

# 2012

Supplement to  
Annual Reports and Resolutions  
Volume 1

153rd Annual Session  
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October 18–23, 2012

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211 East Chicago Avenue  
Chicago, Illinois 60611

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## Board Report 1/ Credentials, Rules and Order

Resolution No. 84 NewReport: Board Report 1 Date Submitted: July 2012Submitted By: Board of TrusteesReference Committee: N/ATotal Net Financial Implication: None Net Dues Impact: Amount One-time  Amount On-going  FTE 0ADA Strategic Plan Goal:  (Required)**REPORT 1 OF THE BOARD OF TRUSTEES TO THE HOUSE OF DELEGATES:  
ASSOCIATION AFFAIRS AND RESOLUTIONS**

This is the first in a series of reports to be presented by the Board of Trustees to the House of Delegates at the 153<sup>rd</sup> Annual Session of the American Dental Association.

**Appreciation to the Council on ADA Sessions and the 2012 Committee on Local Arrangements:** The American Dental Association is pleased to have its 153<sup>rd</sup> Annual Session in San Francisco, California.

The Council on ADA Sessions has created a meeting that lives up to the ADA's reputation for delivering an extraordinary education and exhibition experience. The Board of Trustees wishes to express its sincere gratitude to the Council, and the exceptional leadership of Dr. Kent H. Percy, 2011-2012 Council Chair and Dr. Mark C. Huberty, Program Chair. They have planned and produced not only an innovative continuing education program, but an exhibition that allows dental professionals to experience firsthand the latest in cutting edge dental materials, services and new technologies.

Council members: Richard Andolina, Jr. (ASDA liaison), Dr. Robert E. Barsley, Dr. Hugo F. Bertagni, Dr. Michael M. Blicher (2013 CAS chair-designate), Dr. Barry I. Cohen, Dr. James R. Foster, Dr. Randy G. Fussell, Dr. James E. Galati, Dr. Joseph Hagenbruch (Board of Trustees liaison), Dr. William E. Lee, Dr. Matt A. Niewald (New Dentist Committee Liaison), Dr. David K. Okano, Dr. Steven E. Parker, Dr. Gregory J. Peppes, Dr. John P. Pietrasik, Dr. Robert E. Roesch, Dr. Richard K. Rounsaville, Dr. S. Shane Samy and Dr. Neil E. Torgerson are all to be recognized for their commendable achievement.

The Board also extends its sincere thanks to those chairpersons who so capably assisted Dr. Dennis D. Shinbori, general chair of the 2012 Committee on Local Arrangements: Dr. Stafford J. Duhn, vice chair; Dr. Gary R. Ackerman, registration co-chair; Dr. Natasha A. Lee, registration co-chair; Dr. Jeffrey S. Jang, program co-chair; Dr. James H. Van Sicklen, program co-chair; Dr. William W. Lee, hospitality co-chair; Dr. Erich M. Werner, hospitality co-chair.

Finally, the Board expresses tremendous appreciation to all of the volunteers on the Committee on Local Arrangements for the assistance they provide to the Council in the operation of this annual session. The Board recognizes and thanks the California Dental Association for their contributions to the success of the 2012 San Francisco annual session.

Without the wonderful assistance from these individuals and organizations, and their efforts working as a team with the ADA, this annual session would not be possible.

**Death of Former ADA Officials:** Since the last meeting of the House of Delegates, the following ADA trustee has passed away: Dr. Lloyd J. Phillips, former seventh district trustee, 1970-1976.

**Election of Honorary Membership:** In accordance with Resolution 78H-1980 (*Trans.*1980:590), which empowers the Board of Trustees to elect honorary members of the Association, the following individuals have been elected to Honorary Membership.

Alice DeForest, CAE  
Nancy A. Kelly, MHS

These individuals in various ways have made outstanding contributions to the advancement of the art and science of dentistry or contributions above and beyond expectation to the profession. The Board offers its sincerest congratulations to its newest honorary members.

**Distinguished Service Award:** Established in 1970, the Distinguished Service Award is the highest honor conferred by the Association's Board of Trustees. Each year the Board may select one recipient for the Award. The Board is pleased to announce that the recipient of the 2012 Distinguished Service Award is Dr. Albert H. Guay.

**Albert H. Guay, DMD:** Dr. Guay currently is the Chief Policy Advisor Emeritus at the American Dental Association. He held the position of Chief Policy Advisor from 2001 until his retirement in 2011.

As Chief Policy Advisor, Dr. Guay monitored the dental and general health environment, and identified and researched emerging and potential future issues of concern to the profession and the Association. He also oversaw the operations of the Health Policy Resources Center and the Office of Strategic Planning and Consulting; managed the Hillenbrand Roundtable and Fellowship; and supported several agencies in matters involving Association policies—primarily the House of Delegates, the Board of Trustees, the ADA councils and the Executive Director.

Dr. Guay practiced orthodontics in the Boston area for 26 years, specializing in the treatment of craniofacial anomalies. He is a former ADA trustee from the First District and has served as chair of the ADA Council on Dental Care Programs, delegate to the ADA House of Delegates for several years, and as a member of many ADA committees and task forces. In 1992, Dr. Guay joined the ADA staff as Director of the Council on Dental Practice and later served as Assistant and then Associate Executive Director of the Division of Dental Practice. He graduated cum laude from the Tufts University School of Dental Medicine, and did his specialty training in orthodontics at the Eastman Dental Center at the University of Rochester in New York. In addition, Dr. Guay was a professor at both Tufts and Emerson College in Boston, and served in the United States Army where he achieved the rank of Captain, Dental Corps.

Dr. Guay has published papers and articles on policy and emerging issues in a variety of peer-reviewed journals. A compendium of his writing is housed in the ADA Library and includes a series of reports on the concept and evolution of pay-for-performance, the development of the SNODENT diagnostic code system, globalization and the universal doctor, and eldercare. He has written pieces covering a wide range of subjects, from papers on improving the oral health of Alaska natives and barriers in access to dental care, to articles on Medicaid dental programs, the dental market index, and evidence-based dentistry.

Dr. Guay has received numerous honors throughout his career, including the Joseph G. DiStasio Distinguished Service Award from the Northeast Society of Orthodontists, the first Eastman Dental Center Alumni Award for special distinction in general practice, the Pierre Fauchard Academy Award, the Distinguished Service Award of the American Cleft Association and the U.S. Army Commendation medal.

**Retiring Officers and Trustees:** The Board of Trustees wishes to express its gratitude to the following officers and trustees for services rendered to the Association during their tenure on the Board: Patricia L. Blanton, first vice president; Dr. Thomas J. Soliday, speaker, House of Delegates; Dr. Edward Leone, Jr., treasurer; Dr. Samuel B. Low, trustee, Seventeenth District; Dr. Charles H. Norman, trustee, Sixteenth District; Dr. W. Ken Rich, trustee, Sixth District; Dr. Charles L. Steffel, trustee, Seventh District; and Dr. Edward J. Vigna, trustee, Tenth District.

**Appreciation to Employees:** The Board of Trustees is pleased to bring to the attention of the House of Delegates 30 members of the Association staff for their years of service.

*Forty Years:* Linda Hastings, Administrative Services

*Thirty-Five Years:* Patricia Schranz, Membership, Tripartite Relations & Marketing

*Thirty Years:* Anthony Giuseppetti, Paffenbarger Research Center Health Foundation; Vivian Slack, Human Resources & Organizational Development; Josielen Calloway, Finance & Operations; Rita Tiernan-Stoterau, Membership, Tripartite Relations & Marketing; Corazon Lapuz, Education/Professional Affairs

*Twenty-Five Years:* Marsha Stiegel, Education/Professional Affairs; Cynthia Taylor and Pamela Fryer, Government Affairs, Washington Office; Shirley Ji, Information Technology

*Twenty Years:* Anita Mark, Science/Professional Affairs; Ferdinand Villas, Finance & Operations; Marcene Tyler, Education/Professional Affairs

*Fifteen Years:* Gary Grzesiak, Wayne Thompson and Anthony Yarus, Finance & Operations; Peter Bradley, Rick Limanowski and Christopher Maag, Information Technology; Chrestine Johnson and Amy Lund, ADA Publishing; Cynthia Willett, Education/Professional Affairs; Barbara Ferriter and Patricia Murphy, Conference & Meeting Services; Laura Bangs, Communications & Marketing; Jon Holtzee, State Government Affairs; Joan McGinley, Government Affairs, Gretchen Duppins, Paffenbarger Research Center Health Foundation

**Nominations to Councils and Commissions:** The Board of Trustees annually submits to the House of Delegates nominations for membership to the councils, commissions and New Dentist Committee. Based on the ADA *Bylaws*, the nominees for ADA open positions on the Commission on Dental Accreditation and Council on Scientific Affairs were selected by the Board from nominations open to all trustee districts. Additionally, in accordance with a long-standing House directive, the Board is providing a brief narrative comment on each nominee's qualifications. The *Bylaws*, Chapter VI, Conflict of Interest, requires nominees for Councils and Commissions to complete a conflict of interest statement and file such statements with the Secretary of the House of Delegates to be made available to the delegates prior to election.

The qualifications of these nominees appear on page 1006.

#### **ACCESS, PREVENTION AND INTERPROFESSIONAL RELATIONS**

Yasmi O. Crystal, New Jersey  
G. Lewis Mitchell, Jr., Alabama  
Mary Ellen Wynn, Ohio  
Cheryl D. Watson-Lowry, Illinois  
Matthew B. Roberts, Texas  
Cesar R. Sabates, Florida

#### **ADA SESSIONS**

Sidney R. Tourial, Georgia  
Grace A. Curcuru, Michigan  
James H. Van Sicklen Jr., California  
Calbert M. Lum, Hawaii  
T. Harold Lancaster, North Carolina

**COMMUNICATIONS**

Sally Hewett, Washington  
Ruchi K. Sahota, California  
Robert J. Manzanares, New Mexico  
Joshua A. Austin, Texas  
Ralph L. Howell, Jr., Virginia  
John H. Paul, Florida

**DENTAL ACCREDITATION**

\*Stanley R. Surabian, California

**DENTAL BENEFIT PROGRAMS**

Thomas V. Brady, Connecticut  
David R. Larson, Pennsylvania  
Daniel B. Krantz, New Jersey  
Celeste Coggin, Georgia  
B. Scott Eder, West Virginia  
Ronald D. Riggins, Illinois  
Sammy B. Pak, Washington

**DENTAL EDUCATION AND LICENSURE**

Steven J. Holm, Indiana  
Stanley L. Brysh, Wisconsin  
Ronald L. Rhea, Texas

**DENTAL PRACTICE**

Miranda Childs, Arkansas  
J. Christopher Smith, West Virginia  
Todd W. Marshall, Minnesota  
Gregory J. Bengtson, Idaho  
Jean L. Creasey, California  
Andrew Brown, Florida

**ETHICS, BYLAWS AND JUDICIAL AFFAIRS**

A. Roddy Scarbrough, Mississippi  
Thomas E. Raimann, Wisconsin  
George J. Muller, II, South Dakota  
Douglas A. Auld, Oklahoma  
William M. Walton, Texas

**GOVERNMENT AFFAIRS**

Charles L. Silvius, Massachusetts  
John F. Harrington, Jr., Georgia  
J. Barry Howell, Illinois  
Barrett Straub, Wisconsin  
Richard A. Huot, Florida

**MEMBERSHIP**

K. Drew Wilson, New Hampshire  
Nicole Stachewicz Johnson, Pennsylvania  
William L. Ingram, Alabama  
Gregory J. Pohl, Kentucky  
Michael G. Durbin, Illinois  
Steven P. Bradley, Iowa

**MEMBERS INSURANCE AND RETIREMENT PROGRAMS**

Frank C. Barnashuk, New York  
Louis F. Rubino, Jr., Pennsylvania  
Patrick M. Grogan, Washington, D.C.  
David Houten, Washington  
Paul R. Miller, Florida

**NEW DENTIST**

Chris M. Hasty, Georgia  
Rachel T. Dasher, Tennessee  
Eric T. Childs, Michigan  
Ryan L. Ritchie, Minnesota  
Andrea K. Janik, Texas

**SCIENTIFIC AFFAIRS**

Elliot Abt, Illinois  
Robert G. Hale, Army  
John Barrett Ludlow, North Carolina  
Douglas A. Young

\*In response to Resolution 76H-2010, CODA requested that, beginning in 2012, new Commissioner appointees be identified one year in advance of their term of service to participate in CODA activities.

**Resolution**

**84. Resolved**, that the nominees for membership on ADA councils, commissions and the New Dentist Committee submitted by the Board of Trustees in accordance with Chapter VII, Section 100(H) of the *Bylaws* be elected.

**Retiring Council and Commission Members:** The Board of Trustees wishes to acknowledge with appreciation the service of the following council and commission members.

**ACCESS, PREVENTION AND  
INTERPROFESSIONAL RELATIONS**

Nolan W. Allen, Florida  
Gerald J. Ciebien, Illinois  
Eleanor A. Gill, Mississippi  
David R. Holwager, Indiana  
Todd A. Pankratz, Nebraska  
Sidney A. Whitman, New Jersey

**ADA SESSIONS**

Randy G. Fussell, North Carolina  
Mark C. Huberty, Wisconsin  
David K. Okano, Wyoming  
Kent H. Percy, Georgia  
Richard K. Rounsavelle, California

**COMMUNICATIONS**

Carter W. Brown, South Carolina  
Anita W. Elliott, Arizona  
Thomas J. Olinger, California  
Pamela S. Ray, Texas  
Hugh T. Wunderlich, Florida

**DENTAL ACCREDITATION**

Steven J. Tonelli, Massachusetts

**DENTAL BENEFIT PROGRAMS**

Lauri A. Passeri, Pennsylvania  
D. Mark Prator, Alaska  
Jim G. Richeson, Jr., Washington, DC  
Stephen C. Ura, New Hampshire

**DENTAL EDUCATION AND LICENSURE**

James W. Antoon, Florida  
Charles E. Johnson, Illinois

**DENTAL PRACTICE**

William C. D'Aiuto, Florida  
Roger K. Newman, Montana  
Jamie L. Sledd, Minnesota  
Judee Tippet-Whyte, California  
Mark R. Zust, Missouri

**ETHICS, BYLAWS AND JUDICIAL AFFAIRS**

Patrick J. Foy, Minnesota  
Marilyn S. Lantz, Michigan  
David H. McCarley, Texas  
L. Stephen Ortego, Louisiana  
Kent G. Palcanis, Alabama

**GOVERNMENT AFFAIRS**

Steven M. Dater, Michigan  
Kim U. Jernigan, Florida  
John J. Mooney, Connecticut  
Ronald G. Testa, Illinois  
Richard A. Weinman, Georgia

**MEMBERSHIP**

T. Delton Moore, Mississippi  
Jonathan W. Rich, Kentucky  
Nancy R. Rosenthal, Pennsylvania  
Brett S. Thomsen, Nebraska  
Lisa Vouras, Massachusetts

**MEMBERS INSURANCE AND RETIREMENT  
PROGRAMS**

George B. Dorris, Jr., Florida  
Craig A. Eisenhart, Pennsylvania  
Steven R. Fink, New Jersey  
Spencer S. Jilek, Washington  
Mark J. Weinberger, New York

**NATIONAL DENTAL EXAMINATIONS**

Peter S. Trager, Georgia

**NEW DENTIST**

Keri L. Miller, Alabama  
Matthew A. Niewald, Missouri  
Sarah A. Poteet, Texas  
Danielle R. Ruskin, Michigan  
Eric Unkenholz, South Dakota

**SCIENTIFIC AFFAIRS**

John W. Hellstein, Iowa  
John J. Sauk, Kentucky  
Harold C. Slavkin, California  
Charles F. Streckfus, Texas  
John Timothy Wright, North Carolina

**ADA Institute for Diversity in Leadership:** The ADA Board of Trustees selected the following dentists to be the tenth class of the ADA Institute for Diversity in Leadership, to begin the program in September 2012:

Ahmed, Shahnaz, Ballwin, MO  
Avery-Stafford, Cheska, Waukegan, IL  
Ayson, Paul, Visalia, CA  
Chatterjee-Kirk, Pia, Jackson, MS  
Crawford, Beverly, Philadelphia, PA  
Daniel, Anthony, San Francisco, CA  
Gonzales, Christina, San Antonio, TX  
Maranga, Maria, Northport, NY  
Morell, Maritza, Andover, MA  
Nam, Daniel, Oakland, CA  
Patel, Vishruti, Plainfield, IL  
Verma, Prashant, Baltimore, MD

The high quality of the educational curriculum, faculty, mentors, sponsors, participants and leadership projects of the 2011 Institute for Diversity in Leadership once again confirmed the success of the program that began in 2003. Guided by the Diversity Committee of the ADA Board of Trustees, and bolstered in 2011 with three Institute alumni who serve as consultants to the Committee, the program continues to develop leaders.

In proposing the Institute to the ADA 2002 House of Delegates, the ADA Board described the objectives of the Institute as: "... to build lifetime relationships with minority dentists; to mentor promising leaders with potential to impact diverse communities; and to strengthen alliances with stakeholder institutions, including dental leaders, industry, public and governmental communities of interest." Tracking corresponding metrics since the first class, the program has demonstrated that:

- While participants are going through the program, they report high satisfaction with the quality of the faculty and educational experience. They continue to provide positive reviews in subsequent alumni surveys.
- Beyond their year with program --
  - Institute alumni have been selected for positions as volunteers in ADA governance, including the ADA Board's Strategic Planning Committee, as consultants meeting regularly with the ADA Board's Diversity Committee, the New Dentist Committee, and as delegates or alternates to the ADA House of Delegates over the past several years (with seven in the 2011 House).
  - Institute participants have also served as board members and officers with the Hispanic Dental Association, the National Dental Association, the American Association of Women Dentists, and the Society of American Indian Dentists.
  - Institute alumni have also filled volunteer leadership roles with constituent and component dental societies.
  - Institute alumni play leadership roles within dental schools.
  - Alumni also serve in community leadership positions outside dentistry.

Special thanks and recognition were extended in 2011 to two Institute "guiding lights" from Northwestern University's Kellogg School of Management; Professor Thomas Prince and Associate Dean Vennie Lyons who have both retired from Northwestern and the Institute. Going forward, Professor Keith Murnighan of Northwestern University's Kellogg School of Management, a highly regarded Kellogg faculty member who has been with the program since the beginning, will serve as advisor and faculty liaison.

The program is partially supported through generous contributions from two corporations: Procter & Gamble Oral Health and Henry Schein Dental.

**STATEMENT OF QUALIFICATIONS OF NOMINEES TO COUNCILS AND COMMISSIONS****ACCESS, PREVENTION AND INTERPROFESSIONAL RELATIONS**

*Crystal, Yasmi O., New Jersey, 2016.* Dr. Yasmi Crystal graduated dental school from University of Medicine and Dentistry of New Jersey and got her pediatric dental training from Eastman Dental Center, University of Rochester. She is a past president of the New Jersey Academy of Pediatric Dentistry and has been co-director of continuing education for the New Jersey Society of Dentistry for Children and New Jersey Academy of Pediatric Dentistry for more than 20 years. Dr. Crystal is a Diplomate of the American Board of Pediatric Dentistry, and an active member, past member of the Board of Trustees and spokesperson for the American Academy of Pediatric Dentistry. Dr. Crystal is an associate professor for pediatric dentistry at New York University, College of Dentistry, and, in addition, she is an active member of the American Dental Association, the New Jersey Dental Association, the American Society for the Advancement of Anesthesia and Sedation in Dentistry (ASAAD) and the International Academy of Pediatric Dentistry. She is a Fellow of the American Society for Dental Esthetics. She is also an instructor of pediatric conscious sedation at ASAAD's Dentistry's Conscious Sedation Course in St. Joseph's Hospital in Paterson, New Jersey; an oral health consultant for the American Academy of Pediatrics; lectures to pediatric dentists in the U.S. and abroad; and has published several articles in scientific journals. Dr. Crystal believes all children are entitled to good oral health, so she has volunteered her services at free children dental clinics in Israel, Mexico and the United States. Dr. Crystal is fluent in English, Spanish, French and Italian.

*Mitchell, G. Lewis, Jr., Alabama, 2016.* Dr. Lew Mitchell is a member in good standing of the Alabama Dental Association and the American Dental Association. Dr. Mitchell regularly uses email, distribution lists and listserves in his capacity as an Alabama ADA Delegate and chair of the 5<sup>th</sup> Trustee District. Dr. Mitchell previously served for two years as a dentist in the U.S. Public Health Service and maintains a general dental practice in Gadsden, Alabama. As a member of the Alabama Dental Association's Board of Trustees, Dr. Mitchell is well versed in access to dental issues that are currently being debated by the Alabama Legislature and the State Medicaid Agency. As past president of the University of Alabama School of Dentistry Alumni Association, Dr. Mitchell had the opportunity to work with each of the state dental specialty organizations and the Academy of General Dentistry as he organized the group as a cohesive body in support of the goals of the School of Dentistry.

In 1978, Dr. Mitchell led a coalition of business and union leaders in a successful effort to fluoridate the Gadsden City water supply. Dr. Mitchell currently serves on the Dental Loans and Scholarships Committee for the state of Alabama and has held that position since 2006. This committee approves loans and scholarships for dentists who choose to practice in rural and underserved areas of Alabama. Dr. Mitchell possesses a number of personal strengths, but one of his strongest character traits is building consensus among diverse viewpoints, which will serve him well on this Council. He has the time to serve and is willing to commit himself totally to this opportunity to serve his profession.

*Roberts, Matthew B., Texas, 2014, ad interim.* In January 2012, in accordance with Chapter X, Section 70, of the *Bylaws*, regarding vacancies in the membership of any council, Dr. William Calnon, appointed Dr. Matthew Roberts as *ad interim* member to the Council on Access, Prevention and Interprofessional Affairs to fulfill the unexpired term of Dr. Philip Hunke. This appointment expires at the conclusion of the ADA House of Delegates in October 2014. Because Dr. Roberts will be completing more than 50% of Dr. Hunke's term, he is not eligible for reappointment to the Council.

*Sabates, Cesar R., Florida, 2016.* Dr. Cesar Sabates has been a volunteer for Donated Dental Services, Florida, since 1997, and has been the chair of the Florida D.D.S. program for many years. He recently became the founding president of Dental Lifeline Network, Florida. Dr. Sabates is a founding board member of the US National Oral Health Alliance. He has served as president of the Florida Dental Association (2011-12), president of the South Florida District Dental Association (2000-01), and of his affiliate, the West Dade Dental Society (1996-97). During his tenure as president to the Florida Dental Association, Dr. Sabates was

instrumental in publishing the FDA's white paper on access, "Improving Access to Oral Health Care in Florida."

*Watson-Lowry, Cheryl D., Illinois, 2016.* As a daughter of a dentist, Dr. Cheryl Watson-Lowry has literally grown-up in an environment immersed in dentistry and with obviously a nurturing touch that took hold and guided her to become a dentist as well. Dr. Watson-Lowry is, and has been, a trailblazer from the moment she completed her dental degree and began her private practice. She is one of a very small and respected number of African-American female dental professionals in Illinois (and more specifically in the city of Chicago) whose hard work, determination and leadership has created unmistakable treatment and educational opportunities for individuals in underserved populations. Dr. Watson-Lowry has seen to it that a good number of disadvantaged individuals receive needed dental care and personal oral instruction who otherwise would have most assuredly fallen between the cracks in a city health care system that often struggles from a lack of informed leadership, exhibits derisory sensitivity to encumbering shortcomings and operates under a problematic resource structure that seldom recognizes dentistry as a valid enough entity to justify crucial funding. Those unfortunate circumstances have begun to undergo changes and continues to move in a positive direction through the efforts of Dr. Watson-Lowry and a select group of likeminded dental colleagues.

Dr. Watson-Lowry has an extensive service record with both the Illinois State Dental Society (ISDS) and the Chicago Dental Society (CDS), which includes service at all three levels of the tripartite system as board member (both ISDS and CDS), delegate, alternate delegates (both ISDS and ADA), committee member (and chair both ISDS and CDS), as well as the aforementioned public service in Chicago's huge, politically charged and often seemingly untenable health care system area. With such a busy schedule, Dr. Watson-Lowry still manages to do an incredible job of effectively conducting her demanding and thriving dental practice of compassionate service to her patients.

*Wynn, Mary Ellen, Ohio, 2016.* Dr. Mary Ellen Wynn earned her D.D.S. from The Ohio State University College of Dentistry in 1977 and her MBA in finance from Xavier University in 1984. She has practiced general dentistry in Cincinnati, Ohio, since 1977. Dr. Wynn has served on the Ohio Dental Association Council on Access to Care and Public Service and the Council on Communications and Public Service. She has served as the president of the Cincinnati Dental Society. Dr. Wynn is currently a member of the Ohio State Dental Board. She has served on the Board of Dental Care Plus Group, Inc., which is a dental insurance company owned by southwestern Ohio Dentists.

