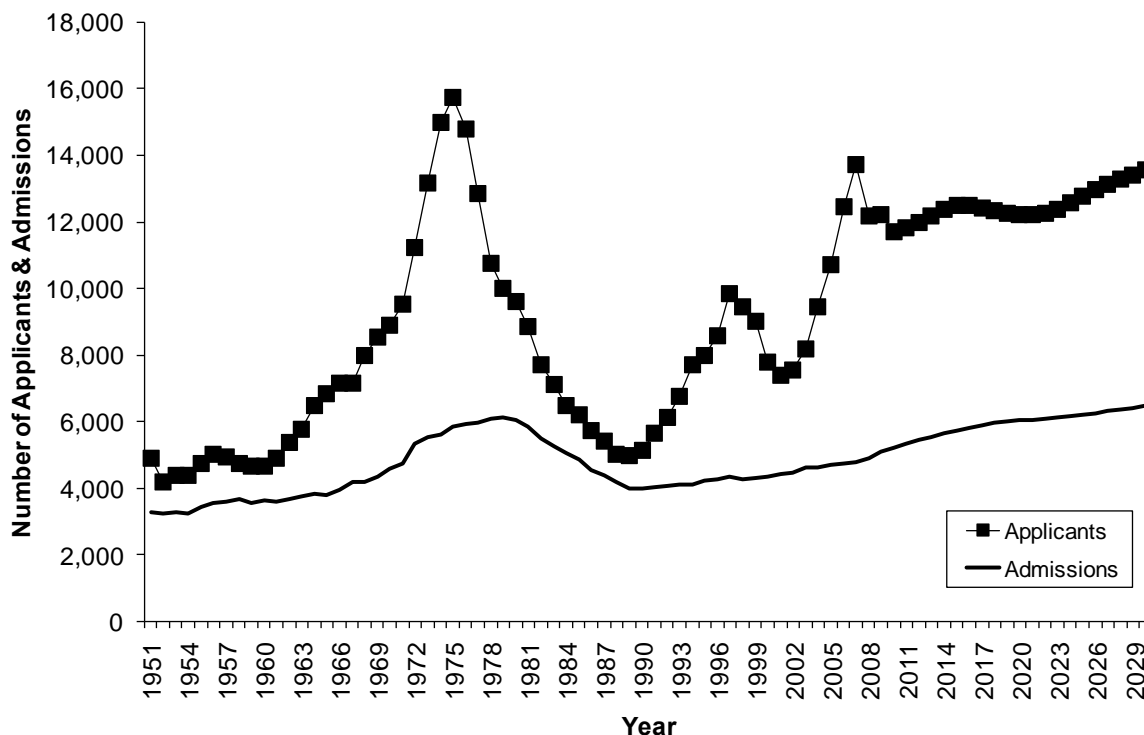
*Applicants.* Dental schools in the U.S. generally experienced substantial declines in the number of applicants during the late 1970s and 1980s, but these numbers rebounded strongly in the early 1990s. The number of applicants fell from a high of 15,734 in 1975 to 4,964 in 1989. This decline can largely be attributed to the relative decrease in dentists' net incomes as compared with net incomes of other professionals and college graduates. During the early to mid-1990s, this trend in net incomes reversed itself and the number of applicants to dental schools increased by 91.9% between 1990 and 1997. These increases occurred during a period (1990-97) in which the U.S. population aged 22 to 26 years declined by 6.9%. This can be explained by the fact that the increase in the applicant rate (fraction of people aged 22-26 years applying to dental schools) caused the number of applicants to increase such that it more than offset the decline in the population in this age group.

From 1997-2001, the number of applicants has dropped each year, falling from 9,829 in 1997 to 7,412 in 2001. This decline can be partly attributed to the decrease in the actual U.S. population aged 22-26 years. Another explanation can be found in the decline in dental income relative to income of other professionals with a bachelor's or higher degree between 1995 and 1997. Particularly, between 1996 and 1997, the ratio of dental income to the income of college graduates fell by approximately 1.5%. In 1998, this ratio increased by 5.4%. The number of applicants has increased every year since 2001. In 2008, the number of applicants decreased to 12,178—an 11.4% decrease from 13,742 in 2007. In 2009, however, the number of applicants increased slightly to 12,202 (a 0.2% increase).

The number of applicants is projected to continue upward over the next ten years. This upward trend is heavily influenced by two major factors: the projected increase in the U.S. population 22-26 years of age until the year 2015; and the continued increase in dental income<sup>10</sup> relative to the income of other professionals with a bachelor's or higher degree.

After the year 2016, the number of applicants is projected to decline for a period and then gradually increase over the span of the projection (see Figure 2 and Table 1a). The initial decline corresponds to the Census Bureau's projected decline for the U.S. population aged 22-26 years during the same period.

**Figure 2: Actual and Projected Dental School Applicants and Admissions, 1951-2030**



Source: American Dental Association, Survey Center, *Survey of Predoctoral Dental Education* (various years), and Health Policy Resources Center, *2011 ADA Dental Workforce Model: 2009-2030*.

**Admissions.** In 2009, the number of admissions or first-year enrollments increased again after briefly stalling in 2004. The number of first-year enrollments increased from 4,918 in 2008 to 5,089 in 2009—a 3.5% increase.

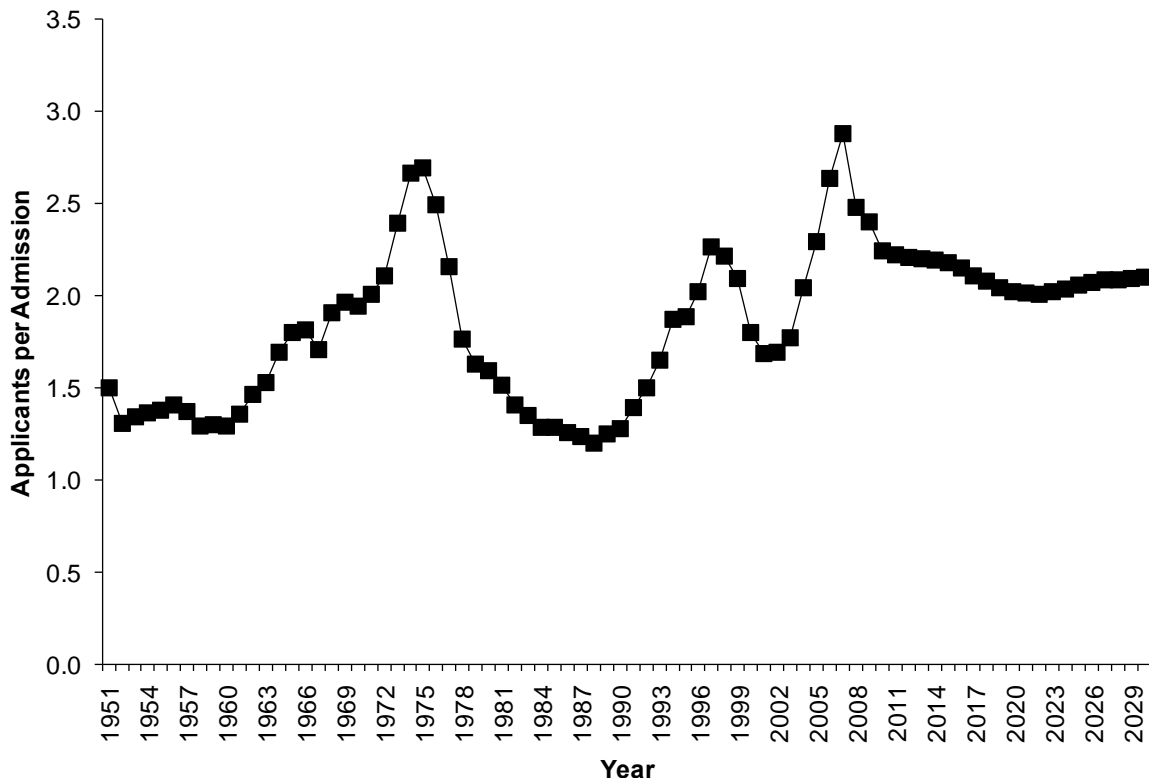
Enrollments in U.S. dental schools have responded to the trends in the number of applicants, with some delays as institutions adjust to large shifts in demand for dental education. Hence, it follows that the enrollments are not very responsive in the short-run, as one would expect. The long-run trend in enrollment shows a moderate but direct response to the size of the applicant pool.

<sup>10</sup> There is recent evidence that the net incomes of dentists, adjusted for inflation, have decreased. This recent decline may be part of another temporary cycle which should be discounted in projections of applicants. Yet, if this is the beginning of a longer trend that outpaces any decline in the incomes of college graduates, it will affect applicants negatively. At this point, it is too early to incorporate this recent evidence into the projections.

When examining the historical trends in dental school admissions, it is evident that the last three decades can be divided into three major phases. The first period occurred from 1970-78. During this period, the number of first-year enrolled dental students increased by 33.6%, or about 4.2% simple average rate per year. The second period of 1978-89 witnessed a decline in first-year enrollments by about 3.2% per year. In the final period, since 1990, the number of first-year enrollments has followed a general trend of increase, increasing an average of 1.4% per year to 5,089 in 2009. The number of first-year enrollments is expected to increase through the end of the projection period.

*Applicants Per Admission.* The number of dental school applicants exhibited periods of relatively sharp increases and decreases in the past decades. Following the declining trend in applications during the 1980s, the number of applicants per admission to dental school reached an all-time low of 1.2 applicants per admission in 1988. This apparent instability in the number of applicants per admission stems from the fluctuation in the number of applicants. The delayed adjustment process of admissions also magnifies this fluctuation. The applicant-per-admission ratio increased each year between 1989 and 1997, reaching a high of 2.3 in 1997. However, since 1997, this ratio decreased each year, reaching a low of 1.7 in 2001—and it remained at 1.7 in 2002 and 2003 before increasing to 2.0 in 2004. The ratio continued to increase reaching 2.9 in 2007. In 2008; however, the applicant per seat ratio decreased to 2.5 and decreased again in 2009 to 2.4.

**Figure 3: Actual and Projected Applicants per Dental School Admission 1951-2030**

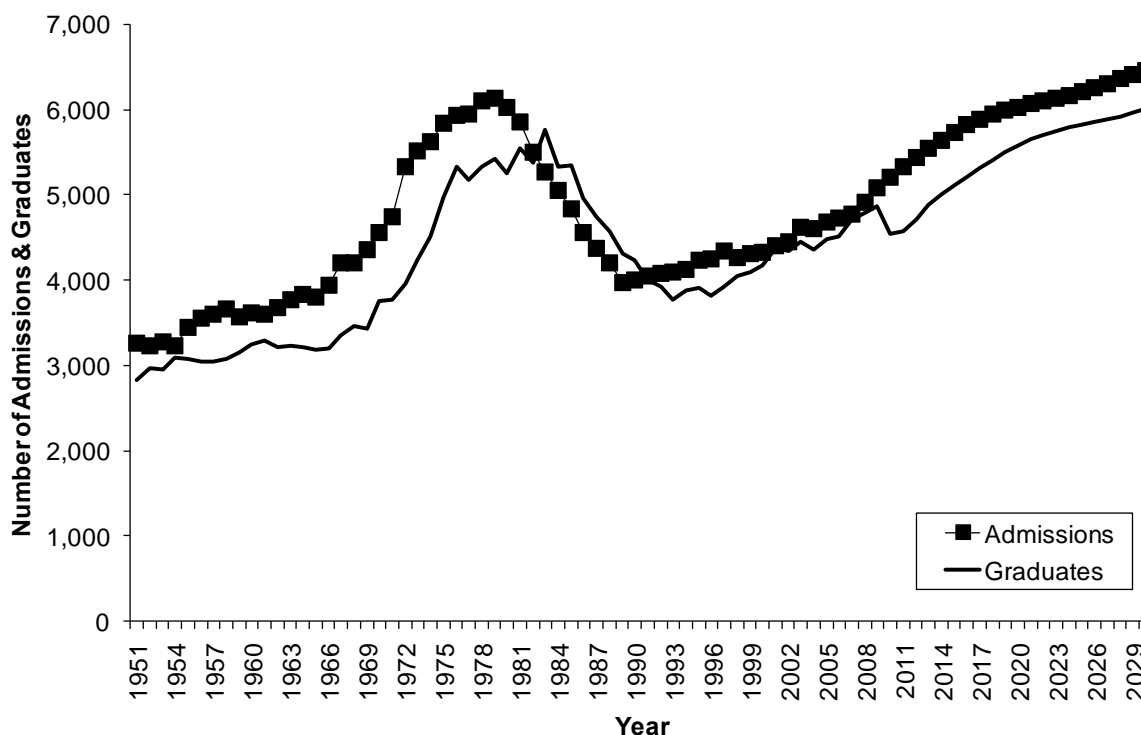


Source: American Dental Association, Survey Center, *Survey of Predoctoral Dental Education* (various years), and Health Policy Resources Center, *2011 ADA Dental Workforce Model: 2009-2030*.

*Graduates.* Trends in the number of dental graduates lag those of applicants and admissions by approximately four years, although the changes are somewhat restricted by the relatively stable number of

seats available in dental schools in the short-run. Not surprisingly, there was a general trend of growth in the number of graduates since 1994, approximately four or five years after a growth trend in applicants emerged. In 2009, the number of graduates increased to 4,873—a 1.6% increase from 4,796 in 2008. A general trend of growth is expected to continue. Figure 4 depicts both the actual and projected numbers of admissions and graduates.

**Figure 4: Actual and Projected Number of Admissions and Graduates, 1951-2030**



Source: American Dental Association, Survey Center, *Survey of Predoctoral Dental Education* (various years), and Health Policy Resources Center, *2011 ADA Dental Workforce Model: 2009-2030*.

**Forecasts of the Dentist Workforce:** When estimating the future size of the active dentist workforce, several factors must be taken into consideration. A starting base, which is derived from the current year's "soft-counts,"<sup>11</sup> is projected into the future as the base, onto which additions and losses are applied. Additions to this base can occur in the form of new dental school graduates or in the form of foreign dentists entering the United States. Losses can occur in the form of death, retirement or transitions to occupations unrelated to dentistry. In light of these factors, it is helpful to review their historical trends in order to better understand the effect they have on each other and the overall size of the active dentist workforce.

<sup>11</sup> Each year, the Survey Center of the American Dental Association surveys one-third of the dentist population to determine the number and occupational status of all dentists in the U.S. The responses to these one-third samples represent the "hard-counts" from which "soft-count" estimations are made based on the history of responses for each individual dentist. For two-thirds of the dentist population not included in an annual survey, estimates of occupational status are constructed based upon previous survey responses and the dentist's age and gender. "Soft-counts" serve as the complete dentist population count.

Throughout the 1980s, dentistry witnessed a general decline in the number of applicants to dental schools. This decline in applicants began in 1976 and was soon followed by a decline in first-year enrollments in dental schools (which began in 1980), a decline in the number of graduates from dental schools (which began in 1984) and five dental school closings. However, these trends reversed during the period of 1989-97, which experienced increases in applicants and first-year enrollments in dental schools. Graduation, which lags these trends by about four years, also increased with the first increase since 1985 occurring in 1994 (a 2.6% increase to 3,875 between 1993 and 1994).

The reversal in the number of applicants between 1990 and 1997 coincided with a stabilization of relative net lifetime earnings between dentists and other college graduates (a relationship that declined between 1972 and the early 1990s). Since 1990, dental lifetime earnings generally increased faster than those of college graduates, making dentistry a more financially appealing profession. The rate of return to dentistry also continued to improve, and is expected to continue to increase into the future.<sup>12</sup> The rapid rise of managed care programs in general medicine also makes dentistry a more attractive alternative to some individuals wishing to work in the health care field.

Considering these trends, it is projected that the total number of active dentists and the number of professionally active dentists and active private practitioners will continue with a general trend of increase over the span of the projection period. However, beyond 2020, the growth in the number of dentists is expected to slow (see Figure 5).

*Professionally Active Dentists and Active Private Practitioners.* Between the period of 1993 and 2009, the number of professionally active dentists and active private practitioners increased 20.2% and 19.9%, respectively. As shown in Figure 5 and Table 1a, the number of both professionally active dentists and active private practitioners is expected to increase over the projection period. Between 2009 and 2030, the number of professionally active dentists is expected to increase 8.9%, reaching 202,913 and the number of active private practitioners is expected to increase 10.7%, reaching 189,343.

The numbers of both professionally active dentists and active private practitioners per 1,000 U.S. resident population are listed in Table 1b. For both groups of dentists this ratio has been fairly stable, but it is projected to decline in the coming years. It should be noted, however, that this ratio implicitly holds constant many relevant factors—such as dentists' productivity—that affect both the population's need and demand for dental care as well as dentists' ability to produce those services. For example, improved productivity<sup>13</sup> in the provision of dental services in the future would mean that in the future, fewer dentists will be able to produce the same amount of dental services as compared to dentists in previous years. Thus, relying solely on dentist-to-population ratios as a measure of workforce adequacy<sup>14</sup> is misleading.

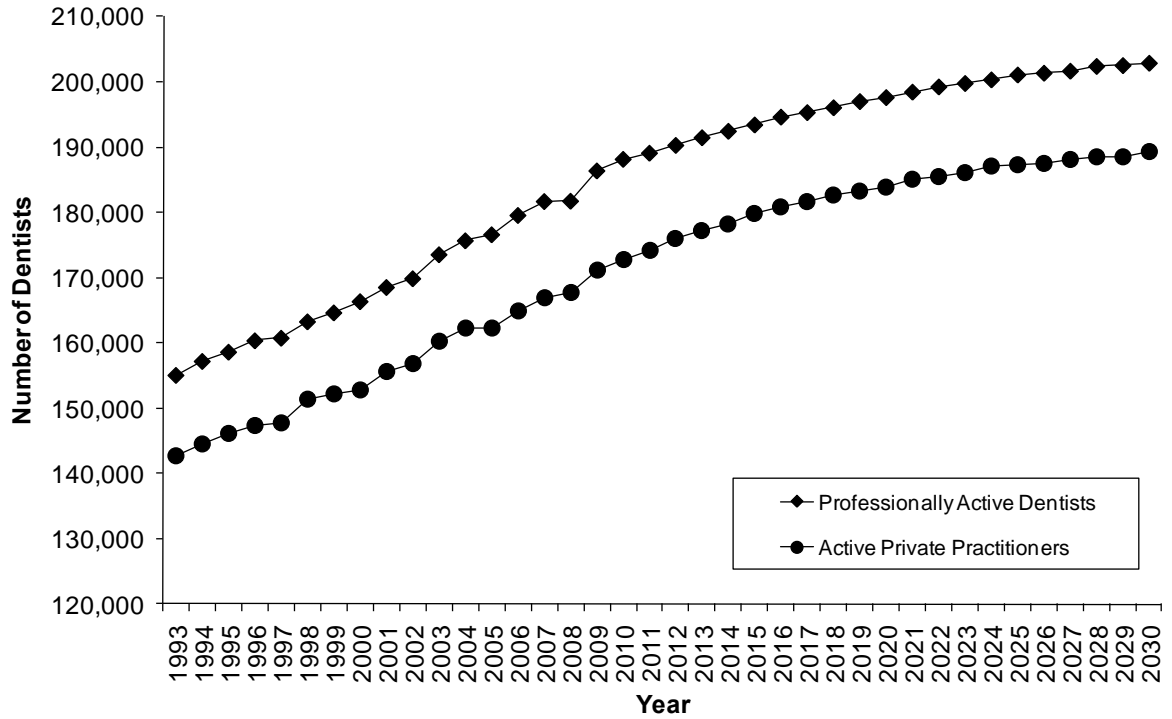
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<sup>12</sup> There is recent evidence that the net incomes of dentists, adjusted for inflation, have decreased. This recent decline may be part of another temporary cycle which should be discounted in projections of applicants. Yet, if this is the beginning of a longer trend that outpaces any decline in the incomes of college graduates, it will affect applicants negatively. At this point, it is too early to incorporate this recent evidence into the projections.

<sup>13</sup> For a detailed discussion of productivity of dentists and the pitfalls of simple dentist-to-population ratios refer to *Future of Dentistry* (American Dental Association. Future of Dentistry. Chicago: American Dental Association, Health Policy Resources Center; 2001). This publication is available online at: <http://www.ada.org/prof/resources/topics/futuredent/>, paper copies can be purchased by calling 800-947-4746.

<sup>14</sup> For a detailed discussion of workforce adequacy, refer to the following ADA reports: *Adequacy of Current and Future Dental Workforce* and/or a more detailed version *Adequacy of Current and Future Dental Workforce: Theory and Analysis*. Both reports can be purchased by calling 800-947-4746.

**Figure 5: Actual and Projected Number of Professionally Active Dentists and  
Active Private Practitioners, 1993-2030**



Source: American Dental Association, Survey Center, *Distribution of Dentists in the United States by Region and State* (various years), and Health Policy Resources Center, *2011 ADA Dental Workforce Model: 2009-2030*.

Table 1a: Census Counts and Projections, 1993-2030

Year	Professionally Active Dentists	Active Private Practitioners	Applicants to Dental School	Applicant Rate	1 <sup>st</sup> -Year Enrollment	Graduates	Applicants per Admission
1993	155,087	142,603	6,761	0.352	4,100	3,778	1.649
1994	157,228	144,581	7,713	0.402	4,121	3,875	1.872
1995	158,641	146,089	7,996	0.421	4,237	3,908	1.887
1996	160,388	147,247	8,598	0.461	4,255	3,810	2.021
1997	160,781	147,778	9,829	0.537	4,347	3,930	2.261
1998	163,291	151,309	9,447	0.528	4,268	4,041	2.213
1999	164,664	152,151	9,010	0.503	4,314	4,095	2.089
2000	166,383	152,798	7,770	0.428	4,327	4,171	1.796
2001	168,556	155,716	7,412	0.399	4,407	4,367	1.682
2002	169,894	156,921	7,538	0.394	4,448	4,349	1.695
2003	173,574	160,184	8,176	0.413	4,618	4,443	1.770
2004	175,709	162,184	9,433	0.464	4,612	4,350	2.045
2005	176,634	162,180	10,731	0.519	4,688	4,478	2.289
2006	179,594	164,864	12,463	0.595	4,733	4,515	2.633
2007	181,725	166,837	13,742	0.652	4,770	4,714	2.881
2008	181,774	167,769	12,178	0.575	4,918	4,796	2.476
2009	186,415 <sup>15</sup>	171,110 <sup>15</sup>	12,202	0.575	5,089	4,873	2.398
2015	193,456	179,836	12,477	0.554	5,737	5,110	2.175
2020	197,654	183,960	12,200	0.559	6,032	5,585	2.022
2025	201,115	187,262	12,755	0.565	6,211	5,819	2.054
2030	202,913	189,343	13,560	0.566	6,464	6,005	2.098

Source: American Dental Association, Health Policy Resources Center, *2011 ADA Dental Workforce Model: 2009-2030*.<sup>15</sup> The 2009 numbers for professionally active dentists and active private practitioners were revised after the *Distribution of Dentists in the United States by Region and State, 2009* was published. The numbers in this table are the correct numbers for 2009.

1 **Table 1b: Census Counts and Projections, Including U.S. Resident Population, 1993-2030**

Year	Population (in thousands)	Professionally Active Dentists	Active Private Practitioners	Professionally Active Dentist per 1,000 U.S. Resident Population	Active Private Practitioners per 1,000 U.S. Resident Population
1993	259,919	155,087	142,603	0.60	0.55
1994	263,126	157,228	144,581	0.60	0.55
1995	266,278	158,641	146,089	0.60	0.55
1996	269,394	160,388	147,247	0.60	0.55
1997	272,647	160,781	147,778	0.59	0.54
1998	275,854	163,291	151,309	0.59	0.55
1999	279,040	164,664	152,151	0.59	0.55
2000	282,172	166,383	152,798	0.59	0.54
2001	285,082	168,556	155,716	0.59	0.55
2002	287,804	169,894	156,921	0.59	0.55
2003	290,326	173,574	160,184	0.60	0.55
2004	293,046	175,709	162,184	0.60	0.55
2005	295,753	176,634	162,180	0.60	0.55
2006	298,593	179,594	164,864	0.60	0.55
2007	301,580	181,725	166,837	0.60	0.55
2008	304,375	181,774	167,769	0.60	0.55
2009	307,007	186,415 <sup>16</sup>	171,110 <sup>16</sup>	0.61	0.56
2015	325,540	193,456	179,836	0.59	0.55
2020	341,387	197,654	183,960	0.58	0.54
2025	357,452	201,115	187,262	0.56	0.52
2030	373,504	202,913	189,343	0.54	0.51

Source: American Dental Association, Health Policy Resources Center, *2011 ADA Dental Workforce Model: 2009-2030*; and United States Census Bureau, International Data Base, Table 094: Total Midyear Population, available at: <http://www.census.gov/ipc/www/idb/groups.php>. Last Revised: December 2010, accessed 4 April 2011.

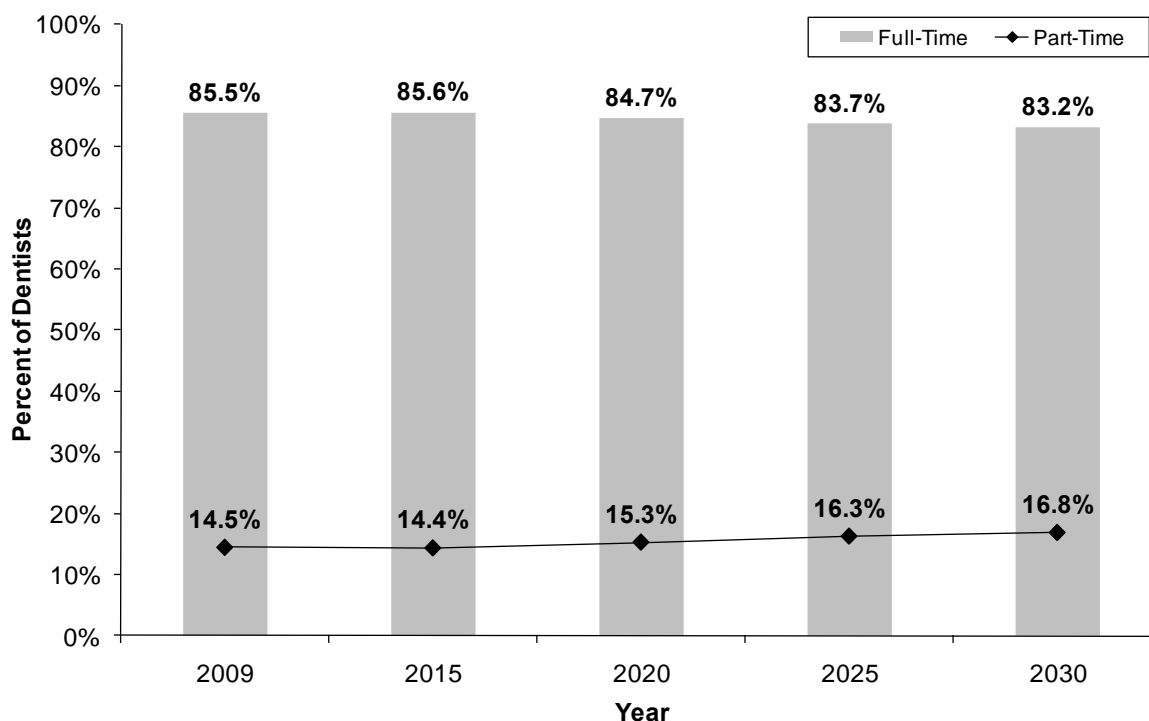
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<sup>16</sup> The 2009 numbers for professionally active dentists and active private practitioners were revised after the *Distribution of Dentists in the United States by Region and State, 2009* was published. The numbers in this table are the correct numbers for 2009.



**Full-Time and Part-Time Status.** The DWM allows for the distinction of full-time active private practitioners (30 or more hours per week) from part-time active private practitioners (less than 30 hours per week). In 2009, 14.5% of active private practitioners were part-time. That is, in 2009, there were 146,368 full-time active private practitioners and 24,742 part-time active private practitioners. The percent of part-time active private practitioners is expected to follow a general trend of increase over the course of the projection. By the year 2030, it is projected that 16.8% of active private practitioners will be part-time (see Figure 6).

**Figure 6: Projected Percentage Distribution of Active Private Practitioners, by Full-Time and Part-Time Status, 2009-2030**



Source: American Dental Association, Survey Center, 2009 *Distribution of Dentists in the United States by Region and State*, and Health Policy Resources Center, 2011 *ADA Dental Workforce Model: 2009-2030*.

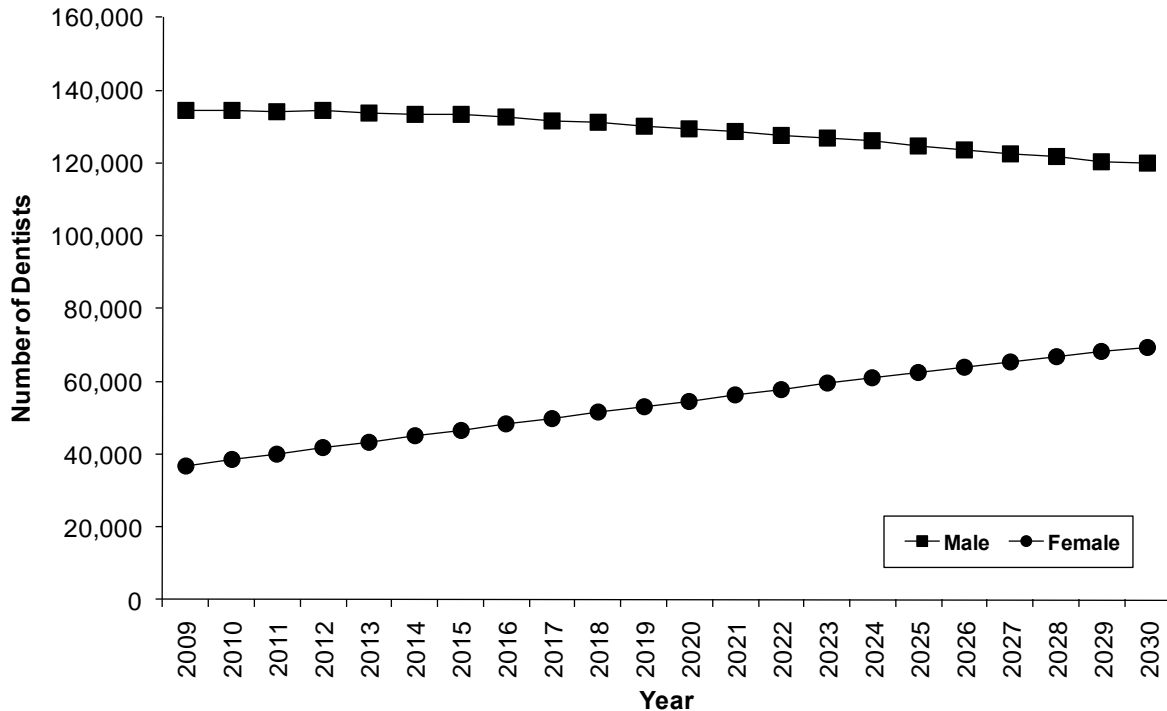
**Female Dentists.** Female dentists are joining the profession in steadily increasing numbers. Judging by the recent increasing percentages of females in dental school enrollments, it is fair to say that the ratio of male to female dentists has yet to stabilize, unlike that of the medical<sup>17</sup> profession. Based on ADA's *Distribution of Dentists in the United States by Region and State*, the percentage of professionally active female dentists has increased from 21.4% in 2008 to 22.1% in 2009. The number of female dental graduates in 2009 reached 2,251 representing 46.2% of the graduating class. As graduating classes continue to move into the profession, women will continue to form an ever-increasing portion of practicing dentists through the foreseeable future (see Figure 7).

Originally, the DWM used only the gender composition of graduating classes to project the future gender composition of the dental workforce. In the 2003 Model, the DWM was updated to also incorporate the

<sup>17</sup> For a data on medical school enrollments go to: <http://www.aamc.org/data/facts/charts1982to2010.pdf>.

gender composition of incoming classes to dental schools. This update has resulted in a slightly higher percentage distribution of female dentists over the course of the projection.

**Figure 7: Projected Number of Professionally Active Dentists, by Gender, 2009-2030**



Source: American Dental Association, Survey Center, *2009 Distribution of Dentists in the United States by Region and State*, and Health Policy Resources Center, *2011 ADA Dental Workforce Model: 2009-2030*.

**Age Distribution.** The projection of the age distribution of professionally active dentists is presented in Table 2 as derived from the DWM for several periods from 2000-30. As can be seen in Table 2 and Figure 8, the upward age shift that had been predicted over the last few years has begun. In 2000, for example, there was a significant peak in the age distribution among the 45-49 age group (17.2% of professionally active dentists); by 2009, the peak (14.2%) in age distribution occurs among the 55-59 age group. By 2015, the age distribution will be flatter and more diffuse with significantly more dentists in higher age groups—the largest distribution of 12.9% occurring among the 60-64 age group.