## ADA SESSIONS

*Curcuru, Grace A., Michigan, 2016.* Dr. Grace Curcuru received her Doctorate in Dental Surgery from the University of Michigan School of Dentistry in 1992 and continued with a Hospital Dentistry General Practice residency in 1993. She continued her training by receiving a Certificate in Periodontics from the University of Michigan School of Dentistry in 1995. Dr. Curcuru has served the Michigan Dental Association in many ways over the years, but her major contribution to the association has been her dedication to the Michigan Annual Session where she has served for 12 years. During her tenure, she chaired the meeting once and served as table clinic co-chair for the last five years. While a member on the Annual Session Committee she has served on all the subcommittees; audio/visual, directional signs, registration, and exhibitors and information. Dr. Curcuru had the opportunity to see firsthand how each sub-committee contributed to a successful event. She can bring her previous experience to the Council on ADA Sessions and be a valuable member contributing on the national level.

*Lancaster, T. Harold, North Carolina, 2016.* Dr. Harold Lancaster is a perfect candidate for the Council on ADA Sessions due to his previous experience as Arrangements chair for the annual meetings of both his component dental society (twice) and the North Carolina Dental Society.

*Lum, Calbert M., Hawaii, 2016.* Dr. Calbert Lum is a 1973 graduate of the University of California School of Dentistry. He has been a member of the ADA since 1976.

*Tourial, Sidney R., Georgia, 2016.* Dr. Sidney Tourial is a graduate of Emory University School of Dentistry and was a Lieutenant in the U.S. Naval Reserves Dental Corps from 1969 to 1971. He is president of the Georgia Dental Association and has served as president of his district society as well as holding many other offices in various professional associations. Dr. Tourial also was the International Alpha Omega Dental Fraternity President in 1999. He was responsible for the planning and implementation of three Alpha Omega International Dental Fraternity meetings and has been an active member of the Thomas Hinman Dental Meeting for over 15 years. Dr. Tourial is a community leader, and as such, has been involved in many community outreach programs.

*Van Sicklen, James H., Jr., California, 2016.* Dr. James Van Sicklen has nine years of meeting planning and administration experience serving with the *California Dental Association (CDA) Presents* Board of Managers and is currently serving in his second year as its chair. He is currently serving on the Committee on Local Arrangements for the ADA Annual Session in San Francisco. This is his second term (having served in San Francisco in 2007 as well) as co-chair of programs. His responsibilities include securing 250-plus hosts (speaker and room) for all lectures and workshops. Dr. Van Sicklen is also a current member of the Programs Committee for the San Joaquin Dental Society. Beyond, and perhaps more importantly than, the qualifications listed above, are the relationships Dr. Van Sicklen has formed within the meeting planning world. He knows, or has knowledge of, most of the speakers presenting nationwide as well as topics in demand. He is familiar with meeting planners from most of the major meetings including staff and volunteers from CAS. In addition to Dr. Van Sicklen's vast meeting planning experience, he has served as the chair of CDA's Council on Dental Practice and Marketing and Communications Task Force. He is also a past president of his local dental society, an active volunteer in his community and a member of the American College of Dentists, Pierre Fauchard Academy and the International College of Dentists. Dr. Van Sicklen's leadership skills, dedication and impressive experience planning major CE events makes him uniquely qualified to serve on the Council on ADA Sessions as defined by the selection criteria.

## COMMUNICATIONS

*Austin, Joshua A., Texas, 2016.* Dr. Joshua Austin is a past chair of the Texas Dental Association (TDA) New Dentist Committee and served on a public relations task force for the TDA. Dr. Austin has produced a number of You Tube podcasts covering both clinical dentistry and dental advocacy. He has great vision and good communication skills. Dr. Austin is currently editor of The New Dentist Blog and is the clinical director of *The New Dentist Magazine*. Dr. Austin will serve both the ADA and the Fifteenth Trustee District well.

*Hewett, Sally, Washington, 2014, ad interim.* In December 2011, in accordance with Chapter X, Section 70, of the *Bylaws*, regarding vacancies in the membership of any council, Dr. William Calnon, appointed Dr. Sally Hewitt as *ad interim* member to the Council on Communications to fulfill the unexpired term of Dr. Renee Watts. This appointment expires at the conclusion of the ADA House of Delegates in October 2014. Because Dr. Hewett will be completing more than 50% of Dr. Watts' term, she will not be eligible for reappointment to the Council in 2014.

*Howell, Ralph L., Jr., Virginia, 2016.* Dr. Ralph Howell has served in many leadership positions with the Virginia Dental Association including president, speaker of the House, and as a delegate to the American Dental Association. In addition, he has also been very active in his community serving in leadership positions with the Rotary Club of which he is a Paul Harris Fellow, Boy Scouts of America Colonial Virginia Council, the Virginia Missions of Mercy, as a leader in organizations, as well as, Virginia Commonwealth University School of Medicine and the Nansemond-Suffolk Academy. His positions have required that he be a spokesperson for the organizations that he has led. Dr. Howell will be a great addition to the Council on Communications.

*Manzanares, Robert J., New Mexico, 2016.* Dr. Robert Manzanares is a 1980 graduate of the University of Southern California School of Dentistry and has been a member of the ADA since 1981. He has served in various roles at the New Mexico Dental Association (NMDA).

1 *Paul, John H., Florida, 2016.* Dr. John Paul served as the editor for his component newsletter for three years  
2 and then served on the Florida Dental Association (FDA) Council on Communications for six years, chairing  
3 the council his final five years. Following that, Dr. Paul served as a trustee to the FDA for three years leaving  
4 to take the position of editor for the FDA this year. He has been a committed representative in leadership in  
5 the FDA for 18 years and has enjoyed ADA media relations training (twice). Dr. Paul was helpful in  
6 developing the FDA's public outreach campaign that included radio public service announcements, oral health  
7 brochures published in multiple languages, and the FDA public website SmileFlorida.org.

8 *Sahota, Ruchi K., California, 2016.* Dr. Ruchi Sahota would be an ideal candidate for the ADA Council on  
9 Communications because she has always believed in organized dentistry – it has always given her a voice.  
10 Her experience as chair of the ADA New Dentist Committee (2009-10) provides a great foundation for future  
11 service on an ADA council. Dr. Sahota's experience on the ADA Strategic Planning Committee (2009-10)  
12 gives her a clear vision of ADA priorities. Her experience as president of the Southern Alameda County  
13 Dental Society (2010) connected her to the local dues-paying member that wants to know how the ADA  
14 communicates the profession's values to the public. Her multiple experiences on CDA committees and  
15 workgroups will allow her to be a dependable Thirteenth District representative to the Council. The coalition  
16 for the Ad Council's oral health campaign for children, the new consumer website, and expansion of  
17 sharecare.com contributions are all projects that the Council is currently working on that Dr. Sahota is  
18 extremely interested in growing and developing. She is extremely passionate about investigating solutions for  
19 our nation's oral health literacy problem and looks forward to seeing the Council collaborate with other ADA  
20 entities to combat this ever-important issue. Dr. Sahota has an impressive resume of volunteer service within  
21 organized dentistry. She has been actively involved since her days in dental school, having served as editor-  
22 in-chief for American Student Dental Association (ASDA) publications and as a member of the ASDA Board of  
23 Trustees. She is currently the associate editor of the *Journal of the California Dental Association* and a  
24 consumer advisor/media spokesperson for the ADA. In 2009-10, she had the pleasure of serving as co-host  
25 of the ADA podcast, "Straight from the Mouth." Other volunteer experience includes service on the CDA  
26 Committee on the New Dentist (chair, 2008-09), delegate to both the CDA and ADA House of Delegates  
27 (2007-present), and member of the ADA Online Continuing Education and Life Long Learning Advisory  
28 Committee (2007-10). Dr. Sahota's experience at the local, state, and national level is extensive; the service  
29 listed above represents only a fraction of what she has contributed. She will truly be an asset to the ADA  
30 Council on Communications.

## 31 **DENTAL ACCREDITATION**

32  
33 *Surabian, Stanley R., California, 2013-2017.* Dr. Stanley Surabian has been actively involved [in general  
34 dentistry] since 1975 as a post-doctoral GPR program director and holds an adjunct faculty position at the  
35 University of the Pacific Arthur A. Dugoni School of Dentistry (UOPAADS) in the department of dental  
36 practice. This experience allows him to interact with new dental graduates as they enter and complete their  
37 residency program, granting him insight into this experience. Occasionally, dental student externs rotate to  
38 the Fresno GPR site and are supervised by adjunct UOPAADS faculty. Dr. Surabian is a Commission on  
39 Dental Accreditation Site Visit Consultant for Postdoctoral GPR and AEGD programs, and has developed a  
40 level of expertise in areas such as accreditation, dental licensure, the dental practice act, and ethics. The  
41 Community Regional Medical Center (CRMC) GPR Program he directs has not received a single CODA  
42 recommendation over a seventeen-year duration of accreditation cycles.

43 Throughout his career, Dr. Surabian has volunteered his time to serve in organized dentistry, during which he  
44 has grown his knowledge and experience base. He keeps abreast of current issues in dentistry and  
45 recognizes the particular impacts of the changing economics for students and residents. His service spans  
46 every level of organized dentistry from president of the Fresno-Madera Dental Society, at the local level, to  
47 being a California Dental Association Trustee; chair of the Council on Education and Professional Relations;  
48 and leading national level activities among numerous other positions. Dr. Surabian is also currently serving  
49 on the ethics and strategy committees of a non-profit hospital association as Community Medical Centers' full-  
50 time chief of dental services and GPR program director. In 2010, the new CRMC Dental Clinic was named  
51 the "Surabian Dental Center" in honor of Dr. and Mrs. Surabian for their support of continuing dental services

1 and postdoctoral education. Dr. Surabian has been active in the area of dental licensure as chair, from 2002  
2 to 2004, of the two California Dental Association task forces on licensure. Many of the task force  
3 recommendations were implemented legislatively. As chair, he headed and appointed a diverse group of  
4 participants to evaluate and recommend on licensure issues. These task forces included state dental board  
5 members and examiners, deans and faculty from dental schools, postdoctoral directors and faculty, ASDA  
6 representatives and recent graduates.

7 Dr. Surabian is a Diplomate of the American Board of Special Care Dentistry in Hospital Dentistry, and a  
8 Fellow of the American College of Dentists, American Association of Hospital Dentists, and the Academy of  
9 General Dentistry. He received his D.D.S. from the University of Southern California School of Dentistry and  
10 his JD from the San Joaquin College of Law in Fresno, California.

## 11 DENTAL BENEFIT PROGRAMS

12 *Brady, Thomas V., Connecticut, 2016.* Dr. Thomas Brady has maintained a general practice in Westbrook,  
13 Connecticut, since 1973. He holds membership in AGD, Pierre Fauchard Academy, American College of  
14 Dentists and International College of Dentists. He is a past president of the Connecticut Dental Association,  
15 and a past chair of the Council on Membership.

16 *Coggin, Celeste, Georgia, 2016.* Dr. Coggin has served as a replacement for an appointee for less than two  
17 years. She is an outstanding Council member.

18 *Eder, B. Scott, West Virginia, 2013, ad interim.* In October, 2011, in accordance with Chapter X, Section 70,  
19 of the *Bylaws*, regarding vacancies in the membership of any council, Dr. William Calnon, appointed Dr. Eder  
20 *ad interim* member to the Council on Dental Benefit Programs to fulfill the unexpired term of Dr. Richard  
21 Dycus. This appointment expires at the conclusion of the ADA House of Delegates in November 2013.  
22 Because Dr. Eder will be completing less than 50% of Dr. Dycus' term, he will be eligible for reappointment to  
23 the Council in 2013.

24 *Krantz, Daniel B., New Jersey, 2016.* Dr. Daniel Krantz has practiced general dentistry for close to 40 years;  
25 he also completed a residency in oral and maxillofacial surgery. Dr. Krantz is past president of Middlesex  
26 New Jersey Dental Society and the New Jersey Dental Association (NJDA). He has served as an alternate  
27 delegate and delegate to the ADA House of Delegates. Active in organized dentistry for years, Dr. Krantz has  
28 served on numerous councils and committees. He is a past member and chair of the NJDA's Council on  
29 Dental Benefits. Dr. Krantz has shown a keen interest and understanding of dental benefit plans having  
30 worked with the NJDA staff in the arena for many years. His knowledge and communication skills should be  
31 an asset to ADA's Council on Dental Benefit Plans.

32 *Larson, David R., Pennsylvania, 2016.* Dr. David Larson is an active member of organized dentistry and is  
33 currently a member of the Pennsylvania Dental Association Board of Trustees. He is thorough, prepared and  
34 can always be counted on.

35 *Pak, Sammy B., Washington, 2016.* Dr. Sammy Pak is a 1999 graduate of Loma Linda University School of  
36 Dentistry. He has served on the peer review committee for the Pierce County Dental Society (PCDS). He  
37 has chaired the legislative committee of the PCDS from 2003 to 2009, as well as chair, New Dentist  
38 Committee, PCDS, from 2004 to 2005, and served on the Dent-PAC for the Washington State Dental  
39 Association from 2003 to 2009. Dr. Pak has served on the PCDS Board of Directors from 2004 to the  
40 present.

41 *Riggins, Ronald D., Illinois, 2013, ad interim.* In October, 2011, in accordance with Chapter X, Section 70, of  
42 the *Bylaws*, regarding vacancies in the membership of any council, Dr. William Calnon, appointed Dr. Ronald  
43 Riggins as *ad interim* member to the Council on Dental Benefit Programs to fulfill the unexpired term of Dr.  
44 Thomas Machnowski. This appointment expires at the conclusion of the ADA House of Delegates in October

2013. Because Dr. Riggins will be completing less than 50% of Dr. Machnowski's term, he will be eligible for reappointment to the Council in 2013.

### DENTAL PRACTICE

*Bengtson, Gregory J., Idaho, 2016.* Dr. Gregory Bengtson recently served as the president of the Idaho State Dental Association (ISDA) for the 2011-12 term of office. Following graduation from the University of the Pacific, he completed a general practice residency. He has been in solo private practice for over 30 years in Lewiston, Idaho. Dr. Bengtson's practice emphasis has been adult restorative, prosthetic and implant dentistry. He has been a delegate from Idaho since 2006. He has served in the Board of the ISDA in different leadership roles since 2003. Dr. Bengtson is a Fellow in the Academy of General Dentistry, the Pierre Fauchard Academy, and the International Congress of Oral Implantologists. He is an Associate Fellow in the American College of Oral Implantology and the American Society of Osseointegration.

*Brown, Andrew, Florida, 2016.* Dr. Andrew Brown has been a practicing orthodontist in the Jacksonville, Florida, area since 1984. During this time, he has been active in both dental and orthodontic organizations including president of his affiliate. He has served in the House of Delegates for the Florida Dental Association (FDA) and is a current delegate to the ADA House of Delegates. He is a past member of the FDA CEBJA and a current member of the FDA GAC. He has been director of legislative PACs and is a current clinical association faculty member of the University of Florida Department of Orthodontics.

*Childs, Miranda, Arkansas, 2015, ad interim.* In January 2012, in accordance with Chapter X, Section 70, of the *Bylaws*, regarding vacancies in the membership of any council, Dr. William Calnon, appointed Dr. Miranda Childs as *ad interim* member to the Council on Dental Practice to fulfill the unexpired term of Dr. Robert Mason. This appointment expires at the conclusion of the ADA House of Delegates in October 2015. Because Dr. Childs will be completing more than 50% of Dr. Mason's term, she is not eligible for reappointment to the Council in 2015.

*Creasey, Jean L., California, 2016.* Dr. Jean Creasey cares deeply about the profession and considers it an honor to volunteer her time and passion to activities that support dentistry and the patients we serve. Dr. Creasey has been involved in organized dentistry leadership for over nine years, serving at all levels of the tripartite, and has become familiar with the issues and challenges facing dentistry. She is currently the chair of the California Dental Association's (CDA) Government Affairs Council, a member of the CalDPAC Executive Committee, a member of the CDA Foundation's Grant Selection Committee and a delegate to the ADA. Past service includes three years on CDA's Policy Development Council, member of an ADA House of Delegates reference committee, president of her local component dental society, and chair of her local political action committee. Outside the tripartite, Dr. Creasey serves on the Nevada County Dental Health Advisory Board, is a member of the UCSF Dental Alumni Association, and has worked as a volunteer community dental health educator. She also has experience lecturing on CAMBRA and other dental practice issues and has authored articles that have been published in distinguished scientific dental journals. As part of a small group practice, Dr. Creasey works with five RDA's, eight RDH's, two lab technicians, and two office administrators. In 27 years, the practice has grown from a two-person operation to its present success, and Dr. Creasey has, at times, served in all auxiliary roles. From these experiences, she developed a great appreciation for the power of the dental team. At a time when dentistry is faced with the challenge of expanding auxiliary duties, her previous background as an RDH gives her special insight into these issues. Committed to early prevention, Dr. Creasey worked with community stakeholders to start a non-profit children's dental clinic and was also a founder of a maternal dental health project for low income moms. These experiences have taught her the importance of building consensus between different agencies in working toward a common goal. Both projects have a focus on prevention and utilize CAMBRA as a disease management model. Through her service as a trustee on the Kellermann Foundation, which supports the Bwindi Community Hospital in Uganda, she has had the opportunity to lead volunteer medical/dental volunteer trips overseas to work with the Batwa pygmy community. She recently conducted her first-ever dental health survey specifically on the Batwa. She has also organized several community based fundraising

events, including a 5K run. As a firm believer in prevention through fitness and exercise, she sponsors and encourages her staff to join her in an annual women's triathlon.

*Marshall, Todd W., Minnesota, 2016.* Dr. Todd Marshall is a member of a large corporate group, not managed by outside group, but fully owned and managed by the doctor owners. Dr. Marshall is involved and will be a great addition to the Council.

*Smith, J. Christopher, West Virginia, 2016.* Dr. Christopher Smith has practiced in a private practice setting since 2001. He has been involved in organized dentistry since entering practice. He has served admirably in multiple positions including president of his society, ADA delegate for four years, has served on the ADA New Dentist Committee, and is a Fellow in the International College of Dentists. Dr. Smith will bring a newer practitioners perspective to the Council.

## EDUCATION AND LICENSURE

*Brysh, L. Stanely, Wisconsin, 2016.* Dr. Stanley Brysh is a 1975 graduate of University of Pittsburgh School of Dental Medicine. In 1976, he completed a one year general practice residency program at Highland View Hospital in Cleveland, Ohio. After that, there was no stopping his passion to teach young dentists. He is a Fellow of the American Association of Hospital Dentists and Diplomat of the American Board of Special Care Dentistry. At the beginning of his career, Dr. Brysh was in a full-time private practice and served as associate staff clinical instructor in community dentistry; assistant clinical professor in community dentistry; general practice residency coordinator, Department of Dentistry Externship Director, Ohio State University; and clinical assistant professor, Section of Primary Care, Ohio State University. In 2000, Dr. Brysh was appointed the director, General Practice Residency, Max W. Pohle Dental Clinic, Meriter Hospital, Inc., Madison, Wisconsin; clinical assistant professor, Department of Surgery, Division of Plastic and Reconstructive Surgery, University of Wisconsin School of Medicine and Public Health; and adjunct assistant professor, Department of Dental Ecology, University of North Carolina School of Dentistry Chapel Hill, NC. In addition, he currently chairs the Department of Dentistry Meriter Hospital Medical Staff. He supervises general practice residents 50% of the time, and treats his own patients in a hospital setting 50% of the time. During his career, Dr. Brysh has served on the Council on Dental Education for the Greater Cleveland Dental Society, and Council on Dental Education and Licensure for the Ohio Dental Association. He served on the ADA Advisory Committee for Planning a Guide on How to Develop an Accredited General Practice Residency and/or Advanced Education in General Dentistry Program, Postdoctoral General Dentistry Review Committee, ADA Commission on Dental Accreditation and ADA Commission on Dental Accreditation, consultant/site visitor. He is a member of the board of directors, Special Care Dentistry Association, American Dental Education Association and Southeast Region Residency Directors Association. Dr. Brysh will be a valuable asset and bring an interesting perspective to the Council.

*Holm, Steven J., Indiana, 2016.* Dr. Steven Holm received his D.D.S. from Loyal University School of Dentistry in 1976. He has practiced general dentistry in Portage, Indiana, since that time. He has served as president of the Northwest Indiana Dental Society. At the Indiana Dental Association (IDA), he has served on the Council on Annual Sessions; Dental Education, which he chaired; and the Committee on Continued Competency. He is currently speaker of the IDA House. At the American Dental Association, Dr. Holm has been a delegate, has served on a reference committee, and has previously served on the Council on Access, Prevention and Interprofessional Relations. Since 1977, he has served as a part-time instructor for the dental hygiene program at Indiana University Northwest, where he has received numerous teaching awards.

*Rhea, Ronald L., Texas, 2013, ad interim.* In October, 2011, in accordance with Chapter X, Section 70, of the Bylaws, regarding vacancies in the membership of any council, Dr. William Calnon, appointed Dr. Ronald Rhea as *ad interim* member to the Council on Dental Education and Licensure to fulfill the unexpired term of Dr. Hilton Israelson. If elected by the House of Delegates, this appointment expires at the conclusion of the ADA House of Delegates in November 2013.

**ETHICS, BYLAWS AND JUDICIAL AFFAIRS**

*Auld, Douglas A., Oklahoma, 2016.* Dr. Douglas Auld has served, with distinction, in many areas for the Oklahoma Dental Association (ODA). He has served as president, 2011-12; the Board of Trustees; as chair of the ODA Constitution and Bylaws Committee; as chair of the 2012 Oklahoma Mission of Mercy Project; and the ADA Workforce Summit. He has served on the Oklahoma Board of Dentistry and is an examiner for the Western Regional Exam Board. He is a Fellow of the American College of Dentists, the International College of Dentists, and the Pierre Fauchard Academy. Dr. Auld is an excellent example of what every dentist should aspire to become. He will make an excellent addition to CEBJA.

*Muller, George J., II, South Dakota, 2016.* Dr. George Muller has been in charge of a re-write of the South Dakota Dental Associations bylaws and has served on the ethics council for American Association of Oral and Maxillofacial Surgeons.

*Scarborough, A. Roddy, Mississippi, 2016.* Dr. Roddy Scarborough is a 1989 graduate of the University of Mississippi School of Dentistry.

*Raimann, Thomas E., Wisconsin, 2016.* Dr. Thomas Raimann is a 1980 graduate of Marquette University School of Dentistry and practices dentistry in Hales Corners, Wisconsin. In 2007, he was installed into the American College of Dentists and is now chair of the Wisconsin section. As chair he is dedicated to informing our member dentists and maintaining high ethical standards for our profession. Dr. Raimann has also served many years on the bylaws committee in Wisconsin charged with the task of keeping them up to date in an ever changing world. In addition, he was the spokesperson for the Ninth District's Legal Legislative and Bylaws reference committee. In 2011, he chaired the Credentials, Rules and Order Committee at the ADA House of Delegates. Dr. Raimann has spent his career serving the underserved and helping those in need through a variety of dental programs. He is a man who cares for people in need and the ethical standards of the profession. He will make an excellent addition to the Council.

*Walton, William M., Texas, 2016.* Dr. William Walton has served on the Texas Dental Association Council on Ethics and Judicial Affairs and is well versed in Parliamentary Affairs, the ethics of the ADA and tripartite system, and is knowledgeable about the ADA *Constitution and Bylaws*. He is motivated to assume this position and will be active on the Council.

**GOVERNMENT AFFAIRS**

*Harrington, John F., Jr., Georgia, 2016.* Dr. John Harrington graduated from Emory University School of Dentistry in 1984. From 1984 to 1987 he served in the United States Air Force completing a general practice residency in 1985. Dr. Harrington has maintained a private practice in general dentistry since 1987 in Milledgeville, Georgia. His experiences include being a member of the Georgia Dental Association (GDA) Governmental Affairs Committee (2003-), GADPAC Board (2003-) and Legislative Strategy Committee (2008-). He has participated in numerous GDA Law Day programs (Legislative Awareness) as well as being a participant in the ADA's Washington Leadership Conference. Dr. Harrington has been an alternate delegate to the ADA House of Delegates since 2008, and served as a Reference Committee (Legal, Legislative and Public Affairs) member in 2011. Currently, he serves as the immediate past president of the GDA.

*Huot, Richard A., Florida, 2016.* Dr. Richard Huot has represented the 17<sup>th</sup> ADA District for ADPAC completing this position in 2012. He has been involved in organized dentistry in Florida as a delegate to the Florida Dental Association House of Delegates and served as the president of his component. Dr. Huot is in his twelfth year as a delegate to the ADA House of Delegates and is currently Delegation Whip of the 17<sup>th</sup> District Caucus and has served as chair of the ADA House of Delegates Legal, Legislative and Public Affairs Reference Committee.

1 *Howell, J. Barry, Illinois, 2016.* Dr. Barry Howell has considerable experience on a whole host of dental  
2 related areas, but probably his strongest competency lies in the governmental and regulatory arena. His  
3 involvement on the state level has been extensive and intense, not to mention that he has served as an action  
4 team leader for his congressional district. At this time, Dr. Howell is the Illinois State Dental Society  
5 President-elect and is exceedingly in his element and masterfully comfortable in all aspect of the leadership  
6 responsibilities that are inherent and necessary for this crucial assignment. Dr. Howell has served proficiently  
7 on many state society committees and continues to serve as a delegate from the Eighth District to the ADA  
8 House of Delegates, as he has done for several years. Dr. Howell is very active in his community in various  
9 capacities and is also an active member and leader in the State of Illinois Medical Emergency Response  
10 Team (IMERT). His preparedness for terrorism and natural disaster circumstances was very beneficial during  
11 the 9-11 tragedy. Dr. Howell has been actively involved in organized dentistry and a staunch dental advocate  
12 even while in dental school and indeed he served in an exemplary manner as a student trustee for ASDA.  
13 In short, Dr. J. Barry Howell has all the necessary knowledge and skills to serve as an exceptional member-  
14 dentist with the Council on Government Affairs.

15 *Silvius, Charles L., Massachusetts, 2016.* Dr. Charles Silvius has served as a constituent officer for seven  
16 years, most recently as president of the Massachusetts Dental Society. During that time he has testified  
17 before both houses of the Massachusetts legislature and has attended Beacon Hill Day since its inception  
18 where he met with state senators and representatives from his voting district. Dr. Silvius has been contact  
19 person for the immediate past Massachusetts Senate President and is currently a contact person for the  
20 Massachusetts Speaker of the House. He has been a member of MDSPAC for over 20 years and a Capitol  
21 Club member of ADPAC for ten years and Capitol Elite for two years. He has been a member of the First  
22 District Caucus Legal and Legislative Committee for ten years.

23 *Straub, Barrett, Wisconsin, 2016.* Dr. Barrett Straub is a 2004 graduate of Marquette University School of  
24 Dentistry and practices general dentistry in Port Washington, Wisconsin. He is a young enthusiastic dentist  
25 with a keen eye for political scene. Dr. Barrett currently serves on the Washington Dental Association (WDA)  
26 Board of Trustees and has served the association in many other ways, but his true talent lies in the political  
27 arena. In 2001, he was ASDA Midwest Regional Legislative Coordinator; 2002-2004, ASDA National  
28 Consultant on Legislation; 2001-2003, attended National Dental Student Lobby Day in Washington, DC, and  
29 in 2004, organized that same event. He served as student representative to the ADA Council on Government  
30 Affairs and received the WDA 2001 Pyramid of Pride Award for Political Action. Dr. Straub presently serves  
31 on the WDA's Legislative Advocacy Committee and was WIDPAC chair from 2006 to 2009. Dr. Straub will be  
32 an excellent addition to the Council.

### 33 MEMBERSHIP

34 *Bradley, Steven P., Iowa, 2016.* Dr. Steven Bradley is a former Iowa Dental Association president and is very  
35 involved in organized dentistry. He is also a current member of the Iowa Dental Board.

36 *Durbin, Michael G., Illinois, 2013, ad interim.* In October, 2011, in accordance with Chapter X, Section 70, of  
37 the *Bylaws*, regarding vacancies in the membership of any council, Dr. William Calnon, appointed Dr. Michael  
38 Durbin as *ad interim* member to the Council on Membership to fulfill the unexpired term of Dr. Kenneth  
39 Yonan. This appointment expires at the conclusion of the ADA House of Delegates in November 2013.  
40 Because Dr. Durbin will be completing less than 50% of Dr. Yonan's term, he will be eligible in 2013 for  
41 reappointment to a full four-year term.  
42

43 *Ingram, William L., Alabama, 2016.* Dr. William Ingram has served his state dental association in many  
44 capacities very capably. Also, his work within the AGD brings experience in the area of membership. Dr.  
45 Ingram is committed to the ADA.

46 *Pohl, Gregory J., Kentucky, 2016.* Dr. Gregory Pohl has served as a leader in his local dental society. In his  
47 present term as president of the Northern Kentucky Dental Society he has brought a new vitality, which has  
48 seen increased member participation. He has been an ambassador enlisting new members, both locally and

regionally, and has demonstrated his leadership as a mentor by encouraging other dentists to be active in organized dentistry. Dr. Pohl has expressed a strong desire to have a larger role in the Association and is open to promoting and educating fellow dentists on the benefits and value of membership. His experience, background and knowledge of diverse practice models, including larger group practices, will make him a valuable asset to both the Council and the Association.

*Stachewicz Johnson, Nicole, Pennsylvania, 2016.* Dr. Nicole Stachewicz Johnson attended Allegheny College where she received her undergraduate degree for her work in chemistry. After which, she continued her education at Case Western Reserve University's School of Dental Medicine, where she received an award for clinical excellence. She has been a member of the tripartite since graduation and became active in her local society. Dr. Stachewicz Johnson is currently the secretary/treasurer of the Erie County Dental Association and will be the vice president next year. She was also the Membership Committee's vice chair and was elected to the chair position. She is looking forward to her position with the American Dental Association's Council on Membership.

*Wilson, K. Drew, New Hampshire, 2016.* Dr. Drew Wilson is a past president of the New Hampshire Dental Society (NHDS) and is a past chair of the NHDS Communications Committee. He is a Master of the Academy of General Dentistry. Dr. Wilson is a graduate of the University of Louisville School of Dentistry and maintains a private practice in Milford, New Hampshire.

#### **MEMBERS INSURANCE AND RETIREMENT PROGRAMS**

*Barnashuk, Frank C., New York, 2016.* Dr. Frank Barnashuk is dependable, a quick learner, knowledgeable, a good communicator, and a team player. He will excel on this Council.

*Grogan, Patrick M., Washington, D.C., 2016.* Dr. Patrick Grogan is a past president of the District of Columbia Dental Association. He has been actively involved in organized dentistry for many years. Dr. Grogan is a delegate to the ADA House of Delegates. He was chair of the committee that evaluated the insurance and retirement plans for the D.C. dental staff. He has excellent communication skills and leadership abilities.

*Houten, David, Washington, 2016.* Dr. David Houten served as president of the Washington Dental Association (WSDA) from 2008 to 2009. He has served in numerous leadership roles for the WSDA Board of Directors since 2002. He has represented WSDA as a delegate or alternate delegates to the ADA House of Delegates since 1999. He has held leadership positions with the Dent-PAC within Washington related to dental legislative concerns. Dr. Houten is a dental Medicaid consultant for the state of Washington. He is a Fellow of the Pierre Fauchard Academy, American College of Dentists, and the International College of Dentists, currently serving as the Deputy Regent, Washington Section of the ICD. In private practice since 1986, Dr. Houten has also served as a board examiner for the Western Regional Examining Board.

*Miller, Paul R., Florida, 2016.* Dr. Paul Miller has been active in organized dentistry at all levels of the ADA tripartite including past president and treasurer of the West Coast District Dental Association and past chair of the Florida Council on Financial Affairs. Presently, Dr. Miller is treasurer of the Florida Dental Association and chair of the Florida Financial Audit Committee. He has been a long term member of the ADA House of Delegates.

*Rubino, Louis F., Jr., Pennsylvania, 2016.* Dr. Louis is a past president of the Pennsylvania Dental Association Insurance Services Board of Directors and has board experience on many levels.

#### **NEW DENTIST COMMITTEE**

*Childs, Eric T., Michigan, 2016.* Dr. Eric Childs is a 2007 graduate of the University of Detroit Mercy School of Dentistry and practices general dentistry in Battle Creek, Michigan. Dr. Childs is an enthusiastic young dentist who has accomplished more in his five years as a dentist than most do in a lifetime. In addition to his

1 numerous awards, honors, teaching and mission work, he finds time to serve on committees on the local and  
2 state levels. Dr. Childs serves as a Southwest District Dental Association Delegates (2009-present),  
3 Michigan Dental Association (MDA) Committee on Membership, Recruitment and Retention (2011-present)  
4 and the MDA Special Committee on the New Dentist (2005-2011) to name a few. He will be a welcome  
5 addition to this Committee.

6 *Dasher, Rachel T., Tennessee, 2016.* Dr. Rachel Dasher practices in a Federally Qualified Health Center and  
7 is active in organized dentistry through her participation and positions in the Tennessee Dental Association  
8 (TDA). This participation in dentistry began with her ASDA affiliation in dental school. She has been active in  
9 the TDA where she provided leadership as both a member and chair of the state new dentist committee. Dr.  
10 Dasher brings to the Committee a knowledge of different practice models, and understanding of the issues  
11 surrounding student debt, community involvement and an understanding of what needs and concerns the  
12 ADA membership should address for the new practitioner. Dr. Dasher has received awards from both the  
13 state and the ADA for her volunteer work and has been extremely active in promoting oral health in her  
14 volunteer work throughout her carrier. She will be an outstanding addition the Committee.

15 *Hasty, Chris M., Georgia, 2016.* Dr. Chris Hasty recognized the importance of organized dentistry early in his  
16 dental education and was actively involved in the American Student Dental Association (ASDA) at the Medical  
17 College of Georgia. Upon graduation, he joined the ADA and the Georgia Dental Association (GDA). After  
18 three years in private practice, he accepted the position of second vice president of the Southwester District  
19 of the GDA. Over the next four years, he worked his way through the chairs of the district, serving on the  
20 Recruitment and Retention Committee for the GDA and the board of trustees. When asked by the GDA, he  
21 was very willing to serve his state and profession. He was selected to serve on the Strategic Planning Task  
22 of the GDA helping to write the strategic plan. He regularly attends his districts LAW Day, only missing one in  
23 seven years. In addition, Dr. Hasty has attended the past two Washington Leadership Conferences in which  
24 he served as an action team leader both years. Dr. Hasty is a current ADA Delegate.

25 *Janik, Andrea K., Texas, 2016.* Dr. Andrea Janik is an active member of the American Dental Association.  
26 She graduated Baylor College of Dentistry in 2008 and is eligible to serve on the New Dentist Committee. Dr.  
27 Janik has never served on any ADA committee or council. She is a member of the Texas Dental Association  
28 New Dentist Committee and currently serves as its chair. This gives her the experience needed to serve on  
29 the ADA New Dentist Committee. Dr. Janik has been very active in organized dentistry at both the  
30 component and state levels. She is fully committed to serving the ADA and will carry out her responsibility to  
31 the best of her abilities.

32 *Ritchie, Ryan L., Minnesota, 2016.* Dr. Ryan Ritchie is a recent ASDA national officer and is currently in  
33 charge of new dentist activity in Minnesota.

#### 34 **SCIENTIFIC AFFAIRS**

35 *Abt, Elliot, Illinois, 2016.* Dr. Elliot Abt's unique qualifications and his remarkable talents have been  
36 recognized by certain individuals at the American Dental Association for a while now and he has been asked  
37 to meaningfully participate in select exercises. Dr. Abt definitely appears to have had noteworthy credentials  
38 from the very beginning of his professional career. Following the completion of his Doctorate of Dental  
39 Surgery degree, he entered a general practice residency program for one year. In addition to his extensive  
40 private practice experience, Dr. Abt has weighty involvement in some other extraordinary activities of  
41 considerable importance. Some of his impressive appointments/commitments include being a member of the  
42 attending medical staff at Illinois Masonic Medical Center, an adjunct associate professor of oral medicine at  
43 the University of Illinois in Chicago, a member of the faculty in biostatistics at the ADA/Forsyth Institute for the  
44 course on evidence-based dentistry, and a member of the Editorial Review Board for the Journal of Evidence-  
45 Based Dental Practice, to name a few.

46 The incredible account of Dr. Abt's service to the profession does not end with the above mentioned items of  
47 masterful involvement. His litany of publications (abstracts, journal articles, educational videos and book

chapters) are nothing short of exemplary evidence of an astonishingly gifted and selfless gentleman who is thoroughly emerged and dedicated to sound-science, the dental profession and to the healing arts, all in the line of service and the advancement of human-kind. Dr. Abt also has the distinction to be one of the members of the special committee recently selected by the ADA Council on Scientific Affairs to thoroughly review workforce models in response to mandate outlined in the 2011 House of Delegates Resolution 41H.

*Hale, Robert G., Army, 2016.* Dr. Robert G. Hale is an Active Duty Colonel, US Army Dental Corps, currently Commander of the US Army Dental and Trauma Research Detachment and Craniomaxillofacial Consultant to the US Army Institute of Surgical Research and the Armed Forces Institute of Regenerative Medicine. Dr. Hale received his Doctor of Dental Surgery degree and postdoctoral certificate in Oral and Maxillofacial Surgery in 1981 and 1989, respectively, at Emory University, Atlanta, Georgia. After specialty training Dr. Hale practiced in Northridge, California from 1989 to 2004 and taught at UCLA School of Dentistry's Department of Oral and Maxillofacial Surgery as lecturer one day a week. Dr. Hale served in the US Army Active Duty from 1981 to 1985 and US Army Reserves from 1985 to 1996 and 2003 to 2005 until returning to Active Duty in 2005 to current date. He is currently Professor of Oral and Maxillofacial Surgery, Postgraduate School of Dentistry, Uniformed Services University of Health Sciences, Bethesda, Maryland.

Dr. (Colonel) Hale commands and defines the mission of an Army Medical Research Lab, comprised of 20 officers, clinicians and scientists and 20 technicians, science budget of over \$6 million/year, and dedicated to mitigation of dental infectious disease, optimization of care for craniomaxillofacial battle injuries and restoration of craniomaxillofacial defects through regenerative and allotransplantation technologies. Current investigations include basic studies on biofilm-impaired wound healing and adipose stem cell influence on cutaneous wounds, translational studies of bone regeneration and facial skin regeneration, and clinical trials on "scarless healing" devices, "spray-on skin" technologies, remodeling scars with adipose tissue transfer and anti-plaque chewing gum. Dr. Hale's researchers collaborate with over 10 other institutions, worldwide. Dr. Hale is also the Army Surgeon General's Consultant for Dental and Craniofacial Research, to include face transplantation. He has contributed over 20 articles and 2 chapters to the professional literature and has been an invited speaker to over 150 academic venues.

Dr. Hale was Chief and Program Director of Oral and Maxillofacial Surgery Postgraduate Training Program, Brooke Army Medical Center, 2007 to 2009. Since 2009, he has graduated 7 OMS residents from 3 month clinical research fellowships from his research institute.

Dr. Hale is a committed member and supporter of organized dentistry with multiple memberships and fellowships: Member American Dental Association, Honorary Member California Dental Association, and Fellow of the American Association of Oral and Maxillofacial Surgeons, American College of Oral and Maxillofacial Surgeons, American Board of Oral and Maxillofacial Surgeons, International College of Dentists and Pierre Fauchard Academy. He was 2004 President of the San Fernando Valley Dental Society, a 1,300 member component of the California Dental Association. He is a regular reviewer for Journal of Oral and Maxillofacial Surgery, Craniomaxillofacial Trauma and Reconstruction, Military Medicine and Journal of Trauma.

Dr. Hale has served on Department of Defense programmatic review committees for Clinical Medicine and Rehabilitation and he has been nominated DOD representative to the National Institute of Dental and Craniofacial Research, pending approval by U.S. Health and Human Services, Madame Secretary Kathleen Sebelius.

Dr. (Colonel) Hale is aware of the responsibilities, obligations and time commitments to the American Dental Association Council for Scientific Affairs and he is dedicated to serve a four year term as member of the Council.

*Ludlow, John B., North Carolina, 2016.* Based on Dr. Ludlow's extensive background in oral radiology, as well as, his current interest in cone beam technology, he would be a perfect fit for the needs of the Council on Scientific Affairs.

1 *Young, Douglas A., California, 2016.* Dr. Douglas Young is a distinguished member of the dental profession.  
2 He is an internationally renowned researcher and educator. Dr. Young practiced general dentistry  
3 successfully for 15 years before realizing that his restorative efforts were doing nothing to treat the disease of  
4 dental caries. Rather than focus on the surgical removal of caries, he refocused his efforts on the prevention  
5 and management of dental disease. For the past 16 years, he has devoted himself to the science of risk-  
6 based caries management (or CAMBRA for caries management by risk assessment). His journey began by  
7 re-educating himself in the fields of cariology, education, leadership and business which provided him with the  
8 tools to help implement new science in the way the dental profession manages this disease. Dr. Young and  
9 Dr. John Featherstone formed the Western CAMBRA Coalition, an inter-organizational collaborative  
10 consisting of educators, researchers, practicing clinicians, third party payers, governmental assistance  
11 agencies, licensure boards, and other interested parties. This led to similar collaborative efforts across the  
12 country. Dr. Young and other leaders decided to form a new cariology special interest group within ADEA to  
13 address caries management curricula. He chaired this group until it received full section status within ADEA.  
14 Since that time, they have collaborated on a total of six CDA Journals and one textbook dedicated to this  
15 topic, and are currently working on the fluoride chapter for the ADA/PDR Dental Therapeutics. This  
16 collaborative has led to both the CDA and ADEA forming policy statements to support CAMBRA. CAMBRA is  
17 now recognized internationally. He has demonstrated a broad range of knowledge and collaboration working  
18 closely with dental schools across the globe, and cariology groups such as AADR, IADR, and of course  
19 ORCA. He has participated in research studies in this emerging science and in addition to publishing a  
20 number of articles in professional journals on this subject, his passion is also evidenced by the significant  
21 number of presentations (over 250) he has made, both nationally and internationally, on subjects related to  
22 CAMBRA and cariology.

23 Dr. Young has the full support of Dr. Brian Novy and Dr. Peter Jacobsen. He has worked closely with Dr.  
24 Brian Novy over the last 6 years, (a current member of the Council on Scientific Affairs) and with Dr. Peter  
25 Jacobsen (a past member of the Council on Scientific Affairs) for over 16 years. Dr. Jacobsen was his first  
26 chair when he began teaching, and they have collaborated on many projects over the years and continue to  
27 do so. Dr. Art Dugoni and Dr. John Featherstone have been two of his mentors over the past 17 years and  
28 can attest to his excellent work. Dr. Young's passion for science and its clinical application to improve oral  
29 health and overall health has filled him with the desire to serve on a national level on the CSA. He has an  
30 open mind and works by collaboration and obtaining consensus.

**ADDENDUM TO REPORT 1 OF THE BOARD OF TRUSTEES TO THE HOUSE OF DELEGATES:  
ASSOCIATION AFFAIRS AND RESOLUTIONS**

**Additional Nominations to ADA Councils and Commission:** Following the distribution and posting to the House of Delegates of the nominees to ADA councils and commissions, the American Hospital Association and American Medical Association submitted their nominations to the Council on Access, Prevention and Interprofessional Relations. In addition, Dr. Charles Silvius, nominee to the Council on Government Affairs was unable to accept the appointment and was replaced by Dr. Raymond Martin, Massachusetts. Statements of qualifications follow:

**Access, Prevention and Interprofessional Relations**

*Pankratz, Todd, Nebraska, American Medical Association (2013).* Dr. Pankratz is a partner with OB/GYN Associates in Hastings, Nebraska. He is a graduate of Hastings College, the University of Nebraska-College of Medicine, and completed his residency at Truman and St. Lukes's Hospitals in Kansas City, Missouri, where he served as chief resident.

Dr. Pankratz has served in numerous leadership roles in the medical community. Within the Nebraska Medical Association his leadership positions include serving as a trustee, president of the Greater NE Caucus, the legislative committee, the maternal child health committee, and the Medicaid committee. He was also a director with the Nebraska Medical Insurance Services. Dr. Pankratz has been also been active within the Mary Lanning Memorial Hospital medical staff including chairing the credentials committee, chairing OB/pediatrics committee, and the executive committee. He is a member of the American College of Obstetricians and Gynecologists and serves as a Nebraska state officer. He has also been a delegate for the Young Physician's Society of the AMA. Dr. Pankratz has been recognized with numerous honors with the most prestigious one being the AMA's Foundation Leadership Award. Dr. Pankratz resides in Hastings, Nebraska with his wife, Jessica Meeske, a pediatric dentist and their two children.

*Lang, Melanie, Washington, American Hospital Association (2013).* Dr. Lang completed her undergraduate training at Union College in Lincoln, Nebraska. After graduating with High Distinction with her Doctor of Dental Surgery in 1991 from the University of Nebraska, Dr. Lang completed a one-year General Practice Residency in Hospital Dentistry at the University of Washington and affiliated hospitals in Seattle, Washington. In 1992, she returned to the University of Nebraska where she completed a one-year Oral & Maxillofacial Surgery Clinical and Research Fellowship. In 1993 Dr. Lang began a six-year dual degree Oral & Maxillofacial Surgery Residency program at the University of Florida in Gainesville which she completed in 1999. She graduated with honors with her Doctor of Medicine from the University of Florida in 1996. Dr. Lang has a special interest in Facial Cosmetic Surgery and pursued subspecialty training in Maxillofacial Cosmetic Surgery at the University of Alabama in Birmingham which she completed in 2000. Dr. Lang has enjoyed practicing in Spokane since she joined Spokane Oral & Maxillofacial Surgery in July of 2000. Dr. Lang works at both the Spokane Valley Ambulatory Surgical Center and Spokane Oral & Maxillofacial Surgery satellite office on the South Hill. Both facilities are accredited by AAAHC and JCAHO. Dr. Lang is also on staff at all the major Spokane hospitals and medical centers and is a Board Certified Surgeon and Diplomate of the American Board of Oral & Maxillofacial Surgery. Currently, Dr. Lang is President of the Washington State Society of Oral & Maxillofacial Surgeons and serves on the Executive Council for the Spokane District Dental Society. She is also a member of several local Dental, Hospital and Medical committees. In addition, Dr. Lang is a member of several professional organizations including: American Association of Oral & Maxillofacial Surgeons, American College of Oral & Maxillofacial Surgeons, American Academy of Cosmetic Surgeons, American Academy of Facial Plastic Surgeons, American Dental Society of Anesthesiologists, American Medical Association, American Dental Association, Washington State Society of Oral & Maxillofacial Surgeons, Spokane County Medical Society, Spokane County Dental Society, American College of Oral Implantologists and International Congress of Oral Implantologists. Dr. Lang has volunteered her time on several occasions to provide surgical care in South America with a non-profit organization, Hearts in Motion. In addition, she has also traveled on a surgical mission to Bosnia with a non-profit group, Care for Children.

**1 Government Affairs**

*Martin, Raymond K., Massachusetts (2016).* Dr. Raymond Martin is a 1983 graduate of the University of Texas Health Science Center at San Antonio and currently maintains a general practice in Mansfield, Massachusetts. Dr. Martin became active in local politics in Mansfield to achieve fluoridation of the town's water supply. He was successful in becoming chairman of the Mansfield Board of Health and then working with the Commonwealth of Massachusetts to implement and pay for fluoridation in the town of Mansfield. In addition, Dr. Martin has taken part in many aspects of the state association's government affairs and grassroots advocacy program. A contributor to the MDS-PAC since 2006, Dr. Martin has also been a member of the Governor's Club, the highest donor club in Massachusetts, for the past five years. He serves as the primary contact for both his state representative and state senator, and has hosted meet and greet events in his office for local dentists to discuss legislative concerns with their elected officials. Dr. Martin is also a regular attendee at Beacon Hill Day, taking his advocacy from the district to the state house, where he also mentors dental students attending the lobby day for the first time. Dr. Martin is a Master in the Academy of General Dentistry and currently serves as a Trustee of the AGD as well as a Trustee of the Massachusetts Dental Society.

**16 Responses to Resolutions from the 2011 House of Delegates**

*23H-2011. Amendment of the ADA Bylaws Regarding Revision of Disciplinary Sentences.* In response to the changes to the *Bylaws* regarding the privileges of active, life or retired members who are under a disciplinary sentence of suspension or probation, the letter and form requesting certification of delegates and alternates were revised to reflect that active, life and retired members under a disciplinary sentence of suspension or probation are not privileged to hold office, either elective, or appointive, including delegates and alternates delegates in such a member's component and constituent societies and this Association.

Furthermore, the process for nominations to councils and commissions was revised to include confirmation that the nominee is in good standing with their state dental association. For a candidate for elective office, the individual's state dental association is contacted to confirm that the candidate is a member in good standing.

*42H-2011. Appointment of Chair of the Board of Trustees' Audit Committee.* In this resolution, the House urged the Board to modify its *Rules* to allow the members of the Audit Committee to elect its own chair from among all voting members of the Committee. At its March 2012 session, the Board of Trustees adopted Resolution B-11-2012, which changed the process for identifying the chair of the Audit Committee. The 2012-13 Audit Committee will elect its own chair.

*43H-2011. Appointment of House Members to Board Standing Committees.* This resolution urged the Board to continue to appoint up to eight members representing the House to serve on the following Board committees: two House members on the Audit Committee; two House members on the Budget and Finance Committee (and therefore the Administrative Review Committee of the Board); two House members on the Pension Committee; and two members on the Strategic Planning Committee.

The Board *Rules* have been amended to reflect that these standing committees include two members from the House of Delegates, with terms appointed annually for up to four years. It should be noted that the Board dissolved the Strategic Planning Committee as previously constituted and assumed the role for monitoring the strategic plan directly. The Board will seek input by outside stakeholders, and in particular from representatives of the House of Delegates, in the development of a new strategic plan beginning in 2013 (Resolution B-32-2012).

*44H-2011. Response to Resolution 124-2010.* This resolution called for all councils to receive annual training on their fiduciary responsibilities to the Association; the development by the appropriate agency of a universal set of assessment criteria for ranking programs as part of the budget process; and appropriate agency review of all resolutions having cost implications for the Association that are

submitted prior to the first mailing of resolutions to the delegates with a written report provided to the House that includes the council or Board's recommendation and assessment in light of the universal set of assessment criteria.