**Table 2: Percentage Age Distribution of Professionally Active Dentists, 2000-2030**

Age Group	2000	2009	2015	2020	2025	2030
Under 30	4.33%	4.16%	2.13%	2.24%	2.40%	2.39%
30-34	9.99%	9.74%	10.57%	9.77%	10.35%	10.74%
35-39	11.98%	11.43%	11.33%	12.13%	11.49%	12.13%
40-44	15.24%	10.58%	11.20%	11.41%	12.25%	11.70%
45-49	17.20%	11.97%	10.48%	10.88%	11.14%	11.99%
50-54	14.94%	14.15%	10.88%	9.97%	10.40%	10.72%
55-59	10.51%	14.18%	12.46%	10.14%	9.32%	9.79%
60-64	6.53%	11.07%	12.86%	11.06%	9.08%	8.39%
65-69	4.69%	6.22%	9.63%	10.69%	9.19%	7.62%
70-74	2.43%	3.10%	5.00%	7.07%	7.94%	6.78%
Over 74	2.16%	3.38%	3.46%	4.64%	6.44%	7.75%

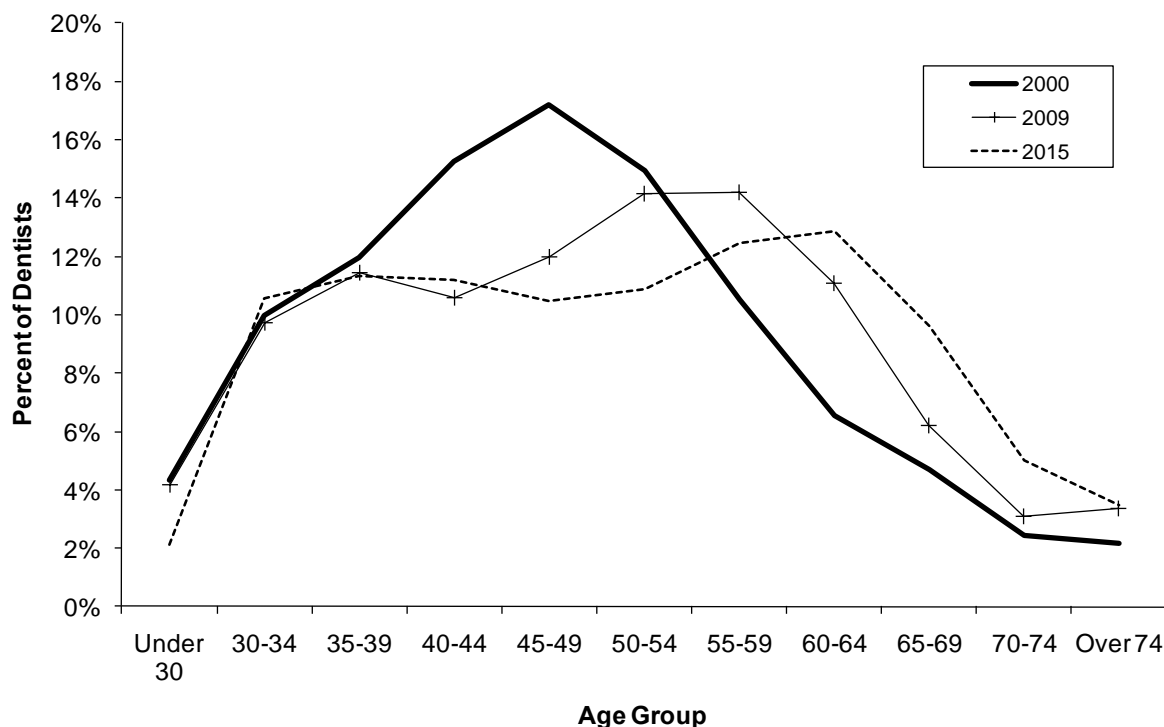
Source: American Dental Association, Survey Center, 2000 and 2009 *Distribution of Dentists in the United States by Region and State*, and Health Policy Resources Center, 2011 *ADA Dental Workforce Model: 2009-2030*.

One can observe from Table 2 that as the projection moves out along the time horizon, a growing proportion of active dentists will move past the most productive period for dentists—35 to 54 years of age. In 1991, 23.4% of active dentists were past this age group (over 54 years old); this trend peaks in 2020 leveling out at 43.7%. In fact, the single largest five-year age bracket in 2010 will be just past the highest productivity period (i.e., dentists 60-64 years old will account for 12.9% of professionally active dentists).

Overall, the percentage of dentists in the most productive age bracket (35-54 years old) was at a peak of 61.6% in 1996, from which it slid to 48.1% in 2009 and is projected to continue falling to 44.4% in 2020. That is, over the next six to 11 years, it is expected that a gradual “graying” of the U.S. dentist population will occur. Beyond 2020, the aging of the large number of 1980s dental graduates will be complete, and the age composition of dentists is expected to become much more stable.

The large “bubble” of the dentists educated in the 1970s—when federal capitation payments were in place and the relative financial returns to dentistry were simultaneously at an all time high—will help stabilize the age composition of dentists. As this group of dentists retires, the profession will encounter smoother workforce transitions. In the absence of future government intervention, the ensuing workforce is expected to be much more stable, both in terms of numbers and age distribution.

**Figure 8: Percentage Age Distribution of Professionally Active Dentists in 2000, 2009 and the Projected Distribution in 2015**



Source: American Dental Association, Survey Center, 2000 and 2009 *Distribution of Dentists in the United States by Region and State*, and Health Policy Resources Center, 2011 *ADA Dental Workforce Model: 2009-2030*.

**Sensitivity Analysis of the 2011 ADA Dental Workforce Model: 2009-2030:** The Dental Workforce Model (DWM) sensitivity analysis explores the sensitivity of various indicators of the dental workforce to the changes in rate of return to dental education (ROR). These indicators include the number of applicants to and graduates of dental schools, the number of professionally active dentists and the number of active private practitioners.

The ROR is a term used to express the return that dental students receive from their education investment over the course of their dental careers. Its calculation is supported with data on dentists' net incomes across all ages, the cost of dental education (net of scholarships), and data on incomes of competing careers, across all ages. Intuitively, one can expect the number of applicants, graduates, professionally active dentists and active private practitioners to rise if the ROR increases and to fall if the ROR decreases.

This section on sensitivity analysis explores the impact of changes in the ROR on future applicants, graduates, professionally active dentists and active private practitioners. The sensitivity analysis examines both a 2.5% increase and a 2.5% decrease in the ROR. In this analysis, a one-time change is applied to the 2009 ROR and, using the DWM, future RORs are projected to 2030. The change is applied to the base RORs, which as shown in Table A-1 ranged from 20.50% in 2009 to 20.72% in 2030.

After a one-time increase in ROR between 2009 and 2010 occurs, there is an increase in applicants almost immediately (see Figure A-1). This increase in applicants leads to an increase in graduates within five years,

1 or by 2014 (see Figure A-2). The effect of the increase in the ROR on graduates continues through the  
2 remainder of the projection. An increase in the number of professionally active dentists begins to emerge by  
3 2015 (see Figure A-3), as does an increase in the number of active private practitioners (see Figure A-4).  
4 This reflects the increase of graduates into the dental workforce from the previous three years. The impact of  
5 an increase in the ROR will continue as more graduates are added into the workforce.

6 A one-time decrease in the ROR has similar downward effects on applicants, graduates, professionally active  
7 dentists and active private practitioners. However, the magnitude of the effect of a downward adjustment of  
8 2.5% in the ROR seems to be slightly stronger compared to a 2.5% upward adjustment. The primary reason  
9 for this is that in the base-case scenario, the ROR is increased by 0.05% annually, including the 2009-10  
10 period when the two ROR adjustments take place. This results in the upward ROR adjustment being closer  
11 to the base-case ROR than the downward ROR adjustment (see Table A-1).

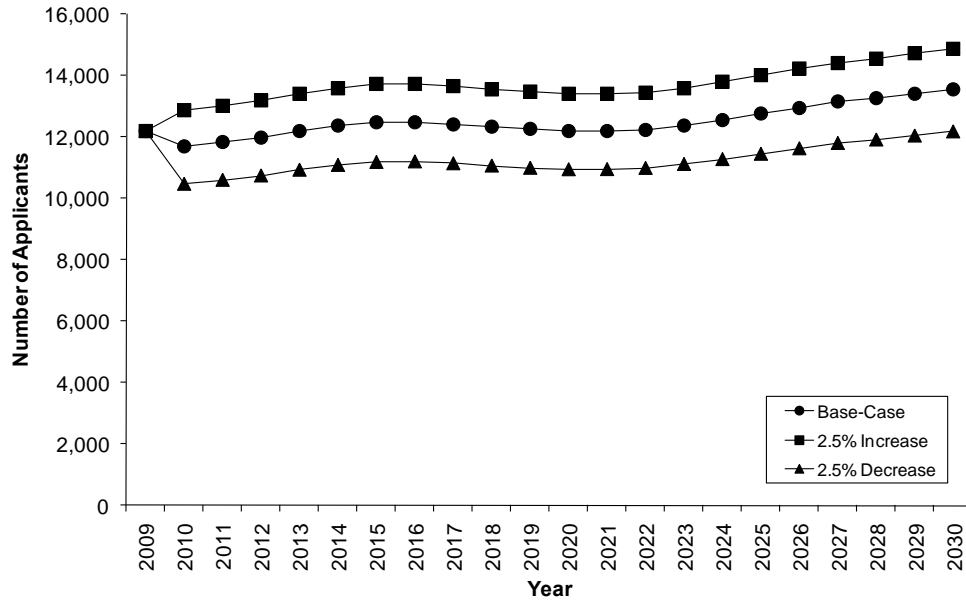
12 In conclusion, an adjustment in the ROR will begin to impact the size of the dental workforce within  
13 approximately six years. This impact will continue as more graduates are added to or as existing dentists are  
14 lost from the dental workforce.  
15

**Table A-1: Three Scenarios of Rate of Return Used for the Projections in Figures A-1 through A-4**

Year	Rate of Return		
	Base-Case	2.5% ROR Increase	2.5% ROR Decrease
2009	20.50%	21.01%	19.98%
2010	20.51%	21.02%	19.99%
2011	20.53%	21.03%	20.00%
2012	20.54%	21.04%	20.01%
2013	20.55%	21.05%	20.02%
2014	20.56%	21.06%	20.03%
2015	20.57%	21.07%	20.04%
2016	20.58%	21.08%	20.05%
2017	20.59%	21.09%	20.06%
2018	20.60%	21.10%	20.07%
2019	20.61%	21.11%	20.08%
2020	20.62%	21.12%	20.09%
2021	20.63%	21.13%	20.10%
2022	20.64%	21.14%	20.11%
2023	20.65%	21.15%	20.12%
2024	20.66%	21.16%	20.13%
2025	20.67%	21.18%	20.14%
2026	20.68%	21.19%	20.15%
2027	20.69%	21.20%	20.16%
2028	20.70%	21.21%	20.17%
2029	20.71%	21.22%	20.18%
2030	20.72%	21.23%	20.19%

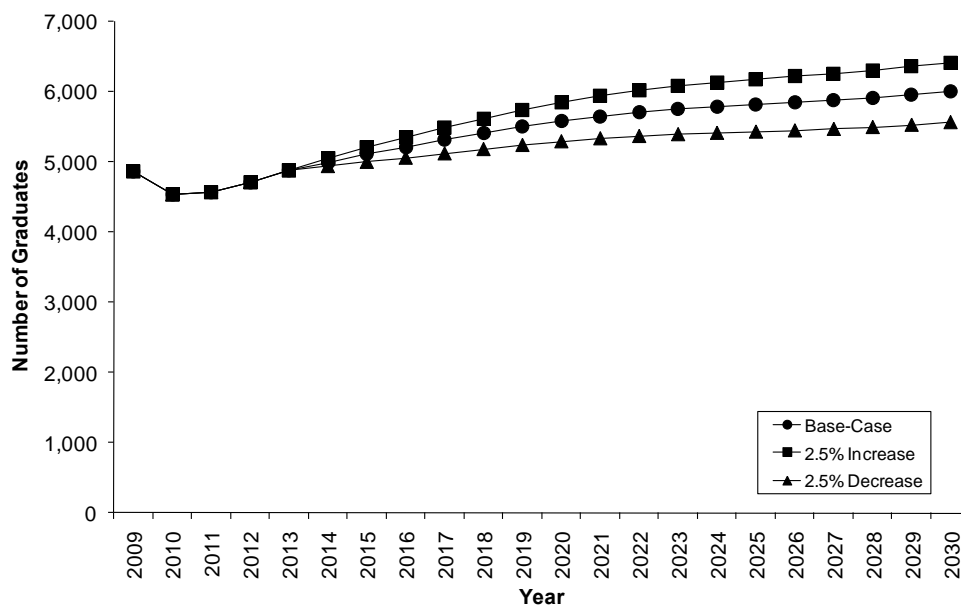
Source: American Dental Association, Health Policy Resources Center,  
2011 ADA Dental Workforce Model: 2009-2030.

**Figure A-1: Projected Number of Dental School Applicants Under Base-Case, Increasing and Decreasing Rate of Return Scenarios, 2009-2030**



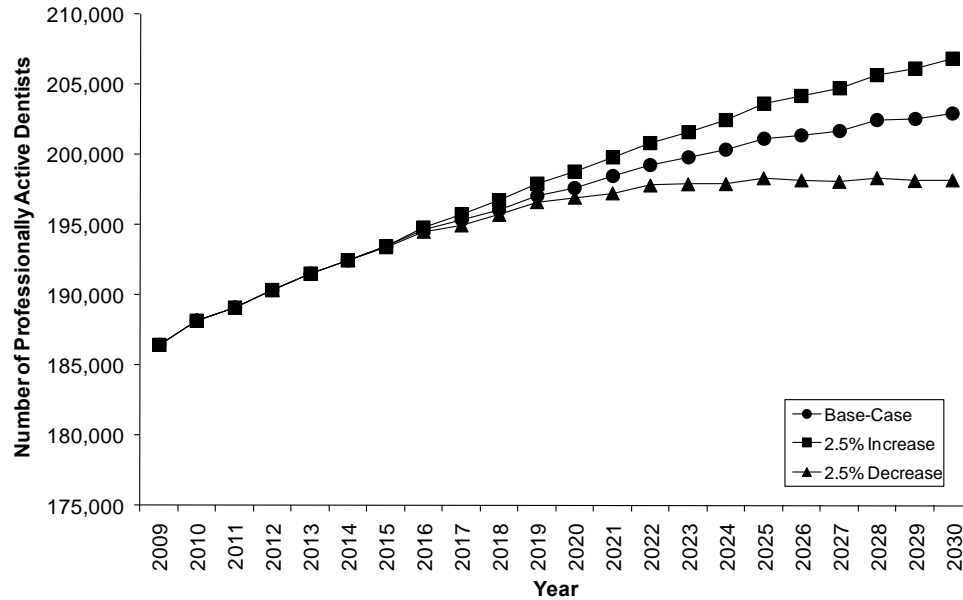
Source: American Dental Association, Health Policy Resources Center, 2011 ADA Dental Workforce Model: 2009-2030.

**Figure A-2: Projected Number of Dental School Graduates Under Base-Case, Increasing and Decreasing Rate of Return Scenarios, 2009-2030**



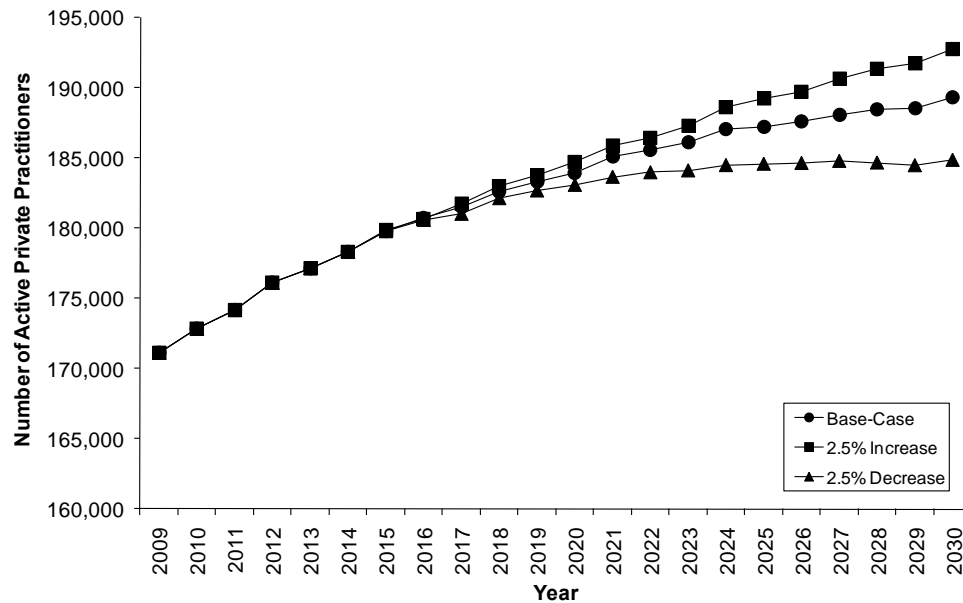
Source: American Dental Association, Health Policy Resources Center, 2011 ADA Dental Workforce Model: 2009-2030.

**Figure A-3: Projected Number of Professionally Active Dentists Under Base-Case, Increasing and Decreasing Rate of Return Scenarios, 2009-2030**



Source: American Dental Association, Health Policy Resources Center, 2011 ADA Dental Workforce Model: 2009-2030.

**Figure A-4: Projected Number of Active Private Practitioners Under Base-Case, Increasing and Decreasing Rate of Return Scenarios, 2009-2030**



Source: American Dental Association, Health Policy Resources Center, 2011 ADA Dental Workforce Model: 2009-2030.



Resolution No. 60 New ☒ Substitute ☐ Amendment ☐  
Report: NA Date Submitted: September 2011  
Submitted By: Fourteenth Trustee District  
Reference Committee: Dental Benefits, Practice and Health  
Total Net Financial Implication: None (FTE 0.01) Net Dues Impact: \$  
Amount One-time \$ Amount On-going \$  
ADA Strategic Plan Goal: Members (Required)

# **LEARNING THE LESSONS OF CONTRACT ANALYSIS**

The following resolution was adopted by the Fourteenth Trustee District and transmitted on September 25, 2011, by Dr. Thomas Schripsema, chair, Resolutions Committee.

**Background:** One of the most difficult decisions dentists face is whether to sign a managed care contract. Too often dentists fail to look past the fee schedule and sign managed care contracts they later regret. The ADA's Contract Analysis Service reviews contracts for constituent dental societies or individual dentists. ADA members should benefit from the numerous contracts that have been reviewed. Making this information available in Association publications and the website will aid many by improving their ability to critically evaluate contracts they may be presented with.

## **Resolution**

**60. Resolved**, that the Council on Dental Benefit Programs in consultation with the Contract Analysis Service and the Council on Communications, prepare a series of articles suitable for publication that document and explain commonly encountered areas of concern in third party contracts, and be it further

**Resolved**, that content from the articles be used to prepare a brochure for distribution to new dentists and others with questions about managed care contracts, and made available on the Association website.

**BOARD RECOMMENDATION:** Received after this section had been reproduced for House distribution.



Resolution No. 61 New ☒ Substitute ☐ Amendment ☐Report: NA Date Submitted: September 2011Submitted By: Fourteenth Trustee DistrictReference Committee: Dental Benefits, Practice and HealthTotal Net Financial Implication: None (FTE 0.25) Net Dues Impact: \$Amount One-time \$ Amount On-going \$ADA Strategic Plan Goal: Members (Required)**PRACTICAL DEVELOPMENT OF TELEDENTISTRY**

The following resolution was adopted by the Fourteenth Trustee District and transmitted on September 25, 2011, by Dr. Tom Schripsema, chair, Resolutions Committee.

**Background:** While many barriers to care are economic, some obstacles are the quantitative and qualitative distances of rural communities, inner cities, and resident care facilities, or cultural isolation in Native American or immigrant communities. Economists point out that underserved populations and distribution of practitioners is largely market driven. Government manipulation of the marketplace is both costly and unsustainable.

Technology does offer possibilities for merging markets to create viable practices or projecting dental care resources that are not fully utilized in urban or suburban areas to alternative care or geographically isolated settings. It also allows remote diagnosis by fully-qualified dentists and supervision of community-based culturally sensitive auxiliaries. Within the profession, digital technology can facilitate the education of students or residents providing care in high need areas or allow the support of rural-based general dentists by remotely located specialists.

As is often the case, the technology is readily available and evolving rapidly, but the ethical, economic and practical considerations of putting it into practice are largely undeveloped. Reporting codes, compensation protocols, liability concerns, and even communications standards are largely non-existent. We are already playing "catch up," which makes it imperative that the brain trust of the profession begin a concerted effort to define what is going to increasingly characterize 21st century practice.

**Resolution**

**61. Resolved,** that the Council on Dental Practice, Council on Access, Prevention and Interprofessional Relations, Council on Government Affairs, Council on Dental Education and Licensure, Council on Dental Benefit Programs, Council on Ethics, Bylaws and Judicial Affairs, and other appropriate Association agencies, consider teledentistry as it relates to their individual missions to identify the following:

- appropriate applications for teledental technology in education and delivery of care
- limits of efficacy, scope of practice and development of practice parameters
- economically viable delivery models
- existing educational, reporting, and reimbursement barriers to technologies and practices
- regulatory and legislative changes needed to expedite IT facilitated care
- ethical and liability considerations of technology-assisted care

1 and be it further

2 **Resolved**, that designated representatives of each of these agencies will conference electronically to  
3 identify priorities and an appropriate Association action plan to be presented to the 2012 House of  
4 Delegates.

5 **BOARD RECOMMENDATION: Received after this section had been reproduced for House**  
6 **distribution.**

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Resolution No.   65                                  New ☒         Substitute ☐         Amendment ☐

Report: NA Date Submitted: September 2011

Submitted By: Fourteenth Trustee District

Reference Committee: Dental Benefits, Practice and Health

**Total Net Financial Implication:** \$300,000 (FTE 0.75)      **Net Dues Impact:** \$2.81

Amount One-time      \$ \_\_\_\_\_      Amount On-going      \$ \_\_\_\_\_

ADA Strategic Plan Goal:      Members      (Required)

## DEVELOPING CDHC PRACTICE MODELS

The following resolution was adopted by the Fourteenth Trustee District and transmitted on September 25, 2011, by Dr. Thomas Schripsema, chair, Resolutions Committee.

**Background:** Although the Community Dental Health Coordinator (CDHC) project is making steady progress, as we enter the stage where they begin to facilitate care, little thought has been given to employing them in settings that are beyond the scope of the pilot projects. In many cases, the ideal model will be private practices that are serving isolated communities through satellites or that are expanding their practices to include previously underserved population. In fact, with public money tight and impending cuts to assistance programs, the only viable long-term models may be private.

## Resolution

**65. Resolved,** that the appropriate ADA councils and agencies develop alternative practice models to integrate Community Dental Health Coordinators (CDHC) into both private and publicly-funded practice settings, and be it further

**Resolved**, that in developing models, the ADA councils and agencies should consult health care economists, practice management specialists and practitioners currently supervising CDHCs, and be it further

**Resolved**, that the ADA councils' and agencies' report be prepared as a white paper suitable for presentation to practitioners and institutions considering adding the services of a CDHC as well as interested government, regulatory and advocacy entities.

**BOARD RECOMMENDATION:** Received after this section had been reproduced for House distribution.



Resolution No. 76 New ☒ Substitute ☐ Amendment ☐Report: NA Date Submitted: October 2011Submitted By: Eleventh Trustee DistrictReference Committee: Dental Benefits, Practice and HealthTotal Net Financial Implication: None (FTE: 0) Net Dues Impact: \$Amount One-time \$ Amount On-going \$ADA Strategic Plan Goal: Members (Required)**ADA ALTERNATE PROPOSAL TO THE MIDDLELEVEL PROVIDER PILOT PROJECT**

The following resolution was submitted by the Eleventh Trustee District Caucus and transmitted on October 6, 2011, by Ms. Amanda Tran, caucus coordinator.

**Background:** During the past three years issues surrounding **workforce solutions to a shortage of patient access to care have revolved around various philanthropic foundations' proposals that so called "midlevel" providers or "dental therapists" would solve this problem due to improved economics that might result in lower patient costs.** This solution, however, ignores the fact that the population being treated still does not have the funding support to receive even reduced fee care or ongoing preventive services. This solution ignores the fact that the money spent to train this type of provider could be better used to pay those dentists who are already trained to do the work on those that have **NO MONEY** to afford care. The other factors not recognized by the foundations are that the narrow scope of practice of midlevel providers does not address the more comprehensive needs of patients in a population that on the whole has more complex problems than the average population.

As a result of this dilemma, the dental profession must recommend **solutions** which would be more effective in solving access to care problems than in the past. These solutions could involve formal loan forgiveness programs for dentists willing to serve in underserved areas both in rural and urban environments, the expansion of general dentistry graduate programs to serve in underserved areas or the **funding of individual dentist service in certain clinics.**

This resolution suggests the latter approach as one solution that could impact the current lack of access and could be expanded without creating a new infrastructure to improve access to care. This resolution might also help the increasing problem of the student debt that dentists are faced with upon graduation from dental schools.

The funding amount of \$8 million which is similar to that invested in the CDHC program would create approximately 32 practitioners providing 12 days of work in underserved clinics per year at approximately 1 day per month at approximately \$600-\$800 dollars a day.

**Resolution**

**76. Resolved,** that the ADA urge the American Dental Association Foundation to form an \$8 million endowment whose interest is used to fund individual dentists to serve in underserved non-profit community clinics at the rate of one day per month per individual dentist, and be it further

1       **Resolved**, that the ADA Foundation be urged to make this funding in the form of grants to up to 32 state  
2       constituent dental society foundations who shall oversee the operation of this pilot in their states, and be it  
3       further

4       **Resolved**, that funding for this pilot project shall come from the ADA Foundation or any other foundation  
5       that wishes to help the underserved and poor in our country that cannot afford dental work and not from  
6       an increase in dues, and be it further

7       **Resolved**, that the ADA Foundation be urged to assess the results of these pilot projects for amount of  
8       production produced at the end of three years as to its impact as one possible solution for the care for  
9       underserved patients as well as the number of dentists it has helped who are not fully employed and to  
10      report to the 2014 House of Delegates.

11      **BOARD RECOMMENDATION: Received after this section had been reproduced for House**  
12      **distribution.**



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## Dental Education, Science and Related Matters



Resolution No. 6 New ☒ Substitute ☐ Amendment ☐  
 Report: NA Date Submitted: July 2011  
 Submitted By: Council on Dental Education and Licensure  
 Reference Committee: Dental Education, Science and Related Matters  
 Total Net Financial Implication: None Net Dues Impact: \$  
 Amount One-time \$ Amount On-going \$  
 ADA Strategic Plan Goal: Members (Required)

**AMENDMENT OF THE POLICY,  
COMPREHENSIVE STUDY OF DENTAL SPECIALTY EDUCATION AND PRACTICE**

**Background:** (*Reports:91*) The following is the pertinent information from the Council on Dental Education and Licensure's annual report.

The Council considered two policies related to the Periodic Review of Dental Specialty Education and Practice and concluded that the 2001 policy, Comprehensive Study of Dental Specialty Education and Practice, should be modified to reflect the recommendation that these reviews continue on an ongoing 10-year basis. The Council believes that the 1992 policy, Periodic Review of Dental Specialty Education and Practice, is redundant and recommends rescission.

**Resolution**

**6. Resolved**, that the policy, Comprehensive Study of Dental Specialty Education and Practice (*Trans.2001:468*), be amended as follows (proposed deletions are ~~stricken~~; proposed additions are underlined):

**~~COMPREHENSIVE STUDY~~ PERIODIC REVIEW OF DENTAL SPECIALTY EDUCATION AND PRACTICE**

**Resolved**, that the Council on Dental Education and Licensure, on behalf of the ~~appropriate~~ Association, ~~agency continue to~~ conduct a periodic reviews of dental specialty education and practice at ten-year intervals, and be it further

**Resolved**, that the Council report the results of the reviews ~~next periodic review of dental specialty education and practice be presented to the 2014 ADA House of Delegates.~~

**BOARD RECOMMENDATION: Vote Yes.**

Board Vote:														
Yes	No	Abstain	Absent		Yes	No	Abstain	Absent		Yes	No	Abstain	Absent	
<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	BLANTON	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	KIESLING	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	STEFFEL
<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	CALNON	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	LONG	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	SUMMERHAYS
<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	ENGEL	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	LOW	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	THOMPSON
<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	FAIELLA	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	NORMAN	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	VERSMAN
<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	FEINBERG	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	RICH	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	VIGNA
<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	GOUNARDES	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	SEAGO	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	WEBER
<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	HAGENBRUCH	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	SMITH, A. J.					Res. 6



Resolution No. 7 New ☒ Substitute ☐ Amendment ☐Report: NA Date Submitted: July 2011Submitted By: Council on Dental Education and LicensureReference Committee: Dental Education, Science and Related MattersTotal Net Financial Implication: None Net Dues Impact: \$Amount One-time \$ Amount On-going \$ADA Strategic Plan Goal: Members (Required)

**RESCISSION OF THE POLICY,  
PERIODIC REVIEW OF SPECIALTY EDUCATION AND PRACTICE**

**Background:** (*Reports:91*) The following is the pertinent information from the Council on Dental Education and Licensure's annual report.

The Council considered two policies related to the Periodic Review of Dental Specialty Education and Practice and concluded that the 2001 policy, Comprehensive Study of Dental Specialty Education and Practice, should be modified to reflect the recommendation that these reviews continue on an ongoing 10-year basis. The Council believes that the 1992 policy, Periodic Review of Dental Specialty Education and Practice, is redundant and recommends rescission.

**Resolution**

**7. Resolved**, that the following policy, Periodic Review of Specialty Education and Practice (*Trans.1992:620*), be rescinded:

**Resolved**, that the concept of the Association maintaining a mechanism for the periodic review of specialty education and practice be endorsed, and be it further

**Resolved**, that beginning in 2001, the Council on Dental Education and Licensure forward recommendations from this review to the House of Delegates for its consideration.

**BOARD RECOMMENDATION: Vote Yes.**

**BOARD VOTE: UNANIMOUS. (BOARD OF TRUSTEES CONSENT CALENDAR ACTION—NO BOARD DISCUSSION)**



Resolution No. 8 New ☒ Substitute ☐ Amendment ☐Report: NA Date Submitted: July 2011Submitted By: Council on Dental Education and LicensureReference Committee: Dental Education, Science and Related MattersTotal Net Financial Implication: None Net Dues Impact: \$Amount One-time \$ Amount On-going \$ADA Strategic Plan Goal: Members (Required)**AMENDMENT OF THE POLICY STATEMENT ON CONTINUING DENTAL EDUCATION****Background:** (*Reports:96*)**Review of the Policy Statement on Continuing Dental Education and the Request of the Council on Ethics, Bylaws and Judicial Affairs to Classify Ethics as a Clinical Subject for Continuing Education**

**Purposes:** In November 2010, the Council reviewed a request from the Joint ADA Subcommittee on Ethics and Integrity in Dental Education and Practice that ethics be classified as a clinical subject for purposes of continuing education. The Council supported the concept that ethics-related continuing education should be, when appropriate, classified as "clinical" continuing education and also that clinical continuing education courses may include ethical education; however, the Council recognized that the recognition of such CE classifications for licensure renewal purposes rests with the licensing jurisdictions.

Subsequently, the Council received correspondence from the Council on Ethics, Bylaws and Judicial Affairs (CEBJA) noting that, "ethics is not simply a matter of management of practice but rather an inseparable component of virtually all clinical treatment decisions."

The Council reviewed the request, the Association's Policy Statement on Continuing Dental Education and the Association's 2009 Continuing Education Regulatory Summary, noting that:

- 13 states allow CE credit for ethics courses
- 37 states allow self-instructional activities, although some have limitations such as no more than half of the CE requirement
- Required courses for many states include CPR and infectious diseases
- Many states do not accept CE credit for instruction in finances, personal health and practice management or money management

The Council concluded that the Association's Policy Statement on Continuing Dental Education should be amended to reflect the changing nature of continuing education and support ethics as continuing education. Accordingly, the Council forwards the following resolution to the House of Delegates:

**Resolution**

**8. Resolved**, that the Association's Policy Statement on Continuing Dental Education (*Trans.*2006: 331) be amended as follows (proposed additions are underlined; proposed deletions are ~~stricken~~):

**Policy Statement on Continuing Dental Education**

**Definition of Continuing Dental Education:** Continuing dental education consists of educational activities designed to review existing concepts and techniques, to convey information beyond the basic dental education and to update knowledge on advances in scientific, clinical, and non-clinical ~~practice~~ related subject matter, including evidence-based dentistry and ethics. The objective is to improve the knowledge, skills and ability of the individual to provide the highest quality of service to the public and the profession. All continuing dental education should strengthen the habits of critical inquiry, ~~and~~ balanced judgment and ethics that denote the truly professional and scientific person and should make it possible for new knowledge to be incorporated into the practice of dentistry as it becomes available.

Continuing education programs are designed for part-time enrollment and are usually of short duration, although longer programs with structured, sequential curricula may also be included within this definition. In contrast to accredited advanced dental education programs, continuing dental education programs do not lead to eligibility for ethical announcements or certification in a specialty recognized by the American Dental Association. Continuing dental education should be a part of a lifelong continuum of learning.

**Acceptable Subject Matter:** In order for specific course subject material to be acceptable for credit, the stated course objectives, overall curriculum design or topical outlines should be clearly stated. The information presented should enable the dental professional to enhance the dental health of the public, either directly or through improved effectiveness of operations in dental practice, or through expansion of present knowledge through research. The dental professional should be able to apply the knowledge gained within his or her professional capacity.

**Acceptable Activities:** Continuing education activities are conducted in a wide variety of forms using many methods and techniques which are sponsored by a diverse group of institutions and organizations. State boards and/or legislatures may specify acceptable activities or content. The Association urges the state boards to allow maximum flexibility for an individual to choose content and learning activities based on individual preferences, needs, interests and resources. Additionally, clinical credit should be awarded for all activities related to the delivery of dental procedures including those with ethical components and self study activities.

Acceptable forms might include but are not limited to:

- attendance at and/or delivery of a formal continuing education course (a didactic and/or participatory presentation to review or update knowledge of new or existing concepts and techniques)
- general attendance at a multi-day convention type meeting (a meeting held at the national, state or regional level which involves a variety of concurrent educational experiences)
- authorship of publications (e.g., a book, a chapter of a book or an article or paper published in a professional journal)
- completion of self study activities individualized continuing education instruction such as online courses and research, webinars, journal articles and downloadable books (~~a individualized~~ course of study which is structured and organized, but is available on an unscheduled and unsupervised basis; a method of providing feedback to the learner on performance or comprehension must be incorporated into the self-study activity)



- enrollment in a preceptor program (an independent course of study with a formally structured, preplanned and prescheduled curriculum where the participant observes and provides patient treatment using criteria and guidelines provided by the instructors; this type of study does not lead to an academic degree)
- academic service (e.g., instruction, administration or research related to undergraduate, postgraduate or graduate dental or allied dental training programs)
- presenting posters or table clinic
- participation on a state dental board, a board complaint investigation, peer review or quality care review procedures
- successful completion of Part II of the National Board Dental Examination, a recognized dental specialty examination or the National Board Dental Hygiene Examination if taken after initial licensure
- test development for written and clinical dental, dental hygiene and dental specialty examinations
- volunteering pro bono dental services or community oral health activities through instruction at a public health facility
- participation in dental research as a principal investigator or research assistant

**BOARD RECOMMENDATION: Vote Yes.**

Board Vote:														
Yes	No	Abstain	Absent		Yes	No	Abstain	Absent		Yes	No	Abstain	Absent	
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<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	ENGEL	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	LOW	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	THOMPSON
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<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	HAGENBRUCH	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	SMITH, A. J.					Res. 8



Resolution No. 13 New ☒ Substitute ☐ Amendment ☐Report: NA Date Submitted: July 2011Submitted By: Council on Scientific AffairsReference Committee: Dental Education, Science and Related MattersTotal Net Financial Implication: None Net Dues Impact: \$Amount One-time \$ Amount On-going \$ADA Strategic Plan Goal: Public Health (Required)**RESCISSION OF POLICY ON USE OF APPROVED MATERIALS  
IN NEW TECHNIQUES AND PRODUCTS****Background:** (*Reports:210*)

**Review of Association Policies:** The Council reviews existing ADA policies and recommends updates or rescissions as appropriate. Pending implementation of the Board of Trustees' timetable and protocol for the new ADA policy review process (per Resolution 111H-2010), the Council conducted sunset review of an ADA policy related to the Seal of Acceptance Program, as addressed in the following section.