This year, all council members were asked to participate in a comprehensive orientation through review of various modules of information, including one on fiduciary duties. In addition, as called for in the resolution, the Board developed a set of Universal Assessment Criteria last December and asked each council that was meeting between then and the time of Administrative Review of the budget to formally utilize the criteria in evaluating its programs. In the next budget cycle, every council will be asked to do so. Finally, no resolutions having cost implications were submitted prior to the first mailing of worksheets to the House.

*71H-2011. Constituent Nominations of New Dentist Delegates.* The House encouraged each state dental association to bring at least one new dentist as a delegate or alternate delegate to the annual ADA House of Delegates and report to each House their respective new dentist delegates or alternates. Through the annual process of certifying delegates and alternates, the official certification form was modified to allow the certifying body to identify new dentist members serving as delegates and alternates. This information will be reported annually to the House through the *Manual of the House of Delegates and Supplemental Information*. On the listing of Delegates and Alternates, which appears in the *House Manual*, new dentists are identified by an asterisk. For 2012, new dentists are those who received a D.D.S. or D.M.D. degree in 2003 or later.

*76-2011. ADA Alternative Proposal to the Midlevel Provider Pilot Project.* Resolution 76-2011 was referred to the appropriate agencies by the House of Delegates. This resolution urged:

- the ADA 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.
- that the funding be made in the form of grants to up to 32 state dental society foundations that will oversee the operation of the pilot in their states
- that the pilot project shall come from the ADA Foundation or any other foundation that wishes to help the underserved and poor in this country who cannot afford dental work, and not be in the form of a dues increase
- that the ADA Foundation assess the results of these pilot projects for amount of production produced at the end of three years as to its impact as one possible solution for the care for underserved patients as well as the number of dentists it has helped who are not fully employed, and report to the 2014 House of Delegates.

The ADA Executive Director Kathleen O'Loughlin shared the resolution with the ADA Foundation President David Whiston, and requested that it be brought to the attention of the Foundation Board. In response, Dr. Whiston, on behalf of the ADA Foundation, stated that the ADAF Board considered this resolution, discussed it in great detail, and concluded that having the ADAF conduct the type of funding and programmatic activities identified in the resolution was not "mission-appropriate" or optimal.

The intent of the resolution can be met through participation in federal or state loan repayment programs (<http://nhsc.hrsa.gov/loanrepayment/index.html>), through the National Health Service corps or associated state health department programs. Greater contracting of health centers with private dentists can also increase the capacity to deliver oral health services to underserved populations, while providing additional practice income to dentists.

**Improving Wi-Fi Performance for the 2012 House of Delegates:** Wi-Fi communication has become a widely used technology over the past 10 years. Many of us have set up Wi-Fi in our homes. Configuring Wi-Fi for 50 users in a room is relatively easy. However, configuring Wi-Fi for 1000 or more densely packed users in a room is significantly more complex. Instead of having one or two Wi-Fi access points, a Wi-Fi infrastructure is needed. The infrastructure must be adjusted specifically for the room and the number of expected users. It must be properly configured so that the access points work together and do not inadvertently interfere with each other. In addition, it is important that users do not bring their own Wi-Fi access points into the facility, as these can interfere with the facility's Wi-Fi infrastructure.

During the 2011 House of Delegates session, the only significant reported problems with Wi-Fi occurred in the HOD meeting at the MGM Grand Conference Center. Most users at the 2011 HOD had problems using the facility provided Wi-Fi. The facility provided Wi-Fi used in other areas of the MGM Grand for Caucus meetings and other functions worked well. ADA IT staff who were on-site and working with the MGM staff determined that the problems in the HOD were due to several factors such as incorrectly configured Wi-Fi infrastructure, a lack of redundancy in that Wi-Fi infrastructure, and a lack of technical knowledge by MGM staff that were responsible for the Wi-Fi infrastructure. The MGM Grand had enough backend internet bandwidth to support the users, but because the Wi-Fi users in the HOD meeting couldn't reliably connect to the Wi-Fi infrastructure they couldn't access that bandwidth.

To ensure reliable Wi-Fi performance for the 2012 House of Delegates session, ADA IT has been working with the Moscone Center (HOD) and the Marriott Marquis (HQ) facilities to make them aware of the Wi-Fi problems we have experienced previously. The ADA has asked for and checked references for meetings that have been supported by these facilities that are of the same size and density as the ADA House of Delegates session. The Moscone Center upgraded their Wi-Fi infrastructure in May 2012 and it has not yet been used for a meeting as large as the ADA HOD session. However, we continue to work with Moscone Center to ensure that their infrastructure will be ready for ADA use. The Moscone Center Wi-Fi infrastructure will undergo a stress test as a part of the commissioning of this new system. The ADA has asked to examine the Wi-Fi commissioning report which should be ready in September 2012. Additionally, the ADA has required that the Moscone Center have their Wi-Fi infrastructure manufacturer's technicians onsite to work with the Moscone Center engineers during the HOD meeting. ADA IT has investigated the Moscone Center's infrastructure redundancy and recovery plans. ADA IT has made the Moscone Center engineers aware that Freeman AV will be using compatible wireless technology in the same room. ADA IT also provide more specific instructions to HOD attendees about personally-provided Wi-Fi functionality. As contracts for these sessions are negotiated years in advance for future HOD meetings ADA IT staff will work with ADA CMS staff to implement Service Level Agreements (SLAs) with the host facility for Wi-Fi functionality.

Communications to the HOD attendees have been drafted and are to be released in the weeks before the HOD session. In a communication entitled, "Power Internet and Tech Support in the House and Caucus Meetings", HOD attendees will learn where they can access power and internet connectivity during their meetings. A section has been added that explains that personally provided Wi-Fi service should not be used in the HOD. The text of that section is as follows:

In Moscone West, only facility provided Wi-Fi is authorized. Personally provided Wi-Fi service interferes with the facility provided Wi-Fi. Attendees must turn off all Wi-Fi personal hotspot functionality on all cellular devices. For example, these must be turned off: iPhone Personal Hotspot function, Verizon Mi-Fi, Verizon Jetpack, AT&T Mobile Hotspot. If you are unsure if your cellular device has personal hotspot functionality enabled, ADA technicians are available on-site to show you how to turn this functionality off and back on. Moscone West uses "rogue access point suppression" to discourage use of unauthorized Wi-Fi services. This may negatively affect the performance of any device that does have personal hotspot functionality enabled. Attendees may use direct cellular connectivity to access the internet if they wish (i.e., PC with cellular data card, iPad with cellular data plan), but we recommend that you use the facility Wi-Fi service instead.

Resolution No. 84 New

Report Board Report 1 Date Submitted: July 2012

Submitted By: Board of Trustees

Reference Committee: N/A

Total Net Financial Implication: None Net Dues Impact: \_\_\_\_\_

Amount One-time \_\_\_\_\_ Amount On-going \_\_\_\_\_ FTE 0

ADA Strategic Plan Goal: \_\_\_\_\_ (Required)

## NOMINATIONS TO ADA COUNCILS AND COMMISSIONS

**Background:** (See page 1006 for qualification of nominees)

### ACCESS, PREVENTION AND INTERPROFESSIONAL RELATIONS

Yasmi O. Crystal, New Jersey  
G. Lewis Mitchell, Jr., Alabama  
Mary Ellen Wynn, Ohio  
Cheryl D. Watson-Lowry, Illinois  
Matthew B. Roberts, Texas  
Cesar R. Sabates, Florida  
Melanie Lang, (AHA), Washington  
Todd Pankratz, (AMA), Nebraska

### ADA SESSIONS

Sidney R. Tourial, Georgia  
Grace A. Curcuro, Michigan  
James H. Van Sicklen Jr., California  
Calbert M. Lum, Hawaii  
T. Harold Lancaster, North Carolina

### COMMUNICATIONS

Sally Hewett, Washington  
Ruchi K. Sahota, California  
Robert J. Manzanares, New Mexico  
Joshua A. Austin, Texas  
Ralph L. Howell, Jr., Virginia  
John H. Paul, Florida

### DENTAL ACCREDITATION

\*Stanley R. Surabian, California

### DENTAL BENEFIT PROGRAMS

Thomas V. Brady, Connecticut  
David R. Larson, Pennsylvania  
Daniel B. Krantz, New Jersey  
Celeste Coggin, Georgia  
B. Scott Eder, West Virginia  
Ronald D. Riggins, Illinois  
Sammy B. Pak, Washington

### DENTAL EDUCATION AND LICENSURE

Steven J. Holm, Indiana  
Stanley L. Brysh, Wisconsin  
Ronald L. Rhea, Texas

### DENTAL PRACTICE

Miranda Childs, Arkansas  
J. Christopher Smith, West Virginia  
Todd W. Marshall, Minnesota  
Gregory J. Bengtson, Idaho  
Jean L. Creasey, California  
Andrew Brown, Florida

### ETHICS, BYLAWS AND JUDICIAL AFFAIRS

A. Roddy Scarbrough, Mississippi  
Thomas E. Raimann, Wisconsin  
George J. Muller, II, South Dakota  
Douglas A. Auld, Oklahoma  
William M. Walton, Texas

**GOVERNMENT AFFAIRS**

**Raymond Martin, Massachusetts**

John F. Harrington, Jr., Georgia  
J. Barry Howell, Illinois  
Barrett Straub, Wisconsin  
Richard A. Huot, Florida

**MEMBERSHIP**

K. Drew Wilson, New Hampshire  
Nicole Stachewicz Johnson, Pennsylvania  
William L. Ingram, Alabama  
Gregory J. Pohl, Kentucky  
Michael G. Durbin, Illinois  
Steven P. Bradley, Iowa

**MEMBERS INSURANCE AND RETIREMENT PROGRAMS**

Frank C. Barnashuk, New York  
Louis F. Rubino, Jr., Pennsylvania  
Patrick M. Grogan, Washington, D.C.  
David Houten, Washington  
Paul R. Miller, Florida

**NEW DENTIST**

Chris M. Hasty, Georgia  
Rachel T. Dasher, Tennessee  
Eric T. Childs, Michigan  
Ryan L. Ritchie, Minnesota  
Andrea K. Janik, Texas

**SCIENTIFIC AFFAIRS**

Elliot Abt, Illinois  
Robert G. Hale, Army  
John Barrett Ludlow, North Carolina  
Douglas A. Young

1  
2 \*In response to Resolution 76H-2010, CODA requested that, beginning in 2012, new Commissioner appointees be  
3 identified one year in advance of their term of service to participate in CODA activities.

4 **Resolution**

5 **84. Resolved**, that the nominees for membership on ADA councils, commissions and the New  
6 Dentist Committee submitted by the Board of Trustees in accordance with Chapter VII, Section  
7 100(H) of the *Bylaws* be elected.

**BOARD RECOMMENDATION: Vote Yes.**

**BOARD VOTE: UNANIMOUS.**

Resolution No. 85-87 NewReport: Credentials Rules and Order Date Submitted: July 2012Submitted By: Standing Committee on Credentials, Rules and OrderReference Committee: N/ATotal Net Financial Implication: None Net Dues Impact: Amount One-time  Amount On-going  FTE 0ADA Strategic Plan Goal:  (Required)**REPORT OF THE STANDING COMMITTEE ON CREDENTIALS, RULES AND ORDER**

**Background:** The Standing Committee on Credentials, Rules and Order of the House of Delegates is charged by the ADA *Bylaws*, Chapter V, HOUSE OF DELEGATES, Section 140Bb, with the following duties:

b. DUTIES. It shall be the duty of the Committee (1) to record and report the roll call of the House of Delegates at each meeting; (2) to conduct a hearing on any contest regarding the certification of a delegate or alternate delegate and to report its recommendations to the House of Delegates; (3) to prepare a report, in consultation with the Speaker and Secretary of the House of Delegates, on matters relating to the order of business and special rules of order; (4) to consider all matters referred to it and report its recommendations to the House of Delegates.

In accordance with its duties, the Committee submits the following report.

**Minutes of 2011 Session of the House of Delegates:** The minutes of the 2011 session of the House of Delegates have been posted (*Trans.*2011:427-558) on ADA.org at [https://www.ada.org/members/sections/about/2011\\_Minutes\\_of\\_the\\_House\\_of\\_Delegates.pdf](https://www.ada.org/members/sections/about/2011_Minutes_of_the_House_of_Delegates.pdf).

Questions or corrections regarding the minutes may be forwarded to Michelle Kruse, manager, House of Delegates at [krusem@ada.org](mailto:krusem@ada.org). The Committee presents the following resolution for House action.

**85. Resolved**, that the minutes of the 2011 session of the House of Delegates, as published in *Transactions, 2011* (pages 427-558), be approved.

**Adoption of Agenda and Order of Agenda Items:** The Committee has examined the agenda for the meetings of the House of Delegates. Accordingly, the Committee recommends adopting the agenda as the official order of business for this session. The Committee also recommends that the Speaker of the House be allowed to rearrange the order of the agenda as deemed necessary to expedite the business of the House.

**86. Resolved**, that the agenda as printed in the *2012 Manual of the House of Delegates and Supplemental Information* be adopted as the official order of business for this session, and be it further

**Resolved**, that with the consent of the House of Delegates, the Speaker is authorized to alter the order of the agenda as deemed necessary in order to expedite the business of the House.

**Referrals of Reports and Resolutions:** A standing rule of the House of Delegates directs that prior to each session of the House, the Speaker shall prepare a list of recommended referrals to reference committees with the list to be available at the opening meeting of the House and be subject to amendment or approval on vote of the House of Delegates.

This preliminary list of referrals (circulated in the form of the Updated General Index to the resolution worksheets) will be provided with the second distribution of resolution worksheets in early October. The

1 Speaker will announce additional referrals during the first meeting of the House of Delegates. A complete list  
2 of referrals, in the form of an agenda, will be available in the reference committee hearing rooms on Saturday  
3 morning, October 20.

4 **87. Resolved**, that the preliminary and supplemental list of referrals submitted by the Speaker of the  
5 House of Delegates be approved.

6 ***The American Institute of Parliamentarians Standard Code of Parliamentary Procedure.*** In 2011, the  
7 House of Delegates adopted Resolution 56H-2011 (*Trans.*2011:541) that identifies the current edition of the  
8 *American Institute of Parliamentarians (AIP) Standard Code of Parliamentary Procedure* as the document that  
9 governs the deliberations of the House of Delegates in all cases in which they are applicable and not in  
10 conflict with the standing rules or the *ADA Bylaws*. The current edition of the *AIP Standard Code* was  
11 released in May 2012. Upon review of both the *Standard Code* and the "Rules of the House of Delegates,"  
12 the Speaker identified areas of the "Rules" that require updating to reflect the current edition of the *AIP*  
13 *Standard Code*.

14 The Committee on Credentials, Rules and Order reviewed changes to the House "Rules" suggested by the  
15 Speaker. The Committee believes that the changes are editorial in nature and ensure that the House "Rules"  
16 reflect the terminology used in the *AIP Standard Code*. For the benefit of the House, these editorial changes  
17 are noted below:

- 18 • References to the motion "adopt in lieu" have been added to the list of main motions and wherever  
19 discussion of main motions appears.
- 20 • In the section "Action on Motions Recommended by Reference Committee," the second paragraph,  
21 which follows, was deleted since this reference is outdated. This paragraph stated:

22 The third edition of the *Standard Code* eliminated the motion to postpone indefinitely because  
23 the revisers felt that it is confusing and prolongs debate unnecessarily. A motion is defeated  
24 by simply voting against the motion to adopt. Therefore, on a motion to adopt, the reference  
25 committee chair will offer the committee's recommendation to vote for or against the motion.

- 26 • The section entitled "Motion to Postpone Temporarily (Table)" has been editorially amended to  
27 remove references to postpone temporarily, since the *AIP Standard Code* uses the term "table." The  
28 amended rule reads:

29 **~~Motion to Postpone Temporarily (Table)~~**

30 A motion to ~~postpone temporarily~~ (table) shall not be used in the House of Delegates since it  
31 stops debate and could force the delegates to vote without full information.

32 The changes are reflected in the *2012 Manual of the House of Delegates and Supplemental Information*.

33 **Annual Reports and Resolutions, Manual of the House of Delegates and Resolution Worksheets:** The  
34 publication, *Annual Reports and Resolutions 2012* was posted in early-July on ADA.org and ADA Connect  
35 and can be accessed through the following link: <http://www.ada.org/2012annualreports.aspx>.

36 In addition, the first set of resolution worksheets will be posted on ADA Connect by end of day, Friday, August  
37 3; posted on ADA.org the following week and mailed to the members of the House of Delegates who had  
38 requested paper copies beginning August 8.

39 The second set of resolution worksheets will become available shortly after the Board of Trustees' September  
40 22-24 session. The second set of resolution worksheets will be posted on ADA Connect by end of day,  
41 Friday, September 28 and mailed by Wednesday, October 3. A limited quantity of the printed first and second  
42 sets of resolution worksheets will be available in the House of Delegates Information and Resources Office,  
43 located in the Juniper Room, located in the Golden Gate Hall (B2 Level) of the Marriott Marquis San  
44 Francisco. Appropriate announcements were included in the cover letter transmitting the worksheets.

The *Manual of the House of Delegates and Supplemental Information* has been developed to complement the resolution worksheets. This booklet incorporates the "Rules of the House of Delegates" and all pertinent meeting information (*i.e.*, House agendas, members of the Standing and Reference Committees, reference committee hearing schedule, and schedule of district caucuses). This booklet was posted on ADA Connect and ADA.org, and mailed with the first set of resolution worksheets.

*Supplement to Annual Reports and Resolutions* is prepared primarily for historical purposes only since it reprints in resolution worksheet form all the reports and resolutions presented to the House of Delegates. This publication will be available online in the first quarters of 2013.

**Hearings of Reference Committees:** The reference committees of the House of Delegates will hold hearings on Saturday, October 20, in various rooms of the Yerba Buena Ballroom located on Lower B2 Level of the Marriott Marquis San Francisco. The list of reference committee hearing rooms appears in the *Manual of the House of Delegates and Supplemental Information*.

### **Saturday, October 20**

7:30 a.m. to 9:30 a.m.	Governance
9:00 a.m. to 11:00 a.m.	Dental Benefits, Practice and Health
10:00 a.m. to Noon	Dental Education, Science and Related Matters
11:00 a.m. to 1:00 p.m.	Budget, Business and Administrative Matters
Noon to 2:00 p.m.	Legal, Legislative and Public Affairs Matters
Noon to 2:00 p.m.	Membership and Related Matters

Hearings will continue beyond the scheduled hours if everyone has not had an opportunity to be heard or if the complete agenda has not been covered.

In accordance with the *Manual of the House of Delegates*, section "General Procedures for Reference Committees," any member of the Association, whether or not a member of the House of Delegates is privileged to attend and participate in the discussion during the reference committee hearings. Guests of the Association are also welcome to attend reference committee hearings provided they identify themselves to the committee. Nonmembers of the Association may participate at hearings only on the invitation of a majority of the reference committee. At reference committees, everyone (individuals/members) will be obligated to disclose any personal or business relationship that they or their immediate family may have with a company or individual doing business with the ADA, when such company is being discussed, prior to speaking on an issue related to such a conflict of interest.

Association staff is available at hearings to provide information requested by members of reference committees or through the Chair by those participating in the discussion.

**Reports of Reference Committees:** Completed reference committee reports will be made available to the chair of record of each delegation on Sunday morning, October 21. A sufficient number of copies of each report will be provided for each delegation's delegates, alternate delegates, secretary, executive director, trustee and editor. Reference committee reports will be posted on ADA Connect and will be available early morning on October 21. A limited number of CDs containing the reference committee reports will also be provided to each district caucus.

Delegates must bring their copies of reference committee reports to the meetings of the House of Delegates since additional printed copies will be limited.

An all-inclusive consent calendar will be used by the reference committees. Each reference committee will submit an all-inclusive consent calendar in addition to its regular report. The consent calendar will contain

every resolution referred to the committee and will reflect the committee's recommendation to adopt, adopt in lieu of, not adopt or refer on each resolution. By adopting the consent calendar resolution, the recommendations of the reference committee will become the actions of the House of Delegates. As customary, before voting on the consent calendar, any delegate has the right to request that a resolution or resolutions be moved for discussion and vote.

**Nominations of Officers:** The nominations of officers (president-elect, second vice president, speaker of the House of Delegates and treasurer) will take place at the first meeting of the House on Friday afternoon, October 19. Candidates for elective office will be nominated from the floor of the House by a simple declaratory statement, which may be followed by an acceptance speech not to exceed four minutes by the candidate. Seconding nominations is not permitted.

No additional nominations will be accepted after the Friday afternoon meeting.

**Nomination of Trustees:** Nominations of members of the Board of Trustees from Districts 6, 7, 10, 16 and 17 will take place at the first meeting of the House. Prior to such nominations, the delegates from each of the districts concerned must caucus for the purpose of determining their nominee or nominees in accordance with the provisions of Chapter VII, Section 40, of the *Bylaws*. A list of caucus meetings appears in the *Manual of the House of Delegates and Supplemental Information*. This listing constitutes official notice of caucus.

The results of the caucus must be reported to the Secretary of the House of Delegates no later than the opening of the meeting on Friday. In the event of a contested trustee election, candidates for the office of trustee shall be nominated from the floor of the House of Delegates by a simple declaratory statement, which may be followed by an acceptance speech not to exceed four minutes for the candidate from the podium. Seconding nominations is not permitted.

**Nominations to Councils and Commissions:** The Board of Trustees presents the list of its nominations to councils and commissions in Report 1, which appears on the appropriate resolution worksheet. Additional nominations of council and commission members may be made from the floor of the House of Delegates only during the Friday afternoon meeting.

**Voting Procedures in the House:** The method of voting in the House of Delegates is usually determined by the Speaker who may call for a voice vote, show of hands (voting cards), standing vote, roll call of the delegations, electronic voting or such other means that the Speaker deems appropriate. The House may also, by majority vote, determine for itself the method of voting that it prefers.

Only votes cast by voting members of the House of Delegates either for or against a pending motion shall be counted. Abstentions shall only be counted in determining if a quorum is present. If the result of a vote is uncertain or if a division is called for, the Speaker may use the electronic voting method or may call for a standing vote. If a standing vote, the count will be made by tellers appointed by the Speaker and reported to the Secretary of the House.

In accordance with the ADA *Bylaws* and the House *Manual* proxy voting is explicitly prohibited in the House of Delegates. However, an alternate delegate may vote when substituted for a voting member in accordance with procedures established by the Committee on Credentials, Rules and Order.

**Election Procedures:** Voting for the offices of president-elect, second vice president, speaker of the House of Delegates and treasurer will be conducted in a separate room located in the vicinity of the House of Delegates (Room 3014, Moscone West, Level 3), from 6:30 a.m. to 8:00 a.m. on Monday, October 22. Members should bring their number 6 meeting card and vote early in order to avoid a delay at the voting machines.

In the event a second balloting is necessary, the number 6 meeting card will be reused. The second balloting will be conducted on Monday, October 22, at a time announced by the Speaker.

The Standing Committee on Credentials, Rules and Order oversees the confirmation and reporting of election results. The Committee will verify the number of votes received by each candidate prior to the election results being placed in a sealed envelope and transmitted to the Secretary of the House. The Secretary will review and forward the results to the Speaker for announcement. CRO members present during the review of election results will remain in the voting area until the House is informed of the election results. If there are any delays in reporting election results, the Committee chair will immediately notify the Secretary of the delay.

**Standing Order of Business—Installation of New Officers and Trustees:** The installation ceremony for new officers and trustees will take place on Tuesday, October 23, as the first item of business with the time to be specified by the Speaker of the House of Delegates.

**Introduction of New Business:** The Committee calls attention to the *Bylaws*, Chapter V, Section 130(Ae) which provides that no new business shall be introduced into the House of Delegates less than 15 days prior to the opening of the annual session, unless submitted by a Trustee District. No new business shall be introduced into the House of Delegates at the last meeting of a session except when such new business is submitted by a Trustee District and is permitted to be introduced by a two-thirds (2/3) affirmative vote of the delegates present and voting. The motion introducing such new business shall not be debatable. Approval of such new business shall require a majority vote except new business introduced at the last meeting of a session that would require a bylaw amendment cannot be adopted at such last meeting. Reference Committee recommendations shall not be deemed new business.

**Resolutions of Reaffirmation/Commendation:** The Committee calls attention to the House rule governing resolutions of reaffirmation or commendation, which states that “Resolutions which (1) merely reaffirm or restate existing Association policy, (2) commend or congratulate an individual or organization, or (3) memorialize an individual shall not be introduced to the House of Delegates” (*Trans.* 1977:958).

**Explanation of Resolution Numbering System:** Original resolutions are numbered consecutively regardless of whether the source is a council, other Association agency, constituent society, delegate, Board of Trustees or House reference committee. Revisions made by the Board, reference committee or House are considered “amendments” to the original resolution. If amended by the Board, the suffix “B” follows the original resolution number (Res. 24B); if amended by a reference committee, the suffix “RC” follows (Res. 24RC).

If a resolution is adopted by the House, the suffix “H” follows the resolution number (Res. 24H). The “H” always indicates that the resolution was adopted.