**ADA Policy on Use of Approved Materials in New Techniques and Products:** At its March 2011 meeting, the Council reviewed a 1977 ADA policy on the Use of Approved Materials in New Techniques and Products, which reads:

**Resolved,** that the use of American Dental Association approved materials in new techniques and products does not constitute approval of such techniques and/or end products by the Association.

The Council determined that the policy's use of the term "approved" is not current as it relates to the Seal of Acceptance Program, which uses the term "Accepted" or "ADA-Accepted" to identify products that meet the Seal Program's evaluation criteria for safety and effectiveness. The Council also agreed that the phrase "techniques and/or end products" refers to professional dental products and related clinical techniques. Given the discontinuation of the Seal Program for professional materials and products, and implementation of professional product evaluation through the *ADA Professional Product Review*, the Council supported submitting a proposal to the 2011 House of Delegates that recommends rescission of the 1977 ADA policy. The Council also considered updating the 1977 policy rather than proposing it for rescission, but the Council learned that issues of this nature are effectively managed via written communication from the ADA Division of Legal Affairs to the offending individual, business or organization.

In accordance with the ADA Strategic Plan goal to "be the trusted resource for oral health information that will help people be good stewards of their own oral health," the following resolution is presented for the House's consideration.

**Resolution**

**13. Resolved,** that the ADA policy statement entitled Use of Approved Materials in New Techniques and Products (*Trans.*1977:939) be rescinded.

**BOARD RECOMMENDATION: Vote Yes.**

**BOARD VOTE: UNANIMOUS. (BOARD OF TRUSTEES CONSENT CALENDAR ACTION—NO BOARD DISCUSSION)**



Resolution No. 39 New ☒ Substitute ☐ Amendment ☐  
 Report: NA Date Submitted: September 2011  
 Submitted By: CODA Monitoring Committee  
 Reference Committee: Dental Education, Science and Related Matters  
 Total Net Financial Implication: None Net Dues Impact: \$  
 Amount One-time \$ Amount On-going \$  
 ADA Strategic Plan Goal: Public Health (Required)

**REPORT OF THE CODA MONITORING COMMITTEE TO THE 2011 HOUSE OF DELEGATES:  
ACTIVITIES UPDATE**

**Executive Summary:** As directed by Resolutions 37H-2008, 53H-2009 and 78H-2010, this report presents the activities of the CODA Monitoring Committee, charged to monitor and assist the Commission on Dental Accreditation in implementing recommendations from the 2008 Report of the Task Force on the Commission on Dental Accreditation. Almost all (31 out of 34) of the Task Force's recommendations have been or are being implemented by CODA, resulting in the CODA Monitoring Committee completing its charge. The Monitoring Committee believes that CODA's implementation of the recommendations, particularly those related to increasing communications with its communities of interest, demonstrates CODA's commitment to implement change. The Monitoring Committee believes that it has completed its charge and that the ADA should rely on its Council on Dental Education and Licensure (CDEL) as well as the ADA Board Liaisons to CODA and CDEL to serve as the ongoing mechanisms for monitoring and communicating CODA business to appropriate ADA agencies. Accordingly, the Monitoring Committee presents a resolution to the House of Delegates to call upon CDEL and the CODA and CDEL Trustee Liaisons to monitor and communicate accreditation matters for the Association and to sunset the CODA Monitoring Committee.

**Background:** The ADA House of Delegates adopted Resolution 37H-2008, directing that a seven-member committee be appointed to assist and monitor CODA's implementation of 34 recommendations cited in the 2008 ADA Task Force Report on CODA. CODA began its review and implementation of the Task Force recommendations in 2009 in conjunction with the Monitoring Committee; activities continued in 2010 and 2011. Resolution 53H-2009 provided for continuation of the Monitoring Committee in 2010.

Resolution 78H-2010 directed the continuation of the activity:

**78H-2010. Resolved,** that the President continue to appoint a monitoring committee for the express purpose of continuing to communicate with and assist CODA in implementing the recommendations of the CODA Task Force Report, and be it further

**Resolved,** that the committee consist of two members of the Board of Trustees (one of whom serves as Board liaison to CODA) and one member of the House of Delegates, and be it further

**Resolved,** that the committee provide regular updates to the ADA Board of Trustees, and be it further

**Resolved,** that the committee submit a report to the 2011 ADA House of Delegates.

Members of the CODA Monitoring Committee for 2011 included Dr. Kathryn Kell, chair, ADA Delegate, IA; Dr. Robert Faiella, ADA First District Trustee; and Dr. Roger Kiesling, ADA Eleventh District Trustee and Liaison to CODA.

**CODA Monitoring Committee 2011 Activities:** Members of the Monitoring Committee met via conference call on January 5, 2011. They reviewed the Committee's charge, status of the recommendations cited in the 2008 CODA Task Force Report, agenda for the February 4, 2011 CODA meeting and a proposed Committee meeting calendar for 2011. The Committee members discussed their belief that there is now a more clear understanding of CODA's membership, communication and financial structures among ADA leadership and members. They discussed potential controversial issues CODA would address in 2011, e.g., a policy on eligibility for accrediting programs in a new allied discipline and potential ways for CODA to become less dependent on the ADA for financial support. They also noted that CODA's application to the Secretary of the U.S. Department of Education for recognition as the accrediting agency for dental, advanced dental and allied dental education programs must be submitted to the Secretary by December 2011. The Secretary will be looking for compliance with established federal regulations and assurances of good accreditation practices related to student achievement, job placement rates, etc.

On January 19, 2011 members of the Monitoring Committee teleconferenced and briefed the four ADA appointees serving on CODA, i.e., Dr. Michael Biermann, Dr. Reuben Pelot, Dr. Steven Schonfeld and Dr. Steven Tonelli. Dr. Kathryn Kell, Monitoring Committee chair, planned to attend the February 5, 2011 CODA meeting but her travel was cancelled due to blizzard weather conditions. Dr. Kiesling did attend the CODA meeting. The Commission reviewed the progress to date in implementing the 34 ADA recommendations cited in the 2008 Task Force Report and actions of the 2010 ADA House of Delegates relating to the ADA Task Force Report. The Commission took the following actions in response to the ADA Task Force Report on CODA and the resolutions adopted by the 2010 ADA HOD:

- The Commission adopted a six-month training period in 2012 for all new Commissioners whose appointments begin in 2013, which will include attendance at a Commission meeting, at the discipline-specific review committee meeting, and at an appropriate site visit. The Commission further directed that the effectiveness of the training period be evaluated at the end of the first cycle to determine if the length is sufficient to accomplish intended goals (recommendation #11).
- The Commission directed that all expenses associated with the six-month training period for new Commissioners be included in the Commission's annual budget (recommendation #11).
- The Commission directed that the annual accreditation fees and application fees for 2012 be increased by 5.75%. This is less than the 7.2% increase proposed to meet the equitable split in expenses between the ADA and the Commission by 2016. This is due to an anticipated decrease in expenses from 2011 and an increase in revenue from initial accreditation applications over 2011(recommendations #3 and #4).

On July 26, 2011, the Monitoring Committee teleconferenced to review the items on CODA's August 4-5 meeting agenda and again review the unmet recommendations cited in the 2008 Task Force Report on CODA. On August 3, Dr. Kell and Dr. Kiesling met personally with three of the ADA-appointed Commissioners, Dr. Michael Biermann, Dr. Steven Schonfeld and Dr. Steven Tonelli.

Drs. Kell, Faiella and Kiesling observed the August 5, 2011 CODA meeting and noted that the Commission took the following actions in response to the recommendations cited in the Report of the ADA Task Force on CODA and suggestions made by CODA's Standing Committee on Communication and Technology:

- Directed the circulation of the electronic newsletter (CODA Communicator) to the CODA Standing Committee on Communication and Technology for review prior to each publication. The Commission directed staff to refine the distribution process used to disseminate the newsletter to create smaller distribution groups and to emphasize with recipients the importance of adding CODA to their address book to alleviate loss of the newsletter in spam filters (recommendation #21).
- Directed the establishment of a "Question and Answer Room" beginning at the 2012 American Dental Education Association Annual Session, with the goal of providing an opportunity for program

administrators and faculty to meet CODA staff and Commissioners to increase accessibility to the Commission and provide one-on-one time for questions and discussion (recommendation #22).

- Directed CODA staff to submit to the ADA Communications and Marketing Division the CODA Strategic Communications Plan worksheet to initiate the process of developing a CODA-specific communication and marketing strategy. The Commission further directed that the Standing Committee engage with the Communications and Marketing Division to establish the proposed plan and provide future updates to the Commission (recommendation #23).
- Directed the re-submission of HOD Resolution 55-2009–Dedicated Staff to Sustain Implementation of CODA Communications Plan, at a future date, following the development of a CODA communications plan and job description for a dedicated staff position (recommendation #24).
- Directed the Standing Committee on Communication and Technology to further study the feasibility of a system for continuous monitoring of programs, including development of criteria and guidelines and determining the methods and frequency for continuous monitoring and to present an update at a future Commission meeting (recommendation #29).
- Directed the CODA Standing Committee on Communication and Technology to continue to monitor enhancements in technology for the purpose of streamlining the self-study and accreditation process (recommendation #30).

The Commission took the following action in response to recommendation #28 cited in the 2008 Report of the ADA Task Force on CODA and suggestion made by CODA's Standing Committee on Quality Assurance and Strategic Planning:

- Directed that a resolution be forwarded to the 2011 ADA House of Delegates, as outlined in the 2008 Report of the ADA Task Force on CODA, requesting financial resources to hire outside facilitation to assist the Commission in developing a strategic plan. (recommendation #28)

Also on August 5, following the Commission's adjournment, a joint meeting of the ADA Monitoring Committee and CODA's Subcommittee charged with addressing the 2008 Report of the ADA Task Force on CODA was held to review the actions taken by CODA related to the recommendations from the Standing Committee on Communication and Technology and the Standing Committee on Quality Assurance and Strategic Planning. The ADA Monitoring Committee was supportive of all of the Commission's actions in response to the recommendations, including the recommendation that CODA pursue funding from the 2011 House of Delegates to hire an outside strategic planning facilitator. A summary of CODA's progress in implementing the recommendations is included in CODA's Supplemental Report 1 to the House of Delegates: Implementation of Recommendations in the Report of the Taskforce on the Commission on Dental Accreditation (Worksheet:4030).

The committees also discussed the Commission's action granting the University of Minnesota's request to develop accreditation standards for dental therapy education programs. The consensus was that the Commission should report this action in a Supplemental Report to the 2011 House of Delegates and include the three options considered by the Commission and the ramifications of denying the request. The committees also believed that this action should be communicated immediately by CODA to the communities of interest.

Finally, the two committees discussed whether an ADA Monitoring Committee should be sunset or re-appointed in 2012 to further assist the Commission in the evaluation and implementation of the ADA Task Force on CODA Recommendations. Both committees acknowledged that the working relationship between the ADA Monitoring Committee and the CODA Subcommittee has been highly effective in assisting the Commission in implementing the ADA Task Force recommendations. They concluded that the changes

initiated by the Commission regarding transparency in communication have been excellent and discussed the merits of calling upon the ADA Council on Dental Education and Licensure (CDEL) as well as the ADA Board Liaisons to CODA and CDEL to now serve as the ongoing mechanism for monitoring and communicating accreditation awareness among ADA agencies and the Commission. It was also noted that ADA *Bylaws* duties of CDEL include:

- “Act as the agency of the Association in matters related to the evaluation and accreditation of all dental educational, dental auxiliary educational and associated subjects,” and
- “Study and make recommendations including the formulation and recommendation on policy on: (1) Dental education and dental auxiliary education..... (6) Associated subjects that affect all dental, dental auxiliary and related education.”

The Monitoring Committee recommends that CDEL include in its budgeting process funding for a Council member to attend CODA’s two meetings each year. Funding for the Monitoring Committee’s activities already included in the Division of Education’s 2012 budget (\$3,500) can be used to fund the two trips for one CDEL member to attend the 2012 CODA meetings (\$2,500).

In summary, the CODA Monitoring Committee believes that it has completed its charge and recommends that future monitoring of accreditation matters on behalf of the ADA be managed by the Council on Dental Education and Licensure in collaboration with the CODA and CDEL Trustee Liaisons. Accordingly, the ADA Monitoring Committee recommends adoption of the following resolution.

### Resolution

**39. Resolved** that the Council on Dental Education and Licensure as well as the ADA Trustee Liaisons to CODA and CDEL serve as the ongoing mechanism for monitoring and communicating accreditation matters among ADA agencies and the Commission, and be it further

**Resolved**, that one member of the Council on Dental Education and Licensure attend the Commission on Dental Accreditation’s two meetings each year and report observations and findings to the Council and other appropriate agencies of the ADA, and be it further

**Resolved**, that as the charge set forth by Resolution 78H-2010 has been completed, the ADA CODA Monitoring Committee be sunset.

### BOARD RECOMMENDATION: Vote Yes.

Board Vote:														
Yes	No	Abstain	Absent		Yes	No	Abstain	Absent		Yes	No	Abstain	Absent	
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Resolution No. 40 New ☒ Substitute ☐ Amendment ☐  
 Report: CODA Supplemental Report 1 Date Submitted: September 2011  
 Submitted By: Commission on Dental Accreditation  
 Reference Committee: Dental Education, Science and Related Matters  
 Total Net Financial Implication: \$23,750 Net Dues Impact: \$ 0.22  
 Amount One-time \$23,750 Amount On-going \$  
 ADA Strategic Plan Goal: Collaboration (Required)

**COMMISSION ON DENTAL ACCREDITATION SUPPLEMENTAL REPORT 1 TO THE HOUSE OF DELEGATES: PROGRESS ON IMPLEMENTATION OF RECOMMENDATIONS IN THE 2008 REPORT OF THE TASK FORCE ON THE COMMISSION ON DENTAL ACCREDITATION**

**Executive Summary:** As directed by Resolution 37H-2008, this report provides a progress report on the Commission on Dental Accreditation (CODA) in implementing recommendations from the 2008 Report of the Task Force on CODA. One resolution is submitted for the Board's consideration and recommendation to the House of Delegates. The following are the highlights of the CODA progress on implementation of ADA Task Force recommendations during the past year.

- The CODA Subcommittee met with the ADA Monitoring Committee at the ADA Headquarters Building following the Commission meeting on August 5, 2011. Implementation status of the ADA recommendations was reviewed.
- At the August 5, 2011 CODA meeting, the Commission took several actions to enhance the effectiveness of its communication efforts, including: the circulation of the electronic newsletter (CODA Communicator) to the CODA Standing Committee on Communication and Technology for review prior to each publication; refinement of the distribution process used to disseminate the newsletter to create smaller distribution groups; the establishment of a "Question and Answer Room" beginning at the 2012 American Dental Education Association Annual Session, with the goal of providing an opportunity for program administrators and faculty to meet CODA staff and Commissioners to increase accessibility to the Commission and provide one-on-one time for questions and discussion; and the submission of the CODA Strategic Communication's Plan worksheet to the ADA Communications and Marketing Division to initiate the process of developing a CODA-specific communication and marketing strategy.
- To date, of the 34 ADA Task Force recommendations, 31 have been implemented or are in the process of being implemented. Of the three recommendations that have not been addressed, one recommendation concerns the hiring of an additional Commission staff person and one recommendation concerns the hiring of outside expertise to facilitate strategic planning. Both of these recommendations have financial implications.
- The Commission is requesting, as outlined in the ADA Task Force on CODA recommendation 28, financial resources from the 2011 ADA House of Delegates to hire outside facilitation to assist the Commission in developing a strategic plan.

**Background:** At its January, 29, 2009 meeting, the Commission received the ADA Task Force on the Commission on Dental Accreditation Report and Recommendations. The ADA report was discussed at great length and the 34 recommendations were reviewed. The Commission considered the report in the spirit of improving the structure, governance, policies, operating procedures, functionality and use of best practices. The consensus was that this could best be accomplished through the appointment of an *ad hoc* Subcommittee by the Commission chair, Dr. James Koelbl. In addition, the Subcommittee would interact

1 directly with the ADA Monitoring Committee established by the House of Delegates through Resolution 37H-  
2 2008 (*Trans.*2008:423) at the 2008 ADA Annual Session.

3 **37H-2008. Resolved**, that the American Dental Association out of its deep concern about aspects of the  
4 accreditation process strongly urges the ADA Commission on Dental Accreditation to accept and  
5 implement the Report of the Task Force on CODA, and be it further

6 **Resolved**, that the American Dental Association urges CODA to work with all interested parties to  
7 implement the recommendations as they are reflected in the body of the Report, and be it further

8 **Resolved**, that the President of the ADA appoint a committee for the express purpose of monitoring and  
9 assisting CODA in implementing the recommendations of the Task Force Report, and be it further

10 **Resolved**, that this committee consist of a chair, three members of the Board of Trustees and three  
11 members of the House of Delegates, and be it further

12 **Resolved**, that this committee provide updates to the Board of Trustees at each of its 2008-2009  
13 meetings prior to the 2009 House, and be it further

14 **Resolved**, that the ADA urges CODA to provide a comprehensive report to the 2009 House detailing  
15 progress on the implementation of the recommendations of the Task Force Report.

16 The charges of the subcommittee are as follows:  
17

- 18 1. To review and prioritize each of the recommendations of the ADA Task Force on the Commission on  
19 Dental Accreditation in light of the mission of the Commission on Dental Accreditation.
- 20 2. To investigate possible implementation strategies for each of the recommendations.
- 21 3. To interact directly with the ADA Monitoring Committee, keeping the Monitoring Committee informed  
22 on the progress of the review process and possible implementation strategies.
- 23 4. To solicit input from and communicate with all Commission Communities of Interest regarding the  
24 ADA Task Force on CODA Recommendations.
- 25 5. To provide overall coordination with other Commission standing committees and ad hoc committees  
26 that are assigned to review ADA Task Force on CODA recommendations.
- 27 6. To make a report to the Commission with possible recommendations for actions at the regular  
28 Commission meetings.
- 29 7. To report to the ADA Board of Trustees and House of Delegates on a regular basis.  
30

31 The current Subcommittee members are: Dr. Don Joondeph (chair), Dr. Eric Carlson, Mr. Gary Gann (former  
32 Commissioner), Dr. Karen Kershenstein, Dr. Judith Messura, Dr. Larry Nissen (former Commissioner), Dr.  
33 Yilda Rivera-Nazario, Dr. Steven Tonelli, and Dr. Alex White.

34 **Meetings in 2009 and 2010:** At a joint meeting on July 31, 2009, the Subcommittee and the ADA Monitoring  
35 Committee formed a Joint Workgroup to study recommendations relating to the structure and finances of  
36 CODA. The Joint Workgroup held five conference call meetings in late fall of 2009 and winter of 2010.  
37 Ultimately, the Joint Workgroup concluded that the current CODA structure should be retained. In addition to  
38 the predominant advantages of this structure, the Joint Workgroup believed this recommendation was  
39 warranted by its observation of the changes that CODA had already implemented since receiving the CODA  
40 Task Force Report and recommendations. Regarding the recommendation on Commission financing,  
41 Workgroup members concurred that ADA has traditionally valued education and will likely need to support  
42 approximately half the cost of accreditation to maintain a strong educational system for the profession.  
43 Accordingly, the Joint Workgroup recommended a funding model with a goal of CODA assuming  
44 responsibility for 50% of total expenses, including both direct and indirect expenses. This will require  
45 successive increases in program annual fees at a rate of approximately 7.2% per year for six years, a rate  
46 approximately 3% higher than CODA's anticipated annual cost-of-living increases.

The Subcommittee met twice at the ADA Headquarters Building in 2010. At the first meeting on February 4, 2010, the CODA Subcommittee provided input to the Joint Workgroup on Commission Structure and Finances. In addition, implementation status of the ADA recommendations was reviewed. At its second meeting on August 5, 2010, the CODA Subcommittee made recommendations to the Commission on implementation of the following ADA Task Force on CODA recommendations: 1, 2, 3, 6, 10, 13, 17, 19 and 23.

**August 6, 2010 Commission Meeting:** The Commission reviewed the verbal report of the CODA Subcommittee, including the progress to date in implementing the 34 recommendations and a summary the five conference calls of the Joint Restructure Workgroup. The Commission took the following actions in response to the report:

- The Commission recommended retaining its current structure in conjunction with implementation of changes in functionality that has already been initiated (recommendations 1, 2 and 3).
- The Commission adopted a funding model in which total expenses, direct and indirect, are shared equally by ADA and the Commission. The Commission will make annual adjustments to its fees over the next six years to achieve this balance (recommendations 3 and 4).
- The Commission approved the definitions of accreditation, certification, recognition, credentialing, and licensure developed by the CDEL/CEBJA/CODA Workgroup on Definitions and these definitions were included the 2010 Supplemental Report of the Commission to the House of Delegates (recommendation 6).
- The Commission expressed its support for the CDEL Resolution to the 2010 HOD on CDEL recognition of interest areas in general dentistry. Further, the Commission determined that post-doctoral general dentistry education programs in Dental Anesthesia, Orofacial Pain and Oral Medicine continue to be eligible for accreditation by the Commission (recommendation 6).
- The Commission directed that new Commissioner Appointees be identified one year in advance of their term of service by the sponsoring organizations and participate in orientation activities that include attendance and observation at Commission meetings, appropriate Review Committee meetings and an accreditation site visit. The Commission will be responsible for covering the expenses associated with attending the Commission meetings, the Review Committee meetings and an accreditation site visit (recommendation 11).
- The Commission will solicit proposals from individuals or agencies to assess current Commission on Dental Accreditation communication efforts and assist in the development and implementation of a detailed communications and public relations plan as outlined in the "Communication RFP" (recommendation 23).
- The Commission will extend the site visit schedule from seven to eight years, with the ad hoc Committee on Alternate Site Visit Methods developing procedures for interim monitoring of educational programs prior to extending the site visit schedule (recommendation 29).
- The Commission recommended the new Commission chair appoint an appropriate number of new members to the CODA Subcommittee and reappoint an appropriate number of current members to the CODA Subcommittee for an additional year to continue to evaluate and develop implementation plans for any outstanding and ongoing ADA Task Force on CODA recommendations. Furthermore, the Commission supported the reappointment of an ADA Monitoring Committee to assist the Commission in the evaluation and implementation of the ADA Task Force on CODA Recommendations.

**ADA House of Delegates Resolutions 2010:** The following resolutions relating to the ADA Task Force on CODA Report and Recommendations were adopted by the 2010 ADA House of Delegates.

- Resolution 75H-2010—The HOD adopted the Commission and the ADA Monitoring Committee's recommendation that the Commission maintain its current structure.

- 1 • Resolution 76H-2010—The HOD adopted the Commission and the ADA Monitoring Committee's  
2 recommendation that Commission appointees be identified one year in advance of the start of their  
3 four-year term by their respective sponsoring organizations for additional training, including attending  
4 a Commission meeting, a relevant review committee meeting and a site visit as an observer. Both the  
5 Commission and the Monitoring Committee have noted that there is a steep learning curve for newly  
6 appointed Commissioners. The HOD determined that the sponsoring organizations should pay the  
7 travel expenses associated with attendance at these meetings.
- 8 • Resolution 77H-2010—The HOD adopted the Commission and the ADA Monitoring Committee  
9 recommendation that the Commission adopt a funding model in which total expenses of the  
10 Commission, including direct and indirect, are shared equally by the ADA and the Commission. This  
11 will require the Commission to make annual adjustments to its fees to achieve this balance,  
12 decreasing ADA support from approximately 60% to 50% of total expenses. Annual fees will be  
13 increased by approximately 7% over the next six years, and to address this potential financial impact  
14 on the educational programs, the HOD recommends the Commission investigate extending the site  
15 visit schedule from seven to eight years, with the implementation of addition procedures for interim  
16 monitoring of programs.
- 17 • Resolution 11H-2010—The HOD revised the CDEL *Bylaws* to reflect that Council duties will include  
18 the recognition of interest areas in General Dentistry.
- 19 • Resolution 12H-2010—The HOD adopted the "Criteria for Recognition of Interest Areas in General  
20 Dentistry."

21 **February 5, 2011 Commission Meeting:** The Commission reviewed the verbal report of the CODA  
22 Subcommittee, including the progress to date in implementing the 34 ADA recommendations. In addition, the  
23 Commission reviewed a summary of the actions of the 2010 ADA House of Delegates relating to the ADA  
24 Task Force on CODA Report and Recommendations. The Commission took the following actions in  
25 response to the ADA Task Force on CODA Report and Recommendations and in response to the resolutions  
26 adopted by the 2010 ADA HOD:

- 27 • The Commission adopted a six-month training period in 2012 for all new Commissioners whose  
28 appointments begin in 2013, which will include attendance at a Commission meeting, at the  
29 discipline-specific review committee meeting, and at an appropriate site visit. The Commission  
30 further directed that the effectiveness of the training period be evaluated at the end of the first cycle to  
31 determine if the length is sufficient to accomplish intended goals (recommendation 11).
- 32 • The Commission directed that all expenses associated with the six-month training period for new  
33 Commissioners be included in the Commission's annual budget (recommendation 11).
- 34 • The Commission directed the annual accreditation fees and application fees for 2012 be increased  
35 5.75%. This is less than the 7.2% increase proposed to meet the equitable split in expenses between  
36 the ADA and the Commission by 2016. This is due to an anticipated decrease in expenses from  
37 2011 and an increase in revenue from initial accreditation applications over 2011 (recommendations  
38 3 and 4).

39 **CODA Standing Committee Meetings:** Both the CODA Standing Committee on Communication and  
40 Technology and the CODA Standing Committee on Quality Assurance and Strategic Planning met prior to the  
41 August 5, 2011 Commission meeting. Both Standing Committees extensively discussed the ADA Task Force  
42 on CODA recommendations relevant to the charges of each committee. In particular, the Standing  
43 Committee on Quality Assurance and Strategic Planning noted that the majority of the strategic planning  
44 recommendations had yet to be addressed, as the recommendations called for the hiring of outside expertise  
45 to facilitate the Commission's strategic planning process. While strategic planning expertise was available  
46 within the ADA at the time of the release of the ADA Task Force Report, this expertise is no longer available.  
47 The Committee considered attempting to develop a strategic plan without outside facilitation; however, after  
48 further discussion, the committee came to the consensus that there was insufficient expertise among current  
49 Commission staff and volunteers to meet the intent of the strategic planning recommendations. In addition,  
50 as strategic planning processes are the same across disciplines and institutions, hiring an outside facilitator

would efficiently allow the committee to focus its expertise on a strategic plan with measurable outcomes specifically for the Commission.

The Standing Committee on Quality Assurance and Strategic Planning also discussed recommendation 12 on unannounced site visits. The committee determined that additional information was needed before a recommendation on implementation can be made to the Commission. The committee directed staff to contact those agencies that use unannounced visits for information on the criteria for conducting an unannounced visit, policies related to unannounced visits, and the agencies' experience in conducting those visits.

**August 5, 2011 Commission Meeting:** The Commission reviewed the progress to date in implementing the 34 ADA recommendations. The Commission took the following actions in response to ADA Task Force on CODA Report and Recommendations from the CODA Standing Committee on Communication and Technology.

- The Commission directs the circulation of the electronic newsletter (CODA Communicator) to the CODA Standing Committee on Communication and Technology for review prior to each publication. The Commission directs CODA staff to refine the distribution process used to disseminate the newsletter to create smaller distribution groups; and directs CODA staff to better emphasize the importance of adding the CODA to the recipient's address book to alleviate loss of the newsletter in spam filters (recommendation 21).
- The Commission directs the establishment of a "Question and Answer Room" beginning at the 2012 American Dental Education Association Annual Session, with the goal of providing an opportunity for program administrators and faculty to meet CODA staff and Commissioners to increase accessibility to the Commission and provide one-on-one time for questions and discussion (recommendation 22).
- The Commission directs CODA staff to submit to the ADA Communications and Marketing Division the CODA Strategic Communication's Plan worksheet to initiate the process of developing a CODA-specific communication and marketing strategy. The Commission further directs that the Standing Committee engage with the Communications and Marketing Division to establish the proposed plan and provide future updates to the Commission (recommendation 23).
- The Commission directs the re-submission of HOD Resolution 55-2009—Dedicated Staff to Sustain Implementation of CODA Communications Plan, at a future date, following the development of a CODA communications plan and job description for a dedicated staff position (recommendation 24).
- The Commission directs the Standing Committee on Communication and Technology to further study the feasibility of a system for continuous monitoring of programs, including development of criteria and guidelines and determining the methods and frequency for continuous monitoring. Further, the Standing Committee could present an update report on this topic, including a framework for continuous monitoring of programs, at a future Commission meeting (recommendation 29).
- The Commission directs the CODA Standing Committee on Communication and Technology to continue to monitor enhancements in technology for the purpose of streamlining the self-study and accreditation process (recommendation 30).

The Commission took the following action in response to the ADA Task Force on CODA Report and Recommendations from the CODA Standing Committee on Quality Assurance and Strategic Planning:

- As outlined in the ADA Task Force on CODA recommendation 28, the Commission will request the financial resources from the 2011 ADA House of Delegates to hire outside facilitation to assist the Commission in developing a strategic plan.

**August 5, 2011 Joint Meeting of the CODA Subcommittee and the ADA Monitoring Committee:** The CODA Subcommittee and the ADA Monitoring Committee met jointly following the open portion of the Commission meeting on August 5, 2011. The committees reviewed the Commission actions related to the recommendations from the Standing Committee on Communication and Technology and the Standing Committee on Quality Assurance and Strategic planning. The ADA monitoring Committee members were

supportive of all the Commission actions in response to the committee recommendations, including the Commission request for funding to hire an outside, strategic planning facilitator.

The committees then reviewed the Commission action to grant the request of the University of Minnesota to develop accreditation standards for dental therapy education programs. The consensus was that the Commission should submit a Supplemental Report to the House of Delegates in a "Frequently Asked Questions" format. The Supplemental Report should address the three options considered by the Commission and the ramifications of denying the request.

Finally, the committees considered the reappointment of an ADA Monitoring Committee to assist the Commission in the evaluation and implementation of the ADA Task Force on CODA Recommendations. While the committees acknowledged that the working relationship between the ADA Monitoring Committee and the Subcommittee has been highly effective in assisting the Commission in implementation of the ADA Task Force Recommendations, the changes initiated by the Commission regarding transparency in communication have made it feasible to utilize the ADA Council on Dental Education and Licensure (CDEL) as the ongoing mechanism for communication and awareness between the ADA and the Commission, in addition to the ADA Board Liaison. It was also noted that ADA *Bylaws* duties of CDEL includes:

- "Act as the agency of the Association in matters related to the evaluation and accreditation of all dental educational, dental auxiliary educational and associated subjects."
- "Study and make recommendations including the formulation and recommendation on policy on:  
(1) Dental education and dental auxiliary education. (6) Associated subjects that affect all dental, dental auxiliary and related education."

The CDEL budget for 2012 would have to be increased to accommodate CDEL member travel to the two yearly Commission meetings; however, there would be no overall impact on the ADA budget, as the ADA Monitoring Committee would no longer require travel funding.

#### **Summary of Progress on Implementation of ADA Task Force on CODA Recommendations:**

1-CODA should restructure to better meet the current and future needs of the dental profession and the public. (Structure)

2-CODA should conduct a comprehensive investigation of appropriate structures. This investigation should build on and extend the work of the Task Force. (Structure)

3-CODA should develop a detailed business plan, complete with timelines and fiscal implications for implementing any recommendations regarding structure. (Structure)

- At the 2010 ADA Annual Session, the HOD adopted the Commission and the ADA Monitoring Committee's recommendation that the Commission maintain its current structure.
- At the 2010 ADA Annual Session, the HOD adopted the Commission and the ADA Monitoring Committee recommendation that the Commission adopt a funding model in which total expenses of the Commission, including direct and indirect, are shared equally by the ADA and the Commission. This will require the Commission to make annual adjustments to its fees to achieve this balance, decreasing ADA support from approximately 60% to 50% of total expenses.

4-CODA and the ADA should maintain their current legal and fiscal relationship. (Governance)

- The legal and fiscal relationship is currently defined in the *Bylaws* of the American Dental Association and the *Rules* of the Commission on Dental Accreditation. This relationship is described as, "...in the best interests of the dental community" in the ADA Task Force on CODA Report. Neither the Commission, nor the ADA Task Force, has recommended any changes in the CODA-ADA legal relationship. In regards to the fiscal relationship, the HOD adopted the Commission and the ADA

Monitoring Committee recommendation that the Commission adopt a funding model in which total expenses of the Commission, including direct and indirect, are shared equally by the ADA and the Commission (see the implementation of recommendation 3 above). In addition, the Commission will clearly report the full extent (direct and indirect expenses) of ADA financial support when determining its annual budget.

- The Commission has increased annual accreditation fees and application fees for 2012 by 5.75%. This is an increase of 1.75% over past yearly fee increases and reflects an annual adjustment with the goal of achieving an 50%-50% split in expenses with the ADA by 2016.

5-CODA and the ADA should clarify their respective roles, responsibilities and expectations and communicate these to their communities of interest. (Governance)

- The ADA Task Force on CODA "...investigated the advantages and disadvantages of creating a formal Memorandum of Understanding (MOU) that defines the respective roles and responsibilities of the ADA and CODA. While this option works for several other accreditation agency/professional association models, the Task Force believes that an MOU for the ADA and CODA may become too cumbersome, too inflexible, and too broad and that it may also result in unintended consequences." The Commission affirmed that CODA is an agency or "arm" of the ADA and agreed with the ADA Monitoring Committee that the term "arms-length" should not be used. As part of the communities of interest, ADA input on policy decisions should be considered due to its prominence in representing a significant proportion of the profession and employers of graduates of education programs, while it would not be appropriate for ADA to have influence on accreditation decisions regarding individual education programs. The Commission has a written policy on conflict of interest that has recently been reviewed and updated. This policy is contained in its *Evaluation and Operational Policies and Procedures* (EOPP) document that is publicly available. The Conflict of Interest Policy is extensively covered in both CODA orientation sessions and information sessions for communities of interest. There are USDE criteria regarding the relationship between a sponsoring organization and its accrediting agency, which includes the requirement that there be a conflict of interest policy that provides for protection from undue influence from any one group and a requirement that CODA must listen to all stakeholders, including the ADA.

6-CODA should openly collaborate with its communities of interest to resolve the issue of perceptions versus realities of CODA accrediting educational programs in non-recognized specialty areas of general dentistry and publicize the results of this process. (Governance)

- The Commission, CDEL, and CEBJA each endorsed the definitions of the terms accreditation, certification, recognition, credentialing and licensure. These definitions were disseminated through the CODA Supplemental Report to the 2010 House of Delegates and the ADA Monitoring Committee Annual report to the 2010 House of Delegates. These definitions are also posted on the CDEL and CODA portions of the ADA website where appropriate.
- The term "non-recognized specialty areas of General Dentistry" is no longer used to describe interest areas of General Dentistry that are not ADA-recognized specialties. The use of the words "non-recognized specialty" has led to misunderstandings amongst the Commission's communities of interest. The most accurate term is: "interest areas of General Dentistry." The Commission policy and procedures has been revised to reflect this change.
- At the 2010 ADA Annual Session, the HOD revised the CDEL *Bylaws* to reflect that Council duties will include the recognition of interest areas in General Dentistry. The HOD also adopted the "Criteria for Recognition of Interest Areas in General Dentistry."

7-CODA should extend its meeting format to allow more time for discussion regarding accreditation decisions. (Policies)

- At the January 2009 Commission meeting, the closed portion of the meeting was moved to the afternoon of the first day, which allowed significantly more time for accreditation discussions and decisions. In addition, detailed, written explanations of outstanding recommendations are provided for all programs that face adverse actions (i.e., intent to withdraw or withdrawal) or for programs reporting a major change. The written explanations have triggered additional questions and discussion of individual programs by the Commissioners.

8-CODA should define the composition of the specialty review committees regarding the number of content experts, and should develop procedures for determining that a critical threshold of generalist, specialist and public members is available for each decision at the review committee level. (Note: The ADA Task Force is not recommending any changes in review committee composition for predoctoral, dental hygiene, dental assisting, dental laboratory technicians and advanced educational general dentistry/graduate programs.) (Policies)

- The composition of each review committee is defined in the Commission's Evaluation and Operational Policies and Procedures (*EOPP*) manual. The policy and procedures regarding the critical threshold of the various categories of Review Committee (RC) members is also defined in *EOPP*. There is a process for adding additional content experts to advanced specialty review committees when the workload of the RC warrants the additional members.

9-CODA should continue to include a public member on each review committee. (Policies)

- Each review committee has a public member. There are no plans to change this policy.

10-CODA should establish a system to permit an academic program to postpone its review if a critical threshold of generalist, specialist and public members is not available at that review committee meeting. (Policies)

- At the August 6, 2010 Commission meeting, the Commission approved the following addition to the "Summary of Review Committee Structure" as outlined in *EOPP*: "10. The Review Committee chairperson may reschedule the date of the Review Committee meeting if there are not an adequate number of content experts on the assigned date of the meeting."

11-CODA should change the term of commissioners from the current policy of one four-year term to the possibility of two three-year terms if desired by the sponsoring agency and by CODA. (Policies)

- In-depth analysis by the Joint Workgroup on CODA Structure and Finances determined that this recommendation is linked with recommendations 1 and 2 on CODA structure and presents significant complications to the functioning of the Commission. The Joint Workgroup noted that three-year terms would be inconsistent with the practices of other ADA agencies and external appointing organizations. The reappointment process for two sequential terms and the 50% rule for filling vacancies would present challenges. The growth in expertise among Commissioners could be compromised if individuals do not continue with the second term. For these reasons, the Joint Workgroup came to the conclusion that changing the terms of commissioners would not be in the best interest of the Commission at this time and both the Commission and the ADA Monitoring Committee agreed with this conclusion.
- The Commission has noted that even with the current in-house training for new Commissioners prior to the start of their term, it still takes a number of meetings for Commissioners to develop sufficient expertise in Commission philosophy, policy and procedure. The Commission agreed that the intent of this ADA Task Force recommendation is to allow Commissioners to utilize the expertise which they have developed over a longer period of time. To this end, the Commission considered different ways of implementing this recommendation without having to change the actual terms of the Commissioners. At the February 2011 Commission meeting, the Commission adopted a six-month training period in 2012 for all new Commissioners whose appointments begin in 2013, which will



1 include attendance at a Commission meeting, at the discipline-specific review committee meeting,  
2 and at an appropriate site visit. The Commission directed that all expenses associated with the six-  
3 month training period for new Commissioners be included in the Commission's annual budget due to  
4 concerns on the budgetary impact of this requirement on the smaller sponsoring organizations.

5 12-CODA should consider site visit flexibility including the authority to conduct unannounced site visits when  
6 deemed necessary. However, the Task Force does not support the concept of routinely conducting  
7 unannounced site visits at this time. (Policies)

- 8 • The Standing Committee on Quality Assurance and Strategic Planning will consider policy and  
9 procedures regarding site visit flexibility, including a review of logistics and the implications on both  
10 the Commission and the educational programs, of unannounced site visits. The Committee will  
11 present a recommendation for Commission consideration at the February 2012 meeting.

12 13-CODA should enhance its pre-nomination education process that provides information regarding  
13 expectations and duties of commissioners, review committee members and site visitors. This information  
14 should be made available by CODA to all communities of interest and interested individuals. (Operating  
15 Procedures)

- 16 • A cover letter detailing information regarding expectations and duties of commissioners, review  
17 committee members and site visitors will be disseminated in the following ways: 1) Attached to all  
18 nomination forms. 2) Posted on the CODA portion of the ADA website. 3) Provided at the ADA and  
19 ADEA open hearings along with other written materials. 4) Verbally referenced at the beginning of  
20 open hearings at the ADA and ADEA meetings. 5) Hyperlinked from the CODA Communicator.

21 14-CODA should continue the nomination process it has initiated. This process calls for multiple nominations  
22 from each group with nominations to be evaluated by CODA's Nominating Committee based on criteria  
23 developed by CODA. The nomination process should be strongly articulated to all nominating  
24 communities. (Operating Procedures)

- 25 • The Commission adopted a revised policy on nominations to specialty or discipline specific positions  
26 on review committees at the July 2009 meeting. The revised policy states that nominating  
27 organizations must submit at least two (2) individuals for the Standing Committee on Nominations to  
28 consider. Organizations may rank their nominees in order of preference; however, the ranking is just  
29 one factor in considering the nominations. In addition, if fewer than two nominees are submitted, the  
30 appointment process will be delayed until such time as the minimum number of required nominations  
31 is received. The requirement of at least two nominations is clearly outlined in the letters sent by the  
32 Commission soliciting nominees.

33 15-CODA commissioners, review committee members, site visitors and volunteers should serve the interest  
34 of CODA without personal or member organization profiles or agendas. This policy should be clearly  
35 articulated internally, and strongly articulated externally to all relevant organizations that supply persons for  
36 positions on CODA or any of its working committees. (Operating Procedures)

- 37 • The Commission strengthened the existing portion of the "Conflict of Interest Policy" by implementing  
38 the following at the July 2009 Commission meeting: 1) At the beginning of the closed session of each  
39 Commission and Review Committee meeting, the Commission/Review Committee chair will reiterate  
40 that Commissioners are expected to evaluate each accreditation action, policy decision or standard  
41 adoption for the overall good of the public. Although Commissioners and most Review Committee  
42 members are appointed by designated communities of interest, their duty of loyalty is first and  
43 foremost to the Commission. 2) At the beginning of the open session of each Commission and  
44 Review Committee meeting, the Commission/Review Committee chair will read a statement  
45 emphasizing that members' duty of loyalty is first and foremost to the Commission. 3) Commissioners  
46 and Review Committee members will no longer refer to the sponsoring organizations that have

1 appointed them when introducing themselves at meetings. The Commission meetings now open with  
2 the roll call and introduction of Commissioners by name and home location rather than by the  
3 organization they represented. 4) Case studies on conflict of interest presented at orientation  
4 sessions for new members will be expanded and emphasized. 5) Information and a case study for  
5 group discussion on this topic will continue to be an emphasized topic at future community of interest  
6 training sessions.

7 16-CODA should continue to develop and improve an orientation and training process for volunteers after the  
8 volunteer is selected but before the volunteer assumes the responsibilities of the position. (Operating  
9 Procedures)

- 10 • New site visitor training, new Review Committee member training, and new Commissioner training  
11 have been expanded in a workshop format facilitated by Commission staff and experienced  
12 volunteers. Prior to the workshops, volunteers are required to complete six online  
13 training/assessment modules. Commission staff continues to refine and modify the training, based on  
14 input from the participants solicited after the training session is completed. In addition, new site  
15 visitors who are unable to attend the in-house training session must observe an experienced  
16 consultant on a site visit prior to being assigned as a site visitor. See also the response to ADA  
17 recommendation 11 regarding the "redshirt year."

18 17-CODA should require all review committee members to observe at least one site visit. (Operating  
19 Procedures)

- 20 • This recommendation was implemented by the Commission at the August 2010 meeting through  
21 minor changes in existing policy. The requirement that all review committee members observe at  
22 least one site visit was added to the "Summary of Review Committee Structure" as outlined in *EOPP*:  
23 "9. Review Committee members who have been on a site visit within the last two (2) years prior to  
24 their appointment on a Review Committee should observe at least one site visit within their first year  
25 of service on the Review Committee."

26 18-CODA should require that all specialty areas of practice continue to be responsible for funding the formal  
27 training of site visitors and should provide content expertise for the training curricula. CODA staff should  
28 continue to conduct the training and assure that the training is well organized and consistent across all  
29 specialty areas. (Operating Procedures)

- 30 • The Commission currently is responsible for the formal training of site visitors and provides content  
31 expertise for the training curricula. New site visitors from each discipline are required to attend an in-  
32 house training session at the ADA Headquarters, with the entire group attending lectures on general  
33 policies and procedures, and discipline-specific breakout groups doing exercises on report-writing  
34 and standards review. CODA staff conducts the training, and post-training surveys show a significant  
35 majority of participants regard the training as well-organized. Commission staff is available to provide  
36 additional training for any discipline that requests it, and this is communicated to the organizations on  
37 a regular basis.
- 38 • In 2011, CODA staff conducted supplemental site visitor training for the following areas of specialty  
39 practice: endodontics, oral and maxillofacial surgery, orthodontics and dentofacial orthopedics, and  
40 periodontics.

41  
42 19-CODA should require that all site visitors not participating in site visits at least every two years should  
43 participate in a training exercise. (Operating Procedures)

- 44 • This recommendation was implemented by the Commission at the August 2010 meeting through  
45 minor changes in existing policy. The requirement that all site visitors not participating in site visits at  
46 least every two years should participate in a training exercise was added to the "Policy Statement on  
47 Consultant Training" as outlined in *EOPP*: "Consultants who have not been assigned on a site visit

1 during the previous two years must re-attend the in-house training provided to new consultants;  
2 observe a site visit in the appropriate discipline; or attend the regularly scheduled update sessions at  
3 the ADEA Annual Meeting, before being assigned to evaluate a program on a site visit.”

4 20-CODA should establish a system by which all members of site visit teams, including the chair, are  
5 evaluated. (Operating Procedures)

- 6 • Evaluation forms for all members of site visit teams, including the chair, have been revised,  
7 expanded, and made more comprehensive. These forms were implemented starting with the fall  
8 2009 site visits. Evaluations are done anonymously and electronically through the ADA survey center.  
9 In addition, the forms are pre-populated with relevant information to reduce the time burden on the  
10 program, institutional personnel, and CODA volunteers that are requested to complete the  
11 evaluations. Discussion and evaluation of survey results is now a regular agenda item for each  
12 January review committee meeting and is reported to the Commission at the winter meeting via the  
13 review committee minutes.

14 21-CODA should communicate more effectively with its communities of interest by improving the quality and  
15 content of its communications. The processes of communication should also be improved. (Functionality)

- 16 • Recommendation 21 is being considered together with recommendations 23 and 24. The  
17 Commission’s Standing Committee on Communication and Technology is currently working with the  
18 ADA Division of Communication to develop an effective communication strategy to improve the  
19 quality and the content of Commission communications with the communities of interest.  
20 • At the August 5, 2011 meeting, the Commission took several actions to address the effectiveness of  
21 its communication efforts, including: the circulation of the electronic newsletter (CODA  
22 Communicator) to the CODA Standing Committee on Communication and Technology for review  
23 prior to each publication; refinement of the distribution process used to disseminate the newsletter to  
24 create smaller distribution groups; the establishment of a “Question and Answer Room” beginning at  
25 the 2012 ADEA Annual Session, with the goal of providing an opportunity for program administrators  
26 and faculty to meet CODA staff and Commissioners to increase accessibility to the Commission and  
27 provide one-on-one time for questions and discussion; the submission of the CODA Strategic  
28 Communication’s Plan worksheet to the ADA Communications and Marketing Division to initiate the  
29 process of developing a CODA-specific communication and marketing strategy; and the re-  
30 submission of HOD Resolution 55-2009–Dedicated Staff to Sustain Implementation of CODA  
31 Communications Plan, at a future date, following the development of a CODA communications plan  
32 and job description for a dedicated staff position.

33 22-CODA should focus its communications efforts on increasing transparency and accountability as well as  
34 communicating the value/outcomes of accreditation. (Functionality)

- 35 • Recommendation 22 was considered together with recommendation 25. The Commission has  
36 implemented the following strategies in order to address these recommendations: 1) The Commission  
37 will continue to utilize time at the beginning of open hearings at the ADA and ADEA annual meetings  
38 to communicate the value and outcomes of accreditation. This was implemented at the 2009 ADA  
39 Annual Session Open Hearings and the 2010 ADEA Annual Session Open Hearing. In addition, at  
40 the 2010 ADA Annual Session Open Hearing, copies of a pamphlet developed by the Council for  
41 Higher Education Accreditation (CHEA) entitled “The Value of Accreditation” was available. 2) The  
42 Commission will continue to conduct two open hearings at the ADA Annual Session. The format of  
43 the open hearings has been expanded to allow for questions and comments on Commission policy  
44 and procedure. 3) The community of interest training session will continue to be conducted on a  
45 regular basis. 4) All information sent to the communities of interest will be sent to individual  
46 educational program directors in order to increase transparency and accountability. The Commission  
47 requested that the same information be sent to the members of the House of Delegates; however, the

Commission was informed that e-mail addresses of delegates and alternates cannot be provided, per ADA policy. 5) The Commission meetings now open with the roll call and introduction of Commissioners by name and home location rather than by the organization they represent, an example of the cultural change that will be emphasized at the beginning of each CODA meeting. 6) The annual report will be sent to the executive director of the ADA for distribution to the HOD and alternates, also, reports will be posted on the "delegates only" portion of the ADA website.

23-CODA should use outside expertise to assess its current communications efforts and assist in the development and implementation of a detailed communications and public relations plan. (Functionality)

- See response to recommendation 21. In an effort to utilize resources in an efficient manner, the Commission is working with the ADA Division of Communication to develop a detailed communications and public relations plan.

24-CODA should create a dedicated staff position requiring specific expertise in communications to sustain the implementation of its communications plan and to assist in cultural change. (Functionality)

- The Commission has determined that a more appropriate timeframe for the hiring of a new Commission staff person dedicated to implementing the communications and strategic plan would be after the Commission has communication plans in place. As the planning will most likely take place during 2011 and 2012, a budget request for an additional Commission staff person would have a better likelihood of success of being approved by the HOD in 2012.

25-CODA should view this effort toward cultural change not just as increasing communication but as a change in its culture regarding transparency, accountability and responsiveness. This cultural change should be emphasized at the beginning of each CODA meeting. (Functionality)

- The Commission meetings now open with the roll call and introduction of Commissioners by name and home location rather than by the organization they represent, an example of the cultural change that will be emphasized at the beginning of each CODA meeting. See response to recommendation 22 above.

26-CODA should establish ongoing evaluation measures to systematically monitor the use of CODA accreditation and its perceived value. This implies the use of an ongoing quality management program tied to strategic planning. (Best Practices)

- Recommendations 26, 27 and 28 are being considered together, as the establishment of an ongoing quality management program tied to strategic planning (recommendation 26) is dependent on the recommendations to hire an outside consultant in both the design and facilitation of strategic planning efforts (recommendations 27 and 28). The Commission noted that the implementation of these three recommendations has significant financial implications. In an effort to begin the process of implementing this recommendation, the Commission restructured the Standing Committees of the Commission, including the formation of a Standing Committee on Quality Assurance and Strategic Planning, at the August 2010 Commission meeting. The charge of this committee is as follows: (1) Develop and implement an ongoing strategic planning process. (2) Develop and implement a formal program of outcomes assessment tied to strategic planning. (3) Use results of the assessment processes to evaluate the effectiveness of the Commission and make recommendations for appropriate changes, including the appropriateness of its structure. (4) Monitor United States Department of Education (USDE), and other quality assurance organizations [CHEA, American National Standards Institute/International Organization for Standardization (ANSI/ISO) and the International Network for Quality Assurance Agencies in Higher Education (INQAAHE)] or trends and changes in parameters of quality assurance. (5) Monitor and make recommendations to the Commission regarding changes that may affect its operations, including expansion of scope and international issues. The formation of a Standing Committee on Strategic Planning ties an ongoing

1 quality management program to strategic planning, as suggested in ADA recommendation 26;  
2 establishes an ongoing strategic planning process and a committee to continue effective strategic  
3 planning, as suggested in ADA recommendation 28; establishes a standing committee charged  
4 specifically with monitoring other quality assurance organizations, as suggested in ADA  
5 recommendations 32, 33, and 34; and shows the Commission regards strategic planning as a  
6 priority.

7 27-CODA should design and implement a quality management system and seek outside assistance in the  
8 design as needed from a quality management system expert. (Best Practices)

- 9
- See response to 26 above.

10 28-CODA should use an outside facilitator to design and support its strategic planning efforts. CODA's  
11 strategic planning efforts should examine (but not be limited to) the following: development and  
12 implementation of an ongoing strategic planning process and the establishment of a committee to continue  
13 effective strategic planning; reassessment of its meeting format in light of its primary focus of accreditation  
14 decisions; consideration of the concept of flexible review cycles; consideration of other models for site  
15 visits, such as the use of professional site visitors or the use of fewer site visitors used more frequently to  
16 enhance consistency and reliability; consideration of important changes that may affect its operations  
17 including expansion of scope and international issues; consideration of its continuing effectiveness and the  
18 appropriateness of its structure. (Best Practices)

- 19
- The Commission considered attempting to strategic plan without expert, outside facilitation; however,  
20 as there is insufficient expertise among current Commission staff and volunteers to meet the intent of  
21 this strategic planning recommendation, the Commission will be requesting additional funding from  
22 the 2011 HOD for use of an outside facilitator to design and support strategic planning efforts. The  
23 estimated expense for this activity is \$23,750.00, which includes:  
24 1. \$2,590.00 for one meeting of the Standing Committee on Quality Assurance and Strategic  
25 Planning Committee held in conjunction with the February 2012 Commission meeting.  
26 2. \$11,100.00 for one meeting of the Commission, which would be held in conjunction with the  
27 August 2012 Commission meeting.  
28 3. Up to \$10,060 in services for hiring an outside facilitator with expertise in strategic planning  
29 (estimate includes travel expenses).

30 29-CODA should explore alternative methods, including the use of enhanced technology for monitoring  
31 programs' continuous compliance with the standards. (Best Practices)

- 32
- Recommendations 29 and 30 are being considered together, as they both concern the use of  
33 technology and its impact on Commission policies and procedures. The Commission is pursuing  
34 several initiatives in the area of technology, which include: (1) directing the Standing Committee on  
35 Communication and Technology, to identify programs interested in participating in a pilot project, as  
36 well as site visitors who would be willing to serve on the team evaluating the program using video-  
37 teleconferencing technology to be conducted in early 2012; (2) investigating standardization of the  
38 self-study to better streamline the site visit process for all disciplines; and (3) exploring web-based  
39 applications for use in the accreditation process, including site visit preparation and continuous  
40 monitoring of accredited programs' compliance with the Accreditation Standards.
  - In an effort to further begin the process of implementing this recommendation, the Commission  
41 restructured the Standing Committees of the Commission, including the formation of a Standing  
42 Committee on Communication and Technology at the August 2010 Commission meeting. The charge  
43 of this committee is as follows: evaluate and recommend alternative methods, including the use of  
44 enhanced technology, for monitoring programs' continuous compliance with the standards; evaluate  
45 and recommend new technological advances in accreditation for reporting and management of  
46 information, allowing accreditation to move toward the concepts of continuous assessment, data  
47

collection, and readiness; monitor technological trends in alternative site visit methods; develop and implement strategies to increase the effectiveness, quality, content, and processes of communication with all the Commission's communities of interest; ensure that Commission communications strategies allow for transparency and accountability; and oversee the publication of the e-newsletter, the CODA Communicator, with emphasis on communicating the value/outcomes of accreditation. The formation of the a Standing Committee on Communication and Technology will enable the Commission to review technology issues on an ongoing basis, due to rapid changes and improvements in this area over time.

30-CODA should evaluate and adopt new technological advances in accreditation for reporting and management of information. This could reduce the burden on CODA as well as the programs it accredits, and thus allow accreditation to move toward the concepts of continuous assessment, data collection, and readiness. (Best Practices)

- See response to 29 above.

31-CODA should maintain its recognition by USDE. (USDE Affiliation)

- Recommendations 31, 32, 33 and 34 are being considered together. The Commission was re-recognized in 2006 as the national accrediting agency for accreditation of predoctoral dental education programs, advanced dental education programs, and allied dental education programs that are fully operational, or have attained "Initial Accreditation" status, and for its programs offered via distance education. The Commission's petition for continued recognition is due in January 2012. The Commission will continue to monitor the relative requirements, benefits, risks, obligations, advantages and disadvantages of recognition by USDE. This monitoring, including government funding of educational programs under the Commission's purview, will be a regular item on the agenda of the Commission's Standing Committee on Quality Assurance and Strategic Planning and it will also be part of the Commission's strategic planning process. The CODA Subcommittee will analyze information relating to alternative recognition processes by CHEA and ANSI as advised by recommendations 33 and 34.

32-CODA should monitor how USDE recognition influences funding for dental education programs. (USDE Affiliation)

- See response to 31 above.

33-CODA should explore advantages of recognition by additional agencies such as CHEA. CODA decision(s) regarding recognition by another agency should not be in lieu of USDE recognition. (USDE Affiliation)

- CODA continues to monitor and assess whether recognition by additional agencies, such as CHEA, is in the best interest of dental education and the Commission. The director of the Commission attended a CHEA Workshop on Eligibility and Recognition on July 19, 2010 in Chicago. CHEA eligibility requirements state that in order to be eligible for CHEA recognition, a majority (50% +1) of the programs accredited by the agency must grant higher education degrees. The Commission does not meet this eligibility criterion, as the Commission accredits 726 certificate programs in postdoctoral advanced specialty and general dentistry, as opposed to 665 degree-granting programs in predoctoral general dentistry, dental hygiene, dental assisting and dental laboratory technology.

34-CODA should monitor the progress of the proposed ANSI recognition system for accreditation agencies as it develops, and, if appropriate, investigate the advantages and disadvantages of also becoming recognized under this system. (USDE Affiliation)

- See response to 31 above.

**Summary:** This report details the progress of the Commission on Dental Accreditation in implementing recommendations from the 2008 Report of the Task Force on the Commission on Dental Accreditation. The Commission previously appointed a Subcommittee to develop implementation strategies for each of the 34 ADA Task Force recommendations and is collaborating with the ADA Monitoring Committee in addressing the recommendations. Of the 34 ADA recommendations, 31 have been implemented or are in the process of being implemented. Several ADA recommendations require ongoing Commission review and evaluation. Of the three recommendations that have not been addressed, one recommendation concerns the hiring of an additional Commission staff person and one recommendation concerns the hiring of outside expertise to facilitate strategic planning. Both of these recommendations have financial implications. The Standing Committee on Quality Assurance and Strategic Planning will consider policy and procedures regarding site visit flexibility, including a review of logistics and the implications on both the Commission and the educational programs, of unannounced site visits (recommendation 12). The Committee will present a recommendation for Commission consideration at the February 2012 meeting. One resolution is presented for consideration of the Board and House of Delegates based on the recommendations of the Commission and the ADA Monitoring Committee.

#### **Resolution**

**40. Resolved,** that the ADA allocate funding up to \$23,750 for the Commission on Dental Accreditation to engage an outside facilitator to design and support its strategic planning efforts as directed by the 2008 ADA Task Force on CODA Report and Recommendations.

**BOARD RECOMMENDATION: Vote Yes.**

**BOARD VOTE: UNANIMOUS.**





Resolution No. 47 New ☒ Substitute ☐ Amendment ☐  
 Report: NA Date Submitted: September 2011  
 Submitted By: Council on ADA Sessions  
 Reference Committee: Dental Education, Science and Related Matters  
 Total Net Financial Implication: \$ None Net Dues Impact: \$  
 Amount One-time \$ Amount On-going \$  
 ADA Strategic Plan Goal: Public Health/Financial (Required)

# **REQUEST FOR POSTPONEMENT OF THE PROPOSED CERP ELIGIBILITY CRITERIA**

The following resolution was adopted by the Council on ADA Sessions and transmitted on September 8, 2011.

**Background:** The following background and resolution is intended to convey the clear message that the Council on ADA Sessions (CAS) wishes to support the Council on Dental Education and Licensure (CDEL) and the CERP Committee in efforts to remove commercial bias from dental continuing education. It should be absolutely clear that we share this common goal.

However, the Council on ADA Sessions has strong concerns that the proposed changes to the ADA CERP Eligibility Criteria will do little to reduce commercial bias and have serious unintended educational, reputational and financial consequences for the ADA and our profession.

On June 23<sup>rd</sup> the Council on ADA Sessions submitted concerns as requested to CDEL regarding the proposed CERP guideline changes. On July 14<sup>th</sup> a conference call was held at the request of CDEL with the CAS Programs Sub-committee, CERP representatives and staff. Based on that call, the CAS, through its Programs Subcommittee reiterated its formal concerns in a letter dated August 1<sup>st</sup>. Although CAS did receive a formal response from CDEL on August 16<sup>th</sup>, CAS remains concerned about the proposed changes and their possible negative impact on dental education and/or the ADA.

CAS still has the following serious concerns:

1. CAS is concerned that there will not be any actual positive benefits for the profession from the proposed changes given there are other programs readily available as an alternative.
2. CAS is concerned with enforcement due to limited CERP funding and how this impacts a level playing field in this area.
3. CAS is concerned by the potential for negative reputational and financial impact these changes will have on the ADA.

Specific questions and further data should be researched and analyzed by CDEL if a recommendation for delay is approved by the House of Delegates. CAS offers its assistance in researching and vetting important questions if capable and requested, but recognizes the purview of CDEL on this issue. CAS recognizes that CDEL has not officially acted upon the proposed CERP criteria changes but plans to consider this item at its November, 2011 meeting. It is not the intent of CAS to imply that CDEL is not the agency with appropriate purview or to question CERP's and/or CDEL's commitment to the advancement of dental education.

1 Therefore CAS submits the following resolutions for the House of Delegates consideration.

2 **Resolution**

3 **47. Resolved,** that the American Dental Association fully supports the principle that all continuing dental  
4 education should be independent from commercial influence, and be it further

5 **Resolved,** that the 2011 House of Delegates urge the Council on Dental Education and Licensure to  
6 postpone adoption of the proposed CERP Eligibility Criteria and reopen the comment period to allow  
7 further study and input on all of the ramifications to the profession and the ADA.

8 **BOARD RECOMMENDATION: Vote Yes.**

Board Vote:														
Yes	No	Abstain	Absent		Yes	No	Abstain	Absent		Yes	No	Abstain	Absent	
<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	BLANTON	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	KIESLING	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	STEFFEL
<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	CALNON	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	LONG	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	SUMMERHAYS
<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	ENGEL	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	LOW	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	THOMPSON
<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	FAIELLA	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	NORMAN	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	VERSMAN
<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	FEINBERG	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	RICH	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	VIGNA
<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	GOUNARDES	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	SEAGO	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	WEBER
<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	HAGENBRUCH	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	SMITH, A. J.					Res. 47

Resolution No. 48 New ☒ Substitute ☐ Amendment ☐  
 Report: NA Date Submitted: September 2011  
 Submitted By: Eighth Trustee District  
 Reference Committee: Dental Education, Science and Related Matters  
 Total Net Financial Implication: None Net Dues Impact: \$  
 Amount One-time \$ Amount On-going \$  
 ADA Strategic Plan Goal: Members (Required)

### 1 RECOGNITION OF SPECIALTY GROUPS

2 The following resolution was adopted by the Eighth Trustee District and transmitted on September 13, 2011,  
 3 by Dr. Robert N. Bitter, president, Illinois State Dental Society.

4 **Background:** In November 2010, the Eighth District initiated correspondence with the ADA and the Council  
 5 on Dental Education and Licensure (CDEL) regarding activities of the American Association of Public Health  
 6 Dentistry (AAPHD). The AAPHD is the sponsoring organization recognized by the ADA for the specialty of  
 7 dental public health. Questions were posed in the letters by the Eighth District to the ADA and CDEL, as  
 8 2011 is the year in which the Council reviews whether each of the dental specialties continues to meet the  
 9 requirements of a dental specialty, and whether each specialty should continue to be recognized as an ADA  
 10 specialty for the next ten years. Several questions were posed to the ADA and CDEL regarding the AAPHD,  
 11 and CDEL has issued a report to the 2011 ADA House of Delegates summarizing its findings (Appendix 4 of  
 12 CDEL Annual Report; 2011 Periodic Review of Dental Specialty Education and Practice to the ADA House of  
 13 Delegates, pages 110-126).

14 The Eighth District was concerned whether the AAPHD met Requirement 1 of the "ADA Requirements of a  
 15 Dental Specialty." Requirement 1 states that "In order for an area to be recognized as a specialty, it must be  
 16 represented by a sponsoring organization: (a) whose membership is reflective of the special area of dental  
 17 practice; and (b) that demonstrates the ability to establish a certifying board." Of special concern was the  
 18 practice of the AAPHD to allow a membership category within their organization that permits full membership  
 19 and voting privileges to both dentists who are not public health specialists and to non-dentists. Specialty  
 20 organizations are conferred a special privilege by their recognition by the ADA. When such an organization  
 21 makes public announcements or reports, it conveys a special authority derived from this recognition.

22 In reviewing the membership numbers of AAPHD, only 41% of their voting membership are actually dental  
 23 public health specialists—the remaining 59% are either non-specialty dentists or non-dentists. Nearly all  
 24 dental specialty groups have membership categories that may allow for non-U.S. specialists or others to be  
 25 members in some affiliated capacity. However, the AAPHD is in a small minority of specialty organizations  
 26 with regard to two aspects of their organizational policies: 1) the AAPHD allows non-specialist and non-dentist  
 27 members to have voting privileges in their organization, and 2) allows for non-specialists and non-dentists to  
 28 be voting members on their governing board and to serve as Officers in their organization. In fact, at the  
 29 present time, a dental hygienist is serving as President of the American Association of Public Health  
 30 Dentistry.

31 The Eighth District was concerned that, with only 41% membership of actual dental public health specialists  
 32 within the voting ranks of the AAPHD, the organization does not meet the requirement that its "membership is  
 33 reflective of the special area of dental practice" as required in Requirement 1. This leads to another concern  
 34 that the policies and statements of this organization may not be reflective of its specialty base. CDEL has

1 obviously taken a different approach to the interpretation of the word “reflective” in Requirement 1—one that  
2 apparently also differs from how every other major, long-standing specialty organization recognized by the  
3 ADA has organized their associations or academies.

4 Dentistry is an educational-based profession. Because of the special recognition the ADA confers through its  
5 recognition of dental specialties, it is essential that these organizations conduct themselves in a manner that  
6 honestly and ethically represents this educational criteria and training in their organizational policies. In order  
7 to promote a more consistent and uniform interpretation of Requirement 1 of the “ADA Requirements of a  
8 Dental Specialty,” the following additional language is recommended.

9 **Resolution**

10 **48. Resolved**, that the Council on Dental Education and Licensure (CDEL) review and refine the effects  
11 for the recognized specialty sponsoring organizations when Requirement 1(a) Recognition of Dental  
12 Specialties set forth in the *Requirements for Recognition of Dental Specialties and National Certifying*  
13 *Boards for Dental Specialists* defines the intent that a recognized specialty sponsoring organization’s  
14 membership should be “reflective” of an organizations specialty members (as defined by the ADA Code of  
15 Ethics, Section 5. H., General Standards, for announcing specialization or limitation of practice), and be it  
16 further

17 **Resolved**, that these recommendations be reported to the 2012 House of Delegates.

18 **BOARD COMMENT:** The Board agrees with the Eighth Trustee District that the Council on Dental Education  
19 and Licensure should be requested to review the process for recognizing the dental specialty sponsoring  
20 organizations as related to Requirement 1(a) of the *Requirements for Recognition of Dental Specialties and*  
21 *National Certifying Boards for Dental Specialists* which states that a sponsoring organization’s membership  
22 must be “reflective” of the special area of dental practice. The Board believes that CDEL should study this  
23 Requirement carefully and consider ways to clarify its intent. For example, the Council may consider if the  
24 Requirement would be more clearly understood if it included a statement that the sponsoring organization  
25 should provide only specialist dentist members the privileges of voting and holding office. The Board also  
26 believes that CDEL should explore any additional changes to Requirement 1(a) and report its  
27 recommendations to the House of Delegates in 2012. Accordingly, the Board recommends adoption of  
28 substitute Resolution 48B.