If a resolution is not adopted or it is referred by the House of Delegates, the resolution number remains the same. For example:

Res. 78B is considered by the House and not adopted, the number remains the same: Res. 78B.

Res. 7RC is considered by the House and referred for study, the number remains the same: Res. 7RC.

If a Board (B) or reference committee (RC) resolution is a substitute for several original resolutions, the Board’s recommended substitute or the reference committee’s recommended substitute uses the number of the first resolution submitted and adds the proper suffix (B or RC). The report will clearly state that the other resolution or resolutions have been considered and are included in the “B” or “RC” resolution. A resolution submitted by an agency other than the Board or a reference committee as a substitute or amendment retains the original resolution number followed by the suffix “S-1” (Res 24S-1). If two substitute resolutions are submitted for the same original resolution, the suffixes are “S-1” and “S-2” (Res. 24S-1, Res. 24S-2).

*Note.* If a substitute resolution is received too late to be introduced to the House of Delegates through a reference committee report, the originator of the substitute resolution is responsible for calling it to the Speaker’s attention when the original resolution is being discussed by the House of Delegates.

**Recognition of Those Waiting to Speak:** When a member wishes to address the House, the individual should approach the microphone, secure the attention of the Speaker through the attendant at the microphone and wait to speak until recognized by the Speaker. The member should then state his or her name, district and state for the benefit of the official reporter and state the purpose of their comments (e.g., speaking for or against a motion, presenting a new motion, etc.). If all members of the House follow this procedure, work will be expedited and all who wish to be heard will be given an opportunity.

When an electronic vote is taken, the Speaker will allow sufficient time for members at the microphone to return to their places before taking the vote. In the event debate continues on the same issue, the Speaker will honor the microphone sequence prior to taking the electronic vote. Therefore, a member who was at the microphone and did not have an opportunity to speak before that vote was called and who wishes to continue debate on the same issue should return to the microphone where he or she was prior to the electronic vote.

**Access to Floor of House:** Access to the floor of the House of Delegates is limited to the officers and members of the House of Delegates, the elective and appointive officers of the Association, the former presidents, the members of the Board of Trustees, the chairs of councils and commissions, the members of councils and commissions when requested by the chair, the secretaries and executive directors of constituent societies, the executive director and president of the American Student Dental Association, an officially designated representative from each of the American Hospital Association and the American Medical Association, and members of the Headquarters Office staff.

Admission to the floor will not be granted without the display of the appropriate annual session badge. Every delegate must also hand the appropriately numbered card to the attendant at the door for each meeting so that the official attendance record may be maintained. Former officers and former trustees will also be admitted to the section reserved for alternate delegates and upon request will receive all worksheet materials distributed to delegates and alternate delegates.

**Secretaries and Executive Directors of Constituent Societies:** In accordance with the standing rule of the House, "The secretary and executive director of a constituent society may be seated with the constituent society delegates on the floor of the House of Delegates even though they are not official delegates." Under the standing rules, it is not permissible to designate an "acting" secretary or executive director of a constituent society so that he or she may be seated on the floor of the House, unless that person is designated as "acting" secretary or executive director for the remaining portion of the annual session.

**Substitution of Alternate Delegates for Delegates:** Delegates wishing to substitute alternate delegates from their delegation for themselves during a meeting of the House of Delegates must complete the appropriate delegate-alternate substitution form. Delegates are required to sign the form and surrender their admission cards for the meeting or meetings not attended before admission cards will be issued to alternate delegates by the Committee on Credentials, Rules and Order. Substitution of alternate delegates may be made during all four meetings of the House of Delegates. In order for a complete and accurate attendance record for all meetings of the 2012 House of Delegates, submission of these completed substitution forms is essential.

**Closed Session:** A closed session is any meeting or portion of a meeting of the House of Delegates with limited attendance in order to consider a highly confidential matter. A closed session may be held if agreed upon by general consent of the House or by a majority of the delegates present at the meeting in which the closed session would take place. In a closed session, attendance is limited to officers of the House, delegates and alternates, and the elective and appointive officers, trustees and general counsel of the Association. In consultation with the Secretary of the House, the Speaker may invite other persons with an interest in the subject matter to remain during the closed session. In addition to senior staff, this is likely to include members and staff of the council(s) or commission(s) involved with the matter under discussion and executive directors of constituent societies and the American Student Dental Association. No official action may be taken nor business conducted during a closed session.

1 Immediately after a closed session, the Speaker will inform delegates that they may present a motion to  
2 request permission to review information which was discussed in the closed session, with the information  
3 being discussed only with members present at the session. This provision is not applicable to an attorney-  
4 client session.

5 *Attorney-Client Session.* An attorney-client session is a form of closed session during which an attorney  
6 acting in a professional capacity provides legal advice, or a request is made of the attorney for legal advice.  
7 During these sessions, the legal advice given by the attorney may be discussed at length, and such  
8 discussion is "privileged." The requests, advice, and any discussion of them are protected, which means that  
9 opponents in litigation, media representatives, or others cannot legally compel their disclosure. The purpose  
10 of the privilege is to encourage free and frank discussions between an attorney and those seeking or  
11 receiving legal advice. The privilege can be lost (waived) if details about the attorney-client session are  
12 revealed to third parties. Once the privilege has been waived, there is a danger that all privileged  
13 communications on the issues covered in the attorney-client session, regardless of when or where they took  
14 place, may become subject to disclosure. For attorney-client sessions, the Speaker and Secretary shall  
15 consult with the General Counsel regarding attendance during the session. No official action may be taken  
16 nor business conducted during an attorney-client session.

17 In accordance with the above information, all those participating in an attorney-client session shall refrain from  
18 disclosing information about the discussion held during the attorney-client session. In certain cases, a  
19 decision may be made to come out of the attorney-client session for purposes of conducting a non-privileged  
20 discussion of the same or related subject matter. The difference will be that during the non-privileged session  
21 there will be no discussion of any legal advice requested by attendees during the attorney-client session or  
22 about any of the legal advice given by the legal counsel. It is such requests for legal advice, legal advice  
23 given, and discussion of the legal advice during the attorney-client session that are protected by the privilege  
24 and that shall not be disclosed or discussed outside of the attorney-client session.

25 **Manual of the House of Delegates:** Each member of the House of Delegates has received a copy of the  
26 *2012 Manual of the House of Delegates* either in paper format with the worksheet mailing or online through  
27 ADA Connect. The *Manual* contains the standing rules of the House of Delegates and the pertinent  
28 provisions of the *Bylaws*.

29 Members of the House should familiarize themselves with the rules and procedures set forth in the *Manual* so  
30 that work may proceed as rapidly as possible.

31 **Distribution of Materials in the House of Delegates:** The Committee calls attention to the procedures to  
32 be followed for distributing materials in the House of Delegates: (1) no material may be distributed in the  
33 House without obtaining permission from the Secretary of the House; (2) material to be distributed must relate  
34 to subjects and activities that are proposed for House action or information; and (3) material to be distributed  
35 on behalf of any member's candidacy for office shall be limited to printed matter on paper only and nothing  
36 else.

37 **Media Representatives at Meetings of the House of Delegates:** On occasion, representatives of the press  
38 and other communications media may be in the visitors' section of the House and in reference committee  
39 hearings.

40 **House of Delegates Information and Resource Office:** An Information and Resource Office will be open  
41 Thursday, October 18 through Sunday, October 21, and will be located in the Juniper Room of the Marriott  
42 Marquis San Francisco (Golden Gate Hall B2 Level). This office will be open to delegates, alternates,  
43 constituent society officers and staff. The office will be equipped with computers, a copier, resource materials  
44 for researching issues, the first and second set of resolution worksheets and printed Reference Committee  
45 reports; and general information about the meetings of the House of Delegates and related activities.  
46 Everyone is urged to use the Information and Resource Office when drafting resolutions or testimony.  
47 Individuals having resolutions for submission to the House of Delegates will be directed to the Headquarters  
48 Office where final resolution processing will occur.

- 1 **Recycling Opportunities:** Recycling containers will be located in the House of Delegates and in the vicinity  
2 of other "paper heavy" meeting rooms (reference committee hearings, caucus meetings and the ADA offices).  
3 The Committee encourages the use of these containers for recyclable materials.

4 **Resolutions**

- 5 Resolution 85 (Worksheet:1029)  
6 Resolution 86 (Worksheet:1030)  
7 Resolution 87 (Worksheet:1031)

Resolution No. 85 New  
Report: Credentials Rules and Order Date Submitted: July 2012  
Submitted By: Standing Committee on Credentials, Rules and Order  
Reference Committee: N/A  
Total Net Financial Implication: None Net Dues Impact: \_\_\_\_\_  
Amount One-time \_\_\_\_\_ Amount On-going \_\_\_\_\_ FTE 0  
ADA Strategic Plan Goal: \_\_\_\_\_ (Required)

**MINUTES OF THE 2011 SESSION OF THE HOUSE OF DELEGATES**

**Background:** The minutes of the 2011 session of the House of Delegates have been posted  
(*Trans.*2011:427-558) on ADA.org at  
[https://www.ada.org/members/sections/about/2011\\_Minutes\\_of\\_the\\_House\\_of\\_Delegates.pdf](https://www.ada.org/members/sections/about/2011_Minutes_of_the_House_of_Delegates.pdf).

Questions or corrections regarding the minutes may be forwarded to Michelle Kruse, manager, House of Delegates at [krusem@ada.org](mailto:krusem@ada.org). The Committee presents the following resolution for House action.

**Resolution**

**85. Resolved**, that the minutes of the 2011 session of the House of Delegates, as published in *Transactions, 2011* (pages 427-558), be approved.

Resolution No. 86 NewReport: Credentials Rules and Order Date Submitted: July 2012Submitted By: Standing Committee on Credentials, Rules and OrderReference Committee: N/ATotal Net Financial Implication: None Net Dues Impact: Amount One-time  Amount On-going  FTE ADA Strategic Plan Goal:  (Required)

1 **ADOPTION OF AGENDA AND ORDER OF AGENDA ITEMS**

2 **Background:** The Committee has examined the agenda for the meetings of the House of Delegates.  
3 Accordingly, the Committee recommends adopting the agenda as the official order of business for this  
4 session. The Committee also recommends that the Speaker of the House be allowed to rearrange the order  
5 of the agenda as deemed necessary to expedite the business of the House.

6 **Resolution**

7 **86. Resolved,** that the agenda as printed in the *2012 Manual of the House of Delegates and*  
8 *Supplemental Information* be adopted as the official order of business for this session, and be it further

9 **Resolved,** that with the consent of the House of Delegates, the Speaker is authorized to alter the order of  
10 the agenda as deemed necessary in order to expedite the business of the House.

Resolution No. 87 New

Report: Credentials Rules and Order Date Submitted: July 2012

Submitted By: Standing Committee on Credentials, Rules and Order

Reference Committee: N/A

Total Net Financial Implication: None Net Dues Impact: 0

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

ADA Strategic Plan Goal: (Required)

## REFERRALS OF REPORTS AND RESOLUTIONS

**Background:** A standing rule of the House of Delegates directs that prior to each session of the House, the Speaker shall prepare a list of recommended referrals to reference committees with the list to be available at the opening meeting of the House and be subject to amendment or approval on vote of the House of Delegates.

This preliminary list of referrals (circulated in the form of the Updated General Index to the resolution worksheets) will be provided with the second distribution of resolution worksheets in early October. The Speaker will announce additional referrals during the first meeting of the House of Delegates. A complete list of referrals, in the form of an agenda, will be available in the reference committee hearing rooms on Saturday morning, October 20.

## Resolution

**87. Resolved**, that the preliminary and supplemental list of referrals submitted by the Speaker of the House of Delegates be approved.

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## Budget, Business and Administrative Matters

\*Resolution No. 57-58 NewReport: Board Report 2 Date Submitted: July 2012Submitted By: Board of TrusteesReference Committee: Budget, Business and Administrative MattersTotal Net Financial Implication: See Resolutions 57-58 Net Dues Impact: Amount One-time  Amount On-going  FTE ADA Strategic Plan Goal: Financial (Required)**REPORT 2 OF THE BOARD OF TRUSTEES TO THE HOUSE OF DELEGATES: 2013 BUDGET****Introduction:** All dollar figures are in thousands with unfavorable variances presented in parentheses.

In accordance with its *Bylaws* duties, the Board of Trustees presents the proposed 2013 operating budget for the Association. This report also provides the House of Delegates with background commentary and an analysis of significant budget changes for 2013. The Board is recommending a 2013 operating budget of \$ 117,272 in revenues and \$116,225 in expenses, income taxes, and capital expenditures net of depreciation generating a net operating cash flow surplus of \$1,047. Pretax operating income, including income from short term financial investments and depreciation, is a deficit of \$ (1,155). In arriving at this proposal, the Board of Trustees and the Administrative Review Committee analyzed budget requests relative to the Association's strategic priorities. Resources were reallocated between programs and divisions in an effort to maximize their effective use in executing the ADA's Strategic Plan for 2011-2014.

The Board of Trustees also approved a resolution recommending a \$30 dues increase which will add \$2,940 in dues revenue to the 2013 budget. If the House of Delegates approves the recommended dues increase, the ADA budget operating cash flow surplus would increase from \$ 1,047 to \$ 3,987. After careful review and consideration, the Board recommended this action to generate an additional surplus to fund reserves as part of a multi-year plan to get reserves to the 50% target level as directed by the House.

**Overview of Budget Improvements**

This report reflects the culmination of many efforts to create a more effective ADA budget process based on suggestions by various volunteer workgroups and best current business practice. In 2011, the Special Committee on Financial Affairs introduced several important concepts that became the catalyst for many changes. This included a discussion of the role of Councils of the House which are uniquely positioned to aid the House in fulfillment of its fiduciary responsibilities and the need to compare all programs within the Association against a universal set of criteria. Councils are also the Association's best informed in their particular areas of bylaws authority. Thus, their input into the relative value of programs and alignment with the strategic plan are especially valuable. As a result, this year's budget process included dedicated time for Council chairs and ADA staff to discuss their prioritization of programs with the Administrative Review Committee.

A budget process improvement workgroup of the Budget and Finance Committee provided oversight to the budget process changes and specifically addressed those that were implemented for the 2013 budget with a particular focus on long term financial stability and sustainability.

While Board Report 2 in prior years focused on reporting organizational units in detail, another goal was to raise the level of review and discussion at this stage in the budget process to address Programs and "what value is being delivered to our members and the public." The Board recognizes that it and the House can

1 relate programs to the strategic goals in a way simply not possible for line-item details presented in past  
2 years.

3 In this new budget process, the ADA Council Chairs, as representatives of the House, received more  
4 detailed information of ranked programs which included specific allocations of Full Time Equivalent ("FTE")  
5 staff headcount, costs (including staff time and division direct costs), revenue, and net financial impact  
6 based on initial budget submissions. And with that specific information, Council leaders served as the  
7 subject matter "experts" to provide input to the budget process through initial budget development at the  
8 Divisional level and, then, consultations with the Admin Review Committee during the April meetings.

9 Following this early focus on Divisional level activities, the budget process moved to the Admin Review  
10 Committee and the Board. The Admin Review Committee and the Board have broader perspectives and  
11 responsibilities for the 2013 budget review process than each individual Council. Trustees oversee the  
12 entire organization and are responsible to the ADA as a whole, its members, as well as the profession and  
13 the public's oral health. As such, these entities are well positioned to compare the relative value of  
14 programs across divisions to help assure that those programs best aligned with our strategic goals and  
15 member emphasis were funded. In the simplest terms, the most basic goal of the budget process is the  
16 prioritization of resources in alignment with the current strategic plan that more specifically defines goals  
17 that serve ADA stakeholders. It is hoped that the House of Delegates, at its annual session, will share this  
18 high level view of the ADA and of the organization and that all resolutions introduced at the House will be  
19 reviewed and prioritized with the same criteria.

20 This year's budget process provided more information arranged by programs and services delivered and  
21 less focus on the divisional accounting structures of the ADA. Only by focusing on programs can rational  
22 assessments of comparative value relative to the Association's strategic goals be made. Central to this  
23 effort, the review of the 2013 budget included a prioritization of agency programs based on universal  
24 assessment criteria with related FTE staff requirements, dollar costs, and revenue data in the same  
25 document.

26 For the first time, the Administrative Review Committee was able to apply this approved set of universal  
27 assessment criteria to create one ranked list of all ADA programs across the organization. Although the  
28 results of the program rankings were not intended to indicate an "all or nothing" decision to fund or not-to-fund  
29 any program or project, this ranking process enabled a focused discussion of prioritization of projects and  
30 programs relative to the Association's strategic priorities as well as other factors. In other words, the  
31 prioritized list of programs provided the Committee and the Board with a rationale and starting point for  
32 budget decisions. Other inputs into these decisions included participation by council chairs or co-chairs in  
33 discussions with the committee. Based on all this, the Administrative Review Committee made initial  
34 decisions to allocate resources between programs to support delivery of the ADA's Strategic Plan for 2011-  
35 2014. The Board next reviewed, approved, or modified those decisions at its June Board meeting.

36 The ability to systematically rank programs by relative merits was achieved, in part, through use of a  
37 specialized collaborative decision making software application called Decision Lens, purchased by the  
38 ADA in 2010. This has been used by major organizations such as Pfizer, Kraft, NASA, and several U.S.  
39 government agencies to reach budget prioritization decisions.

40 Over the last several years, the ADA has been challenged by falling revenue and rising costs. For the  
41 2013 budget, initial submissions included lower dues and non-dues revenue and higher operating costs,  
42 and, as a result, we had to close a seven million dollar deficit. While there have been many cost reduction  
43 efforts over the last three years that have focused on organizational efficiency, the 2013 budget deficit  
44 required focus on those programs best aligned with strategic goals and the elimination of other programs  
45 which were less effective at delivering member value to enable an adequate reduction in resources to  
46 achieve a balanced budget. In the past, programs tended to continue into the future without a careful  
47 analysis of the program against set criteria. This year's budget process represents a significant step  
48 forward in developing a prioritized budget.

1 The use of universal assessment criteria, as suggested by the Special Committee on Financial Affairs, to  
2 prioritize programs and services was therefore a very valuable approach to ensure that 2013 budget  
3 reductions were balanced to provide savings while still supporting member value and financial  
4 sustainability.. The ADA does not have the resources to be “all things to all people”.

5  
6 To ensure financial stability, the need for a balanced budget was considered a critical goal of the process.  
7 It is equally important that the Board and House have an accepted method to evaluate the impacts (value  
8 vs. costs) from investing in one service or program versus another to make necessary tradeoffs to keep  
9 budgets in balance. Several years of deficit spending combined with lower investment returns have  
10 resulted in a decline in net assets, as fiduciaries of the ADA, this is unacceptable. While some of these  
11 impacts may be due to uncontrollable economic conditions, much of the ADA’s current financial situation is  
12 under the ADA’s control. It is imperative that the ADA generate a positive return on its operating activities.

13 This year, the ADA has been significantly challenged by the evolution of the new budget process itself as well  
14 as the nature and magnitude of required staff reductions resulting from the prioritization of projects. This  
15 would not be an easy process in a corporate environment with clearer lines of command and control, let alone  
16 one with the complex politics and the complex governance structure of the ADA.

17  
18 We are heading in the right direction in terms of ensuring the ADA’s short and long term financial stability  
19 and sustainability. Despite the fact that this year’s budget process is a transition to a more strategic and  
20 results-oriented process for the 2014 budget, the 2013 budget preparation presents a far more “surgical”  
21 and strategic approach to creating the ADA budget than in past years. .

## 22 **Program Prioritization Process**

23 In response to a 2011 House Resolution, the ADA Board developed a set of Universal Assessment Criteria to  
24 be used to evaluate the alignment of programs with the ADA’s strategic goals and help assess the  
25 comparative value of programs in relation to other existing and proposed programs.

26 Resolution 44H-2011 further stated that all resolutions having cost implications for the Association which have  
27 been submitted prior to the first mailing of resolutions to delegates be provided to the appropriate council (or  
28 Board) to prepare for the House a written report that includes the council’s (or Board’s) recommendation and  
29 assessment in light of the universal set of assessment criteria.

30 In response to this direction, the Association embarked upon a new, largely “zero based” budget process in  
31 which funding decisions were based on creation and application of the Universal Assessment Criteria. Rather  
32 than creating budgets based on prior year budget methods, the specific activities of each agency division  
33 (“programs”) were defined and ranked based on each of the Universal Assessment Criteria.

34 The ADA had previously purchased Decision Lens software as a tool to support decision-making with multiple  
35 stakeholders. Decision Lens is a collaborative planning tool that takes subjective inputs and summarizes  
36 them into an objective prioritization of programs. Although there are growing pains in the first year of a new  
37 budget process, Decision Lens appears almost “custom made” for the task of prioritization of programs at the  
38 ADA. Because Decision Lens software is based on a two step process, the first tied to setting decision  
39 criteria and the second step separately rating each program against those criteria, this tool can enable input  
40 by multiple groups of ADA stakeholders to contribute to the prioritization process.

41 Each division provided a ranked list of programs, some through Decision Lens and some through a less  
42 formal method. All of this information was shared with the Admin Review Committee. Three Councils that  
43 were scheduled to meet between January and the initial budget submission due date in March used Decision  
44 Lens to rank their proposed 2013 projects.

45 The remaining agency programs were also rated against the universal assessment criteria using Decision  
46 Lens. In this Decision Lens two-step process, all of the program ratings from all sources were combined with  
47 the weighting of criteria decided by the Admin Review Committee to produce a ranked list of all proposed

2013 programs across the ADA. Going forward, all Councils will use Decision Lens to rank projects for the 2014 budget in next year's process.

Each agency division shared the results of this ranking process with the Council they supported. The council chairs, vice chairs and related staff discussed rankings on conference calls during the Administrative Review Committee meeting. Each call followed a consistent format with a brief overview of the process and a review of the basis for 2013 Budget decisions that included:

- A. Universal Assessment Criteria used for Rankings in Decision Lens,
- B. FTE staff requirements, Costs and related Revenue, if any, generated by program,
- C. Council Chair input, and
- D. The need to deliver a balanced budget to the Board and the House of Delegates.

Council Chairs were provided with the opportunity to discuss any inconsistencies between the Councils' program rankings and decision lens ranking of Council programs to ensure that the most important programs were identified by Council Chairs to the Admin Review Committee and the Chairs had the opportunity to explain any additional factors, not covered by universal assessment criteria that should be considered in funding decisions.

The Decision Lens rankings were only a guide and just one input to the program review and prioritization process. All budget decisions were ultimately made by the Admin Review Committee subject to final review and approval by the Board of Trustees and the House of Delegates.

#### **Budget Development Timeline and Organizational Impacts**

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The 2013 budget timeline is outlined here to provide additional insight into the complex and resource intensive process that was managed over a six month period. In addition, this section explains several significant issues related to the implementation of the changes included in the proposed 2013 budget.

*Initial Development:* Each of the ADA divisions began the budget process by creating draft budgets based on the current strategic plan needs of the ADA. At this stage, the work was initiated by division staff, and from the start, all staff were directed to engage all ADA councils, committee and commissions in the budget process.

After all the initial budgets were submitted, the Finance Division reviewed all the budgets for completeness and accuracy. Finance also developed budget summaries as one method to highlight the nature and extent of the net deficit at this early draft stage of the budget process.

In mid March, using these initial budget drafts and summaries, the Executive Director, Chief Financial Officer, Chief of Governance and Strategy Management, Managing Vice President of Human Resources and Organizational Development, Director of Accounting and Financial Planning Managers conducted internal budget reviews and met with each division individually to understand the department/divisional assumptions and initiatives that supported the initial operating budget submissions.

*Program Definitions, Ranking, and Costing:* Beginning in mid to late March, each agency division defined a list of programs that represent their work products, i.e.-what the division accomplishes that creates member value. These programs and their descriptions are provided in each of the division sections of this document. Each program was then ranked in Decision Lens against the Universal Assessment Criteria created by the Board of Trustees.

In addition, the new data collection model was built in Hyperion to enable each division to allocate the estimated % of total staff time of each employee that would be spent to deliver each program. This information, in addition to the staff cost and direct cost data already included in Hyperion, enabled the model to estimate costs to deliver the programs for each division. The model included error checks to ensure that

100% of each budgeted FTE employee's time was accounted for. And all costs for the division, including administration, were included and allocated to programs. This cost detail by project, based on initial budget submissions only, was provided to Council leaders and staff, the Administrative Review Committee, and Board with related revenue to support budget decisions.

One significant challenge to this new program costing process was that the estimates of employee time to deliver projects often resulted in a fractional FTE headcount that could also represent work delivered by more than one individual. As a result, at several points in the budget process, each division with cost reduction targets from eliminated programs was challenged to review its funded programs to determine how to restructure its staff to cover the remaining work. By the end of the budget process, this required the identification of specific positions, or "whole" FTEs, that must be eliminated to meet the FTE reduction goals. This was and is an extremely complex and confidential reorganization process that, although completed with estimates to generate the target cost reductions included in this report, will continue after the House approves the budget in its final form. **Given this protracted timeline and the extremely sensitive employee relations issues at the core of this process, it is important that all parties recognize the extraordinary effort needed to finalize the plans and implement the staffing changes. All decisions impacting ADA personnel will be completed and communicated by August 24, 2012.**

*Administrative Review Committee and Process:* The Administrative Review Committee is made up of the Budget and Finance Committee with the Treasurer serving as chair. Again this year, two House members were included on the committee and played an invaluable role in the analysis of the proposed budget. The Administrative Review Committee met for two days from April 22-23 for review of each division's budget and associated programs with an agenda that was heavily weighted to conference calls with each council. The Admin Review Committee's discussions with each council served to educate the Committee on the objectives of each program and provide the Council's input on the value and ranking of each program.

The entire Administrative Review Committee was trained on Decision Lens software and weighted the universal assessment criteria in a facilitated session. The Administrative Review Committee also held a separate conference call with a facilitator in advance of its two day meeting and reviewed the Decision Lens rankings and revisited the criteria weightings before deciding on a final prioritization.

Several conference calls were also held with Council Chairs, Vice Chairs and staff in advance of the Administrative Review meetings to provide background on the new budget process and plans for the new format of the Administrative Review Committee meetings.

The Administrative Review meetings started with an overview of the 2013 initial budget submissions which included all proposed decision packages and spending requests from divisions. Because Council staff had continued to consult with volunteers on Council budgets, the 2013 budget initial submission was expected to include all potential programs. Agency decision packages were mixed in with the program rankings and noted as such. This approach ensured that all programs, old and new, plus decision packages, were ranked together in one list for the entire organization.

Based on this variety of inputs, the Administrative Review Committee, led by the Treasurer, reviewed and reallocated resources across divisions in a way that optimized the Associations' total portfolio of programs. To reiterate, the assessment criteria and Decision Lens were only tools and final decisions to fund or not fund programs were in the hands of the ADA's volunteer leaders who could also consider other decision factors.

After the Administrative Review Committee Meeting, the Finance and Human Resources Division management met with each Division to discuss the potential budget and staffing implications of the Committee's recommendations.

*Board of Trustees:* Based on the work of the Administrative Review Committee meeting in April, the Finance Division developed draft budgets with similar detail documentation for review by the full Board.

1 Budget summaries including background on the Admin Review Committee's view of the merits of  
2 proposed programs were then prepared for the Full Board of Trustees and reviewed in the June Board  
3 Meeting.

4  
5 The Board of Trustees, at its June meeting, considered all of this information over the greater part of its  
6 three day meeting. In addition to the written material, the Treasurer provided guidance and comment.  
7 The Board thoroughly reviewed the work of the Administrative Review Committee and its  
8 recommendations, questioned staff on specific issues in the budget and discussed input received by  
9 trustees from particular councils. In most cases, the Board endorsed the resource allocations of its  
10 Administrative Review Committee.

11 After the June Board of Trustees budget actions, the Finance Division met again with each division head to  
12 modify department expense statements in the Hyperion budgeting system to align with the Board of Trustee  
13 decisions. These revised budgets are reflected in this document.

14 This ADA "budget basis" presentation represents a modified cash basis reporting format that includes the  
15 "cash basis" funding requirements of the ADA's pension plan and an "add back" for non-cash depreciation  
16 and annual operating capital replacements. It should be noted that this "budget basis" presentation format is  
17 consistent with the ADA's internal planning and reporting formats since this approach was adopted by the  
18 Board in 1992 for the 1993 budget. However, this "budget basis" approach is not consistent with the accrual  
19 basis financial statements prepared in accordance with U.S. Generally Accepted Accounting Principles  
20 ("GAAP") which are presented in the annual ADA consolidated audit reports.

21 Furthermore, although this "budget basis" presentation, which reflects a small surplus, includes this net  
22 depreciation and capital "add back," it is important to note that most organizations strive to generate positive  
23 operating results at a higher level without any depreciation or capital adjustment.

**American Dental Association Operating Fund**

2013 Budget Summary by Natural Account

\$ 000

	2011 Actual	2012 Budget	2013 Budget	2013 v 2012 Variance	
				Fav / (Unfav)	
				\$	%
Membership Dues	54,289	54,812	54,536	(276)	-0.5%
Advertising	8,087	10,792	9,617	(1,175)	-10.9%
Rental Income	5,402	5,500	5,645	146	2.6%
Publication & Product Sales	5,914	8,644	6,740	(1,905)	-22.0%
Testing Fees & Accreditation	17,129	17,427	18,020	592	3.4%
Meeting & Seminar Income	8,885	11,634	10,225	(1,409)	-12.1%
Grants & Contributions	1,615	1,970	1,907	(64)	-3.2%
Royalties	5,998	4,960	5,293	333	6.7%
Investment Income	777	2,063	2,085	22	1.0%
Other Income	2,548	2,709	3,205	497	18.3%
<b>Total Revenues</b>	<b>110,644</b>	<b>120,512</b>	<b>117,272</b>	<b>(3,240)</b>	<b>-2.7%</b>
<b>Salaries and Temporary Help</b>					
Salaries (Base Compensation)	37,508	39,877	38,653	1,224	3.1%
Agency Compensation (incl Severance)	793	724	1,300	(576)	-79.6%
2012 Cost Reduction Target	-	(1,000)	-	(1,000)	100.0%
Temporary Help	912	400	258	142	35.5%
<b>Total Salaries and Temporary Help</b>	<b>39,213</b>	<b>40,001</b>	<b>40,211</b>	<b>(210)</b>	<b>-0.5%</b>
<b>Fringe Benefits</b>					
Pension - Normal Cost	5,200	1,800	1,703	97	5.4%
Pension - Catchup Supplemental Funding	5,439	6,102	6,192	(90)	-1.5%
401k Contribution	209	452	1,719	(1,267)	-280.3%
All Other Benefit Costs	7,145	6,391	6,012	379	5.9%
<b>Total Fringe Benefits</b>	<b>17,993</b>	<b>14,745</b>	<b>15,626</b>	<b>(881)</b>	<b>-6.0%</b>
Total Payroll Taxes	2,640	2,927	2,739	188	6.4%
Total Travel Expenses	5,548	6,180	5,857	323	5.2%
Printing, Publication & Marketing	9,205	12,118	10,900	1,218	10.1%
Meeting Expenses	1,660	3,513	2,290	1,223	34.8%
Consulting and Outside Services	5,909	7,023	5,309	1,714	24.4%
Professional Services	7,890	8,754	9,465	(710)	-8.1%
Bank & Credit Card Fees	1,108	1,149	1,193	(44)	-3.8%
Office Expenses	4,602	5,422	5,177	245	4.5%
Facility & Utility Costs	4,933	5,304	5,818	(514)	-9.7%
Grants and Awards	2,226	2,530	2,313	217	8.6%
Endorsement Costs	612	647	695	(48)	-7.4%
Depreciation/Amortization	6,398	6,088	6,358	(270)	-4.4%
Other Expenses	1,041	2,350	2,576	(226)	-9.6%
ADA Health Foundation - Grant	3,925	1,892	1,900	(8)	-0.4%
<b>Total Expenses</b>	<b>114,902</b>	<b>120,642</b>	<b>118,427</b>	<b>2,215</b>	<b>1.8%</b>
Income Before Taxes	(4,258)	(130)	(1,155)	(1,024)	-785.8%
Income Taxes	(1,341)	(1,250)	(1,300)	(50)	-4.0%
Net Surplus/(Deficit) Before Depr/Capital Add Back	(5,599)	(1,380)	(2,455)	(1,074)	-77.8%
Net Deprec/Capital Add Back	3,976	1,753	3,502	1,749	-99.8%
<b>Net Budget Basis Oper Cash Flow</b>	<b>(1,624)</b>	<b>373</b>	<b>1,047</b>	<b>674</b>	<b>180.9%</b>

**American Dental Association Operating Fund**

2013 Budget Summary by Division

\$ 000

	2011 Actual	2012 Budget	2013 Budget	2013 v 2012	
				Fav / (Unfav)	
				\$	%
Contingency General	-	-	-	-	NA
Administrative Services	-	-	-	-	NA
Legal Affairs	33	50	62	12	24.1%
Government & Public Affairs	62	368	42	(326)	-88.6%
Communications	55	31	692	662	2162.9%
Membership, Tripartite Relations & Marketing	1,548	1,743	1,742	(1)	-0.1%
Division of Global Affairs	36	-	-	-	NA
Conference & Meeting Services	9,522	12,207	10,787	(1,421)	-11.6%
Headquarters Building	3,869	3,808	3,849	41	1.1%
Washington Building	1,527	1,670	1,782	112	6.7%
Product Development and Sales	7,435	9,426	8,214	(1,211)	-12.9%
Finance and Operations	1,018	1,576	1,900	324	20.5%
Information Technology	-	-	-	-	NA
Dental Practice/Professional Affairs	55	104	408	304	291.3%
Health Policy Resource Center	51	118	60	(58)	-49.1%
Science	889	713	688	(25)	-3.5%
Education	17,892	18,853	19,058	206	1.1%
ADA Publishing	8,831	11,639	10,020	(1,619)	-13.9%
Corp. Rel & Strat. Mkng Alliances	-	-	-	-	NA
Central Administration	57,822	58,207	57,969	(238)	-0.4%
<b>Total Revenue</b>	<b>110,644</b>	<b>120,512</b>	<b>117,272</b>	<b>(3,240)</b>	<b>-2.7%</b>
Contingency General	925	1,000	1,000	-	0.0%
Administrative Services	5,965	7,845	7,595	250	3.2%
Legal Affairs	3,323	4,112	4,153	(42)	-1.0%
Government & Public Affairs	7,671	10,379	9,248	1,131	10.9%
Communications	3,021	4,491	4,835	(344)	-7.7%
Membership, Tripartite Relations & Marketing	6,445	9,029	8,750	279	3.1%
Division of Global Affairs	951	1,377	1,361	16	1.2%
Conference & Meeting Services	6,315	10,204	8,357	1,847	18.1%
Headquarters Building	4,491	5,129	5,363	(233)	-4.6%
Washington Building	905	870	1,046	(176)	-20.2%
Product Development and Sales	3,270	4,588	4,048	540	11.8%
Finance and Operations	2,975	4,371	4,082	289	6.6%
Information Technology	5,931	9,815	10,399	(584)	-6.0%
Dental Practice/Professional Affairs	2,442	3,657	3,522	136	3.7%
Health Policy Resource Center	1,584	2,574	2,534	40	1.6%
Science	5,009	7,314	6,415	900	12.3%
Education	12,681	15,528	14,175	1,353	8.7%
ADA Publishing	7,551	9,573	9,111	462	4.8%
Corp. Rel & Strat. Mkng Alliances	415	581	677	(96)	-16.6%
Central Administration	33,033	8,204	11,758	(3,554)	-43.3%
<b>Total Expense</b>	<b>114,902</b>	<b>120,642</b>	<b>118,427</b>	<b>2,215</b>	<b>1.8%</b>
Income Before Taxes	(4,258)	(130)	(1,155)	(1,024)	-785.7%
Income Taxes	(1,341)	(1,250)	(1,300)	(50)	-4.0%
Net Deprec/Capital Add Back	3,976	1,753	3,502	1,749	-99.8%
<b>Net Budget Basis Op Cash Flow</b>	<b>(1,624)</b>	<b>373</b>	<b>1,047</b>	<b>675</b>	<b>180.9%</b>

## Revenues

Total revenues in the 2013 budget are \$ 117,272. Highlights of various revenue categories are provided below.

**Membership Dues:** The Division of Membership, Tripartite Relations and Marketing estimates the future membership levels for each dues paying category and multiplies those numbers by the various dues rates. Currently, 28 different dues categories with unique dues rates exist. The 2013 budget anticipates 174,936 members, of which 92,060 will pay full dues of \$ 512 per year. The average dues rate per member is \$ 310 per year including discount such as Active Life and Retired Life. These figures do not reflect any dues increase or assessment as put forth by the Board of Trustees in a separate resolution.

**Advertising:** This category primarily includes advertising sales in ADA publications, new initiatives in electronic media and secondarily at annual session. The 2013 revenue of \$ 9,617 is a (10.9) % decline from 2012 budget but a 18.9 % increase over 2011 actual. Traditional advertising in ADA news and JADA are assumed to reverse downward trends in 2013, while new sources of revenue such as the consumer website and digital advertising are assumed to contribute additional growth.

### American Dental Association Operating Fund

#### Advertising Revenue

	2011 Actual	2012 Budget	2013 Budget
Communications Division--New Consumer Website	-	-	688
Membership Division	56	68	-
Conference and Meeting Services Division	264	511	309
JADA	1,781	2,231	2,241
ADA News	4,733	5,941	4,881
Digital Advertising	1,232	2,041	1,498
Other	20	-	-
Total Publishing Division	7,766	10,213	8,620
<b>Total Advertising Revenue</b>	<b>\$ 8,087</b>	<b>\$ 10,792</b>	<b>\$ 9,617</b>

**Rental Income:** This revenue category primarily includes rental income from the Headquarters Building and the Washington DC Building. Revenue of \$ 5,645 is an increase of 2.6 % from 2012 budget.

**Publication and Product Sales:** The decline of \$ (1,905) or (22) % brings revenue closer to year-to-date actual trends. Declines are seen across most product categories. 2012 is the last year that CDT sales were made on a 2 year cycle. Starting in 2013, CDT updates are sold on an annual basis and revenue should be consistent year to year thereafter.

**Testing Fees and Accreditation:** This has been the ADA's largest source of revenue growth over the last few years. Revenues from testing and accreditation fees are expected to rise by \$ 592 or 3.4 %, and this is not a greater growth than the actual 2012 trends.

**Meeting and Seminar Income:** Most of the \$ (1,409) decline is related to the location of the 2013 annual session versus the 2012 annual session. Costs similarly vary proportionately. Separately, in Continuing Education the lower 2012 budget brings us closer to the actual 2011 and 2012 trends to date.

**Grants, Contributions, and Sponsorships:** Grants, contributions, and sponsorships is projected to decline by \$ (64k) or (3.2) %. The 2012 budget anticipated new grants in areas such as CAPIR that are not being achieved.

**Royalties:** Includes royalties received from the *ADA Business Resources* program, CDT licenses, domestic and international product licenses, and the selling of mailing lists. The growth of 333 or 6.7 % is due to ongoing growth in CDT licenses.

**Investment Income:** Projected revenue of \$ 2,085 for 2013 includes both interest and dividends on Reserve Fund assets and investment earnings on cash flow within the operating account. This category also includes \$300,000 in revenue related to the appreciation/depreciation of deferred compensation investments that has an offsetting expense in the Fringe Benefit category.

**Other Income:** This category is composed of miscellaneous revenue, including such items as overhead revenue from subsidiaries and the member's insurance program, and Seal Program revenues. In the Dental Practice Area, the Center for Practice Success and Quality Assessment adds \$ 200k in 2013 versus 2012 budget.

### Expenses

Total operating expenses are budgeted at \$ 118,427 a reduction of \$ 2,215k or 1.8 % versus the 2012 budget. Significant reductions to employee staffing levels and employee benefit programs more than offset increases such as in Professional Services for the new consumer website and JADA on-line seminar series.

Highlights of various expense categories are provided below.

**Salaries (Base Compensation):** Base salary expenses are budgeted at \$ 38,653, a decrease of \$ 1,224 or 3.1% from the 2012 budget. The decline in base salaries is the result of \$ 2,537 of staff and vacancy rate reductions. Partially offsetting the decline is \$ (1,200) for merit/market rate adjustments.

**Agency Compensation (includes Severance):** This category includes expense associated with severance pay, off cycle salary increases and service awards and is projected to be unfavorable by \$ (576k) or (79.6%). The increase is due to an increase in severance pay as a result of projected staff reductions.

**2012 Cost Reductions Target:** The 2012 budget included a \$1,000 target reduction to for "sunsetting programs" that was not assigned to any division budget.

**Temporary Help:** The ADA hires temporary staff for annual session and to assist divisions when staff positions are open during the year.

**Pension – Normal Cost:** This category is to cover annual contributions to the modest new pension plan that went into effect January 1, 2012. The expense in this category declined by \$ 97k or 5.4% when compared to 2012. The decline is the direct result of the projected staff reductions in 2013.

**Pension – Catch-up Supplemental Funding:** The ADA must continue to fund the liability of the full employee pension plan that was offered to employees prior to 2012.

**401K Contribution:** The new limited pension plan was also designed to be accompanied by a 401K benefit expected to cost an additional \$(1,300) in 2013.

**All Other Benefit Costs:** Expenses in this category include group medical premiums, dental direct reimbursement, life insurance, workers compensation, deferred compensation benefits and union dues for two building engineers. The expenses in this category are expected to decline by \$379k or 5.9% from 2012. Benefit costs will decline Association-wide as a result of the projected staff reductions in 2013.

**Payroll Taxes:** This category includes expense associated with employer related taxes such as FICA, SUI and FUI. The reduction in the budget for this category is based on reduced staffing levels.

**Travel Expenses:** Travel expenses are usually comprised of about three quarters volunteer travel and one quarter staff travel. Budget expenses for travel are projected to decline by \$ 323k or 5.2 % versus the 2012 budget. This would bring the 2013 budget is approximately in line with the 2011 actual.

**Printing, Publications and Marketing:** This expense reduction is due to fewer pages printed for advertising and declining sales of printed products.

**Meeting Expenses:** The 2012 budget has a \$ 1,400 expense for payment to the California Dental Association (CDA) related to the annual session. Reduction in this cost for 2013 is the largest driver of the \$ 1,223 total reduction in meeting expenses.

**Consulting Fees and Outside Services:** Expenses in this area fall by \$1,714 or 24.4 %, including a drop of \$ 836k related to the location of the ADA Annual Session. The remainder of the cost decline is driven by reductions of about three hundred thousand dollars each in the following three divisions: Government and Public Affairs, Information Technology, and Administrative Services.

**Professional Services:** Most of the \$ (710k) increase in these expenses are due to the new consumer website in the Communications division and the JADA On-Line Seminar Series in the Publishing Division. These two divisions contribute \$ (242k) and \$ (298k) respectively. This line also includes legal and audit fees managed by the Legal division.

**Bank and Credit Card Fees:** This category represents transaction fees paid to financial institutions and reimbursements to state and local societies for credit card fees related to ADA membership dues collection. .

**Office Expenses:** The \$ 245 reduction versus 2012 budget in office expenses is driven by a \$ 400k reduction in Office Equipment Repairs and Maintenance in the Information Technology Division. This reduction was partially offset by increases in several divisions association-wide.

**Facility and Utility Costs:** These expenses represent costs for building management and operations, maintenance, and real estate taxes for the ADA Headquarters and Washington DC buildings. The increase of \$ (514k) includes: property taxes and the transfer of some engineering functions to the building management company in the headquarters building, and Utilities in the DC building.

**Grants and Awards:** The ADA distributes grants to support various organizations for specific functions. The \$ 217k savings is largely due to a reduction in State Public Affairs grants of \$ 190k. This is an 8 % reduction in SPA grants versus 2012 budget and a (31) % increase over the 2011 actual.

**Endorsement Costs:** This category represents monies paid to state societies that participate in the *ADA Business Resources* program and to the AMA for use of medical codes in *CDT* related products.

**Depreciation and Amortization:** This category shows a \$(270k) increase from \$6,088 to \$6,358 in 2013. Depreciation fluctuates annually based on prior year and proposed current year capital acquisitions.

**Other Expenses:** Other expenses include general insurance, recruiting costs, staff development, overhead recovery, and the contingency fund. The increase of \$ (226k) or (9.6) % includes contingency fund of \$(156k). The ADA budgets \$1M per year in the contingency fund and as requests are approved by the Board of Trustees, the expenses are allocated to the appropriate natural account categories.

**ADA Foundation Grant:** The Association's annual grant to the Foundation remains relatively constant in 2013, with an addition of \$8 to bring the total to \$1,900.

**Net Depreciation Add-Back**

The depreciation budget in Central Administration and Association-wide exceeds the capital budget by \$3,502 which is added back to the operating budget to more closely approximate operating cash flow. See Schedule below for summary:

<b>Summary of Depreciation and Capital</b>			
	2011	2012	2013
	Actual	Budget	Budget
Depreciation	\$ 6,398	6,088	6,358
Capital Spending	(2,422)	(4,335)	(2,856)
Net Depreciation/Capital Add Back	\$ 3,976	1,753	3,502

**Number of Employees****American Dental Association Operating Fund**

Year End Full Time Equivalent Employees

	2012 Budget	2013 Budget	Variance
Administrative Services	22.8	20.8	(2.0)
Legal Affairs	17.0	16.6	(0.4)
Government & Public Affairs	33.0	29.0	(4.0)
Communications	26.0	25.0	(1.0)
Membership, Tripartite Relations & Marketing	53.0	52.0	(1.0)
Division of Global Affairs	4.6	5.1	0.5
Conference & Meeting Services	22.0	20.0	(2.0)
Headquarters Building	3.0	2.0	(1.0)
Product Development and Sales	9.0	9.0	-
Finance and Operations	40.0	36.0	(4.0)
Information Technology	45.5	46.5	1.0
Dental Practice/Professional Affairs	22.0	19.0	(3.0)
Health Policy Resource Center	14.0	14.0	-
Science	41.8	38.8	(3.0)
Education	70.1	56.0	(14.1)
ADA Publishing	26.0	25.0	(1.0)
Corp. Rel & Strat. Mkng Alliances	3.0	3.0	-
<b>Total</b>	<b>452.8</b>	<b>417.8</b>	<b>(35.0)</b>

This chart reports the budgeted year end FTE positions by division for the 2012 and 2013 budget years.

Full Time Equivalent ("FTE") employee headcount in this chart includes part time employees on a pro-rata basis. For example, a half time employee is included as 0.5 FTE. Temporary employees, consultants and contractors are not included. In 2013, the FTE in the middle of the year is expected to be higher than the above year-end figures because the Library gradually reduces employees throughout the year. On average

the ADA has about a 7% employee vacancy rate at any point in time during the year due to the attrition and hiring cycle.

#### **Division of Administrative Services**

The Division of Administrative Services includes the following areas: Office of the Executive Director/COO, Office of Strategy Management, Department of Board and House Matters, Department of Officer Services and the Department of Human Resources. As a Shared Services division, this area serves primarily as administrative infrastructure to the Association through implementation of actions and policies of the House of Delegates and Board of Trustees; supervision of activities of Association staff and agencies by the *Office of the Executive Director/COO*; and administration of personnel policies and practices, and recruitment, retention and development of staff through the *Department of Human Resources*.

The *Department of Board and House Matters* manages the coordination of regular and special sessions of the Board of Trustees and its standing committees. Through the Department's budget the members of the Board are provided funding that allows them to fulfill their leadership role as the administrative body of the Association. This is accomplished through the attendance at Board meetings; the annual session of the House of Delegates; state annual meetings held in the Board member's district; committee, liaison and special assignments made by the President; and the Washington Leadership and New Dentist Conferences. The Department coordinates administrative activities for the Board and House such as council and reference committee nominations, and under the direction of the Chief of Governance and Strategy Management coordinates orientation activities for the Board of Trustees and House of Delegates.

Under the direction of the Speaker and Secretary of the House of Delegates, the *Department of Board and House Matters* manages the annual session meeting of the House of Delegates, which includes the set-up of the House meeting space at annual session, coordinating the preparation and distribution of all House materials in both electronic and paper format; managing the organization and functionality of ADA Connect along with postings to that site; coordinating the credentialing of delegates/alternates and delegate registration; developing unofficial House actions and minutes; producing the historical publications in both paper and electronic format (Annual Reports and Resolutions, Supplement, Transactions, Current Policies, Index of Official Actions); and providing administrative support to the Election Commission.

The *Department of Officer Services* supports the ADA President, President-elect and Executive Director by coordinating their extensive schedules of meetings and travel. Funding is provided for officer travel to state annual meetings, regional conferences, Washington, D.C., Board and committee meetings, and meetings with industry and government agencies.

Establishing, implementing and coordinating strategic planning activities are managed by the *Office of Strategy Management*. Administrative support is provided through this office for the Mega Topic Session held annually at the ADA House of Delegates.

Natural account summary for the Division of Administrative Services is below:

**Administrative Services**2013 Budget Summary by Natural Account  
\$ 000

	2011 Actual	2012 Budget	2013 Budget	2013 v 2012 Variance	
				Fav / (Unfav)	
				\$	%
<b>Expenses</b>					
Total Salaries and Temporary Help	2,935	2,814	2,875	(61)	-2.2%
Total Fringe Benefits	-	876	830	46	5.2%
Total Payroll Taxes	-	170	156	14	8.2%
Total Travel Expenses	879	1,179	1,096	83	7.0%
Printing, Publication & Marketing	133	205	202	3	1.5%
Meeting Expenses	60	60	57	3	4.5%
Consulting and Outside Services	366	709	396	313	44.1%
Professional Services	1,078	1,057	1,058	(1)	-0.1%
Office Expenses	236	314	334	(20)	-6.5%
Grants and Awards	4	5	5	0	0.0%
Other Expenses	273	458	586	(128)	-28.0%
<b>Total Expenses</b>	<b>5,965</b>	<b>7,845</b>	<b>7,595</b>	<b>250</b>	<b>3.2%</b>
Net Budget Basis Operating Cash Flow	(5,965)	(7,845)	(7,595)	250	3.2%

This division shows a favorable variance of \$250k or 3.2% when comparing the 2013 budget to the 2012 budget. The favorable variance is largely due to the one-time 2011 House resolution calling for a governance study in 2012. One-time resolutions that were budgeted in 2012 were not included in the 2013 budget.