29 **48B. Resolved**, that the Council on Dental Education and Licensure (CDEL) review the criteria and  
30 process for the recognition of specialty sponsoring organizations, and be it further

31 **Resolved**, that this review consider Requirement 1(a) in the *Requirements for Recognition of Dental*  
32 *Specialties and National Certifying Boards for Dental Specialists* which states that a recognized specialty  
33 sponsoring organization’s membership should be reflective of the special area of dental practice (as  
34 defined by the ADA Code of Ethics, Section 55.H., General Standards, for announcing specialization or  
35 limitation of practice), and be it further

36 **Resolved**, that CDEL consider interpreting “reflective” to mean that only specialist dentist members be  
37 able to vote and to hold office, and be it further

38 **Resolved**, that any additional recommendations for change be reported to the 2012 House of Delegates.

39 **BOARD RECOMMENDATION: Vote Yes on the Substitute.**

40 **BOARD VOTE: UNANIMOUS.**

Resolution No. 53 New ☐ Substitute ☐ Amendment ☐Report: Board Report 12 Date Submitted: September 2011Submitted By: Board of TrusteesReference Committee: Dental Education, Science and Related MattersTotal Net Financial Implication: None Net Dues Impact: \$Amount One-time \$ Amount On-going \$ADA Strategic Plan Goal: Collaboration (Required)**REPORT 12 OF THE BOARD OF TRUSTEES TO THE HOUSE OF DELEGATES:  
ACCREDITATION STANDARDS FOR DENTAL THERAPY PROGRAMS**

**Background:** The Board reviewed CODA Supplemental Report 3, noting that in 2009, CODA first received requests to accredit the Dental Therapy and Advanced Dental Therapy Educational programs in the state of Minnesota from the Minnesota Board of Dentistry; the University of Minnesota (Dental Therapy Program-baccalaureate degree); the Minnesota Dental Association; and the Metropolitan State University of the Minnesota and State Colleges and Universities System (Advanced Dental Therapy Program-master's degree). In August 2010 the Commission determined that the request to accredit the Minnesota programs did not include sufficient information and evidence to warrant establishing an accreditation program and standards at that time. Specifically, the Commission determined that there was insufficient information and evidence to meet the Commission's Criteria to initiate such a process:

- Has the allied dental education area been in operation for a sufficient period of time to establish benchmarks and adequately measure performance?
- Is there evidence of need and support from the public and professional communities to sustain educational programs in the discipline?

At its most recent meeting in August 2011, CODA revised its Principles and Criteria Eligibility of Allied Dental Programs for Accreditation by the Commission on Dental Accreditation. CODA also considered a more specific request from the University of Minnesota to establish accreditation standards for a baccalaureate degree program in Dental Therapy. The Commission granted this request concluding that the University of Minnesota had supplied sufficient documentation and evidence to show that each of the "Principles and Criteria—Eligibility of Allied Dental Programs for Accreditation by the Commission on Dental Accreditation" was met. The Board strongly disagrees with this conclusion, believing that Criteria F-2 and F-5 still are not met:

- F-2: Has the allied dental education area been in operation for a sufficient period of time to establish benchmarks and adequately measure performance?
- F-5: Is there evidence of need and support from the public and professional communities to sustain the educational programs in the discipline?

In regard to Criteria F-2, only two programs in one state have begun operating at this time. Only recently have students graduated from the programs. Dental therapy programs are not national in scope.

In regard to Criteria F-5, CODA did not seek evidence or input from the communities of interest or stakeholders prior to taking action on this request. Hearings were not conducted; there was no official call for comment. The ADA was not given the opportunity to make its position clear that only dentists are qualified to

1 diagnose, do treatment planning and perform surgical/irreversible procedures. The ADA and other  
2 stakeholder groups were not provided a venue to voice their positions and present their policies regarding  
3 dental therapist models prior to CODA's decision to move forward with developing accreditation standards.

4 For these reasons, the Board recommends the following resolution to the House of Delegates.

### 5 Resolution

6  
7 **53. Resolved**, that the Commission on Dental Accreditation be strongly urged to delay the process of  
8 developing accreditation standards for dental therapy programs for the purpose of further review of  
9 compliance with CODA's Principles and Criteria Eligibility of Allied Dental Programs.

### 10 BOARD RECOMMENDATION: Vote Yes.

Board Vote:														
Yes	No	Abstain	Absent		Yes	No	Abstain	Absent		Yes	No	Abstain	Absent	
<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	BLANTON	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	KIESLING	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	STEFFEL
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<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	GOUNARDES	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	SEAGO	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	WEBER
<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	HAGENBRUCH	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	SMITH, A. J.					Res. 53

Resolution No. None New ☐ Substitute ☐ Amendment ☐Report: CODA Supplemental Report 3 Date Submitted: September 2011Submitted By: Commission on Dental AccreditationReference Committee: Dental Education, Science and Related MattersTotal Net Financial Implication: None Net Dues Impact: \$Amount One-time \$ Amount On-going \$ADA Strategic Plan Goal: Collaboration (Required)

**COMMISSION ON DENTAL ACCREDITATION SUPPLEMENTAL REPORT 3 TO THE HOUSE OF DELEGATES: INFORMATIONAL REPORT ON DEVELOPING ACCREDITATION STANDARDS FOR DENTAL THERAPY PROGRAMS**

**Executive Summary:**

- On June 29, 2011, the Commission received correspondence from Dr. Patrick Lloyd, Dean of the University of Minnesota, School of Dentistry, supplementing his 2009 request that the Commission begin the process of establishing accreditation standards for a baccalaureate degree program in Dental Therapy. The formal request included documentation which addresses the five "Principles and Criteria-Eligibility of Allied Dental Programs for Accreditation by the Commission on Dental Accreditation."
- At the open portion of its' August 5, 2011 meeting, the Commission considered the request by the University of Minnesota School of Dentistry to develop accreditation standards for dental therapy education programs.
- After significant discussion and review of submitted documentation, the Commission directed the Commission Chair to appoint a task force to develop standards for dental therapy education programs and report progress at the August 2012 Commission meeting.
- The Commission has taken the first step in a multi-year process to develop new accreditation standards for dental therapy education programs. Until the accreditation standards are developed and implemented, dental therapy programs are not eligible for accreditation.
- In making its decision, the Commission concluded that it has the ability, by virtue of its mission and expertise, as well as the obligation to set educational standards to help ensure patient safety.

**Background:** In the fall of 2009, the Commission received requests to accredit the Dental Therapy and Advanced Dental Therapy Educational programs in the state of Minnesota from the Minnesota Board of Dentistry; the University of Minnesota (Dental Therapy Program-baccalaureate degree); the Minnesota Dental Association; and the Metropolitan State University of the Minnesota and State Colleges and Universities System (Advanced Dental Therapy Program-master's degree). Students are already enrolled in both programs and the statutory language addresses program accreditation by requiring that an applicant for licensure have "...graduated with a baccalaureate degree or a master's degree from a dental therapy education program that has been approved by the board or accredited by the ...Commission on Dental Accreditation or another board-approved national accreditation organization." The requests asked the Commission to develop a document that defines educational standards for dental therapy and advanced dental therapy.

At the February 2010 Commission meeting, the Commission noted that its mission is to serve the public by ensuring quality education and patient safety. The accreditation review of programs in areas other than predoctoral dental education and dental specialties is feasible and within its purview as evidenced by its

review of programs in advanced general dentistry, dental hygiene, dental assisting and dental laboratory technology. The Commission directed the Chair to form a Task Force to investigate the requests to accredit Dental Therapy and Advanced Dental Therapy programs in Minnesota.

The Task Force met on May 10, 2010 and reviewed extensive background documentation, including outlines of models of dental therapy education from throughout the world. The Task Force noted that there is currently no Commission policy, nor are there criteria, for determining whether the Commission should establish a process of accreditation for educational programs in new areas of allied dentistry. The Task Force came to the consensus that the generic principles and criteria that were used to determine whether the Commission should establish a process of accreditation for interest areas in general dentistry, could be used to evaluate the Dental Therapy requests. The Task Force also recommended that the Commission form a new Task Force to coordinate a national survey of state dental associations, state dental boards, and other stakeholder groups to determine need and support from the public and professional communities for accreditation of dental therapy educational programs beyond a single state (Minnesota) and to develop standards for dental therapy education programs if such a need and support are indicated by the national survey.

At the August 10, 2010 Commission meeting, the Commission directed that criteria and principles used by the Task Force on New Dental Team Members to make the determination of whether educational programs for proposed new member of the dental team are eligible for accreditation by the Commission on Dental Accreditation should be formalized as official Commission policy and added to the Evaluation and Operational Policies and Procedures Manual (Appendix 1). In addition, the Commission acknowledged that accreditation of education programs in areas such as dental therapy would be consistent with the Commission's mission and scope; however, the Commission determined that the requests to accredit the Dental Therapy and Advanced Dental Therapy Programs in the State of Minnesota did not include sufficient information and evidence to warrant establishing an accreditation program and standards at this time. In particular, the Commission determined that there was insufficient information and evidence regarding the following criteria:

B. Has the allied dental education area been in operation for a sufficient period of time to establish benchmarks and adequately measure performance?

E. Is there evidence of need and support from the public and professional communities to sustain educational programs in the discipline?

**The Request to Accredite the Dental Therapy Education Program at the University of Minnesota:** On June 29, 2011, the Commission received correspondence from Dr. Patrick Lloyd, Dean of the University of Minnesota, School of Dentistry, requesting that the Commission begin the process of establishing accreditation standards for a baccalaureate degree program in Dental Therapy. The formal request included documentation which addresses the five "Principles and Criteria-Eligibility of Allied Dental Programs for Accreditation by the Commission on Dental Accreditation." The following points summarize the information and supporting rationale included with the request by the University of Minnesota:

- The programs of dental therapy fall within the mission of CODA as its graduates will be an important part of the dental care team. Included in CODA's mission is the responsibility to reflect the evolving practice of dentistry. Left without guiding standards, programs that may be developed in other states may be more reflective of the results of political haggling rather than the standards of the profession that are developed in a careful, thoughtful manner by bodies that understand best how to educate dental health care professionals.
- Dental therapy in the United States is here, and it desperately needs guidance, conformity, and a regulating body. The development of programs that vary in prerequisites, length of program, quality of program, scope of practice, maturity level of matriculates, differing levels of supervision, and varied objective confuses outcomes the public, alienates current dental providers, prohibits the movement of health care providers from state to state and is not in the best interest of the profession.



- Most successful programs are part of a dental school which offers clear advantages for the quality of the program and for team building. Programs that have been established in Minnesota lead to either a Bachelors of Science degree or a Masters degree. The dental therapy programs at the University of Minnesota are totally integrated into the accredited predoctoral and dental hygiene programs.
- No new individuals with special credentials need to be sought for expertise in teaching dental therapy. As has been mentioned, dental therapists do not need didactic or clinical expertise for their scope of practice that is not already available in dental schools currently. Dental schools not only have well qualified dental professionals (dentists and dental hygienists) but also have individuals with expertise in teaching all of the didactic and clinical topics that comprise the curriculum for dental therapists.
- Currently, nine students that are enrolled will graduate in December 2011; ten students are in the class to graduate in December 2012; and ten students have been chosen for the class entering in fall 2011. The number of applicants to the program has been in the range of 25-35 for a class of ten. Of particular interest is that every class has students from outside the state of Minnesota and the class entering in the fall will have four of the ten students from states other than Minnesota.

**August 5, 2011 Commission Meeting:** At the open portion of the August 5, 2011 meeting, the Commission considered the request by the University of Minnesota School of Dentistry to develop accreditation standards for dental therapy education programs. The three options considered by the Commission included:

- Deny the request, due to insufficient documentation and evidence that each of the "Principles and Criteria-Eligibility of Allied Dental Programs for Accreditation by the Commission on Dental Accreditation" had been met.
- Form a task force to further study the request and supporting documentation and report back to the Commission at the February 2012 meeting.
- Grant the request, as the University of Minnesota had supplied sufficient documentation and evidence to show that each of the "Principles and Criteria-Eligibility of Allied Dental Programs for Accreditation by the Commission on Dental Accreditation" had been met.

A motion was made to grant the request, directing the Commission Chair to appoint a task force to develop standards for dental therapy education programs and report progress at the August 2012 Commission meeting. Several Commissioners spoke in opposition to the motion and spoke to the option of appointing a task force to further evaluate the request. Some Commissioners expressed concern that the practice of dental therapy is not national in scope, and that there are only two dental therapy educational programs operating in one state at the present time. It was stated that dental therapy is going to create a paradigm shift in the practice of dentistry, so further study is needed to understand all the consequences of this change. A further question was raised regarding whether the Commission should devote resources for such a small group of students and programs. None of the Commissioners spoke to the first option of denying the request outright. Commissioners who spoke in favor of the motion made the following points:

- The establishment of standards for dental therapy education is reflective of the Commission's mission, which is to serve the public by establishing, maintaining and applying standards regarding the quality and continuous improvement of dental and dental-related education.
- The Commission is the only entity that has expertise in accreditation of dental education programs and can set standards on a national basis. There is the potential for fragmentation of the accreditation process if the state dental boards or other accrediting agencies accredit programs.
- Students will graduate within the next six months and they will be treating patients in Minnesota in 2012. The incoming class for the fall of 2011 is filled, so the program appears to be sustainable. There appears to be broad interest in the dental therapy model in a number of states, including Missouri, Washington, and Illinois.

- 1 • Patient welfare and patient care could be adversely affected if there are no educational standards for  
2 dental therapy. The Commission has the ability and the obligation to set educational standards to  
3 help ensure patient safety.  
4
- 5 • The Commission has the ability to provide a leadership role in defining scope of practice and defining  
6 the standards for quality education in dental therapy.  
7
- 8 • The Commission extensively studied this issue last year, forming a Task Force in 2010 when the  
9 Commission received the first request to establish dental therapy standards from Minnesota Board of  
10 Dentistry; the University of Minnesota; the Minnesota Dental Association; and Metropolitan State  
11 University. In this second request, the University of Minnesota has provided sufficient documentation  
12 and evidence in addressing the two criteria that were previously unmet.

13 The motion carried 17-8, with one abstention.

14 **Frequently Asked Questions:** Given the degree of scrutiny and contention surrounding the dental therapy  
15 education programs in Minnesota, the following "Frequently Asked Questions" are offered to clarify the  
16 Commission's action to develop accreditation standards for dental therapy education programs:

17 **Q.** Will the Commission immediately begin accrediting programs that train dental therapists?

18 **A.** No, the Commission has taken the first step in a multi-step process spanning more than one or two years  
19 to develop new accreditation standards for dental therapy education programs. Until the accreditation  
20 standards are developed and implemented, dental therapy programs are not eligible for accreditation.

21 **Q.** What is the process for developing standards?

22 **A.** Accreditation standards are developed based on broad input and participation of the affected  
23 constituencies, with the appropriate communities of interest substantially involved in all stages of the process.  
24 The process culminates in the adoption of accreditation standards which become the property of the  
25 Commission. Standards are developed to reflect disease and practice patterns; scientific or technological  
26 advances; or in response to changing professional needs for which the Commission has documented  
27 evidence. Standards also help to define scope of practice issues.

28 During the initial step of the process, representatives from the discipline involved are invited to participate in  
29 the development of the preliminary document. The communities of interest include, but are not limited to, the  
30 following: sponsoring organizations and certifying boards of all dental and dental related disciplines under the  
31 purview of the Commission, program directors, dental school deans, private practitioners, administrators of  
32 non-dental school institutions offering dental programs, and constituent societies of the American Dental  
33 Association.

34 Once the preliminary document is developed by the selected representatives of the discipline involved, it is  
35 considered by the appropriate review committee. The review committee may make further revisions to the  
36 preliminary document before recommending circulation by the Commission to the communities of interest for  
37 comment. If the Commission concurs with the review committee recommendation, then the document is  
38 released to the public for comment, usually for one year. Open hearings are held at the ADA annual session,  
39 the ADEA annual session, and any other appropriate sponsoring organization annual meeting. Written  
40 comments may also be submitted at any time during the open comment period. All comments received are  
41 compiled by CODA staff and reviewed by the appropriate review committee. The review committee may  
42 make further revisions to the draft document based on the input. When the changes are relatively minor  
43 (word-smithing, etc.) the review committee may make a recommendation to the Commission to accept the  
44 document as final and to set an implementation date, or it may make a recommendation to recirculate for  
45 further comment if changes are significant. Once again, the Commission approves changes and authorizes

1 implementation timeframe or recirculation to the communities of interest for comments. These last steps can  
2 be repeated, depending upon the significance of changes.

3 **Q.** How can an individual dentist or member of the public have input on Commission policy or accreditation  
4 standards?

5 **A.** The Commission routinely seeks written and oral comments from its communities of interest when  
6 proposing a change in Commission policy or accreditation standards. A call for comment is sought through a  
7 variety of methods, which may include: posting on the "Accreditation News" section of the CODA website;  
8 announcements in the Commission e-newsletter "CODA Communicator"; and posting in the Unofficial Report  
9 of Major actions immediately following the biannual Commission meeting. The Commission minutes also  
10 detail the calls for comment. Open hearings are routinely conducted at the American Dental Education  
11 Association's annual session and the American Dental Association's annual session. All comments, whether  
12 written or oral, are provided to the Review Committees, as appropriate, and to the Commission for their  
13 consideration.

14 **Q.** Will the Commission set the scope of practice for dental therapists?

15 **A.** For allied dental areas, the Commission looks to develop and revise accreditation standards based on a  
16 national norm in scope of practice and on its determination of what is in the public's best interest.

17 **Q.** What role do state dental boards have in defining scope of practice?

18 **A.** State dental boards can and do set the specific scopes of practice for the dentists and allied dental  
19 personnel over which the boards have jurisdiction. This is particularly significant when considering the  
20 Commission's decision to create accreditation standards. State boards of dentistry can certify educational  
21 and training programs *without* those programs seeking or receiving Commission accreditation. In fact,  
22 advocates who are working to create therapist programs in several states are attempting to pressure those  
23 states' legislatures to rewrite their dental practice acts to accomplish this.

24 **Q.** Then why is CODA accreditation needed?

25 **A.** First, the Commission is the only entity that has expertise in accreditation of dental education programs  
26 and can set quality standards on a national basis. If accreditation standards are established, state dental  
27 boards can look to the accreditation standards as a guide to setting the scope of practice. Second, there is  
28 the potential for fragmentation of the accreditation process if the state dental boards or other accrediting  
29 agencies accredit programs. Finally, the establishment of standards for dental therapy education is reflective  
30 of the Commission's mission, which is to serve the public by establishing, maintaining and applying standards  
31 regarding the quality and continuous improvement of dental and dental-related education.

32 **Q.** Why doesn't the Commission take into account ADA policy when making decisions?

33 **A.** While the Commission is an agency of the ADA, accreditation decisions, standard setting and accreditation  
34 policy is solely under the Commission's purview, as outlined in the ADA *Bylaws*. The Commission must also  
35 conduct its evaluation program in a manner consistent with universally established accreditation practices and  
36 criteria of the U.S. Department of Education. The Commission must be independent in its actions, based on  
37 the nature of its role and the incredible responsibility given to it by the U.S. Department of Education. It is not,  
38 nor can it ever be, the ADA's eyes, ears and voice on dental accreditation. It must protect the integrity of the  
39 accreditation process (through consistent application of its high standards, plus adherence to the  
40 accreditation process and maintenance of the confidentiality of the process). The Commission's credibility  
41 and integrity with the U.S. Department of Education, the educational institutions that go through the

1 accreditation process, the dental profession and the American public would be in serious jeopardy if the  
2 Commission ever took an action that failed to abide by these important principles.

3 This does not mean that the Commission will not consider input from the ADA. As part of the communities of  
4 interest, ADA input on policy decisions is considered due to its prominence in representing a significant  
5 proportion of the profession and employers of graduates of education programs. ADA input is solicited on a  
6 regular basis, along with input from all the communities of interest. Ultimately though, the Commission bases  
7 policy and accreditation decisions on the overall welfare of the patient and the student, and the effect on the  
8 quality of dental education.

9 **Q. What will happen next?**

10 **A.** CODA Chairman Dr. Donald Joondeph will appoint a task force of dental educators and practitioners with  
11 experience in dental education to develop new standards for dental therapy education programs. The task  
12 force will report to the Commission on its progress at the August 2012 CODA meeting.

13 **Summary:** The Commission considered a request to develop accreditation standards for dental therapy  
14 education programs by the University of Minnesota. The Commission determined that each of the five  
15 "Principles and Criteria-Eligibility of Allied Dental Programs for Accreditation by the Commission on Dental  
16 Accreditation" was sufficiently addressed through documentation and evidence to begin the process of  
17 developing standards. A Task Force to develop standards will be appointed by the Commission chair, with a  
18 report on progress at the Commission's August 2012 meeting.

## 19 Resolutions

20 This report is informational and no resolutions are presented.

21 **BOARD COMMENT:** The Board believes that the Commission may not have performed a complete and  
22 thorough review and analysis of the documentation submitted by the University of Minnesota. In addition, it  
23 was noted in the supplemental report summary of the August 5, 2011, Commission meeting, that the state of  
24 Illinois was included on a list of states that may be considering a dental therapy model of care. The Trustee  
25 from the Eighth District informed the Board that Illinois is not currently considering this model of care, so the  
26 broad interest from other states cited at the Commission meeting is not an accurate portrayal.

27 **BOARD RECOMMENDATION: Vote Yes to Transmit with Comments.**

28 **BOARD VOTE: UNANIMOUS.**

Resolution No. None New ☐ Substitute ☐ Amendment ☐Report: CSA Supplemental Report 1 Date Submitted: September 2011Submitted By: Council on Scientific AffairsReference Committee: Dental Education, Science and Related MattersTotal Net Financial Implication: None Net Dues Impact: \$Amount One-time \$ Amount On-going \$ADA Strategic Plan Goal: Members and Collaboration (Required)**COUNCIL ON SCIENTIFIC AFFAIRS SUPPLEMENTAL REPORT 1 TO THE HOUSE OF DELEGATES:  
UPDATE ON RESPONSE TO ASSIGNMENTS FROM THE 2010 HOUSE OF DELEGATES AND OTHER  
MATTERS****Response to Assignments From the 2010 House of Delegates:** This report updates the status of two assignments from the House: 101H-2010 and 71H-2010.

*Health Screening Program Funding (Resolution 71H-2010).* In accordance with Resolution 71H-2010, which provided funding support for the 2011 Health Screening Program (HSP), the Council plans to offer a full range of screening tests at the 2011 HSP in Las Vegas to study issues impacting the health and safety of clinical dental professionals and their patients. A contract has been executed with a new vendor to supply some of the HSP screenings. This change will enhance both member service and data management related to research projects, since the vendor uses the latest technology to track, store and protect test results and personal information.

Collaborations have also been arranged with external researchers to offer the following: Point-of-service rapid finger-stick blood tests and education; salivary diagnostics demonstrations and education; range of motion studies; and carpal tunnel syndrome and latex allergy evaluations. HSP is also collaborating with the Council on Dental Practice's Dentist Well-Being Advisory Committee to supplement CDP's research and continuing education activities related to dentist well-being, including range-of-motion and other ergonomic evaluations.

As directed by the HOD, fundraising efforts were initiated to help defray HSP expenses. Fundraising continues under the direction of the ADA Division of Corporate Relations and Strategic Marketing Alliances. However, to date, commitments have been received totaling \$212,500 in direct funding and over \$75,000 in additional in-kind support. The direct funding includes a \$107,094 research grant from the ADA Foundation. These funds will help offset the expense of the \$350,000 allocated by the HOD.

In July 2011, the Council discussed and approved both the 2011 HSP program, and a plan to enhance and expand HSP research collaborations, including prospective studies. The Council continues to work with internal and external stakeholder organizations to refine the HSP's research and education initiatives, which the Council believes will continue to result in data and information that are valuable to all ADA members and the profession generally.

*Medication-Induced Xerostomia (Resolution 101H-2010 and Resolution 45-2009).* The Council reported to the 2010 House of Delegates on CSA's activities related to a referred resolution, 45-2009, which proposed that ADA encourage the Food and Drug Administration (FDA) to require warning labels for medications that cause dry mouth and a resultant increased risk of tooth decay. The Council then updated information on 45-2009 in its 2011 annual report, and reported the completion of 101H-2010, which directed ADA to encourage

the FDA to require warning labels for medications that cause dry mouth and an elevated risk of dental caries or other potential complications that should be discussed with a dentist.

ADA News prepared an announcement regarding the letter to FDA (<http://www.ada.org/news/5750.aspx>) and the letter is also available in PDF format on ADA.org: [http://dev.ada.org/sections/newsAndEvents/pdfs/ltr\\_dry\\_mouth\\_110427.pdf](http://dev.ada.org/sections/newsAndEvents/pdfs/ltr_dry_mouth_110427.pdf). In its response to the ADA, the FDA “acknowledges that the prescription drug labeling is a critical tool for prescribers to the most accurate information to prescribe drugs appropriately.” The standard for labeling information is high: “based on data from human experience.” Although the FDA did agree to post a new dry mouth information page on its website earlier this year (<http://www.fda.gov/ForConsumers/ConsumerUpdates/ucm254273.htm>), the agency advised ADA that it would need additional data to act on ADA’s request. In its letter, the FDA acknowledged that chronic dry mouth can lead to a number of serious complications. The agency pointed out that “many drug products and drug classes...identify dry mouth as an adverse reaction.” FDA invited the ADA to submit data on any products that may cause moderate to severe xerostomia that do not already include dry mouth as a potential adverse reaction. The Agency also invited ADA to submit data of which it is aware (e.g., from published studies) that would “support inclusion of additional information about the risk and complications of moderate to severe dry mouth for any particular drug.”

The Council is in the process of developing a response to the FDA letter, thanking them for their attention to this issue and for developing and posting the new dry mouth information page on their website. The response will also advise FDA that the ADA does not know of data that would support new labeling for xerostomia for medications that do not currently include the warning. Additionally, the response will point out that although data from published studies on the secondary effects of dry mouth from specific medications is either non-existent or exceedingly limited, the Council on Scientific Affairs will continue to monitor this area and advise the FDA if appropriate supporting studies are identified.

Given the cost and difficulties associated with conducting clinical research on the secondary effects of xerostomia for *specific* medications, the Council suggests that the most productive and efficient use of ADA resources will be to continue to develop and disseminate information to dentists and the public on the risks of medication-induced dry mouth and dry mouth from other causes. However, since pharmaceutical companies conduct research to support product approval and the sequelae of chronic dry mouth are significant, the ADA follow up letter to FDA will urge that the Agency consider new industry guidance for clinical development of medications that may cause dry mouth. Clinical studies to support product approval for such drugs should include an assessment of oral health status and complications that result from xerostomia. The Council will continue to collaborate with internal and external organizations, including FDA, and provide the latest scientific information on the oral complications of dry mouth through various ADA media, including ADA.org, ADA News and other means.

The Council will also pursue development of an updated ADA report on xerostomia, which will be submitted to JADA for publication when complete. Additionally, the planned medication-induced dry mouth press release was completed and released in August 2011 by ADA in collaboration with the Academy of General Dentistry (AGD), American Academy of Periodontology (AAP) and the American Pharmacists Association (APhA). The press release is available online at: <http://www.ada.org/6114.aspx>

**Caries Classification System: Status Update**—The Council assessed progress on this project in 2010 and approved an updated project plan and targets for 2010-2011. The Council updated the plan again at its July 2011 meeting. The changes push back delivery of a caries classification system (CCS) and implementation plan from 2011 to 2012 to allow more time for validation testing. In the meantime, the Council has acted on the suggestion of stakeholders to revise the CCS categories and definitions. The Council also reviewed and approved the initial mapping of the CCS concepts into the ADA SNODENT diagnostic code system. A paper CCS form which demonstrates the use of the system was also reviewed and approved by CSA. The Council approved proceeding with clinical validation testing for the system in collaboration with external stakeholders.

1 It is anticipated that validation testing will be completed in time to prepare a CSA report with  
2 recommendations to the 2012 House of Delegates.

3 The project is complex and has the potential for significant impact on the dental profession. Implementation  
4 of a new system of this scope requires extensive coordination and cooperation among numerous internal and  
5 external stakeholders, including academia, industry, research and dental practitioners.

6 **Resolutions**

7 This report is informational and no resolutions are presented.

8 **BOARD RECOMMENDATION: Vote Yes to Transmit.**

9 **BOARD VOTE: UNANIMOUS. (BOARD OF TRUSTEES CONSENT CALENDAR ACTION—NO BOARD**  
10 **DISCUSSION)**





Resolution No. None New ☐ Substitute ☐ Amendment ☐Report: CODA Supplemental Report 2 Date Submitted: September 2011Submitted By: Commission on Dental AccreditationReference Committee: Dental Education, Science and Related MattersTotal Net Financial Implication: None Net Dues Impact: \$Amount One-time \$ Amount On-going \$ADA Strategic Plan Goal: Collaboration (Required)**COMMISSION ON DENTAL ACCREDITATION SUPPLEMENTAL REPORT 2 TO THE HOUSE OF DELEGATES: UPDATE ON INTERNATIONAL ACCREDITATION****Executive Summary:**

- On January 1, 2007, the Joint Advisory Committee on International Accreditation (JACIA) began accepting initial applications (PACV surveys) from international, predoctoral programs. The JACIA has met regularly since 2007 to review applications from international programs, review and update policies and procedures, and monitor budgetary matters including revision of international accreditation fees.
- The expenses and revenues associated with the activities of the JACIA and international accreditation have been assigned to a specific, international consultation and evaluation cost center since the inception of the program in 2005. Both expenses and revenues have been less than projected since 2006.
- The process established by the JACIA involves three steps—a PACV survey, a consultation visit and evaluation by the JACIA and an application for accreditation by CODA. Since 2007, 10 international programs have submitted PACV surveys (initial applications) to the JACIA for its consideration. Following review and discussion, JACIA approved each of the ten programs to attend a U.S.-based comprehensive visit and submit a PACV self-study.
- Since 2009, four international programs have submitted a PACV self-study and have requested a PACV site visit. Following review of the self-studies, the JACIA determined that one program in Lima, Peru did not provide sufficient information to warrant a PACV site visit. Two programs (Dharwad, India and Jeddah, Saudi Arabia) provided sufficient documentation to schedule a comprehensive PACV site visit and staff was directed to make arrangements for a committee of dental professionals with experience in dental education in the United States and/or who have served as site visitors to predoctoral programs to complete a consultation visit to the schools. The JACIA deferred a decision on the fourth PACV self-study pending receipt of additional information from the program.
- No international predoctoral dental education programs have been accredited by the Commission at this time.
- At its May 12 and July 28, 2011 meetings, the JACIA reaffirmed that Standard 1.7 should be the only standard for which equivalency may be considered.
- The Commission currently monitors compliance of accredited programs during the interim between site visits through surveys that education programs are required to complete in order to maintain their accredited status. The Commission also has several policies related to continual compliance with the standards, including the Policy on Major Change; the Policy on Integrity; and the Formal Complaint Policy. International programs will be required to provide the same survey data that U.S.-based programs provide and will be required to adhere to each of these policies.
- The JACIA does request information on the dental practice milieu of the country from which the international program is applying in the PACV survey; however, as a main purpose of accreditation is

1 the evaluation of the quality of educational programs, the regulation and/or licensure of individuals  
2 practicing dentistry in any given country, including the U.S., does not fall under the purview of the  
3 Commission.

4 **Background:** In October 2004, the American Dental Association's House of Delegates adopted Resolution  
5 41H-2004 (*Trans.*2004:320):

6 **41H-2004 Resolved**, that the Association urge the Commission on Dental Accreditation to make  
7 available, upon request, fee-based consulting services and evaluation to international dental schools  
8 which are preparing general dentists for practice, and be it further

9 **Resolved**, that the Commission be urged to submit with its 2006 budget a business plan showing how  
10 the international consultation and evaluation program will become self-sufficient within three years of  
11 implementation and recover start-up costs within six years, and be it further

12 **Resolved**, that the Commission be urged to report annually to the communities of interest, including the  
13 House of Delegates, on the progress of this activity, and be it further

14 **Resolved**, that the Commission be urged to select an ad hoc committee composed of two  
15 Commissioners and two ADA trustee appointees to continue to give input on this new activity and other  
16 activities related to consultation and evaluation, and be it further

17 **Resolved**, that the appropriate agency of the ADA monitor the impact of international consultation  
18 evaluation on the dental workforce in the United States.

19 In response to Resolution 41H-2004, an Ad Hoc Committee was appointed to continue the dialogue regarding  
20 international consultation and evaluation activities. In 2005, the Ad Hoc Committee, with assistance of the  
21 Center for International Development and Affairs, distributed a questionnaire to approximately 750  
22 international dental schools in 97 countries. Sixty-one responses were received from dental schools in 30  
23 countries. Twenty-seven schools expressed an interest in attaining accreditation by the Commission on  
24 Dental Accreditation. While the volume of international interest in the ADA/CODA's services appeared small,  
25 the Ad Hoc Committee expressed concern that if the ADA/CODA did not enter into international consultation,  
26 evaluation and accreditation activities, individual states would continue to establish independent processes for  
27 approving or accrediting international dental schools with varied criteria. Further, there was concern about  
28 potential risk to the Commission's credibility as the only recognized accrediting agency for dental education if  
29 state dental boards or other agencies were to accredit schools. The limited response to the questionnaire  
30 and modest interest also indicated that the number of international dental schools that might achieve  
31 accreditation was quite small and that a large influx of international graduates would be unlikely if the  
32 Commission were to become involved in international accreditation.

33 In October 2005, the American Dental Association's House of Delegates adopted Resolution 39H-2005  
34 (*Trans.*2005:299)—Consultation and Evaluation of International Dental Schools.

35 **39H-2005. Resolved**, that the ADA and its Board of Trustees support the Commission on Dental  
36 Accreditation's initiative to offer consultation and accreditation services to international dental schools,  
37 and be it further

38 **Resolved**, that the ADA and Commission on Dental Accreditation establish a standing, joint advisory  
39 committee to provide guidance to the Commission in the selection, development and implementation of  
40 an international program of consultation and accreditation for dental education, and be it further

41 **Resolved**, that the advisory committee include two representatives from the Commission and three  
42 representatives from the ADA with one of these representatives from the ADA Board of Trustees as chair  
43 and two at-large members from the practicing community appointed by the President, and be it further

1       **Resolved**, that the terms of office of the ADA representatives be a staggered three-year term and be  
2       eligible for one additional term of appointment, and be it further

3       **Resolved**, that the advisory committee in conjunction with the Commission on Dental Accreditation  
4       provide a report annually on the progress of international activities to the House of Delegates.

5       In 2006, in response to Resolution 39H-2005, the Joint Advisory Committee on International Accreditation  
6       (JACIA) was appointed and the Committee spent the year establishing international accreditation policies,  
7       procedures, and guidelines for international accreditation. The process established by the JACIA involves  
8       three basic steps: 1) submission and approval of a PACV, 2) submission and acceptance of a self-study for a  
9       consultation site visit to evaluate the comparability of dental education and practice to U.S. standards and 3)  
10      submission and acceptance of an application for Initial Accreditation to CODA.

11      On January 1, 2007, the JACIA began accepting initial applications (PACV surveys) from international,  
12      predoctoral programs. The JACIA has met regularly since 2007 to review applications from international  
13      programs, review and update policies and procedures, and monitor budgetary matters including revision of  
14      international accreditation fees. A summary of all meetings of the JACIA, with a list of the major actions is  
15      attached as Appendix 1.

16      The following is a report which addresses the specific topics raised by the Board of Trustees at the June 2011  
17      meeting:

18      **Budget:** The expenses and revenues associated with the activities of the JACIA and international  
19      accreditation have been assigned to a specific, international consultation and evaluation cost center since the  
20      inception of the program in 2005. Resolution 41H-2004 called for the international consultation and evaluation  
21      program to become self-sufficient within three years of implementation and recover start-up costs within six  
22      years. A summary of revenue and expenses from 2006 to the present can be found in Appendix 2, Table 1.

23      Recurring expenses include the following:

- 24          • Assignment of 20% of salary and benefits of the Manager for Predoctoral Dental Education and a  
25          Senior Project Assistant based on projected time spent on international activities.
- 26          • Meetings of the JACIA at the ADA Headquarters Building in Chicago.
- 27          • Telephone calls/routine office expenses

28      The assignment of 20% of salary and benefits of two CODA staff has not been an accurate reflection of the  
29      amount of time spent on international accreditation activities. Actual staff time spent on international activities  
30      has been in the 3-5% range. It is anticipated that as international site visits begin to be conducted,  
31      approximately 10-15% of salary and benefits of the Manager for Predoctoral Dental Education could be  
32      assigned to international activities, depending on the number of site visits during a given year. Senior Project  
33      Assistant staff time is anticipated to remain in the 3-5% range. ADA incurs no travel and related expenses for  
34      international consultation site visits, as the international program is required to pay all expenses associated  
35      with the site visit. As is the case for consultation site visits, international programs would be required to pay  
36      all expenses associated with Commission site visits for initial accreditation and renewal of accreditation. U.S.-  
37      based programs pay an annual fee and are not charged for costs associated with regular site visits.

38      In regards to revenue related to international accreditation, as early as 2008 the JACIA determined that  
39      revenue projections made in 2005 of the number of programs submitting PACV self-studies and associated  
40      fees were optimistic. At that time, the JACIA noted there were no fees associated with submission of the  
41      initial application (PACV survey), even though staff, office, and meeting expenses were incurred. Therefore,  
42      the JACIA instituted an application fee for submission and evaluation of the PACV Survey. Due to collection  
43      of PACV survey fees and PACV self-study fees, revenue from international accreditation activities has been  
44      realized in 2009, 2010, and 2011. If an international program achieves accreditation by the Commission,  
45      annual fees would be charged, which are higher than the annual fee paid by U.S.-based programs. This is to

account for the additional administrative expenses associated with monitoring international programs. The current fee structure for international accreditation can be found in Appendix 3.

If the assignment of 20% of salary and benefits of the Manager for Predoctoral Dental Education and a Senior Project Assistant is used as an expense line item in international consultation and evaluation cost center, then the program has not become self-sufficient within three years of implementation, nor has it recovered start-up costs within six years, as outlined in Resolution 41H-2004. If the assignment of a percentage of salary and benefits reflects the actual time spent by staff on international accreditation issues, then the program has recovered start-up costs. A determination of self-sufficiency can only be made once there are accredited programs providing a reliable revenue stream through annual fees. Appendix 2, Tables 2 and 3 outline scenarios on the effect of changing the percentage of the assignment of salary and benefits has on the ratio of expenses to revenue.

**Number of Schools Submitting PACV Surveys:** The Committee began to accept requests for information on consultation visits beginning in January 2007. The Committee evaluates PACV surveys using the "Broad Eligibility Criteria for Preliminary Accreditation Consultation Visit Surveys" as outlined in the Commission's Guidelines for International Consultation and Preliminary Accreditation Consultation Visit (PACV) Survey ([www.ada.org/4294.aspx](http://www.ada.org/4294.aspx)).

The following international programs have submitted PACV surveys since 2007:

1. Saraswati Medical and Dental College, Lucknow, India
2. King Abdulaziz University School of Dental Medicine, Jeddah, Saudi Arabia
3. Universidad de la Salle Bajio AC Dental Education Program, Leon, Mexico
4. Universidad de San Martin de Porres, Lima, Peru
5. Yonsei University College of Dentistry, Seoul, South Korea
6. Seoul National University, School of Dentistry, Seoul, South Korea
7. Yeditepe University Faculty of Dentistry, Istanbul, Turkey
8. Sri Dharmasthala Manjunatheshwara College of Dental Sciences and Hospital, Dharwad, India
9. King Khalid University, College of Dentistry, Abha, Saudi Arabia
10. Universidad Autonoma de Nuevo Leon, Monterrey, Mexico

Following review and discussion, JACIA approved all of the programs listed above to attend a U.S. comprehensive visit and submit a PACV self-study. In several instances, the Committee has requested that programs submit further information and clarifications. For instance, it has been unclear from the PACV surveys submitted by the programs in Saudi Arabia the extent of gender separation of students during didactic and clinical education experiences. The Committee has requested additional information to determine if courses, laboratory experiences, and planned clinical experiences are equivalent for male and female students. The Committee has also requested additional information to determine if there are Saudi Arabian travel restrictions and regulations that may influence the makeup of a visiting committee.

PACV-approved program representatives observed U.S.-based predoctoral visits as follows: two (2) programs in 2009, four (4) programs in 2010, three (3) programs in 2011. One program is scheduled to observe a U.S.-based site visit in 2012. Following attendance at comprehensive visits, programs are asked to respond if they intend to continue to pursue consultation. To date, all programs that have sent representatives to attend comprehensive, U.S.-based site visits have indicated that they intend to pursue additional consultation services.

**Number of Schools Submitting PACV Self-Studies:** A PACV self-study and all required fees were received in March 2009 from Universidad de San Martin de Porres, Lima, Peru. Following review of the self-study in May 2009, the Committee determined that the school provided insufficient information to determine if they are ready for a consultation visit and potential accreditation. Reviewers felt the school did not fully understand the process and did not have an understanding of the standards, especially those standards related to competency and quality assurance. In addition, it appeared the program may have had difficulty

1 translating their responses into English; therefore, the Committee determined that a PACV should not be  
2 scheduled.

3 In March 2011, a PACV self-study and appropriate fees were received from SDM College of Dental Sciences  
4 and Hospital, Dharwad, India. At its May 12, 2011 meeting, JACIA reviewed documentation related to  
5 equivalency to Standard 1-7 as well as standards one (1) through six (6) of the Accreditation Standards for  
6 Dental Education Programs. The Committee determined that based on the documentation provided, a  
7 comprehensive PACV should be scheduled and directed staff to make arrangements for a committee of  
8 dental professionals with experience in dental education in the United States and/or who have served as site  
9 visitors to predoctoral programs to complete a consultation visit to the school. The Preliminary Accreditation  
10 Consultation Visit has been scheduled for September 20 to 23, 2011. The site visit team will be chaired by Dr.  
11 Patrick Ferrillo, dean, University of Pacific Arthur A. Dugoni School of Dentistry. Consultation site visitors  
12 include Dr. Bob Hutchins, Baylor College of Dentistry, Dr. Michael Ferguson, New York University College of  
13 Dentistry, and Dr. Kamal Vibhakar, a dental practitioner in Lyons Illinois. The four day visit will provide  
14 comprehensive consultation to the school in the areas of planning, curriculum, student services, patient care  
15 services and research.

16 Also in March 2011, a PACV self-study and appropriate fees were received from King Abdulaziz University  
17 School of Dental Medicine, Jeddah, Saudi Arabia. At its May 12, 2011 meeting, JACIA reviewed  
18 documentation related to equivalency to Standard 1-7 as well as standards one (1) through six (6) of the  
19 Accreditation Standards for Dental Education Programs. During their review, the Committee had questions  
20 regarding the makeup of student committees and due process available to students as required in Dental  
21 Education Standard 4-2. The Committee deferred a decision on the PACV self-study pending receipt of  
22 additional information from the program on these matters. The requested information was obtained from the  
23 school, and following discussion at the July 28, 2011 JACIA meeting, the Committee determined that, based  
24 on the documentation provided, a comprehensive PACV should be scheduled. JACIA directed staff to make  
25 arrangements for a committee of dental professionals with experience in dental education in the United States  
26 and/or who have served as site visitors to predoctoral programs to complete a consultation visit to the school.

27 In June 2011, a PACV self-study and appropriate fees were received from Universidad de la Salle Bajio AC  
28 Dental Education Program, Leon, Mexico. JACIA reviewed documentation related to equivalency to Standard  
29 1-7 as well as standards one (1) through six (6) of the Accreditation Standards for Dental Education  
30 Programs. During their review at the July 28, 2011 JACIA meeting, the Committee had questions regarding  
31 academic freedom available to faculty in conducting research as required in Dental Education Standard 3-4.  
32 The Committee deferred a decision on the PACV self-study pending receipt of additional information from the  
33 program on this matter.

34 **Activities Related to Complying with Standards:** JACIA has drafted policies specific to international  
35 consultation and accreditation fee-based services to be made available, upon request, to established  
36 international predoctoral dental education programs. Policies that have been discussed and/or developed are  
37 related to the composition of the site visit team, the time interval between site visits for international programs,  
38 notification of relevant national dental associations, government agencies, and internal accrediting agencies,  
39 required observation of a site visit at U.S.-based programs prior to submission of the PACV self-study, and  
40 appeal and due process for international programs wishing to challenge committee decisions.

41 The accreditation standards that are used to evaluate the quality of international predoctoral dental education  
42 programs are the same standards used to evaluate the quality of U.S.-based programs. Equivalency for  
43 Dental Education Standard 1-7 for international predoctoral dental education programs has been developed,  
44 as this is the accreditation standard which requires predoctoral dental education programs to be housed in  
45 institutions of higher education that are accredited by a regional accrediting agency recognized by the United  
46 States Department of Education (USDE). Typically, regional accrediting agencies do not accredit institutions  
47 outside the U.S., nor does the USDE have jurisdiction outside the U.S. Without equivalency status for

Standard 1-7, international programs could not comply with this standard and therefore, no international programs could be accredited by the Commission.

As an alternative means for assessing compliance with Standard 1-7, international programs are required to address nine (9) additional criteria in the PACV survey questions that are designed to determine equivalency to U.S. regional accreditation. Resources used in determining the additional questions came from institutional accreditation standards of the Southern Association of Colleges and Schools (SACS) and the Higher Learning Commission (HLC). Substantiation of information derived from these questions by the site visitors is part of the consultation site visit and the Commission site visit. The additional questions request the following information on the sponsoring institution:

- Degree granting authority;
- Authority of the governing board;
- Board oversight related to applicable governmental laws and regulations;
- Institutional mission, goals, and/or values;
- Board oversight and authority related to institutional planning and budgeting;
- Financial stability of the sponsoring institution;
- Adequacy of institutional administrative personnel; and
- Institutional policies and procedures regarding evaluation of administrators, faculty and staff; ownership and copyright; protection of academic freedom; protection of confidentiality and integrity of student records; ethical conduct in research and instructional activities; grievance procedures; nondiscrimination policy.

The 2009 ADA House of Delegates adopted Resolution 57H-2009 (*Trans.*2009:455), Determining Equivalency for International Predoctoral Dental Education Programs Seeking Accreditation.

**57H-2009. Resolved**, that the Joint Advisory Committee on International Accreditation and the Commission on Dental Accreditation implement policies and procedures to determine equivalency for Predoctoral Dental Education Standard 1-7 for International Predoctoral Dental Education Programs seeking accreditation, and be it further

**Resolved**, that the information used to determine equivalency for Predoctoral Dental Education Standard 1-7 be substantiated as a part of the Preliminary Accreditation Consultation Visit.

The ADA Board of Trustees discussed accreditation of international dental education programs at their April 10-13, 2011 and June 5-7, 2011 meetings. The discussion centered on the Board's concerns that compromises might be made in applying the dental education standards because of cultural differences. Following discussion, the ADA Board of Trustees passed the following resolution by a unanimous vote.

**B-54-2011. Resolved**, that the Board urge the Joint Advisory Committee on International Accreditation, established by the ADA House of Delegates, that the established CODA predoctoral standards with the exception of standard 1.7 be continued and not modified in the ADA international accreditation process.

At its May 12 and July 28, 2011 meetings, JACIA discussed the Board of Trustees resolution and reaffirmed their agreement that Standard 1.7 should be the only standard to which equivalency is granted. Additionally, the Committee determined that in reference to some standards, the written documentation from the programs may be incomplete and/or unclear. In these instances, as occasionally happens even with U.S.-based programs, visiting the dental education program is the only way for consultants to verify that the program has potential to meet accreditation standards.

**Challenges of Accrediting International Education Programs:**

- Language barriers which prevent the program from accurately portraying itself.
- Cultural and societal differences and the effects on the dental education process.
- Differences in the higher education systems between the U.S. and other countries.
- Understanding the U.S. accreditation system.
- Definition and qualifications of full-time faculty.
- International programs' understanding and ability to implement policies and procedures to come into compliance with U.S. regulations (i.e., HIPAA, student privacy, non-discrimination, due process, etc.)
- Travel difficulties-obtaining appropriate travel documentation and approval on a timely basis; changes in U.S. Department of State travel warnings; lengthy travel times to potentially remote locations.

**Monitoring Compliance during the Interim between Site Visits:** The Commission currently monitors compliance of accredited programs during the interim between site visits, through surveys that education programs are required to complete in order to maintain their accredited status. With the exception of the survey on curriculum which is done biannually, all surveys are done on an annual basis. International programs will be required to provide the same survey data that U.S.-based programs provide. The surveys collect data on major programmatic changes, general school information, facilities, patient care, support staff information, admissions, student lists, individual student preclinical and clinical grades, and finances. Reports are generated from the above surveys on a yearly basis. Commission staff monitor the reports for any year-to-year major changes.

The Commission also has several policies related to continual compliance with the standards, including the Policy on Major Change; the Policy on Integrity; and the Formal Complaint Policy. International programs are required to adhere to each of these policies. Failure to do so may result in review by the Commission, a possible special-focus site visit, and may jeopardize the program's accreditation status.

The JACIA has discussed the idea of a shortened period of time between site visits for international programs due to the perceived difficulties in monitoring programs from such a great distance. However, as there are no international programs accredited at this time, the Commission has not been able to make a judgment as to whether monitoring international programs is more problematic than monitoring U.S.-based programs. The Commission's Standing Committee on Communication and Technology is currently investigating additional mechanisms and procedures for continual monitoring of dental education programs during the interim between site visits; however, this would be in conjunction with a potential increase in the interval between site visits from seven to eight years.

**Evaluation of the Regulation of the Profession in a Country's Governance Structure:** The JACIA does request information on the dental practice milieu of the country from which the international program is applying in the PACV Survey. In the "Broad Eligibility Criteria for Preliminary Accreditation Consultation Visit (PACV) Survey," one of the criteria states:

- Health care standards and standards of care for dentistry support the practice of dentistry in essentially the same manner as in the U.S.

However, as the main purpose of accreditation is the evaluation of the quality of educational programs, the regulation and/or licensure of individuals practicing dentistry in any given country, including the U.S., does not fall under its purview. If a graduate of CODA-accredited international programs wishes to practice in the U.S., he/she would still have to pass Parts I and II of the National Boards; a regional clinical examination; and meet any other state requirements for licensure (i.e., a jurisprudence exam). As stated in the original report to the House of Delegates in 2005:

1 Inconsistent and uncoordinated mechanisms for regulating and assuring the quality of dental practice and  
2 dental education could have a detrimental effect on oral health care in the U.S. The Board believes that  
3 the Commission's standards and policies have been designed for relevance to the U.S. education system  
4 and health care environment and that it will be important to ensure that a program of international  
5 accreditation be developed and implemented to promote a process that is appropriate and effective in  
6 light of regional differences in education and health care systems across the world. In particular, dentists  
7 must be able to practice in a manner consistent with prevailing standards for patient care and ethical  
8 conduct in the U.S. and be capable of complying with state and federal regulations governing oral health  
9 care.

10 **Summary:** Since the implementation of the process for international consultation and accreditation, ten  
11 international programs that have submitted PACV surveys (initial applications) to the JACIA for its  
12 consideration. Following review and discussion, JACIA approved each of the ten programs to attend a U.S.-  
13 based comprehensive visit and submit a PACV self-study. A Preliminary Accreditation Consultation Visit  
14 (PACV) has been scheduled for September 20 to 23, 2011 to the SDM College of Dental Sciences and  
15 Hospital in Dharwad, India. The four-day visit will provide comprehensive consultation to the school in the  
16 areas of planning, curriculum, student services, patient care services and research. At its July 28, 2011  
17 meeting the JACIA determined that, based on the documentation provided, a comprehensive PACV should  
18 be scheduled to the King Abdulaziz University School of Dental Medicine, Jeddah, Saudi Arabia. There are  
19 no international predoctoral dental education program accredited by the Commission at this time.

#### 20 **Resolutions**

21 This report is informational and no resolutions are presented.

22 **BOARD RECOMMENDATION: Vote Yes to Transmit.**

23 **BOARD VOTE: UNANIMOUS.**



**Appendix 1. Summary of JACIA Meetings**

<b>JACIA meeting dates</b>	<b>Meeting type</b>	<b>Important actions</b>
March 6, 2006	In person	<ol style="list-style-type: none"> <li>1. Begin the process for accreditation of international programs</li> <li>2. Assign a sub-committee to develop business/marketing plan</li> </ol>
May 12, 2006	In person	<ol style="list-style-type: none"> <li>1. Adopt the business/marketing plan.</li> <li>2. Determine implementation steps</li> </ol>
January 23, 2008	In person	<ol style="list-style-type: none"> <li>1. Approved PACV surveys               <ol style="list-style-type: none"> <li>a. Saraswati Medical &amp; Dental College; Lucknow, India</li> <li>b. King Abdulaziz University; Jeddah, Saudi Arabia</li> <li>c. Universidad de la Salle; Leon, Guanajuato Mexico</li> <li>d. Universidad de San Martin de Porres; Lima, Peru</li> <li>e. Yonsei University College of Dentistry; Seoul, South Korea</li> </ol> </li> </ol>
July 17, 2008	Conference call	<ol style="list-style-type: none"> <li>1. Approved PACV survey; Seoul National University; Seoul, South Korea</li> </ol>
August 25, 2008	Conference call	<ol style="list-style-type: none"> <li>1. Approve PACV survey; Yeditepe University; Istanbul, Turkey</li> <li>2. Discussion of international site visitor training</li> <li>3. Discussion of equivalency to Standard 1-7</li> </ol>
January 20, 2009	Conference call	<ol style="list-style-type: none"> <li>1. Continued discussion of equivalency; Review of other accrediting agencies' policies on equivalency for international programs</li> </ol>
March 9, 2009	Conference call	<ol style="list-style-type: none"> <li>1. Approved PACV survey; SDM College of Dental Sciences and Hospital; Dharwad, India</li> </ol>
May 28, 2009	In person	<ol style="list-style-type: none"> <li>1. Rejected PACV self study; San Martin De Porres; Lima, Peru</li> <li>2. Discussed revision of processes</li> <li>3. Appoint subcommittee to revise processes</li> </ol>
July 21, 2009	Conference call of subcommittee	<ol style="list-style-type: none"> <li>1. Determined revision of processes for international consultation.</li> <li>2. Determined revised fee structure</li> <li>3. Determined revised PACV survey</li> <li>4. Determined additional questions to determine equivalency to Standard 1-7</li> </ol>
August 11, 2009	Conference call	<ol style="list-style-type: none"> <li>1. Adopted revisions from subcommittee discussion as listed above</li> <li>2. Adopted resolution to go before HOD on equivalency to Standard 1-7</li> </ol>
January 14, 2010	Conference call	<ol style="list-style-type: none"> <li>1. Discussion of PACV self study draft; S.D.M. College of Dental Sciences &amp; Hospital; Dharwad, India</li> </ol>

<b>Appendix 1. Summary of JACIA Meetings (<i>continued</i>)</b>		
<b>JACIA meeting dates</b>	<b>Meeting type</b>	<b>Important actions</b>
December 2, 2010	Conference call	<ol style="list-style-type: none"> <li>1. Requested additional information related to PACV survey King Khalid University; Abha, Saudi Arabia</li> <li>2. Discussion of PACV self study draft; King Abdulaziz University; Jeddah, Saudi Arabia</li> </ol>
September 23, 2010	Conference call	<ol style="list-style-type: none"> <li>1. Approved PACV survey King Khalid University; Abha, Saudi Arabia</li> </ol>
May 5, 2011	Conference call	<ol style="list-style-type: none"> <li>1. Reviewed BOT resolution on international accreditation</li> <li>2. Approved PACV self study &amp; determined that consultation visit could be scheduled; SDM College of Dental Sciences &amp; Hospital, Dharwad, India</li> <li>3. Requested additional information related to PACV self stud; King Abdulaziz University Faculty of Dentistry; Jeddah, Saudi Arabia</li> <li>4. Adopted extension of deadlines for PACV self-studies</li> </ol>
July 28, 2011	Conference call	<ol style="list-style-type: none"> <li>1. Reviewed BOT discussion on international accreditation</li> <li>2. Requested additional information related to PACV self study; Universidad De la Salle Bajio, Faculty of Odontology; Leon, Mexico</li> <li>3. Approved PACV survey. Universidad Autonoma de Nuevo Leon; Monterrey, Mexico</li> <li>4. Approved PACV self study &amp; determined that consultation visit could be scheduled; King Abdulaziz University Faculty of Dentistry; Jeddah, Saudi Arabia</li> </ol>

**Appendix 2. International Consultation and Accreditation Budget Summary****Table 1-20% Salary and Benefits**

<b>Year</b>	<b>Revenue</b>	<b>Expenses</b>	<b>Net</b>
<b>2006</b>	<b>0</b>	<b>13,578</b>	<b>(13,578)</b>
<b>2007</b>	<b>0</b>	<b>21,288</b>	<b>(21,288)</b>
<b>2008</b>	<b>0</b>	<b>22,370</b>	<b>(22,370)</b>
<b>2009</b>	<b>8,982</b>	<b>34,102</b>	<b>(25,120)</b>
<b>2010</b>	<b>28,000</b>	<b>28,888</b>	<b>(888)</b>
<b>2011</b>	<b>52,980</b>	<b>23,973</b>	<b>29,007</b>
<b>TOTAL</b>	<b>89,962</b>	<b>144,199</b>	<b>(54,237)</b>

**Table 2-10% Salary and Benefits**

<b>Year</b>	<b>Revenue</b>	<b>Expenses</b>	<b>Net</b>
<b>2006</b>	<b>0</b>	<b>13,578</b>	<b>(13,578)</b>
<b>2007</b>	<b>0</b>	<b>13,092</b>	<b>(13,092)</b>
<b>2008</b>	<b>0</b>	<b>12,417</b>	<b>(12,417)</b>
<b>2009</b>	<b>8,982</b>	<b>20,345</b>	<b>(11,363)</b>
<b>2010</b>	<b>28,000</b>	<b>15,157</b>	<b>12,843</b>
<b>2011</b>	<b>52,980</b>	<b>15,955</b>	<b>37,025</b>
<b>TOTAL</b>	<b>89,962</b>	<b>90,544</b>	<b>(582)</b>

**Table 3-5% Salary and Benefits**

<b>Year</b>	<b>Revenue</b>	<b>Expenses</b>	<b>Net</b>
<b>2006</b>	<b>0</b>	<b>13,578</b>	<b>(13,578)</b>
<b>2007</b>	<b>0</b>	<b>8,993</b>	<b>(8,993)</b>
<b>2008</b>	<b>0</b>	<b>7,441</b>	<b>(7,441)</b>
<b>2009</b>	<b>8,982</b>	<b>13,467</b>	<b>(4,485)</b>
<b>2010</b>	<b>28,000</b>	<b>8,308</b>	<b>19,692</b>
<b>2011</b>	<b>52,980</b>	<b>11,946</b>	<b>41,034</b>
<b>TOTAL</b>	<b>89,962</b>	<b>56,255</b>	<b>33,707</b>

**Appendix 3. 2011 International Consultation and Accreditation Fees**

Application fee for PACV Survey	\$3000
Focused Consultation Service	\$12,500 + costs for travel (est. \$12,500 to 15,000 )
Preliminary Accreditation Consultation Site Visit (PACV)	\$25,000 + costs for travel (est. \$25,000 to \$30,000)
Accreditation Site Visit	Cost for travel (est. \$44,300 to \$47,000 )
Annual fee	International-\$7,800.00 U.S.-based -\$4,500.00

Resolution No. None New ☐ Substitute ☐ Amendment ☐  
Report: Board Report 10 Date Submitted: September 2011  
Submitted By: Board of Trustees  
Reference Committee: Dental Education, Science and Related Matters  
Total Net Financial Implication: None Net Dues Impact: \$  
Amount One-time \$ Amount On-going \$  
ADA Strategic Plan Goal: Members (Required)

**REPORT 10 OF THE BOARD OF TRUSTEES TO THE HOUSE OF DELEGATES:  
STATUS OF RESOLUTION 51H-2009: ADA LIBRARY ON THE WEB**

**Executive Summary:** Key Issues include:

- 2009 House of Delegates asked for evaluation of options for providing online library resources to members, including revenue potential.
- Four major content providers have been identified and contacted.
- Price information received from vendors was very expensive, vague, or non-existent.
- Vendors have been asked again to consider our request and provide price estimates.

**Risk/Benefit:**

- Benefit: Access to online journals or a chairside clinical tool could be a major member benefit.
- Risk: Costs are potentially quite high. Actual usage may not justify the cost. Technical and usability issues need to be resolved.

**Action Desired:** No resolution is proposed at this time, but any new pricing scenarios that seem practical will be forwarded to the Board for consideration.

**Background:** Resolution 51H-2009 (*Trans.*2009:445), ADA Library on the Web, reads as follows:

**51H-2009. Resolved,** that the Board of Trustees and appropriate agencies investigate the development of a web-based literature search and access service through the ADA library, and be it further

**Resolved,** that the revenue generating potential of such a service be evaluated along with its value as a member benefit, and be it further

**Resolved,** that the Board report to the 2010 House of Delegates on the demand, feasibility, costs and related issues of implementing such a service.

Resolution 51H aims to provide ADA members with greater online access to full-text journal articles. With the ADA's current support of evidence-based dentistry, access to the literature on dental research is more relevant than ever.

**Member Expectations:** With growing familiarity with online resources, ADA members would like to have online access to the dental literature that offers a single interface to multiple resources and provides subject searching.

**Barriers to Information Access:** Most major dental journals are available only from publishers by subscription or per-article purchase. Most dentists subscribe to a very limited number of journal titles and few are affiliated with an academic or local library with dental literature. They may depend on resources which are freely available on the web, but these differ widely in quality and trustworthiness.

**Current Options:** To obtain journal articles, ADA members now have several options available to them:

- ***ADA Library document delivery***

- Articles scanned from print and delivered in PDF by email
- Delivery: same day to 2 days
- Cost: \$7 per article
- Popular with users, but many members unaware of service
- Ordering available through PubMed's Loansome Doc service (see below)

- ***Online or print subscriptions to individual journals***

- Available through the publisher
- Some society publications unavailable to non-members
- Delivery: immediate if electronic; monthly or less if print
- Cost: range of \$100-\$500 per title

- ***Online purchase of article***

- Download from publisher/vendor
- Delivery: immediate
- Cost: range of \$15-\$50 per article

- ***PubMed/MEDLINE database***

- Usually abstract only
- Some links to "open access" dental journals
- Some links to paid publisher sites
- Loansome Doc ordering system sends ADA member request to ADA Library
- Delivery: immediate for open access journals or per-article purchase; 1-2 days for Loansome Doc requests (ADA Library)
- Cost: none for abstracts or open access; \$15-50 for paid journals; \$7 for ADA Library delivery

**Scope of Project:** Though there is no single source for all dental journals. In 2010 the ADA Library sought price quotes from three major dental publishers (Elsevier, Quintessence, and Wiley-Blackwell) which together control access to 60+ journals of primary interest for this project, as well as from aggregated content provider EBSCO. Access to other journals would require license agreements with many smaller publishers.

Each publisher or content provider has their own pricing structure and licensing norms. Each agreement must be individually negotiated. Access would be through each vendor's interface, so the user experience will vary from vendor to vendor and may involve investment in additional software. Subject access and direct links to individual articles might require access through MEDLINE/PubMed.

**Response from Vendors:** One publisher was concerned about the technical details of “monitoring remote usage” for such a large user group and would not make a commitment to provide access. A second vendor promised several times to provide pricing, but never delivered. The third publisher submitted a price quote of “around \$70,000” for staff and member access for 27 journals. However, the price would be higher if the ADA charged members for access. Our request was referred to a separate division of the company who never provided a proposal.

The aggregated content provider EBSCO offered their DOSS database (Dentistry & Oral Science Source) with a single interface for e-journals from multiple publishers, plus some e-books. Some journals are full-text; others are blocked for the last 12 months. The vendor quoted a price of \$5 per ADA member, a total of \$750,000 for 150,000 members. If JADA was included in DOSS (for access by all DOSS clients), the price could be \$1-2 per member, or \$150,000 - \$300,000.

A second EBSCO database, DynaMed, is a mobile-ready clinical reference tool with much medical but limited dental content. In 2010 EBSCO quoted a price of \$49,500 for both databases for staff use only. EBSCO expressed an interest in partnering with the ADA in developing more dental content for DynaMed. ADA Library and Dental Practice staff who reviewed the current product felt that with enhanced content it could be a valuable chairside resource for ADA members, potentially more useful than full text journal access. The product would provide “point-of-care” dental and medical content, support EBD, and provide references to clinical literature. The accompanying report on Cost Projections provides greater details on content from the four vendors.

**Revenue Potential:** It is difficult to determine what revenue potential might exist for the ADA. As indicated above, at least one publisher has indicated that the ADA's fees would be higher if members were charged for access (it then becomes a commercial “document delivery” service). How much would members be willing to pay? Would they prefer an annual fee or pay-per-use?

The DynaMed clinical tool has the potential to provide revenue, but after much investment in broader content.

#### **Implementation Issues:**

- *Selection of journals to offer.* It is not financially or technically possible to entirely duplicate the ADA Library's collection. Not all content is available online, especially older materials. Which journals are available online, from which vendors? Which titles do members want? Do they want back issues as well as recent years?
- *Licensing.* Multiple vendors require multiple license agreements. Usage terms may differ. Library staff and the Division of Legal Affairs would manage the various agreements and work with vendors to resolve issues that might arise.
- *Copyright.* Usage would be legally restricted to personal use by members. No redistribution or online posting would be permitted. The ADA would be responsible to inform members on usage limitations.
- *Technical elements.* Access would be restricted to members only. Working with multiple vendors means multiple interfaces. Single-interface access and direct access to articles may require additional software and costs. Interface should provide searching capabilities of content.
- *Clinical tool.* The chairside resource product would require greater dental content to provide maximum benefits to dentists. The ADA could collaborate with the vendor to develop a product targeting the needs of dental professionals. This would take more time, but working with a proved product would give the ADA a head start in providing such a resource.

**Usage by Members:** Member usage would be tracked by the various products, to determine the actual cost per utilizing member. Dental faculty and students already enjoy online access to the major dental journals through their institution. The question is whether non-academic ADA members will use online journal access in sufficient numbers to justify the additional expense by the ADA. The clinical tool is already provided to

1 students and faculty by some dental schools, but is probably used by few private practitioners. It could be  
2 valuable to that group.

3 Broad usage of this new member benefit would require promotion of these resources, how to access them,  
4 and what limitations apply. Library staff could provide assistance to members by phone in using the products  
5 effectively. Member satisfaction should be evaluated on the resources available, the interface(s), and the  
6 support received.

7 **Summary:** No solid proposal was presented in 2010, due to high costs or lack of vendor response. In 2011  
8 the Library staff is again attempting to gather pricing information from vendors. If this is more successful and  
9 a realistic proposal is obtained, the information will be forward to the BOT Information Technology Committee,  
10 which may choose to bring it to the 2012 HOD.

# 11 **Resolutions**

12  
13 This report is informational in nature and no resolutions are presented

14 **BOARD RECOMMENDATION: Vote Yes to Transmit.**

15 **BOARD VOTE: UNANIMOUS. (BOARD OF TRUSTEES CONSENT CALENDAR ACTION—NO BOARD**  
16 **DISCUSSION)**



Resolution No. None New ☐ Substitute ☐ Amendment ☐Report: RFP Process for Portfolio-Style Clinical Examination Date Submitted: September, 2011Submitted By: Workgroup on Resolution 42H-2010Reference Committee: Dental Education, Science and Related MattersTotal Net Financial Implication: None Net Dues Impact: \$Amount One-time \$ Amount On-going \$ADA Strategic Plan Goal: Members (Required)**REPORT OF THE WORKGROUP ON RESOLUTION 42H-2010 TO THE 2011 HOUSE OF DELEGATES:  
RFP PROCESS FOR PORTFOLIO-STYLE CLINICAL EXAMINATION****Background:** The 2010 ADA House of Delegates adopted resolution 42H-2010:

**42H. Resolved,** that a Request for Proposals (RFP) process be initiated calling for the development of a portfolio-style examination for licensure purposes designed to assess a candidate's clinical competence with a third-party assessment that is valid and reliable psychometrically, including a complementary written/interactive examination to assess issues not deemed adequately addressed in the portfolio model, such as ethics and professionalism, and be it further

**Resolved,** that a new workgroup composed of two representatives from the Board of Trustees, three from the Council on Dental Education and Licensure (one appointee each from the ADA, ADEA and AADB), one from the Committee on the New Dentist, and one from the American Student Dental Association be appointed to oversee the development and announcement of the RFP process in 2011 and consideration of the received proposals in 2012, and be it further

**Resolved,** that appropriate progress reports be made available to both the 2011 and 2012 House of Delegates.

President Gist appointed the following individuals to serve on the 42H-2010 Workgroup:

Dr. Samuel Low, Seventeenth District Trustee, chair; Dr. Edward Vigna, Tenth District Trustee; Dr. Brian Kennedy (CDEL-ADA); Dr. Patrick Lloyd (CDEL-ADEA); Dr. David Perkins (CDEL-AADB); Dr. Chris Salierno (NDC), and Ms. Brittany Bensch (ASDA).