**Division of Legal Affairs**

The ADA Division of Legal Affairs actively advances the ADA's Mission & Vision for the public's oral health by protecting, defending and advocating for the legal rights and interests of the ADA. The Legal staff works collaboratively both within the Division and with volunteer leaders and staff colleagues to help ADA agencies achieve their objectives. Legal's work supports the entire Association by performing services beneficial to the organization in the follow ways:

**Promoting ADA's Financial Stability**

- Promoting and protecting ADA's valuable intellectual property assets, including its patents, trademarks, ADA.org content, publications and other proprietary materials.

**Engaging in Risk Management**

- Protecting the legal rights and interests of the Association, including in such areas as litigation and compliance with federal, state and local laws;
- Ensuring that documents affecting or creating Association's legal rights and interests, such as contracts and similar instruments are drafted, reviewed, and executed in a manner that furthers ADA's business objectives and minimizes legal and financial risk;
- Managing risk of harm to ADA's assets by researching and securing appropriate insurance coverage;

- Reviewing ADA statements intended for dissemination to the public, official agencies, or other entities in order to ensure that such statement conform to ADA's legal and reputational interests.
- Supporting the activities and direction of the ADA's independent Audit Committee including the management of budgets for its external and internal auditors.

#### Providing Member Value

- Utilizing legal advocacy to help position the ADA in its efforts to protect patients and the dental profession;
- Supporting the Council on Ethics, Bylaws and Judicial Affairs, housed in the Division, which oversees the enforcement of the ADA *Principles of Ethics and Code of Professional Conduct* and reviews proposed changes of the ADA *Constitution and Bylaws*; provides education in best governance practice for volunteers, ADA staff and the Tripartite
- Maintaining the ADA Contract Analysis Service, housed in the Legal Division, which provides informational legal reviews of contracts offered to dentists by third party payers, dental management service organizations and informational reviews of contracts that offer dental students scholarships or loans in exchange for commitments of future employment;
- Supporting and advancing ADA positions in the legal arena through any available means, including submissions to regulatory agencies and *amicus curiae* briefs with the state and federal courts throughout the country;
- Tracking legal developments and disseminating legal information in areas relevant to professional practice and dental care through ADA publications and resources.

#### Acting in Ways Essential to ADA's Operations

- Acting as a legal and business resource to facilitate and advance the work and mission of ADA's members and staff;

Providing legal counsel to the ADA House of Delegates, Board of Trustees, Executive Director, Councils, Commissions, Committees and other ADA agencies and staff, and to the governing bodies, officers and staff of the ADA's not-for-profit and wholly-owned for-profit affiliates.

Natural account summary for the Division of Legal Affairs is below:

**Legal Affairs**2013 Budget Summary by Natural Account  
\$ 000

	2011 Actual	2012 Budget	2013 Budget	2013 v 2012 Variance	
				Fav / (Unfav)	
				\$	%
<b>Revenues</b>					
Other Income	33	50	62	12	24.1%
<b>Total Revenues</b>	<b>33</b>	<b>50</b>	<b>62</b>	<b>12</b>	<b>24.1%</b>
<b>Expenses</b>					
Total Salaries and Temporary Help	1,938	2,082	2,055	27	1.3%
Total Fringe Benefits	-	650	645	5	0.8%
Total Payroll Taxes	-	127	125	2	1.7%
Total Travel Expenses	60	92	96	(4)	-3.8%
Printing, Publication & Marketing	4	7	6	1	16.7%
Meeting Expenses	0	2	3	(0)	-15.2%
Consulting and Outside Services	1	-	-	-	NA
Professional Services	1,288	1,082	1,168	(86)	-7.9%
Office Expenses	29	59	52	6	10.6%
Facility & Utility Costs	1	1	1	(0)	-33.3%
Grants and Awards	3	4	3	1	26.8%
Other Expenses	-	6	1	5	83.6%
<b>Total Expenses</b>	<b>3,323</b>	<b>4,112</b>	<b>4,153</b>	<b>(42)</b>	<b>-1.0%</b>
Net Budget Basis Operating Cash Flow	(3,290)	(4,062)	(4,091)	(30)	-0.7%

There are no significant variances to report in the Division of Legal Affairs.

**Division of Government & Public Affairs**

The Division of Government and Public Affairs oversees the federal and state political, legislative and advocacy activities of the ADA on behalf of the dental profession. The Division is organized into several departments to accomplish its mission with the Council on Government Affairs providing input and proposing policy. The Department of State Government Affairs assists state and local dental societies to achieve their regulatory and legislative goals. The Congressional Affairs and Federal Affairs departments function as liaisons and advocates with Congress and the Executive branch via testimony, personal meetings and communications. The budget supports some of the administrative expenses of ADPAC, an organization that allows member dentists to support federal candidates who have positive views toward dentistry and involve dentists on political issues important to the profession. With support from the Communications Division and in concert with the Council on Government Affairs, and the State Public Affairs Oversight Committee, the Division operates the State Public Affairs (SPA) program, which assists state dental societies in pursuing their policy and advocacy goals on issues of national importance. The CAPIR Department was added to the Division in April 2012, which includes the CAPIR Council.

The programs in this division are listed below and are in order of how they ranked utilizing the Decision Lens tool:

**Fluoridation and Prevention Administration**

National Fluoridation Advisory Committee (NFAC), Water Fluoridation Technical Assistance, Fluoridation Facts, Fluoride Toolkit, CE programs

**Passage of McCarran-Ferguson (antitrust legislation)**

The ADA supports repeal of the McCarran-Ferguson antitrust exemption in a manner that restores application of the federal antitrust laws to the business of health insurance. The Association believes this will enhance competition, benefiting consumers and practitioners.

**Passage of ERISA Bill**

The ACA includes language that authorizes (but does not provide funding for) the “Alternative Dental Health Care Providers Demonstration Project.” The term “alternative dental health care providers” includes community dental health coordinators, advance practice dental hygienists, independent dental hygienists, supervised dental hygienists, primary care physicians, dental therapists, dental health aides, and any other health professional that the Secretary determines appropriate. Since passage of the ACA, the ADA has successfully worked to ensure funding is not provided. Further, through the SPA program, State Government Affairs is working with states across the nation on the workforce challenges posed by the foundations supporting change and other pressure groups.

**Eliminating/Reducing Harmful Regulations**

ADA opposes federal regulations that make the delivery of dental services more expensive without an adequate offsetting benefit and regulations that unduly interfere with the doctor-patient relationship. For example, the Affordable Care Act’s 2.3% medical device tax would adversely affect virtually all dental practices.

**State Non-Covered Services**

The ADA supports efforts by the constituent dental societies to pass state laws that prohibit or limit the ability of insurance companies to dictate fees charged by participating dentists for services not covered by the contract. That support extends to other benefit issues like coordination of benefits and assignment of benefit laws.

**FTC Related Issues**

In recent years, the Federal Trade Commission, whose authority includes pursuit of unfair methods of competition and consumer protection, has taken an interest in the activities of medical and dental boards that are tasked by their respective states to regulate the specified professions. The Commission has begun, through letters addressed to the boards or others or through enforcement proceedings, to challenge actions of the boards that it views as anticompetitive or beyond the boards’ authority. This has become a significant issue to the boards and the professions that they regulate.

**Fluoridation and Prevention Collaboration**

Prevention Summit, Tobacco Conference, School Health Conference

**CAPIR Administration**

Council Meetings Chair annual session trip

**Health Information Technology**

The ADA has long been involved in assuring that as health information technology develops (e.g. movement from paper to electronic record keeping) the special concerns and interests of the profession and dental patients are represented in a manner that protects the doctor-patient relationship to the maximum extent possible.

**State Legislative Bill Tracking**

GPA tracks hundreds of state bills and proposed regulations that effect health care broadly and dentistry specifically. In tracking the proposals, GPA is able to detect trends to aid in early response as needed and advise all states of impending issues.

**State Public Affairs (SPA) Program**

The SPA program promotes the association's positions on several key issues and provides strategic direction and day-to-day oversight for public affairs campaigns in 22 states. The collective ability to observe the similarities and differences of campaigns across the states assists the states in identifying their own active solutions for enhancing the public's health and promoting the profession of dentistry.

**Access, Infrastructure and Capacity Administration**

State technical assistance, Medicaid Provider Advisory Committee (MPAC), Public Health Advisory Committee (PHAC), National Oral Health Conference (NOHC) support, CE

**State Legislative Report**

GPA communicates with a large audience of dental advocates one a month via the State Legislative Report (SLR). The SLR features overview of current state (and local as needed) legislative topics with a comprehensive look at all state health policy issues and activities. The newsletter informs the audience of state legislative activities on a host of relevant topics in all states.

**HCR Implementation**

Implementation of the Patient Protection and Affordable Care Act (ACA) involves ensuring dentistry's voice at both the national and state levels is heard by decision makers. Unless the law is fundamentally changed by legislative or legal means, health care exchanges will be established in all states by January 1, 2014, and the dental delivery system will be affected.

**CAPIR Collaboration**

National Oral Health Conference, Trips staff and volunteers ( examples) National Dental Association (NDA), Hispanic Dental Association (HDA) , Institute of Medicine(IOM); Washington DC trips (etc)

**Interprofessional Relations Admin/Accreditation**

Medical Dental Interface: American Medical Association (AMA), American Hospital Association (AHA), The Joint Commission (TJC), American Association of Ambulatory Health Care (AAAHC), CE programs

**Give Kids A Smile Initiative**

Advisory Committee, Annual Session, Promotion

**Workforce Demonstration Projects**

The ACA includes language that authorizes (but does not provide funding for) the "Alternative Dental Health Care Providers Demonstration Project." The term „alternative dental health care providers" includes community dental health coordinators, advance practice dental hygienists, independent dental hygienists, supervised dental hygienists, primary care physicians, dental therapists, dental health aides, and any other health professional that the Secretary determines appropriate. Since passage of the ACA, the ADA has successfully worked to ensure funding is not provided. Further, through the SPA program, State Government Affairs is working with states across the nation on the workforce challenges posed by the foundations supporting change and other pressure groups.

**ADPAC Marketing Campaign**

In 2010, ADPAC undertook a significant pilot marketing campaign, focusing on two primary goals determined by the ADPAC Board of Directors: 1) educate ADA members on the value of ADPAC, and 2) encourage more members to donate to ADPAC. Since then, awareness about ADPAC has increased, and giving at the Annual Session reached record levels (analysis is currently being done for donations from dues statements). The campaign has largely consisted of advertising in ADA News and other publications, email outreach to members, promotion at conferences, and a giving to ADPAC via the dues statement.

**Washington Leadership Conference**

Annually, ADA leadership and grassroots team leaders (dentists who serve as contacts for Members of Congress through the ADA's political action committee) meet in Washington, D.C. and lobby Congress on several key legislative initiatives.

**Access, Infrastructure, Capacity Collaboration**

National Primary Oral Health Care Conference, CDC & other federal agencies, FQHCs/Safety Net (National Network for Oral Health Access, National Association of

**Interprofessional Relations Collaboration**

National Interprofessional Initiative on Oral Health (NIIOH), National Roundtable for Dental Collaboration (NRDC) Medical Advisory Committee (MAC), CDC Emergency Room Project, Staff/volunteer physician association, perinatal oral health guideline meetings .

**Amalgam Issues**

FDA Amalgam Classification: The FDA is considering the need to reexamine its 2009 decision to classify encapsulated dental amalgam as a Class II medical device. EPA Amalgam Separator Rule: The EPA intends to propose new rule that would mandate the use of amalgam separators in dental offices. Global Mercury Treaty: The State Department is taking part in an international treaty negotiation that would commit signing nations to reduce mercury emissions into the environment.

**Geriatrics and Special Needs Administration – Partial Reduction**

National Elder Care Advisory Committee (NECAC) Symposia, Seminars, Publications and CE

**Geriatrics and Special Needs Collaborations - Partial Reduction**

Dental Lifeline Network (DNL), Special Care Dentistry Association, American Geriatric Society, staff/volunteer travel special meetings

**Lobbyist Conference**

Annually, the ADA's Department of State Government Affairs hosts representatives from the constituent dental societies who are involved in advocacy within the various states to facilitate the sharing of information among the states and to provide details on federal regulations and laws that affect the states.

**Dental Student and New Dentist Issues**

As the future of the profession, dental students and new dentists are disproportionately affected by issues that impact their ability to start and maintain their professional career. The expansion of student loan interest deductions is a key issue, as well maximizing opportunities to practice in the settings and locations of their choice.

**2013 Prevention Summit Decision Package**

The ADA plans to host a three-day national summit in 2013 that will provide an opportunity for diverse stakeholders to collaborate and initiate a process for identifying cooperative solutions to the complex issues surrounding the prevention of oral disease in at risk vulnerable populations as a realistic approach to the access to dental care crisis that has captured the attention of the media and the policy makers of late.

**Funding for Federal Oral Health Programs**

The ADA advocates annually for sufficient funding for federal oral health programs that support dental research, dental residencies, student loans, funding for dental school programs and military dental research. In spite of economic climate we have been able to maintain these programs without any serious reductions. This is especially important because many of these federal programs support state programs which have seen reductions.

**Special Care Dentistry Act Medicaid coverage for underserved elderly**

Most states provide little or virtually no dental coverage for underserved childless adults through their Medicaid program. The ADA believes this population (which generally cannot afford dental services) and society as a whole (fewer costly emergency room visits) will benefit from passage of "The Special Care Dentistry Act of 2011" (H.R. 1606). The bill requires states to provide oral health services to aged, blind or disabled individuals under the Medicaid program.

**Federal Dental Services**

The ADA has a long standing commitment to support Federal dentistry and the dentists that serve in the Armed Services, the Public Health Service and the Veterans Administration, as well as oral health research conducted by the Federal services. In addition, the ADA continues to support pay and rank equality for Federal dentists with our physician colleagues and opposes any efforts that would adversely impact the oral health of members of the armed services, those in the care of the Public Health Service and veterans. In 2011, the ADA was successful in preventing the reduction in rank for the chief dental officers of the Army and Air Force and anticipates that this will also be an issue for 2012.

**Indian Health Issues**

ADA annually participates in coalitions that support the Indian Health Service and American Indian/Alaska Native tribes and individually lobbies for sufficient funding of the IHS. The ADA also provides support of constituent dental society and tribal initiatives through the ADA's State Public Affairs (SPA) program. Specifically, the SPA program's Native American Oral Health Care Project identifies workable solutions to dental care issues facing tribes in Arizona, New Mexico, North Dakota and South Dakota.

Natural account summary for the Division of Government and Public Affairs is below:

**Government & Public Affairs**2013 Budget Summary by Natural Account  
\$ 000

	2011 Actual	2012 Budget	2013 Budget	2013 v 2012 Variance	
				Fav / (Unfav)	
				\$	%
<b>Revenues</b>					
Meeting & Seminar Income	19	40	32	(8)	-20.0%
Grants & Contributions	43	328	10	(318)	-97.0%
<b>Total Revenues</b>	<b>62</b>	<b>368</b>	<b>42</b>	<b>(326)</b>	<b>-88.6%</b>
<b>Expenses</b>					
Total Salaries and Temporary Help	3,173	3,346	3,089	257	7.7%
Total Fringe Benefits	-	1,104	1,024	79	7.2%
Total Payroll Taxes	-	234	213	20	8.8%
Total Travel Expenses	993	922	837	85	9.2%
Printing, Publication & Marketing	111	226	46	180	79.7%
Meeting Expenses	74	95	64	30	32.1%
Consulting and Outside Services	1,360	1,719	1,461	258	15.0%
Professional Services	38	36	47	(11)	-30.3%
Bank & Credit Card Fees	0	1	1	-	0.0%
Office Expenses	212	277	232	45	16.3%
Grants and Awards	1,704	2,414	2,222	192	7.9%
Other Expenses	5	6	10	(5)	-85.9%
<b>Total Expenses</b>	<b>7,671</b>	<b>10,379</b>	<b>9,248</b>	<b>1,131</b>	<b>10.9%</b>
Net Budget Basis Operating Cash Flow	(7,609)	(10,010)	(9,206)	804	8.0%

1

2 This division shows a favorable net budget basis variance of \$804k or 8% when comparing the 2013 budget

3 to the 2012 budget. The favorable variance is largely due to reductions in CAPIR costs and a reduction in

4 State Public Affairs program.

5 **Division of Corporate Relations & Strategic Marketing Alliances**

6 The Division of Corporate Relations and Strategic Marketing Alliances formulates and implements the ADA's

7 corporate relations strategy and tactics, as well as certain strategic marketing alliances. The division also is

8 responsible for securing the ADA's corporate sponsorships, as well as fundraising for certain Give Kids A

9 Smile activities, such as the Awards Gala. Until a permanent Business Development director is hired, the

10 division is the lead agency for the ADA's new Business Development function.

11 Natural account summary for the Division of Corporate Relations & Strategic Marketing Alliances is below:

**Corp. Rel & Strat. Mknng Alliances**

2013 Budget Summary by Natural Account

\$ 000

	2011 Actual	2012 Budget	2013 Budget	2013 v 2012 Variance	
				Fav / (Unfav)	
				\$	%
<b>Expenses</b>					
Total Salaries and Temporary Help	407	418	418	-	0.0%
Total Fringe Benefits	-	126	128	(2)	-1.7%
Total Payroll Taxes	-	24	24	0	0.1%
Total Travel Expenses	5	7	26	(18)	-251.6%
Printing, Publication & Marketing	-	1	1	-	0.0%
Meeting Expenses	2	2	2	(1)	-41.2%
Consulting and Outside Services	-	-	75	(75)	NA
Office Expenses	2	3	3	0	3.1%
<b>Total Expenses</b>	<b>415</b>	<b>581</b>	<b>677</b>	<b>(96)</b>	<b>-16.6%</b>
Net Budget Basis Operating Cash Flow	(415)	(581)	(677)	(96)	-16.6%

This division, on a net budget basis shows an unfavorable variance of (\$96k) or (16.6%) when comparing the 2013 budget to the 2012 budget. This variance is due to new funding related to the business development activities. This activity supports research and development for potential new business ideas that potentially generate additional non-dues revenue.

**Division of Membership, Tripartite Relations & Marketing**

*Purpose:* All of the Division's programs have one aim: focusing ADA on member needs. With outreach to all dentists across their full range of professional and leadership roles, the Division's programs fulfill the Board's Universal Assessment Criteria for ADA services. The Division builds community as it develops and promotes member value; recruits and retains members; fosters a collaborative tripartite network; provides leadership development; brings consistency to membership marketing strategies, messages and branding; and positions the ADA as America's leading advocate for oral health.

*Volunteer Leadership:* Core to the Division's role is supporting volunteer leaders on two ADA councils and two committees of the ADA Board: the Council on Membership, the Council on Members Insurance and Retirement Programs, the New Dentist Committee, and the Diversity Committee.

Per the ADA *Bylaws*, the Council on Membership has the responsibility to: formulate and recommend membership related policies; identify and monitor trends and issues that affect membership recruitment and retention; support development of membership benefits; and enhance tripartite membership efforts and to act as an advocate for member benefits. The Council also oversees the Annual Membership Recruitment and Retention Conference.

The Council on Members Insurance and Retirement Programs responsibilities include: evaluating Association-sponsored and other insurance programs, recommending courses of action for insurance programs, assisting constituent societies on insurance programs, advising on retirement programs, and providing aid to dentists in managing their risks.

1 The New Dentist Committee creates and provides resources and programs to help dentists less than ten  
2 years out of dental school succeed in practice; to develop as leaders in organized dentistry; and to reinforce  
3 the value of ADA membership among dental students and new graduates. To achieve these goals, the  
4 Committee hosts the annual New Dentist Conference, publishes *ADA New Dentist News* quarterly, and  
5 supports tripartite new dentist leadership development, among other activities.

6 The Diversity Committee monitors and advises the Board on diversity and inclusion initiatives in support of the  
7 ADA's strategic plan, including oversight for the ADA Diversity and Inclusion Plan, Institute for Diversity in  
8 Leadership and initiatives from the 2010 National Summit on Diversity in Dentistry.

9 *Departments:* The Division's departments deliver a comprehensive range of membership services. The  
10 Department of Membership Marketing strives to increase ADA's market share in direct member categories,  
11 leads membership market research, supports tripartite recruitment and retention, and provides  
12 comprehensive services for federal dental service and affiliate members. Membership Marketing oversees  
13 the national marketing collaborative campaigns which provide customized recruitment and retention outreach  
14 in collaboration with the constituent dental societies.

15 The New Dentist Committee/Office of Student Affairs provides member service to ADA dental student  
16 members, manages the student membership data and the relationship with the American Student Dental  
17 Association, and coordinates initiatives to convert students to active membership upon graduation. The  
18 department also coordinates the Success Dental Student Programs to introduce students to the ADA as a  
19 lifelong resource and support their professional success, and manages the implementation of New Dentist  
20 Committee initiatives.

21 The Council on Membership and Membership Outreach departments administers the Membership Program  
22 for Growth, a program that funds innovative programs at the constituent and component level to recruit and  
23 retain members, and also provide tools, training, and consultation to foster tripartite dental societies'  
24 membership growth efforts.

25 The Member Service Center is responsible for improving the member/customer experience by functioning as  
26 the first point of contact for members in support of the ADA's recruitment, retention and non-dues revenue  
27 generation strategies by centralizing transactions such as orders and inquiries, and thus providing a more  
28 streamlined member/customer experience.

29 The Council on Members Insurance and Retirement Programs works with sponsored programs and endorsed  
30 vendors to provide insurance plans and retirement programs to enhance the value of ADA membership, and  
31 to provide useful information to member dentists and dental students to help them in achieving their personal  
32 and professional risk management and financial goals.

33 The Department of Membership Information maintains the database of record for the profession and is  
34 responsible for accurate membership, occupation and demographic data for over 236,000 dentist and student  
35 records. Membership Information works with constituent dental societies to process member dues.

36 The Department of Dental Society Services focuses tripartite collaboration on ADA priorities through  
37 leadership and management programs, services, and liaison with constituent and component societies. The  
38 department also staffs the Institute for Diversity in Leadership, the Diversity Committee of the Board, and  
39 ADA's management education program for dentists with Northwestern University (Kellogg School of  
40 Management-not associated with the foundation or the cereal company of the same name). The staff also  
41 consults with 113 dental societies on using Tripartite System, a cost-saving shared system, for timely sharing  
42 of membership data, dues payment processing, member marketing, meetings management, grass roots  
43 advocacy and other member service and association management purposes.

44 **The programs in this division are listed below and are in order of how they ranked utilizing the**  
45 **Decision Lens tool:**

**Council on Membership Administration**

Activities necessary to hold Council meetings and operate the membership program for growth (includes related salaries, supplies, etc.)

**DMM Retention**

Supports retention outreach to tripartite and direct member dentists, and reaches lagging market segments with retention messaging, allowing the ADA to maintain an annual 96-97% retention rate for full-dues paying members.

**Council on Members Insurance and Retirement Programs**

CMIRP generates income through its endorsement of the ADA Members Retirement Program and IRA as well as expense reimbursement through the ADA Member Insurance Plans through the Great West Insurance company that provide member value to 65,000 insured dentists, providing net revenue to the association.

**Council Meeting Expense**

Includes all efforts in support of the February and June Council on Membership Meetings including volunteer travel activities.

**Department of Dental Society Services**

DSS helps focus Tripartite collaboration on ADA priorities through leadership and management programs, services, and liaison. As part of this, DSS supports 112 dental societies who use Tripartite System (TS), a cost-saving shared system that facilitates timely cash flow for dues remittances, quality of member database and use of data for member outreach and service and association management. TS, a "home grown" ADA application will be converting to Aptify during 2012-2013.

**Department of Membership Marketing**

Direct marketing campaigns to support direct member and tripartite recruitment and retention, and important lagging segments. Oversees membership research, the marketing collaborative program, membership processing and comprehensive member services through the Federal Dental Services Membership Office and Office of Affiliate Membership. Administrative and staff resources are also included in this project ID.

**Marketing Collaborative**

The Marketing Collaborative is a key recruitment strategy to conduct three national multi-channel membership campaigns targeting nonmember dentists and conversion of recent graduates to active membership and other membership communications materials that are co-branded and may be customized by each constituent dental society. This reinforces the value of the tripartite and supports the recruitment of first-time members and former members.

**Tripartite Membership Growth Support**

The program that provides constituent societies, component societies and MC2 volunteers tools, resources, training and consultation to support their membership outreach efforts.

**DMM Research**

Member market research has two objectives: 1. Support qualitative and quantitative membership research to assess key metrics such as loyalty, value and benefits. 2. Assess member and nonmember needs and opinions on professional issues, future directions for the ADA, products and services, critical issues and professional trends.

**Membership Program for Growth**

Activities to administer and fund constituent and components innovative programs to recruit and retain members whose applications are accepted through the program.