**March 2011 Meeting:** The Workgroup met March 21-22, 2011 at the ADA Headquarters in Chicago. Dr. Low called the meeting to order at 8:35 a.m. on Monday, March 21. He began the meeting by inviting each of the members to answer four questions in relation to the Workgroup's charge - What do we know? If there were no limits, what would we want? What can we actually expect? Where do we go? Common elements the members identified during the discussion included that the exam should be 1) universally accepted, 2) ethical, 3) cost effective, 4) psychometrically valid, 5) respectful of states' rights, and (6) a true Curriculum Integrated Format (CIF) to eliminate patient brokering in the future. Most importantly, the members of the Workgroup agreed that an independent third party should have oversight of the portfolio evaluation, as was directed by the House of Delegates Resolution 42H-2010. Members recognized that trust needs to be established among all the stakeholders to accept the concept in order for this activity to be successful.

**COMIRA Report.** The group discussed the COMIRA report that was developed for the Dental Board of California during its study of an alternative to the current clinical examination process. The Dental Board ultimately selected the hybrid portfolio. One member commented that it was thorough and well done, but

contained some bias. Another member noted that with the portfolio system oversight of dental school faculty by the state licensing jurisdiction could be problematic. The portfolio examination could also increase costs for dental schools. The Workgroup agreed that the portfolio examination should be available to new dental school graduates, not dentists seeking licensure by credentials.

*Concepts for the RFP.* The Workgroup members spent considerable time discussing concepts to be included in the RFP. They determined the examination sought to be developed by the RFP should:

1. Be ethical and professional—use patients of record within the school's current system of evaluation (CIF); candidate must have done work independently without faculty assistance;
2. Have oversight by respective state licensing jurisdiction – examiners should make final determination of competency, not faculty;\*
3. Assess clinical competencies;
4. Be psychometrically sound (valid and reliable);
5. Be cost effective and feasible—should not require additional resources from students, schools or state licensing jurisdictions and should minimize disruption;
6. Have a built-in system for external audit;
7. Have mechanisms to assess outcomes;
8. Enable portability among states while respecting states' rights; and
9. Have a remediation process.

\*There was considerable discussion around the actual competency assessment and the resulting portfolio evaluation. The Workgroup discussed the pros and cons in having calibrated faculty associated with the respective school versus independent outside evaluators being the individuals performing the direct competency assessments. The difficulty with independent outside evaluators was time and logistics resulting in cost. Therefore, the RFP should include seeking creative methodologies by which a student is evaluated for individual competencies possibly by a calibrated faculty member but with a process that can be audited by an external reviewer. All agreed that the portfolio assessment should be conducted by an external evaluator.

*Competencies.* Dr. Edward Tsai, manager, Research and Development/Psychometrics, ADA Department of Testing Services, presented information to the Workgroup on portfolio assessments and the appropriate process for development of an RFP. Following Dr. Tsai's presentation, the Workgroup discussed the competencies (domains of knowledge) that should be included in the portfolio assessment. The Workgroup identified the following proposed competencies/domains:

1. Endodontics
2. Direct restoration (amalgam, composite)
3. Indirect restoration/fixed prosthodontics (inlays, onlays, crowns, bridges, veneers)
4. Removable prosthodontics
5. Periodontics
6. Oral Surgery
7. Anesthesia, infection control, diagnosis and treatment planning - to be observed during completion of the above listed competencies

**Next Steps:** The Workgroup's proposed timeline is included as Appendix 1. The Request for Proposals (Appendix 2) is completed and scheduled for release in October 2011. The Workgroup plans to work with outside experts to review the submitted responses to the RFP and make recommendations for selecting an agency. The proposed 2012 budget contains \$11,442 in funding to support the review process, which includes two expert reviewers (\$3,000) and one two-day Workgroup meeting to review the proposals (\$8,442).

1 **Resolutions**

2 This report is informational and no resolutions are presented.

3 **BOARD RECOMMENDATION: Vote Yes to Transmit.**

4 **BOARD VOTE: UNANIMOUS.**

C:\Users\barbushk\Desktop\Worksheets 2011\2nd Set of Worksheets\File 11 Workgroup Rpt on Portfolio-Style Clinical Exam.doc

**Appendix 1**  
**Proposed Timeline**  
**Process for Developing a Portfolio-Style Clinical Examination**

	<b>2011</b>  <b>Develop and Announce Request for Proposals</b>	<b>2012</b>  <b>Review Proposals and Submit Report to 2012 House of Delegates with Recommendations</b>	<b>2013</b>  <b>Selected RFP Implemented</b>
<b>January</b>			
<b>February</b>		Outside reviewers submit report to Workgroup for consideration.	
<b>March</b>	First meeting of the 42H-2010 Workgroup	Workgroup meets to review the RFP submissions and report from outside reviewers	Grantee to submit progress report to Workgroup
<b>April</b>		Interviews with individuals from top rated responses to the RFP	
<b>May-June</b>	Development of RFP	Selected proposal(s) in response to the RFP announced	Grantee to submit progress report to Workgroup
<b>July-August</b>	Development of RFP		
<b>September</b>	Report transmitted to Board of Trustees and House of Delegates	Report transmitted to Board of Trustees and House of Delegates	Grantee to submit progress report to Workgroup  Progress Report transmitted to House of Delegates
<b>October</b>	Report considered by House of Delegates  Announce RFP	Report considered by House of Delegates	Progress report considered by House of Delegates
<b>November</b>		If approved with funding, award grant to selected agency	
<b>December</b>	Deadline for RFP submissions  Send RFPs to outside reviewers	Grantee begins work on portfolio-style exam	Final project due to the ADA

Appendix 2

**Development of a Portfolio-Style Assessment of Clinical Skills  
for the Purposes of State Dental Licensure**

**REQUEST FOR PROPOSAL**

**Release Date: October 24, 2011**

American Dental Association

211 East Chicago Avenue

Chicago, Illinois 60611

**TABLE OF CONTENTS**

1		
2		
3	1. INTRODUCTION/STATEMENT OF PURPOSE .....	3
4	a. Eligibility Criteria	
5		
6	2. BACKGROUND AND GENERAL INFORMATION .....	3
7	a. About the American Dental Association	
8	b. Existing Dental Licensing Process	
9		
10	3. SCOPE OF WORK, SPECIFICATIONS & REQUIREMENTS.....	6
11	a. Description of Work	
12	b. Requirements	
13	c. Timelines and Deliverables	
14	d. Communication	
15		
16	4. PROPOSAL FORMAT .....	9
17	a. Understanding the RFP	
18	b. Experience and Qualifications	
19	c. Proposal Submission	
20		
21	5. EVALUATION .....	10
22	a. Criteria for Selection	
23	b. Notification	
24		
25	6. CONTRACT INFORMATION .....	10
26		
27	7. TERMS AND CONDITIONS .....	11
28		
29	8. ATTACHMENTS	
30	a. Regional Testing Agency Membership Chart.....	12
31	b. ADA Statement on Ethical Use of Patients.....	13
32		
33	9. APPLICATION COVER SHEET .....	16
34		
35	10. PROPOSAL PREPARATION AND INSTRUCTIONS .....	17
36		

## 1. INTRODUCTION/STATEMENT OF PURPOSE

The American Dental Association (ADA) is soliciting proposals in response to an October 2010 ADA House of Delegates directive to develop a portfolio-style examination for licensure purposes that could assess clinical competence of candidates for initial licensure via a psychometrically valid and reliable third-party assessment process. This directive also calls for a complementary written/interactive examination to assess issues not deemed adequately addressed in the portfolio model, such as ethics and professionalism. This RFP requests proposals from agencies that could develop an examination process using a portfolio-style assessment for the ADA as directed by the House of Delegates.

- a. Eligibility Criteria: Applicants are encouraged to apply, who are affiliated with a qualified organization, knowledgeable and experienced in educational measurement, and knowledgeable and experienced in certification and/or licensure testing. Examples of qualified organizations include: testing service agencies and organizations, clinical examination agencies, and corporations and individuals with expertise in test development and psychometric principles.

## 2. BACKGROUND AND GENERAL INFORMATION

- a. About the American Dental Association. Founded in 1859, the American Dental Association (ADA) is the oldest national association of dentists in the United States. It is a non-profit corporation organized under the laws of the State of Illinois. The ADA is a voluntary organization of dentists whose objective is to promote the art and science of dentistry and to encourage the improvement of the health of the public. The membership of the ADA includes 157,000 professionals making it the largest national association of dentists. ADA members have access to a wide variety of benefits, products and services ranging from scientific and clinical resources, insurance and retirement programs, continuing education, meetings and publications such as the Journal of the American Dental Association (JADA). The governing body of the ADA is the House of Delegates composed of representative ADA member dentists and representative dental students in ADA Commission on Dental Accreditation-accredited education (DDS/DMD) programs. The administrative body of the ADA is the Board of Trustees composed of active, dues-paying members of the ADA.
- b. The Existing Dental Licensing Process. Dental licensing is the responsibility of the individual jurisdiction's (state) government. This responsibility is usually delegated to the jurisdiction's board of dentistry, also known as state board of dental examiners. Specific dental licensure requirements vary among jurisdictions, but all jurisdictions have three common requirements for initial licensure: an educational requirement, a written (theoretical) examination requirement and a clinical (performance) examination requirement.

The educational requirement for nearly all licensing jurisdictions is graduation from a dental education program accredited by the ADA [Commission on Dental Accreditation](#) (CODA). Only one jurisdiction (MN) does not require graduation from an accredited program, but rather reviews graduates of non-accredited (international) programs on a case-by-case basis and makes a determination if the program they attended is equivalent to a CODA-accredited program.

The written (theoretical) examination requirement is the [National Board Dental Examinations](#) (Parts I and II) that is administered by the [Joint Commission on National Dental Examinations](#) (JCNDE) of the American Dental Association. These examinations are designed to assist the state boards of dentistry in determining whether or not a candidate for licensure has assimilated the theoretical basis of biomedical and dental sciences taught in those schools to a level of competency that protects the health, welfare and safety of the public. Part I is focused on the basic sciences (anatomic sciences, biochemistry, physiology, microbiology, pathology, dental

1 anatomy and occlusion) and students usually take this examination at the end of their second  
2 year of dental school. Part II tests the dental sciences and includes a case-based component  
3 that asks questions related to patient care. Dental students usually take Part II during their fourth  
4 year of dental school. The JCNDE is currently in the process of developing an integrated  
5 examination that is intended to replace the current Parts I and II. This new examination is  
6 expected to be ready for implementation within the next five years.

7 The clinical patient-based examination requirement serves as a capstone assessment of a  
8 candidate's clinical skills to assist states in determining whether initial licensure candidates can  
9 demonstrate critical competencies necessary for safely providing oral health services to the  
10 public. Currently, there are five regional dental clinical testing agencies and four independent  
11 states administering clinical examinations (*Attachment 8a*). State dental boards contract  
12 with/become members of one or more of these regional testing agencies to administer the clinical  
13 examination requirement for initial licensure in their states. The five regional testing agencies are  
14 [Central Regional Dental Testing Service](#) (CRDTS), [Council of Interstate Testing Agencies](#) (CITA),  
15 [North East Regional Examining Board](#) (NERB), [Southern Regional Testing Agency](#) (SRTA) and  
16 the [Western Regional Examining Board](#) (WREB). Four jurisdictions (DE, FL, NV and the VI)  
17 administer exams independently of a regional testing agency. Some states may also accept  
18 examination results from testing agencies in which they are not members.  
19

20 In spring 2005, the American Board of Dental Examiners (ADEX)<sup>1</sup> was established as an  
21 examination development agency with the intent of developing a common examination that all  
22 state boards would utilize and accept. Initially, the majority of state and regional testing agencies  
23 participated in development of the examination, but when the ADEX Dental and Dental Hygiene  
24 Examinations were ready for use in fall 2005, only NERB and CRDTS administered the ADEX  
25 Examinations. In 2009, CRDTS withdrew from ADEX leaving NERB the only regional testing  
26 agency and Nevada the only independent state using the ADEX Examinations. In 2011, the  
27 Florida legislature eliminated its own clinical examination and approved the use of the ADEX  
28 Examinations effective October 1, 2011. As of this writing, NERB, Nevada and Florida administer  
29 the ADEX Examinations, while the remaining state and regional testing agencies administer their  
30 own exams.  
31

32 The lack of one common clinical examination that is accepted by all state dental boards presents  
33 a challenge to dentists seeking licensure and to state dental boards alike. Dentist provider  
34 mobility between states is negatively affected, which in certain geographic areas presents a  
35 significant challenge to the public in accessing care from a dentist. Other challenges related to  
36 clinical examinations have for many years created discussion and disagreement among the  
37 dental practicing, education and licensing communities. These challenges include that the clinical  
38 examination is only a snapshot of candidate's competence, exams are not standardized due to  
39 patient variability and examiner variability and calibration, and there is potential difficulty in finding  
40 patients with standard, appropriate conditions for the examinations. Some of these challenges  
41 present ethical dilemmas for students, such as patient brokering and delaying a patient's needed

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<sup>1</sup> ADEX is a private not for profit consortium of state and regional dental boards throughout the United States and its territories that provides for the ongoing development of a series of common, national dental licensing examinations that are uniformly administered by individual state or regional testing agencies on behalf of their participating and recognizing licensing jurisdictions.



1 treatment as much as a year in order to use that patient for the clinical examination. The ADA  
2 encourages testing agencies, dental education programs and students to adhere to its position  
3 statement, *Ethical Considerations When Using Human Subjects/Patients in the Examination*  
4 *Process (Attachment 8b)*.

5  
6 For the reasons noted above, states have begun to look at alternatives to the current clinical  
7 examination. For example, New York eliminated the clinical examination requirement for initial  
8 licensure in 2001 and mandated completion of a postdoctoral residency program accredited by  
9 the ADA Commission on Dental Accreditation that is at least one year in length (PGY-1). Several  
10 other states (CT, MN, WA, CA) grant licensure applicants the option of completing the PGY-1 in  
11 lieu of a clinical examination. However, the examination community is concerned that this option  
12 lacks an objective assessment of the PGY-1 resident. The widespread lack of confidence on the  
13 part of various state boards with regard to the programs' perceived inability to dismiss residents  
14 for poor academic performance is a barrier to acceptance of the PGY-1 pathway by the  
15 examining community. The PGY-1 concept is accepted in the policies of the ADA, American  
16 Student Dental Association and the American Dental Education Association. Currently, only the  
17 American Association of Dental Boards opposes this approach.

18  
19 Another alternative pathway for initial licensure is the two-part examination of the National Dental  
20 Examining Board of Canada (NDEB). The Minnesota Board of Dentistry adopted this pathway in  
21 2010 for graduates of the University of Minnesota. This examination consists of a written  
22 examination that tests the ability to apply basic and clinical science knowledge in assessing and  
23 planning care for patients and an Objective Structured Clinical Examination (OSCE) that employs  
24 clinical scenarios to test clinical decision making. To date, Minnesota is the only state utilizing  
25 this model.

26  
27 Lastly, California conducted an extensive study of alternative models and ultimately agreed to  
28 pursue the portfolio model. (Comira, Psychometric Services Division, prepared a complete  
29 report for the Dental Board of California - *Alternative Pathways for Initial Licensure for General*  
30 *Dentists, Final Report, February 2009*). In 2010, the governor signed into law a new school-  
31 based portfolio initial licensure examination option; this is in addition to the existing options of  
32 taking the Western Regional Examining Board clinical examination or completing a one-year  
33 general practice residency. The California portfolio examination can be described as a series of  
34 examinations administered in a series of patient encounters in several competency domains as  
35 outlined below. Students are rated according to standardized rating scales by faculty examiners  
36 who are formally trained in their use. The new law became effective January 1, 2011. The  
37 Dental Board is in the process of adopting regulations containing the specific details of the  
38 process before the option can be made available.

### 39 40 3. SCOPE OF WORK, SPECIFICATIONS & REQUIREMENTS

- 41  
42 a. Description of Work: The agency should develop, pilot, validate and recommend an  
43 implementation process for a portfolio model examination to assess the clinical competency of  
44 students enrolled or graduating from an accredited dental education program via an independent  
45 third party for the purpose of state licensure. Competencies/domains to be included are:
- 46 • Endodontics
  - 47 • Direct restoration (e.g., amalgam, composite)
  - 48 • Indirect restoration/fixed prosthodontics (e.g., inlays, onlays, crowns, bridges, veneers)
  - 49 • Removable prosthodontics
  - 50 • Periodontics
  - 51 • Oral Surgery

- Anesthesia, infection control, diagnosis and treatment planning - to be observed/assessed in conjunction with the above listed competencies/domains

Proposals should adhere to the following concepts - the model portfolio examination process should:

- Be ethical and professional—use patients of record within the school's current system of evaluation [curriculum integrated format (CIF)]<sup>2</sup>; candidate must perform services independently without faculty or examiner assistance;
- Have oversight by respective state licensing jurisdiction – examiners should make final determination of competency, not faculty; (Be conducted by an independent 3<sup>rd</sup> party)
- Assess clinical competencies;
- Be psychometrically sound (valid and reliable);
- Be cost effective and feasible—should not require additional resources from students, schools or state licensing jurisdictions and should minimize disruption;
- Have a built-in system for external audit;
- Have mechanisms to assess outcomes of the portfolio process;
- Enable portability among states while respecting states' rights; and
- Have a remediation process.

Proposals may consider the following as an example of a potential process for evaluating a competency:

1. Allow mechanisms for state boards to audit process at their discretion to ensure integrity of process/exam
2. A proposed process:
  - a. The student/candidate will designate a procedure for his competency/assessment and work with a designated, calibrated faculty member.
  - b. A computer program will record all required data generated during the competency exam.
  - c. The patient's medical history, pre-op radiograph and digital photograph, pre-op digital recording of the tooth selected as well as any other relevant material will be entered into a computer data base.
  - d. The candidate will prepare the selected tooth to "ideal" and record another digital reading of the preparation. The candidate will determine if the preparation needs to be altered for any reason and document any requests for alterations in writing specifying the exact location, amount of tooth structure needed to be removed and the reason for the request. The faculty/examiner will review the request and evaluate the appropriateness for the modifications. The faculty/examiner will grant or deny each request. No further information is given to the student. The faculty/examiner will note into the database the reason for denial. Any requests with no clinical

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<sup>2</sup> **Curriculum Integrated Format:** An initial clinical licensure process that provides candidates an opportunity to successfully complete an independent "third party" clinical assessment prior to graduation from a dental education program accredited by the ADA Commission on Dental Accreditation.

If such a process includes patient care as part of the assessment, it should be performed by candidates on patients of record, whenever possible, within an appropriately sequenced treatment plan. The competencies assessed by the clinical examining agency should be selected components of current dental education program curricula.

All portions of this assessment are available at multiple times within each institution during dental school to ensure that patient care is accomplished within an appropriate treatment plan and to allow candidates to remediate and retake any portions of the assessment which they have not successfully completed.

justification or that demonstrate a complete lack of clinical judgment or knowledge could result in the termination of the exam and temporization. When the student has completed his/her preparation to his/her satisfaction s/he will then take another digital recording of the preparation. If caries remains or an unrecognized pulp exposure is present the tooth should be temporized. If all caries has been removed and there has not been a pulp exposure then the student may restore the tooth. A digital recording should then be taken of the final restoration. A digital photograph of each critical stage should also be included in the database.

- e. The student will decide if s/he wants to submit this case for portfolio evaluation to an independent third party evaluation prior to any "feedback" by the faculty/examiner.

b. Requirements.

Materials to include in the proposal:

- Applicant qualifications for this project
- Model portfolio examination, process and protocols
- Plan outlining timelines to submit deliverables
- Proposed software applications and any related technology requirements for the model examination and implementation
- Budget for design and implementation of the model examination
- Examination administration, scoring and security requirements

c. Timelines and Deliverables.

Timelines. The following is a tentative timeline that will apply to the RFP, but may change in accordance with the ADA's needs or unforeseen circumstances. Changes will be communicated by e-mail to all applicants.

October 24, 2011	Issue request for proposal
December 26, 2011	Deadline for receipt of proposals
May 18, 2012	Announcement of selected RFP(s)
October 22, 2012	Report and funding request submitted to the ADA House of Delegates for Approval
November 1, 2012	Approved agency notified
December 1, 2012	Project start date
December 1, 2013	Project due date

During the course of the project, quarterly status updates via conference call or e-mail will be expected.

Deliverables: The proposal shall include a highly detailed project description containing an executive summary. The proposal shall include:

- Components of the portfolio examination.
- Technical Specifications.  
The proposal should be delivered so it can be viewed using desktop operating system – Windows 7 and software application system – Microsoft Office Word and Excel. The proposal should contain software applications and any related technology requirements for the model examination and implementation.
- Administrative, Grading/Scoring, and Security Processes.  
*Scoring Methods.* The proposal shall provide psychometrically sound procedures for scoring and score reporting as it relates to purpose of this Project, including criteria for scoring,

software requirements, method and materials for calibration of examiners and remediation policies.

*Security.* The proposal shall describe in a clear and concise manner the protocols used in the administration of the portfolio examination and the adequacy of those methods for the security of the content of the examinations and confidentiality of candidate personal information and results.

- Pilot. The proposal shall include a description of the process for piloting the portfolio examination.
- Financial Implications. The proposal shall include a detailed list of anticipated costs which correspond to the total proposed sum to be paid to the applicants(s).
- Significant Dates. The proposal shall include the dates when significant steps in the Project will be completed.

- d. Communication. Inquiries, questions and requests for clarification related to this RFP are to be directed in writing (mail, e-mail or fax) and directed to:

American Dental Association	Phone: 312-440-2694
Attn: Ms. Lois Haglund	Fax: 312-440-2915
211 E. Chicago Avenue	E-mail: <a href="mailto:haglundl@ada.org">haglundl@ada.org</a>
Chicago, IL 60611	

The ADA will make a good faith effort to respond in writing to each question and request for clarification within 10 business days.

#### 4. PROPOSAL FORMAT

- a. Understanding the RFP. This section should contain a description of the applicant's understanding of the objective of the project and its scope. In responding to this RFP, the applicant accepts full responsibility to understand the RFP in its entirety, including making any inquiries to the ADA as necessary.
- b. Experience and Qualifications. This section should demonstrate that the consultant has the experience, qualifications, and resources to meet the requirements of the RFP. If the consultant is part of a consulting organization, a detailed explanation of the organization should be submitted. The consultant, including the individual(s) assigned to the project, should hold a Ph.D. in Educational Psychology or Educational Measurement and should have experience in consulting for certification or licensure examinations within the past five years. Resumes or curriculum vitae of consultants, or individuals assigned to this project by the consulting organization, are to be included with the proposal. These documents should include the names and references of clients to whom these individuals have provided consulting services within the past five years.
- c. Proposal Submission. An application cover sheet and complete proposal preparation instructions are provided at the end of this RFP. Submitted proposals must include the required items listed under "Deliverables" on page 8.

Proposals may be submitted in electronic format, CD or print form. Electronic proposals are to be submitted to [haglundl@ada.org](mailto:haglundl@ada.org). If submitted in CD or print form, please provide ten (10) copies. All proposals must be submitted by December 26, 2011 to:

Ms. Lois Haglund  
Portfolio RFP  
American Dental Association  
211 East Chicago Avenue  
Chicago, IL 60611

The receipt of each proposal will be acknowledged in writing.

## 5. EVALUATION

- a. Criteria for Selection. The proposals will initially be evaluated by outside, independent reviewers engaged by the ADA for this purpose. An ADA Review Committee comprised of members of the ADA Board of Trustees, the ADA's Council on Dental Education and Licensure (CDEL), the New Dentist Committee and the American Student Dental Association will review the outside reviewers' evaluations of the proposals. The Committee will make the final selection based on the reviewers' reports and on the following:
- the overall experience and qualifications of the applicant with work of a similar nature, including computer software to be used to capture all required data generated during the portfolio exam;
  - potential of applicant to develop materials as defined;
  - capacity to pilot the examination;
  - willingness to work with the ADA to assess pilots and make revisions, as appropriate; and
  - demonstrated mechanisms for participants to evaluate the examination process and evaluators;
  - appropriateness and competitiveness of the budget, timetable and other key factors.
- b. Notification. The selected applicant(s) will be notified in writing on May 18, 2012. A funding request to move forward with the development of the portfolio-style assessment will be considered by the 2012 ADA House of Delegates.

## 6. CONTRACT INFORMATION

A contract, incorporating the terms of the RFP and the proposal of the applicant(s), will be provided by the American Dental Association.

The services of the applicant(s) shall be required as stipulated in the RFP and the Proposal. The term of the contract may be modified by mutual consent of both the applicant(s) and the American Dental Association. Modifications must be in writing and signed by both parties to be binding.

The American Dental Association reserves the right to terminate any contract awarded related or pursuant to this RFP upon thirty (30) days written notice.

All materials submitted in response to this RFP with the exception of copyrighted examination materials, questions, answers and clinical material reproductions utilized in the examination materials will become the property of the American Dental Association. Proposals not selected will be considered confidential and will not be disclosed.

The resulting contract will be for the amount specified in the selected proposal and approved by the 2012 ADA House of Delegates.

All services shall be performed between December 1, 2012 and December 31, 2013.

The Final Report, when submitted, shall become the property of the American Dental Association.

All costs incurred in meeting the requirements of this project will be the responsibility of the applicant(s). Two payments will be made to the applicant(s). A payment of thirty percent (30%) of the total cost will be paid within two weeks of the signing of the contract. A final payment, the unpaid balance of the amount agreed upon in the proposal, will be made to the applicant(s) upon acceptance of the Final Report by the American Dental Association.

## **7. TERMS AND CONDITIONS**

Neither this RFP nor any responses hereto shall be considered a binding offer or agreement. If ADA and any responding Respondent decide to pursue a business relationship for any or all of the services or equipment specified in this RFP, the parties will negotiate the terms and conditions of a definitive, binding written agreement which shall be executed by the parties. Until and unless a definitive written agreement is executed, ADA shall have no obligation with respect to any Respondent in connection with this RFP.

This RFP is not an offer to contract, but rather an invitation to a Respondent to submit a bid. Submission of a proposal or bid in response to this RFP does not obligate ADA to award a contract to a Respondent or to any Respondent, even if all requirements stated in this RFP are met. ADA reserves the right to contract with a Respondent for reasons other than lowest price. Any final agreement between ADA and Respondent will contain additional terms and conditions regarding the provision of services or equipment described in this RFP. Any final agreement shall be a written instrument executed by duly authorized representatives of the parties.

Respondent's RFP response shall be an offer by Respondent which may be accepted by ADA. The pricing, terms, and conditions stated in Respondent's response must remain valid for a period of one hundred twenty (120) days after submission of the RFP to ADA.

This RFP and Respondent's response shall be deemed confidential ADA information. Any discussions that the Respondent may wish to initiate regarding this RFP should be undertaken only between the Respondent and ADA. Respondents are not to share any information gathered either in conversation or in proposals with any third parties, including but not limited to other business organizations, subsidiaries, partners or competitive companies without prior written permission from ADA.

ADA reserves the right to accept or reject a Respondent's bid or proposal to this RFP for any reason and to enter into discussions and/or negotiations with one or more qualified Respondents at the same time, if such action is in the best interest of ADA.

ADA reserves the right to select a limited number of Respondents to make a "Best and Final Offer" for the services or equipment which are the subject of this RFP. Respondents selected to provide a "Best and Final Offer" shall be based on Respondent qualifications and responsiveness as determined solely by ADA.

All Respondent's costs and expenses incurred in the preparation and delivery of any bids or proposals (response) in response to this RFP are Respondent's sole responsibility.

ADA reserves the right to award contracts to more than one Respondent for each of the services identified in this RFP. If Respondent's bid or proposal is based on a group purchase, Respondents must specifically identify this in their response.

All submissions by Respondents shall become the sole and exclusive property of ADA and will not be returned by ADA to Respondents.

**Attachment 8a: Regional Testing Agency Membership Chart**

This table contains information known at the time of publication about states' affiliations with the clinical testing agencies. Some states may also accept examination results from testing agencies in which they are not members. This information is subject to change. Candidates seeking licensure in a specific state should contact that state's board of dentistry to obtain the most up-to-date information about which examination results are accepted in the state prior to registering for any clinical examination. For state dental board contact information go to [www.dentalboards.org](http://www.dentalboards.org). Current as of May 2011.

Council of Interstate Testing Agencies, Inc. (CITA) <a href="http://www.citaexam.com">http://www.citaexam.com</a>			
Alabama	Mississippi	Puerto Rico	
Louisiana	North Carolina	West Virginia	
Central Regional Dental Testing Services, Inc. (CRDTS) <a href="http://www.crdts.org">http://www.crdts.org</a>			
Colorado	Kansas	North Dakota	Wisconsin
Georgia	Minnesota	South Carolina	Wyoming
Hawaii	Missouri	South Dakota	
Illinois	Nebraska	Washington <sup>1</sup>	
Iowa	New Mexico	West Virginia	
North East Regional Board of Dental Examiners, Inc. (NERB) (ADEX) <sup>6</sup> <a href="http://www.nerb.org">http://www.nerb.org</a>			
Connecticut	Maryland	New York <sup>3</sup>	Vermont
District of Columbia	Massachusetts	Ohio	West Virginia
Indiana	Michigan	Oregon	Wisconsin
Illinois	New Hampshire	Pennsylvania	
Maine	New Jersey	Rhode Island	
Southern Regional Testing Agency, Inc. (SRTA) <a href="http://www.srta.org">http://www.srta.org</a>			
Arkansas	South Carolina	Virginia	
Kentucky	Tennessee	West Virginia	
Western Regional Examining Board (WREB) <a href="http://www.wreb.org">http://www.wreb.org</a>			
Alaska	Kansas	North Dakota	Utah
Arizona	Missouri	Oklahoma	Washington
California <sup>2</sup>	Montana	Oregon	Wyoming
Idaho	New Mexico	Texas	
Independent States that Administer Clinical Licensing Examinations			
Delaware 302-744-4500	Florida (ADEX) <sup>5</sup> 850-245-4474	Nevada (ADEX) <sup>4</sup> 702-486-7044	Virgin Islands 340-774-0117

<sup>1</sup> **Washington** is a member of WREB. Only the dental examination falls under CRDTS.

<sup>2</sup> **California**. California is a WREB member and administers its own state board examination.

<sup>3</sup> **New York** accepts NERB dental hygiene examination. No longer requires a clinical examination for initial dental licensure; applicants must complete an accredited postgraduate program at least one year in length (PGY-1).

<sup>4</sup> **Nevada** is not a member of any clinical testing agency but is a member of ADEX<sup>5</sup> and administers the ADEX Dental and Dental Hygiene Examinations. Nevada also accepts WREB results.

<sup>5</sup> **Florida** is not a member of any clinical testing agency but is a member of ADEX<sup>5</sup> and administers the ADEX Dental and Dental Hygiene Examinations.

<sup>6</sup> **ADEX** – ADEX is a private not for profit consortium of state and regional dental boards throughout the United States and its territories that provides for the ongoing development of a series of common, national dental licensing examinations that are uniformly administered by individual state or regional testing agencies on behalf of their participating and recognizing licensing jurisdictions.

**Attachment 8b: ADA Statement on Ethical Use of Patients**  
**Ethical Considerations When Using Human Subjects/Patients in the Examination Process: American**  
**Dental Association Council on Ethics, Bylaws and Judicial Affairs**

The following information is intended to assist dental licensure candidates, as well as examiners and educators involved in the testing process, in recognizing ethical considerations when patients are part of the clinical licensure process.

**Background:** Dental licensure is intended to ensure that only qualified individuals are licensed to provide dental treatment to the public. Most licensing jurisdictions have three general requirements: an educational requirement-graduation from a dental education program accredited by the Commission on Dental Accreditation; a written (theoretical) examination-to determine whether the applicant has achieved the theoretical bases at a level of competence that protects the health, welfare and safety of the public; and a clinical examination in which a candidate demonstrates the clinical knowledge, skills and abilities necessary to safely practice dentistry.

Anecdotal information and experiences reported in the literature by licensees and educators have raised ethical considerations when human subjects/patients are used in the examination process.<sup>1-6</sup> While others disagree, it is recognized that the profession must ensure that the welfare of patients is safeguarded in every step of the clinical licensure examination process.<sup>7</sup>

The licensure examination process is evolving. Many clinical examination agencies continue to monitor developments for applicability and affordability of alternatives to human subjects/patients in providing valid and reliable assessment of clinical competence.

The ADA has voiced its position regarding the use of human subjects/patients in clinical examinations through a series of resolutions culminating with the adoption of the 2005 House of Delegates' Resolution 20H-2005.<sup>8</sup>  
<sup>10</sup> This resolution reaffirms ADA support for the elimination of human subjects/patients in the clinical licensure examination process while giving exception to a more recent methodology for testing known as the curriculum-integrated format (CIF). The 2006 ADA House of Delegates directed the ADA Council on Dental Education and Licensure to develop a definition of CIF and present it to the 2007 House of Delegates. The 2007 House adopted the following definition (1H:2007):

Curriculum Integrated Format: An initial clinical licensure process that provides candidates an opportunity to successfully complete an independent "third party" clinical assessment prior to graduation from a dental education program accredited by the ADA Commission on Dental Accreditation.

If such a process includes patient care as part of the assessment, it should be performed by candidates on patients of record, whenever possible, within an appropriately sequenced treatment plan. The competencies assessed by the clinical examining agency should be selected components of current dental education program curricula.

All portions of this assessment are available at multiple times within each institution during dental school to ensure that patient care is accomplished within an appropriate treatment plan and to allow candidates to remediate and retake any portions of the assessment which they have not successfully completed.

Given that currently there are no new technologies that completely eliminate the use of human subjects/patients in the clinical examination processes, the ADA Council on Ethics, Bylaws and Judicial Affairs (CEBJA)<sup>11</sup> called on major stakeholders, including the ADA's Council on Dental Education and Licensure (CDEL), to provide input for the development of a statement that would identify key ethical considerations and provide guidance to help ensure the welfare of the patient remains paramount.



**Ethical Considerations When Using Human Subjects/Patients in the Examination Process**

1. **Soliciting and Selecting Patients:** The ADA Principles of Ethics and Code of Professional Conduct<sup>12</sup> (ADA Code), Section 3, Principle: Beneficence states that the “dentist’s primary obligation is service to the patient” and to provide “competent and timely delivery of dental care within the bounds of clinical circumstances presented by the patient, with due consideration given to the needs, desires and values of the patient.” The current examination processes require candidates to perform restorative and periodontal treatments on patients. In light of the principle stated above, this may create an ethical dilemma for the candidate when seeking patients to sit for the exam. Candidates should refrain from the following:

- a. Reimbursements between candidates and patients in excess of that which would be considered reasonable (remuneration for travel, lodging and meals).
- b. Remuneration for acquiring patients between licensure applicants.
- c. Utilizing patient brokering companies.
- d. Delaying treatment beyond that which would be considered acceptable in a typical treatment plan (e.g. delaying treatment of a carious lesion for 24 months).

2. **Patient Involvement and Consent:** The ADA Code, Section 1, Principle: Patient Autonomy states that “the dentist’s primary obligations include involving patients in treatment decisions in a meaningful way, with due consideration being given to the patient’s needs, desires and abilities.” Candidates and dental examiners support patient involvement in the clinical examination process by having a written consent form that minimally contains the following basic elements:

- a. A statement that the patient is a participant in a clinical licensure examination, that the candidate is not a licensed dentist, a description of the procedures to be followed and an explanation that the care received might not be complete.
- b. A description of any reasonably foreseeable risks or discomforts to the patient.
- c. A description of any benefits to the patient or to others which may reasonably be expected as a result of participation.
- d. A disclosure of appropriate alternative procedures or courses of treatment, if any, that might be advantageous to the patient.
- e. An explanation of whom to contact for answers to pertinent questions about the care received.
- f. A statement that participation is voluntary and that the patient may discontinue participation at any time without penalty or loss of benefits to which the patient is otherwise entitled.

3. **Patient Care:** The ADA Code, Section 3, Principle: Beneficence states that the dentist has a “duty to promote the patient’s welfare.” Candidates can do this by ensuring that the interests of their patient are of primary importance while taking the exam. Examiners contribute to this by ensuring that candidates are adequately monitored during the exam process such that the following treatment does not occur:

- a. Unnecessary treatment of incipient caries.
- b. Unnecessary patient discomfort.
- c. Unnecessarily delaying examination and treatment during the test.

4. **Follow-Up Treatment:** The ADA Code, Section 2, Principle: Nonmaleficence states that “professionals have a duty to protect the patient from harm.” To ensure that the patient’s oral health is not jeopardized in the event that he/she requires follow-up care, candidates and dental examiners should make certain that the patient receives the following:

- a. A clear explanation of what treatment was performed as well as what follow-up care may be necessary.
- b. Contact information for pain management.
- c. Complete referral information for patients in need of additional dental care.
- d. Complete follow-up care ensured by the mechanism established by the testing agency to address care given during the examination that may need additional attention.

Sources:

1. Dr. Lloyd A. George Nov. 3, 2005 Letter to Dr. James W. Antoon, chair CEBJA
2. CEBJA March 2, 2006 Strategic Issue Discussion – Use of Patients in Clinical Licensure Examinations
3. Richard R. Ranney, D.D.S., et al., “A Survey of Deans and ADEA Activities on Dental Licensure Issues” Journal of Dental Education, October 2003
4. Allan J. Formicola, D.D.S., et al., “Banning Live Patients as Test Subjects on Licensing Examinations,” Journal of Dental Education, May 2002
5. “The Agenda for Change,” Objectives Developed at the Invitational Conference for Dental Clinical Testing Agencies by representatives of the clinical testing agencies and other organizations with an interest in dental licensure sponsored by the American Dental Association. It is considered informational and does not represent policy of the ADA. March 4, 1997
6. ASDA Resolution 202RC-2005, Revision of Policy L-1 Initial Licensure Pathways
7. Position Statement of the American Association of Dental Examiners in Response to ADA Resolution 64H, Oct. 12, 2001
8. ADA HOD Resolution 34-2006, Definition of Curriculum Integrated Format
9. ADA HOD Resolution 20H-2005, Elimination of the Use of Human Subjects in Clinical Licensure/Board Examinations
10. ADA House of Delegates (HOD) Resolution 64H-2000, Elimination of the Use of Human Subjects in Clinical Licensing/Board Examinations
11. CEBJA is the ADA agency responsible for providing guidance and advice and for formulating and disseminating materials on ethical and professional conduct in the practice and promotion of dentistry.
12. The entire text of the ADA Principles of Ethics and Code of Professional Conduct can be found on the ADA website at [www.ada.org](http://www.ada.org).

October 2008

**9. Application Cover Sheet**

1. Applicant/Agency/Institution/Affiliation: \_\_\_\_\_
2. Please attach one electronic copy of the applicant agency/institution/affiliation's tax exempt status (e.g. IRS 501 (c) (3), other certification of immunity from taxation, or W-9 form) to this application.
3. Total Project Duration: From \_\_\_\_\_ to \_\_\_\_\_
4. Budget request: \$ \_\_\_\_\_
5. Name and Title of Project Leader: \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_  
State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Telephone: \_\_\_\_\_ Fax: \_\_\_\_\_  
E-mail: \_\_\_\_\_
6. Name and title of Applicant's Authorized Representative, if relevant.  
Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_  
State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Telephone: \_\_\_\_\_ Fax: \_\_\_\_\_  
E-mail: \_\_\_\_\_
7. Signature of Project Leader: \_\_\_\_\_ Date: \_\_\_\_\_

Only the original signatures of the designated individuals are acceptable. Signatures verify that all information in this application is true, complete and accurate to the best of the individual's knowledge.

**10. Proposal Preparation and Instructions****Submission Deadline:** December 26, 2011

**Contact:** Lois Haglund  
Portfolio RFP  
American Dental Association  
211 East Chicago Avenue  
Chicago, IL 60611  
[haglundl@ada.org](mailto:haglundl@ada.org)  
312-440-2694

Items A through F are required materials to be included, in order, in your proposal. The completed proposal in electronic format must be submitted by December 26, 2011 to [haglundl@ada.org](mailto:haglundl@ada.org). If electronic submission is not available, please mail 10 (ten) CDs or hard copies by December 26, 2011 to the above address.

- A. Cover sheet
- B. Table of Contents that labels each of the following sections of the proposal:
  1. An abstract of the proposed project. The abstract should serve as a concise and accurate description of the proposed work when it is separated from other application materials.
  2. A Proposal Narrative that includes the information listed below. This section of the application should be no more than 10 pages, double-spaced in 11-point type with one-inch margins. All pertinent figures, charts, tables should be included in this section.
    - a. Relevant background information for the proposed activity, high-lighting how the proposed project meets the objective of the RFP.
    - b. The model, process and protocols for the project, including administration, scoring and security.
    - c. A description of the software technology and any related technology requirements for the exam and implementation to be employed in the project including
      - i. A clear description of how any data is to be collected and how it is to be organized to facilitate the production of sample reports, and
      - ii. The details of proposed analytic methods, statistical tools or software applications to be used.
- C. Proposed Budget including a breakdown of the details of each expenditure category for which the funds are requested.
- D. The qualifications of the principal investigator and other key members of the project team (including consultants) should be briefly described in the Proposal Narrative and included on the Biographical Data Form.
- E. Brief description of the adequacy of the project's timetable and of other key project resources to reach the stated objectives.
- F. Appendices are to be used only as necessary, but should include
  - a. Literature cited, including complete titles and all authors
  - b. Current biographical data forms for key project team members
  - c. For proposals that include the participation or collaboration of organizations or individuals outside of the applicant agency, a letter of agreement documenting each agency's and any consultant's willingness to cooperate, should be included. The letter must include a description of their roles in the project.
  - d. Contact information for five references (if possible) from projects similar in size, application and scope and a brief description of their implementation.

Resolution No.   66                                  New ■              Substitute □              Amendment □

Report: NA Date Submitted: September 2011

Submitted By: Fourteenth Trustee District

Reference Committee: Dental Education, Science and Related Matters

Total Net Financial Implication:	\$230,000 (outsourced) OR \$50,000+3.5 FTEs (in-house)	Net Dues Impact:	\$2.15 \$0.47
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Amount One-time	\$230,000 (outsourced) OR \$50,000+3.5 FTEs (in-house)	Amount On-going	\$
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ADA Strategic Plan Goal:      Members      (Required)

## DEFLATING THE DENTAL EDUCATION BUBBLE

The following resolution was adopted by the 14th Trustee District and transmitted on September 25, 2011, by Tom Schripsema, Resolutions Committee, chair

**Background:** Physicists and economists tell us that every bubble bursts. There is a point that it can simply no longer get bigger. The material from which it is made can no longer contain more under pressure. When it does, there is catastrophic failure of the system and devastation and loss of all that it represented. One need look no further than our current “Great Recession,” to see what catastrophic failure means. Interestingly, many people observed and warned of the housing bubble’s danger. Most were only surprised by how big it ended up getting and how truly devastating the failure really was.

We find ourselves in a similar situation in dental education. Student debt is a bubble which will burst with disastrous results, not only for those with debt, but for our educational institutions, the entire profession and patients that need affordable care. Our “Tattered Safety Net” can be summed up in one word: debt. Neither institutions nor practitioners can afford to provide the “net,” and it is only going to get worse.

Students and educators naively believe that “they” would not lend the money if “they” did not think it could be afforded. Like the housing bubble they are sadly mistaken. Student loan rules, like those that created the housing bubble, are there to ensure that everyone, particularly those without other means, can afford an education. Unfortunately, no one can afford an unsubsidized dental education. Without substantial subsidies, it is simply too costly for an individual to pay.

It is fine to be the bellwether of the impending disaster, but to do nothing would be to our shame. Steps must be taken to reduce the cost of education as well as increasing funding support. Only then can the safety net be restored and the future of the profession returned to a healthy track. This will require some hard decisions and the cooperation of educators, practitioners, government leaders and institutions. It is going to require us to make an investment when our Association funds are tight, but bear in mind that what we will spend gathering important information and considering new ideas will probably be less than the amount of debt most dental students have personally acquired for a year of education. Radical innovation is needed now and patient and sometimes painful progress must be sustained. Unless we take the first step, we will never get there.

## Resolution

**66. Resolved**, that the Board of Trustees with the assistance of appropriate councils and expert consultants, study, document and analyze the current and future economics of dental education, student

1 debt and the impact on dental practice and access to care, utilizing existing environmental scan and other  
2 available data, and be it further

3 **Resolved**, that the Board with the assistance of CDEL and consultants with expertise in dental education  
4 identify innovations in dental education that reduce costs without diminishing quality and recognize  
5 barriers to broader implementation, and be it further

6 **Resolved**, that the Board, with the assistance of consultants with expertise in practice economics and  
7 subsidized care, consider the role educational institutions, students, residents and new graduates have  
8 played in the dental "safety net," and innovative ideas to improve that function while reducing student  
9 debt, and be it further

10 **Resolved**, that the Board prepare a detailed report including short term and long range action  
11 recommendations to reduce dental student debt for consideration at the 2012 House of Delegates.

12 **BOARD RECOMMENDATION: Received after this section had been reproduced for House**  
13 **distribution.**

Resolution No. 58 New ☒ Substitute ☐ Amendment ☐  
 Report: NA Date Submitted: September 2011  
 Submitted By: Fourteenth Trustee District  
 Reference Committee: Dental Education, Science and Related Matters  
 Total Net Financial Implication: \$226,100 Net Dues Impact: \$2.12  
 Amount One-time \$226,100 Amount On-going \$ None  
 ADA Strategic Plan Goal: Collaboration (Required)

### 1 REASSESSING STANDARDS FOR ACCREDITATION

2 The following resolution was adopted by the 14th Trustee District and transmitted on September 25, 2011, by  
 3 Tom Schripsema, Resolutions Committee, chair

4 **Background:** The founders of our country understood that safeguarding liberty and the integrity of  
 5 government required a set of checks and balances that prevent any one group from having too much power  
 6 over another. The principle holds true for most free governments today and is found everywhere from  
 7 Fortune 500 boardrooms to association bylaws. Auditors routinely make recommendations to institutionalize  
 8 these checks and balances into our own Association infrastructure.

9 One area of our profession that benefits from the principle of checks and balances relates to education.  
 10 Schools have a great deal of freedom to innovate and consider improved methods of teaching. At the same  
 11 time, the profession must assure the public and regulators that the competence and quality of dental school  
 12 graduates remains high. Licensing exams provide one way of maintaining the quality of graduates, but they  
 13 represent only a sampling of a person's skills. Of greater importance is insuring that the training programs  
 14 themselves operate at the highest level that the profession prescribes. Educational institutions must routinely  
 15 submit to evaluation, to demonstrate their compliance with the standards the profession requires. The  
 16 Commission on Dental Accreditation's role is to perform these evaluations and judge whether standards are  
 17 being met.

18 It is not in the profession's or the public's best interest to have the same entity setting standards and judging  
 19 whether they are being met. It would be like letting the IRS determine tax rates or police setting the speed  
 20 limit. Even when well-intentioned, the danger of losing objectivity or bending rules is too great not to have the  
 21 appropriate checks in place. A reassessment of the relationship of CODA and the Association to be sure that  
 22 each entity's role is adequately and appropriately fulfilled is an important and necessary function of the  
 23 Association.

24 Recent issues have strained CODA's abilities, these last few years. International accreditation, new non-  
 25 traditional school models and now so-called "mid-level providers," all challenge the traditional standards the  
 26 Profession has established. Many of our standards are predicated on traditional models of education, North  
 27 American cultural norms and familiar ethics. Issues like teledentistry, gender apartheid and many others, are  
 28 largely unanticipated tests for our standards. Accommodating educational innovation and cultural challenges  
 29 should not be left to the handful of people serving on CODA. Some issues are too important to simply learn  
 30 from our mistakes.  
 31

**Resolution**

**58. Resolved**, that the Board in consultation with counsel reevaluate the relationship of the Association and the Commission on Dental Accreditation and propose any necessary governance revisions, and be it further

**Resolved**, that CODA be urged to place a moratorium on further efforts to accredit dental programs outside the United States and Canada to allow review of protocols for establishing equivalency and that fees collected to date be returned pending a decision to proceed in the future, and be it further

**Resolved**, that a dialog between the Association and CODA be established regarding non-traditional education models and that protocols for establishing standards be developed, and be it further

**Resolved**, that CODA be urged to take no final actions on the accreditation of programs for new dental team members until thorough consideration of standards by the profession, and be it further

**Resolved**, that the Board provide a report to the 2012 House of Delegates on these activities.

**BOARD RECOMMENDATION: Received after this section had been reproduced for House distribution.**



Resolution No. 59 New ☒ Substitute ☐ Amendment ☐  
Report: NA Date Submitted: September 2011  
Submitted By: Fourteenth Trustee District  
Reference Committee: Dental Education, Science and Related Matters  
Total Net Financial Implication: None Net Dues Impact: \$  
Amount One-time \$ Amount On-going \$  
ADA Strategic Plan Goal: Members (Required)

### 1 INVESTIGATION OF EXPANDING THE SCOPE OF DENTISTRY

2 The following resolution was adopted by the 14th Trustee District and transmitted on September 25, 2011, by  
3 Tom Schripsema, Resolutions Committee, chair

4 **Background:** While dentists have never really lost sight of the fact that the mouths we work on are attached  
5 to a whole organism, in general, we have been fairly content to keep our attentions focused on an area the  
6 size of a softball. Gradually, the links to systemic disease and advances in diagnostic technology are drawing  
7 us into the broader world of whole body health. As we are increasingly called upon to routinely test for a  
8 myriad of systemic conditions with oral manifestations, there are questions about what our scope really is.  
9 Dentistry is no stranger to scope-of-practice debates, but typically it is because hygienists or someone else  
10 wants to do something only dentists are doing. We should know from our experience that as we look beyond  
11 our traditional horizons there is likely to be resistance from those that have been providing care in those  
12 realms and must be sensitive both to their experience and training. At the same time, if the scope-of-practice  
13 lines are going to be debated and potentially redrawn, we would be wise to consider what our training  
14 qualifies us for and what expertise is reasonably acquired in the continuing education format.

### 15 Resolution

16 **59. Resolved,** that the Council on Dental Practice and the Council on Dental Education and Licensure  
17 review procedures being performed by dentists that are not part of the traditional scope and identify  
18 additional areas that could become part of a dentist's scope and what type of training might be necessary.

19 **BOARD RECOMMENDATION: Received after this section had been reproduced for House**  
20 **distribution.**



Resolution No. 67 New ☒ Substitute ☐ Amendment ☐Report: NA Date Submitted: October 2011Submitted By: Board of TrusteesReference Committee: Dental Education, Science and Related MattersTotal Net Financial Implication: None Net Dues Impact: \$Amount One-time \$ Amount On-going \$ADA Strategic Plan Goal: Public Health (Required)**PROPOSAL TO REALIGN OVERSIGHT OF THE ASSOCIATION'S  
EVIDENCE-BASED DENTISTRY ACTIVITIES**

**Background:** At its June 2011 meeting, the Board of Trustees reviewed a report of the ADA Advisory Committee on Evidence-Based Dentistry ("EBD Advisory Committee"), which is included as an attachment (Appendix A). In this report, the committee presents a rationale to dissolve the EBD Advisory Committee and realign oversight of the Association's EBD activities to a new interagency subcommittee of the Council on Scientific Affairs. The committee recommends that the interagency subcommittee meet annually in person. Funding for the meeting is included in the 2012 base budget. The Board agreed with the EBD Advisory Committee's recommendation and adopted Resolution B-66-2011.

**Resolved,** that the Board transmit the Report of the ADA Advisory Committee on Evidence-Based Dentistry to the 2011 House of Delegates with the following resolution:

**Resolved,** that the Advisory Committee on Evidence-Based Dentistry be dissolved, and be it further

**Resolved,** that funding for the Advisory Committee on Evidence-Based Dentistry be transferred to the proposed 2012 budget of the Council on Scientific Affairs to support a new CSA subcommittee with representation of other relevant ADA agencies to obtain interagency input on appropriate science and research topics.

This proposal is presented in accordance with the *Bylaws* duties of the Council on Scientific Affairs, which directs the CSA to "guide, assist and collaborate with the ADA Center for Evidence-Based Dentistry" and "to promote evidence-based practice." In 2007, the Association established the ADA Center for Evidence-Based Dentistry, which works closely with the Council on Scientific Affairs and other ADA agencies on a range of EBD projects, including the EBD website (ebd.ada.org), the EBD Champions Conference and the Evidence-Based Clinical Recommendations Program. The Board recommends adoption of the following resolution:

**Resolution**

**67. Resolved,** that the Advisory Committee on Evidence-Based Dentistry be dissolved, and be it further

**Resolved,** that funding for the Advisory Committee on Evidence-Based Dentistry be transferred to the proposed 2012 budget of the Council on Scientific Affairs to support a new CSA subcommittee with representation of other relevant ADA agencies to obtain interagency input on appropriate science and research topics.

**BOARD RECOMMENDATION: Vote Yes.**

**BOARD VOTE: UNANIMOUS. (BOARD OF TRUSTEES CONSENT CALENDAR ACTION—NO BOARD DISCUSSION)**

## APPENDIX 1

## REPORT OF THE ADA ADVISORY COMMITTEE ON EVIDENCE-BASED DENTISTRY

*Supports ADA Strategic Plan (2011-14) Goal 2: Be the trusted resource for oral health information that will help people be good stewards of their own oral health.*

**Background:** In 2001, the House of Delegates approved an EBD action plan submitted by the Board of Trustees that included the Board's proposal to establish an ADA Advisory Committee on Evidence-Based Dentistry (Resolution 107H-2001). The Advisory Committee is composed of a Board liaison, the committee chair, and one representative from each of the following Association councils: Access, Prevention and Interprofessional Relations; Dental Benefit Programs; Dental Education and Licensure; Dental Practice; Ethics, Bylaws and Judicial Affairs; Communications; and Government Affairs. The Advisory Committee also has two members from the Council on Scientific Affairs and two expert consultants. Dr. Jeffrey Hutter chairs the 2011 Advisory Committee.

The purpose of the Advisory Committee is to assure that the entire spectrum of research, dental practice and education are taken into account as the Association moves forward on any given activity related to EBD. The House approved funding for one annual meeting of the Advisory Committee in the budget of the Council on Scientific Affairs beginning in 2002. The Advisory Committee has continued to meet on an annual basis and funding of the meeting is again proposed in the 2012 budget of the Center for Evidence-Based Dentistry. The action proposed in this report to dissolve the Advisory Committee and transfer its duties to the Council on Scientific Affairs would also transfer the Advisory Committee's meeting budget to CSA to support a new CSA subcommittee with representation from other agencies.

**February 2011 Committee Meeting:** The EBD Advisory Committee met on February 9, 2011 at the ADA Headquarters. Attendees included: Dr. Jeffrey Hutter (chair), Dr. Brian Novy (CSA), Dr. Brian E. Scott (CAPIR), Dr. Philippe P. Hujoel (consultant), Dr. Amid I. Ismail (consultant), Dr. Brian Kennedy (CDEL), Dr. John Nase (CC), Dr. Stephen Glenn (CDP), Dr. Carl Sebelius, Jr. (CEBJA), Dr. Bruce Toy (CDBP), Dr. George W. Taylor, III (CSA), Dr. R. Wayne Thompson (Board Liaison). The CGA representative, Dr. Kim Jernigan, was not able to attend the meeting.

The Committee held a conference call in advance of the February 9 meeting. During the call Committee members shared goals and metrics for EBD activities involving their agencies and finalized plans for a face-to-face meeting in Chicago on February 9, 2011.

At the February 9 meeting a presentation of the Center's current initiatives was given, including the EBD web site, the EBD Champion Conference, the ADA Evidence Reviewer Program, the upcoming ADA/Forsyth EBD Course, the Clinical Recommendations Program, and grant opportunities to fund some of these initiatives. The Committee members presented updates to their goals and metrics. The Committee also held a strategic discussion on the EBD Champion Conference.

The Advisory Committee considered a motion that was tabled at its 2010 meeting dealing with the future of the Committee. The Committee discussed that its original purpose has largely been met and discussed the option of recommending re-assignment of the Committee's functions to CSA, which has responsibility for EBD activities under the ADA Bylaws. The CSA representatives on the Advisory Committee noted that CSA collaborates with other ADA agencies on science projects, such as the ADA's Research Agenda. CSA could create a subcommittee with representatives of other councils to coordinate these activities as well as EBD. The Committee specifically discussed CAPIR, CGA, CDEL, CC, CDP, CEBJA and CDBP in this context. Upon discussion, the Committee agreed to recommend to the House that its duties be assigned to CSA and that the Advisory Committee be disbanded. If the House agrees, the Advisory Committee recommends that funding in the EBD Center's proposed 2012 budget for the annual meeting of the Advisory Committee be transferred to the CSA and used instead to fund the activities of the CSA subcommittee.

1 The Advisory Committee was subsequently informed at its March, 2011 meeting that CSA passed a resolution  
2 supporting the Advisory Committee's recommendation. The following resolution is presented for the Board's  
3 consideration:

4 **Proposed Resolution**

5 **B-66. Resolved**, that the Board transmit the Report of the ADA Advisory Committee on Evidence-Based  
6 Dentistry to the 2011 House of Delegates with the following Resolution:

7 **Resolved**, that the Advisory Committee on Evidence-Based Dentistry be dissolved,  
8 and be it further

9 **Resolved**, that funding for the Advisory Committee on Evidence-Based Dentistry be transferred to  
10 the proposed 2012 budget of the Council on Scientific Affairs to support a new CSA subcommittee  
11 with representation of other relevant ADA agencies to obtain interagency input on appropriate  
12 science and research topics.

Prepared by: Dr. Julie Frantsve-Hawley, director, ADA Center for Evidence-Based Dentistry  
Ms. Kathleen M. Todd, senior director, administration, Science/Professional Affairs  
Committee Chair: Dr. Jeffrey Hutter, Advisory Committee on Evidence-Based Dentistry  
Division Director: Dr. Daniel M. Meyer, senior vice president, Science/Professional Affairs



1                   **REINSTITUTION OF THE SUBSCRIPTION TO THE COCHRANE LIBRARY**

2           The following resolution was submitted by the Eighth, Ninth and Eleventh Trustee Districts and transmitted on

3           September 30, 2011, by Drs. Jeffery Johnston and Steven Stoll, Ninth Trustee District Delegation Chairs, Mr.

4           Greg Johnson, executive director, Illinois State Dental Society, Dr. Robert Bitter, Eighth Trustee District

5           Delegation Chair and Dr. Greg Ogata, Eleventh Trustee District Delegation Chair.

6           **Background:** The sponsors of this resolution applaud the efforts of the Board of Trustees in addressing

7           budget issues in this environment of limited Association resources. Included in these cuts was a line item in

8           the ADA Library budget that funded member access to literature searches from the Cochrane Library. We

9           believe that this funding should be continued in order to enhance patient care; assist our Association with

10          member recruitment and retention; provide our members the tools needed in advocacy with third-party payers

11          and to aid our members in compliance with our Code of Ethics.

12          The ADA recognizes that Dentistry is a science-based profession. That we must always examine new

13          evidence and consider it along with existing science in order to evaluate guidelines and recommendations for

14          patient care. In service to this mission, the Council on Scientific Affairs has created several “clinical

15          guidelines’ for patient care and promoted the **Center for Evidence-based Dentistry (EBD)** as a service to

16          our members in providing them the needed resources to integrate evidence based practices into their patient

17          care. The Center provides members with the ADA’s EBD web site and training through the Champions’

18          Conferences. To date no less than four annual programs have been hosted by the ADA to train a strong

19          team of EBD Champions with the tools needed to return to their respective communities to teach their

20          colleagues on how to implement EBD into their practice lives.

21          The need to provide our members with access to literature search engines is growing and evolving not only

22          through the grassroots efforts of our trained Champions, but also from recent graduates who are schooled in

23          EBD principles and have an expectation for access to these tools. The ADA Library provides access to

24          literature searches from the Cochrane Library through the ADA’s Library link at [www.ada.org/library](http://www.ada.org/library) and

25          through a link on our EBD web page <http://ebd.ada.org> The Cochrane subscription provides ADA members

26          access to the full text of their systematic reviews. Only abstracts are available through PubMed or the ADA’s

27          EBD website.

28          New accreditation standards through CODA state that “curricular content and learning experiences must

29          incorporate the principles of evidence-based inquiry, and involve faculty who practice EBD and model critical

30          appraisal for students during the process of patient care.” Many dental schools provide Cochrane Library

31          services as part of their efforts to address these standards. Following graduation, the student’s access

32          comes to an end. The portal the ADA provides its members to Cochrane will have increasing value as a

33          membership recruitment and retention tool as we address the needs of recent graduates.

1 ADA members rank among their top concerns issues they encounter with third party payers. Access to  
2 current literature provided through Cochrane can be used in drafting narratives for filing an appeal for benefit  
3 coverage when issues with claims adjudication arise. The ability to defend the care decisions that were made  
4 and how these decisions conform to the current evidence can be a powerful tool in achieving a successful  
5 appeal for coverage with a benefit carrier.

6 It is also interesting to note from Resolution 10 (Worksheet:5002) that it is the intent of the Council on Ethics,  
7 Bylaws and Judicial Affairs to add an aspirational statement in the ADA *Code* encouraging dentists to  
8 incorporate the ADA principles of evidence-based dentistry into their practices. Continued access to  
9 Cochrane search engines will aid our members in incorporating the ADA principles of evidence-based  
10 dentistry in patient care.

11 The original 2010 funding level for the Association's Cochrane subscription was set at \$33,000.00.  
12 Negotiations reduced the fee from Cochrane to \$16,500.00 for 2011. At the time of the budget cuts proposed  
13 by the Board of Trustees, negotiations for the 2012 subscription were ongoing but the cost is not expected to  
14 exceed \$18,000.00. The current ADA subscription to the Cochrane Library expires December 31, 2011.  
15 Favorable action on this resolution by the House of Delegates will allow for seamless, uninterrupted access to  
16 the Cochrane search engines for our members.

17 Based on the reduction in the proposed fee; the impact this decision can have on patient care decisions;  
18 member recruitment and retention efforts; members' ability to advocate with third party payers and address  
19 ethical practice needs, be it

## 20 Resolution

21 **69. Resolved**, that the American Dental Association House of Delegates reinstate funding of the  
22 Association's subscription to the Cochrane Library.

23 **BOARD RECOMMENDATION: Received after this section had been reproduced for House**  
24 **distribution.**



Resolution No. 72 New ☒ Substitute ☐ Amendment ☐  
 Report: NA Date Submitted: October 2011  
 Submitted By: Ninth Trustee Districts  
 Reference Committee: Dental Education, Science and Related Matters  
 Total Net Financial Implication: None Net Dues Impact: \$  
 Amount One-time \$ Amount On-going \$  
 ADA Strategic Plan Goal: \_\_\_\_\_ (Required)

### AUTONOMY OF THE ADA EDITOR

The following resolution was submitted by the Ninth Trustee District and transmitted on October 3, 2011, by Drs. Jeffery Johnston and Steven Stoll, Ninth Trustee District Delegation Chairs.

**Background:** Scientific journals today must meet an ever-increasing standard of scrutiny in order to maintain their position of trust, authority and credibility, both in their professional community and with the public at large. The responsibility for maintaining an environment of independent thought and objectivity falls to both the editors of those journals and the owners that support this work—in many cases, professional associations. In this context, the respective roles of the owners of scientific journals and the journal's editors have been analyzed, debated and defined more specifically in recent years.

The World Association of Medical Editors<sup>1</sup> has described the relationship between owners and editors and provides a set of guidelines for protecting the responsibility and authority of both. Owners are charged with selecting and hiring the editor and explicitly stating his or her responsibilities, including mechanisms for resolving conflict. "Editors-in-chief should have full authority over the editorial content of the journal...including original research, opinion articles and news reports...and how and when information is published."

In a review of the ADA *Bylaws* under the powers of the Board of Trustees, a conflict arises with regards to the implicit duty of an editor as described by the World Association of Medical Editors. Whereas the ADA *Bylaws* state in Chapter VII, Board of Trustee, Section 90. Powers: paragraph D. ... [The Board of Trustees...vested with full power to:] "D. Cause to be published in, or to be omitted from, any official publication of the Association any article in whole or in part."

### Resolution

**72. Resolved,** that the appropriate ADA agency review Chapter VII, Board of Trustees, Section 90. Powers: paragraph D of the ADA *Bylaws* to suggest new language for the bylaws consistent with the principles supported by the World Association of Medical Editors, and be it further,

**Resolved,** that the changes be submitted to the 2012 ADA House of Delegates.

**BOARD RECOMMENDATION: Received after this section had been reproduced for House distribution.**

1. The relationship between journal editors-in-chief and owners (formerly titled Editorial Independence). Originally posed June 19, 2000; modified versions posted May 15, 2006 and July 25, 2009. Accessed on 8-17-11;  
<http://www.wame.org/resources/policies#independence>



Resolution No.    41BS-1                                  New ☐              Substitute ☒              Amendment ☐

Report: NA Date Submitted: October 2011

Submitted By: Eleventh Trustee District

Reference Committee: Dental Education, Science and Related Matters

**Total Net Financial Implication:** \$40,000 (FTE: 2.5)      **Net Dues Impact:** \$0.37

Amount One-time	\$	Amount On-going	\$
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ADA Strategic Plan Goal:      Members      (Required)

**SUBSTITUTE TO RESOLUTION 41B:  
ADA SCIENTIFIC REVIEW OF ALTERNATIVE DENTAL WORKFORCE MODELS**

The following substitute for Resolution 41B (Worksheet:3041) was submitted by the Eleventh Trustee District and transmitted on October 7, 2011 by Ms. Amanda Tran, caucus coordinator.

## Resolution

(Additions underscored; deletions stricken through)

**41BS-1. Resolved**, that the American Dental Association, through the appropriate ADA agencies, conduct or contract with an independent agency to conduct a systematic scientific review critical appraisal of the literature (including a systematic review of possible and excluding other studies authorized by the House of Delegates) on workforce models where non-dentists diagnose patients, formulate treatment plans and or provide irreversible or surgical dental procedures, which are in development or are already developed in this country or similarly developed countries worldwide and issue a report evaluating the information, and be it further

**Resolved**, that the information from this research be reported to the 2012 ADA House of Delegates.

**BOARD RECOMMENDATION:** Received after this section had been reproduced for House distribution.



Resolution No. 81 New ☒ Substitute ☐ Amendment ☐

Report: NA Date Submitted: October 2011

Submitted By: Sixteenth Trustee District

Reference Committee: Dental Education, Science and Related Matters

Total Net Financial Implication: \$20,000 (FTE: 0) Net Dues Impact: \$0.19

Amount One-time \$                     Amount On-going \$                    

ADA Strategic Plan Goal: \_\_\_\_\_ (Required)

## PROFESSIONAL PRODUCTS REVIEW STUDY

The following resolution was submitted by the Sixteenth Trustee District and transmitted on October 10, 2011, by Mr. Phil Latham, executive director, South Carolina Dental Association.

**Background:** The ADA *Professional Products Review (PPR)* has been a publication of the ADA Division of Science since 2006. The *PPR* was created as an enhanced member benefit to provide members with unbiased scientifically sound, clinically relevant, and user-friendly information on professional products. Readers' surveys indicate 90% of readers have used *PPR* to make purchasing decisions. *PPR* has a clear brand among members and is recognized as a member benefit. The *PPR* is published quarterly and mailed with *JADA* as a separate publication.

As part of a cost-cutting plan, the Division of Science and the Division of Publishing are planning to merge *PPR* into the *JADA* in January or February 2012. The *JADA* and *PPR* are distinctively different ADA publications from a mission and production concept. If continued, members would have to “rip out” the *PPR* to place in a notebook rather than receive it as a pre-punched publication.

## Resolution

**81. Resolved**, that the ADA conduct a study with readers' survey of the effectiveness of the *PPR* utilization as a member benefit as part of *JADA* versus a separate publication, and be it further

**Resolved**, that this survey and the cost of separating the *PPR* from *JADA* be reported to the 2012 House of Delegates.

**BOARD RECOMMENDATION:** Received after this section had been reproduced for House distribution.