**Membership Initiative**

Activities necessary to operate membership outreach activities (includes related salaries, travel, supplies, etc.)

**DMM Recruitment**

Supports direct marketing campaigns for tripartite and direct member recruitment, reaching lagging market segments with recruitment messaging, and manages recruitment campaigns and strategies through the marketing collaborative program, resulting in 4500-4750 applications from new and former members annually.

**Office of Student Affairs**

Introduces students to the ADA through student membership, offers resources to help them thrive in school and supports transition to practice and membership as a dentist. Creates 5,000 new student records annually, and continually maintains database of 20,000 student records; processes ADA student membership dues and supports an ADA student market share of 86-88%. Coordinates conversion activities resulting in the transition of 65-69% of new graduates to active membership.

**ASDA Consultant Program**

Offers ASDA student leaders a voice through representation on ADA Councils and Commissions and the New Dentist Committee. Fosters collaboration between the ADA and ASDA and keeps students and ADA informed on important issues.

**Recruitment and Retention Conference**

The conference provides a forum for constituent and component dental society membership staff and volunteers to learn and share best practices, and attracts 125+ attendees from across the country annually. Activities associated with preparing for the conference including obtaining speakers, coordinating curriculum, holding meeting functions, processing registrations, acquiring sponsors and promoting the event.

**New Dentist Committee and New Dentist Programs**

Helps new dentists succeed and demonstrate member value by offering relevant resources to new dentist members and by supporting the New Dentist Committee Network of 450+ constituent and component society volunteers and staff, including leadership development and mentoring activities throughout the tripartite. The NDC serves as the voice of dentists fewer than ten years out of dental school, represents their views to Board and agencies, advocates for development of member benefits, services and resources to facilitate professional and practice success, publishes the quarterly ADA New Dentist News, and hosts the annual New Dentist Conference, a three-day meeting where new dentists receive leadership training, up to 13 hours of CE, plus networking and social events.

**FDS Membership**

Supports recruitment, retention and processing of dentists practicing in the federal services and dentists working in civil service and other positions in the federal government. Activities include providing member service to this membership group, processing of dues and managing communications efforts to recruit and retain members to maintain an FDS membership market share of 58-60%.

**Success Programs -speaker development & dental school**

Provide essential practice information to dental students while positioning the ADA as a lifelong resource for dentists through Success Dental Student Programs. For 2011-2012 academic year, volunteer dentists were invited to present 105 programs, reaching approximately 7,800 students. ADA speaker development trains dentists to present Success programs.

**Institute for Diversity in Leadership**

Visibly demonstrates to diverse members, non-members and diverse national associations the ADA's continued commitment to the program approved by the 2002 House and positioned by the Board to "... to build lifetime relationships with minority dentists; to mentor promising leaders with potential to impact diverse

communities; and to strengthen alliances with stakeholder institutions, including dental leaders, industry, public and governmental communities of interest”

#### Leadership Inclusion Network Decision Package

The Leadership Inclusion Network engages leaders and executives from ADA and an expanding set of national associations representing diverse dentists for collaboration on reducing oral health disparities and for increasing opportunities for dental careers and inclusive leadership (serving one of the Board diversity and inclusion goals.

Natural account summary for the Division of Membership, Tripartite Relations & Marketing is below:

### Membership, Tripartite Relations & Marketing

2013 Budget Summary by Natural Account  
\$ 000

	2011 Actual	2012 Budget	2013 Budget	2013 v 2012 Variance	
				Fav / (Unfav)	
				\$	%
<b>Revenues</b>					
Advertising	56	68	-	(68)	-100.0%
Meeting & Seminar Income	134	164	149	(16)	-9.6%
Grants & Contributions	444	481	462	(19)	-3.9%
Other Income	914	1,030	1,131	102	9.9%
<b>Total Revenues</b>	<b>1,548</b>	<b>1,743</b>	<b>1,742</b>	<b>(1)</b>	<b>-0.1%</b>
<b>Expenses</b>					
Total Salaries and Temporary Help	4,043	4,367	4,270	96	2.2%
Total Fringe Benefits	29	1,546	1,544	2	0.1%
Total Payroll Taxes	16	321	313	8	2.5%
Total Travel Expenses	483	532	533	(2)	-0.3%
Printing, Publication & Marketing	715	1,301	979	322	24.8%
Meeting Expenses	133	167	160	7	4.2%
Consulting and Outside Services	135	148	237	(90)	-60.7%
Professional Services	60	89	71	19	20.8%
Bank & Credit Card Fees	4	5	5	1	10.0%
Office Expenses	223	296	276	20	6.9%
Facility & Utility Costs	4	5	5	0	8.5%
Grants and Awards	425	-	-	-	NA
Other Expenses	174	253	358	(105)	-41.5%
<b>Total Expenses</b>	<b>6,445</b>	<b>9,029</b>	<b>8,750</b>	<b>279</b>	<b>3.1%</b>
Net Budget Basis Operating Cash Flow	(4,897)	(7,286)	(7,008)	278	3.8%

This division, on a net budget basis shows a favorable variance of \$278k or 3.8% when comparing the 2013 budget to the 2012 budget. The favorable variance is due to expense reductions throughout the division.

**1 Division of Conference and Meeting Services**

2 The Division of Conference and Meeting Services develops, plans and coordinates the annual session,  
3 provides meeting and event services across the organization, coordinates the use of in-house conference  
4 facilities, oversees operations of in-house food/audio visual service, and coordinates travel and  
5 accommodations for volunteers and staff. The greatest proportion of divisional activity is directed toward the  
6 annual session at the direction of the Council on ADA Sessions. The annual session provides the dental  
7 community with a broad spectrum of professional, educational and social activities, connecting grassroots  
8 members with the ADA in one of the most tangible ways. Planning and production of this event is a  
9 collaborative effort of staff, volunteers, and contractors, and includes a myriad of activities such as marketing,  
10 promotion, registration, ticket sales, exhibit booth sales, sponsorship, program coordination and publication  
11 production. Annual Session helps dentists succeed throughout their careers through cutting-edge CE,  
12 exposure to the latest products and services, networking interaction with peers, and establishing and revising  
13 policy for the profession. In addition, the Annual Session has consistently generated net non-dues revenue for  
14 the organization.

15 **This division has only one program and the description of the program is detailed below:**

**16 ADA Sessions**

17 At the direction of the Council on ADA Sessions, ADA staff develop, plan and implement one of the largest  
18 dental meetings annually. The event includes several key components including the House of Delegates, over  
19 280 CE offerings, a large dental exposition with over 600 companies, social events, etc. The Annual Session  
20 is a significant generator of non-dues revenue for the ADA.

21 Natural account summary for the Division of Conference and Meeting Services is below:

**Conference & Meeting Services**

2013 Budget Summary by Natural Account

\$ 000

	2011 Actual	2012 Budget	2013 Budget	2013 v 2012 Variance	
				Fav / (Unfav)	
				\$	%
<b>Revenues</b>					
Advertising	264	511	309	(203)	-39.6%
Rental Income	56	46	55	9	18.9%
Meeting & Seminar Income	8,091	10,444	9,245	(1,199)	-11.5%
Grants & Contributions	744	850	862	12	1.4%
Royalties	179	110	78	(32)	-29.1%
Other Income	189	246	238	(8)	-3.3%
<b>Total Revenues</b>	<b>9,522</b>	<b>12,207</b>	<b>10,787</b>	<b>(1,421)</b>	<b>-11.6%</b>
<b>Expenses</b>					
Total Salaries and Temporary Help	1,509	1,822	1,590	232	12.7%
Total Fringe Benefits	-	655	583	72	11.0%
Total Payroll Taxes	-	137	119	18	13.3%
Total Travel Expenses	460	588	556	32	5.4%
Printing, Publication & Marketing	457	543	775	(232)	-42.7%
Meeting Expenses	1,125	2,921	1,730	1,191	40.8%
Consulting and Outside Services	865	1,458	621	837	57.4%
Professional Services	581	669	678	(9)	-1.3%
Bank & Credit Card Fees	143	248	210	38	15.4%
Office Expenses	914	984	1,317	(333)	-33.8%
Facility & Utility Costs	173	32	71	(39)	-120.7%
Endorsement Costs	10	12	10	2	16.7%
Depreciation/Amortization	-	4	7	(4)	-75.0%
Other Expenses	79	131	90	41	31.0%
<b>Total Expenses</b>	<b>6,315</b>	<b>10,204</b>	<b>8,357</b>	<b>1,847</b>	<b>18.1%</b>
Net Budget Basis Operating Cash Flow	3,207	2,003	2,430	426	21.3%

This division, on a net budget basis shows a favorable variance of \$426k or 21.3% when comparing the 2013 budget to the 2012 budget. Annual Session revenue and expense fluctuates based on the location of the meeting. The 2012 meeting is in San Francisco and the 2013 meeting is in New Orleans.

**Headquarters Building - Chicago**

The Headquarters Building houses the majority of ADA staff in a premier location in Chicago. Approximately half of the building is rented to outside tenants. ADA does not pay rent -this has an economic value to the ADA of approximately \$3.8m per year. Jones Lang LaSalle provides day-to-day building management services, as well as providing or coordinating property construction management, janitorial, security, and leasing services.

Natural account summary for the Headquarters Building is below:

**Headquarters Building**

2013 Budget Summary by Natural Account

\$ 000

	2011 Actual	2012 Budget	2013 Budget	2013 v 2012 Variance	
				Fav / (Unfav)	
				\$	%
<b>Revenues</b>					
Rental Income	3,834	3,792	3,826	34	0.9%
Other Income	35	16	23	7	45.3%
<b>Total Revenues</b>	<b>3,869</b>	<b>3,808</b>	<b>3,849</b>	<b>41</b>	<b>1.1%</b>
<b>Expenses</b>					
Total Salaries and Temporary Help	243	233	160	73	31.3%
Total Fringe Benefits	10	93	55	38	40.7%
Total Payroll Taxes	-	19	13	6	31.4%
Printing, Publication & Marketing	25	27	28	(2)	-5.6%
Consulting and Outside Services	1	-	-	-	NA
Professional Services	175	216	261	(46)	-21.3%
Office Expenses	55	72	69	3	4.6%
Facility & Utility Costs	3,907	4,354	4,688	(334)	-7.7%
Depreciation/Amortization	-	11	22	(12)	-111.4%
Other Expenses	74	106	66	40	37.6%
<b>Total Expenses</b>	<b>4,491</b>	<b>5,129</b>	<b>5,363</b>	<b>(233)</b>	<b>-4.6%</b>
Net Budget Basis Operating Cash Flow	(622)	(1,321)	(1,514)	(192)	-14.6%

The Headquarters Building 2013 budget is unfavorable by (\$192k) or (14.6%) on a net budget basis when compared to 2012. This variance is attributable to an increase in building maintenance/service costs, property taxes and management fees, partially offset by reduction in salaries and benefits for a building engineer who retired and who's cost is now included in property management fees.

**Washington DC Building**

The Washington DC Building houses the majority of ADA Government Affairs staff. Ten of the twelve floors are rented to outside tenants. Borger Management provides day-to-day building management services as well as providing or coordinating property construction management, janitorial, security, and leasing services.

Natural account summary for the Washington DC Building is below:

**Washington DC Building**

2013 Budget Summary by Natural Account

\$ 000

	2011 Actual	2012 Budget	2013 Budget	2013 v 2012 Variance	
				Fav / (Unfav)	
				\$	%
<b>Revenues</b>					
Rental Income	1,512	1,661	1,764	103	6.2%
Other Income	15	9	18	9	100.9%
<b>Total Revenues</b>	<b>1,527</b>	<b>1,670</b>	<b>1,782</b>	<b>112</b>	<b>6.7%</b>
<b>Expenses</b>					
Professional Services	54	1	1	-	0.0%
Bank & Credit Card Fees	0	0	0	-	0.0%
Office Expenses	9	13	13	(1)	-6.0%
Facility & Utility Costs	821	821	964	(143)	-17.4%
Depreciation/Amortization	-	11	44	(32)	-286.2%
Other Expenses	21	24	24	-	0.0%
<b>Total Expenses</b>	<b>905</b>	<b>870</b>	<b>1,046</b>	<b>(176)</b>	<b>-20.2%</b>
Net Budget Basis Operating Cash Flow	622	800	736	(64)	-8.0%

The Washington Buildings 2013 budget is unfavorable by (\$64k) or (8%) on a net budget basis when compared to 2012. This variance is attributable to an increase in building maintenance and service costs.

**Division of Finance and Operations**

Finance and Operations consists of two major areas of core services:

Finance which provides all ADA transaction accounting (payroll, accounts payable, accounts receivable), financial reporting and treasury management functions.

Central services provides duplicating, shipping, receiving and administrative support services to the Association through centralized purchasing, mail processing, shipping and receiving, and in-house photocopying, printing, and supplemental services. Central Services also oversees the relationships with our outside property management and leasing agents who oversee the Chicago and D.C. building operations for the ADA and its tenants.

These efforts are supported by volunteers who serve on the Budget and Finance Committee, as well as the Board of Trustees. Finance also assists the Board and House in fulfilling their fiduciary responsibilities through audited financial statements and other reports, as well as providing financial oversight.

Although Finance had been primarily focused on compliance and reporting initiatives over the past two years as prior compliance, accounting and reporting non compliance issues were identified and resolved, 2012 and 2013 activities are increasingly focused on forward-looking and ADA value-adding financial analysis and planning to support operating divisions. Similarly, Central Services is evaluating its core services and building management goals to identify opportunities to generate better value for the Association.

Natural account summary for the Division of Finance and Operations is below:

**Finance and Operations**

2013 Budget Summary by Natural Account

\$ 000

	2011 Actual	2012 Budget	2013 Budget	2013 v 2012 Variance	
				Fav / (Unfav)	
				\$	%
<b>Revenues</b>					
Investment Income	981	1,563	1,785	222	14.2%
Other Income	38	13	115	102	784.6%
<b>Total Revenues</b>	<b>1,018</b>	<b>1,576</b>	<b>1,900</b>	<b>324</b>	<b>20.5%</b>
<b>Expenses</b>					
Total Salaries and Temporary Help	2,832	2,879	2,701	179	6.2%
Total Fringe Benefits	-	1,069	1,010	59	5.5%
Total Payroll Taxes	-	217	201	16	7.3%
Total Travel Expenses	3	4	6	(2)	-57.3%
Printing, Publication & Marketing	39	34	20	14	40.6%
Professional Services	38	48	42	6	12.5%
Bank & Credit Card Fees	1	0	0	(0)	-50.0%
Office Expenses	61	108	81	27	25.2%
Facility & Utility Costs	0	0	-	0	100.0%
Depreciation/Amortization	-	8	18	(10)	-124.5%
Other Expenses	0	4	4	0	10.0%
<b>Total Expenses</b>	<b>2,975</b>	<b>4,371</b>	<b>4,082</b>	<b>289</b>	<b>6.6%</b>
Net Budget Basis Operating Cash Flow	(1,957)	(2,795)	(2,183)	612	21.9%

The Division of Finance and Operations 2013 budget is favorable by \$612k or 21.9% on a net budget basis when compared to 2012. The favorable variance is partially due to an anticipated increase in interest and dividends on Operating Cash and Reserve Fund assets. Interest and dividends projections are based on anticipated short-term interest rates and market conditions. Additionally, other income is expected to increase due to a projected sale of equipment. Also contributing to the net improvement is a reduction in staffing costs based on the transfer of one headcount from ADA Finance to the ADA Foundation.

**Central Administration**

Central Administration combines into one area those revenue and expense activities that do not directly relate to any one division but rather reflect upon the Association in its entirety. These include membership dues revenue, royalty income, endorsement costs, depreciation, grants and the like. Additionally, travel and compensation savings are also budgeted in Central Administration. It should be noted that as a result of the Hyperion implementation, fringe benefits starting in 2012 have been budgeted at the departmental level throughout the ADA. You will notice that the 2011 actual column still include budget for these expenses. The new method of budgeting could only be done starting with the 2012 budget.

Natural account summary for the Division of Central Administration is below:

**Central Administration**2013 Budget Summary by Natural Account  
\$ 000

	2011 Actual	2012 Budget	2013 Budget	2013 v 2012 Variance	
				Fav / (Unfav)	
				\$	%
Membership Dues	54,289	54,812	54,536	(276)	-0.5%
Royalties	3,131	2,468	2,640	172	7.0%
Investment Income	(204)	500	300	(200)	-40.0%
Other Income	606	427	493	66	15.5%
<b>Total Revenues</b>	<b>57,822</b>	<b>58,207</b>	<b>57,969</b>	<b>(238)</b>	<b>-0.4%</b>
Total Salaries and Temporary Help	738	(1,254)	1,509	(2,763)	220.4%
Total Fringe Benefits	17,954	701	2,250	(1,550)	-221.2%
Total Payroll Taxes	2,624	-	-	-	NA
Total Travel Expenses	(0)	(450)	(465)	15	-3.3%
Consulting and Outside Services	44	40	40	-	0.0%
Professional Services	24	23	25	(3)	-11.1%
Bank & Credit Card Fees	484	464	484	(20)	-4.3%
Office Expenses	0	7	9	(3)	-40.0%
Facility & Utility Costs	11	9	11	(3)	-30.6%
Grants and Awards	73	85	73	13	14.7%
Endorsement Costs	480	500	535	(35)	-7.0%
Depreciation/Amortization	6,398	5,894	5,102	792	13.4%
Other Expenses	276	295	286	10	3.2%
ADA Health Foundation - Grant	3,925	1,892	1,900	(8)	-0.4%
<b>Total Expenses</b>	<b>33,033</b>	<b>8,204</b>	<b>11,758</b>	<b>(3,554)</b>	<b>-43.3%</b>
Net Budget Basis Operating Cash Flow	24,790	50,003	46,211	(3,792)	-7.6%

Overall, the net budget basis is unfavorable by (\$3,792) or (7.6%) when comparing the 2013 budget to the 2012 budget. There are a few categories that warrant explanation based on the dollar variance and the explanations are detailed below.

**Membership Dues:** Since membership dues are the result of all activities of the Association, they are recorded in this area. The forecasted reduction in Membership Dues is related to more members moving out of the active full dues paying categories into the discounted reduced/retired categories. Dividing this budgeted dues amount by the full dues rate calculates a number for full dues equivalent members.

	2012	2013
Membership dues budget (before dues rebate & prior year dues)	\$54,698,113	54,431,062
Dues Rate	512	512
Full dues equivalent members	106,832	106,310
Rounded	106,850	106,300

Dues revenue includes an offset for the dues rebate paid to constituent dental societies that submit their dues to the Association in December, January, or February. This rebate is expected to remain at \$5k in 2013.

Membership dues collected from members related to prior years is budgeted at \$110k in 2013 which is slightly higher than in 2012.

**Royalty Revenue:** Royalty income is derived from monies received through the *ADA Business Resources* program. The ADA receives approximately 55% of the gross program royalties. Such income is expected to increase from \$2.47M in 2012 to \$2.64M in 2013. ADA Business Resources revenue was increased in all business lines including credit card, practice financing and patient financing royalties.

**Investment Income:** Projected revenue of \$300k for 2013 relates to the appreciation/depreciation of deferred compensation investments and fluctuates on an annual basis. There is an offsetting expense in the Staff Compensation category of expenses.

## Expenses

**Total Salaries and Temp Help:** This category includes an expense offset of \$1M for compensation savings and \$1.3M to cover severance pay, off cycle salary increases and service awards. The unfavorable variance in this category is due to including \$1M for sunseting of programs/resource reductions in 2012. Additionally, severance pay increases in 2013 due to the significant number of projected staff reductions. Finally, \$ (1,200) for merit/market rate adjustments is included in the 2013 budget. See natural account summary/explanations on pages 2008 through 2011 for complete breakdown of Association-wide compensation expenses.

**Fringe Benefits:** This category includes expense associated with the appreciation/depreciation of deferred compensation investments. There is offsetting revenue in the Other Income category. Furthermore, this category includes budget dollars for workers compensation insurance and union benefits for the building engineers that are ADA staff. This category in 2013 also includes pension and 401K expenses. The ADA must continue to set aside funds to cover the cost of the previous employee pension plan that was offered to employees prior to 2012. The new limited pension plan is also designed to be accompanied by a 401K savings match budgeted to cost \$(1,300) in 2013. Upon approval by the House of Delegates, the additional pension and 401K expenses will be allocated to all divisions of the ADA. See natural account summary/explanations on pages 2008 through 2011 for complete breakdown of Association-wide fringe benefit expenses.

**Depreciation and Amortization:** This category shows a decrease from \$5.9M in 2012 to \$5.1M in 2013. The decline is attributable to the depreciation on assets approved for purchase prior to 2012. Starting in 2012 depreciation is budgeted in the divisions/departments requesting the asset purchases. As assets purchased prior to 2012 become fully depreciated, the expense in Central Administration will continue to decline.

## Contingency Fund

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Annually the ADA budget includes monies for Contingency items. These items are for unanticipated expenses that come up after the budget is approved by the House of Delegates. Because the ADA budget is developed many months in advance of the actual calendar year, there is need to have a contingency fund to handle requests for additional unanticipated funding throughout the year.

Prior to each Board of Trustees meeting, staff is asked if any contingency fund requests need to be presented to the Board of Trustees for approval. The requests that are submitted are provided to the Finance and Budget Committee who evaluate the requests and provide the Board of Trustees with their recommendation on each individual request. The Board of Trustees then votes to approve or deny each individual request.

The 2013 budget includes \$1M for Contingency fund requests which is the same amount as budgeted in 2012.

Natural account summary for the Contingency Fund is below:

## Contingency General

2013 Budget Summary by Natural Account  
\$ 000

Expenses	2011 Actual	2012 Budget	2013 Budget	2013 v 2012 Variance	
				Fav / (Unfav)	
				\$	%
Total Salaries and Temporary Help	228	-	-	-	NA
Total Travel Expenses	45	21	-	21	100.0%
Printing, Publication & Marketing	20	-	-	-	NA
Meeting Expenses	2	-	-	-	NA
Consulting and Outside Services	215	125	-	125	100.0%
Professional Services	177	-	-	-	NA
Office Expenses	227	-	-	-	NA
Grants and Awards	10	10	-	10	100.0%
Other Expenses	-	844	1,000	(156)	-18.4%
<b>Total Expenses</b>	<b>925</b>	<b>1,000</b>	<b>1,000</b>	<b>-</b>	<b>0.0%</b>
Net Budget Basis Operating Cash Flow	925	1,000	1,000	-	0.0%

As items in the contingency fund are approved by the Board of Trustees, the budgeted dollars are transferred to the appropriate line items.

## Division of Information Technology

The Division of Information Technology is comprised of three technology-related departments: Content and Data Management Solutions, IT Architecture/Infrastructure and Enterprise Systems Solutions, which provide cost-effective technology and telephone support to the Association and its divisions in Chicago, and Washington DC through a number of PC, Web and LAN-based application systems, office automation, and network services. In addition, these departments provide technology support to the tripartite through the Tripartite System (TS) and directly to members and the public through ADA.org and MouthHealthy.org on the Internet. They also provide technology support to the Association's revenue-generating programs. This division is also comprised of one administrative department, Office of the Chief Technology Officer, which provides the leadership and support for the Association's technology resources provided by these three departments.

These department budgets are meant to fund ongoing daily operations. Although cost saving measures are important in managing this functional area, it is critical that periodic upgrades and replacements occur to maintain and enhance service levels. If the technology environment is not kept relatively current, eventual replacement would come at a much higher cost in the future.

Natural account summary for the Division of Information Technology is below:

**Information Technology**

2013 Budget Summary by Natural Account

\$ 000

	2011 Actual	2012 Budget	2013 Budget	2013 v 2012 Variance	
				Fav / (Unfav)	
				\$	%
<b>Expenses</b>					
Total Salaries and Temporary Help	3,899	4,503	4,697	(194)	-4.3%
Total Fringe Benefits	-	1,486	1,584	(98)	-6.6%
Total Payroll Taxes	-	336	351	(15)	-4.5%
Total Travel Expenses	16	23	47	(24)	-103.8%
Meeting Expenses	1	-	-	-	NA
Consulting and Outside Services	556	1,298	1,016	282	21.7%
Office Expenses	1,459	1,968	1,568	400	20.3%
Facility & Utility Costs	-	10	10	0	0.6%
Depreciation/Amortization	-	124	1,085	(961)	-773.4%
Other Expenses	-	67	41	26	38.8%
<b>Total Expenses</b>	<b>5,931</b>	<b>9,815</b>	<b>10,399</b>	<b>(584)</b>	<b>-6.0%</b>
Net Budget Basis Operating Cash Flow	(5,931)	(9,815)	(10,399)	(584)	-6.0%

This division shows a (\$584k) or (6%) unfavorable variance when comparing the 2013 budget to the 2012 budget. This variance is largely attributable to the depreciation expense being higher in 2013 due to asset requests from decision packages and standard hardware purchases in 2012 that are expected to be purchased late in 2012 having a full year worth of depreciation in 2013 as compared to only a few months in 2012. 2012 is the first year that depreciation of capital items is budgeted at the divisional level. Prior to 2012 all depreciation expense was budgeted in Central Administration.

The increase in salary, fringe benefit and payroll tax expenses is due to one new position being requested. Additionally, several positions are open within the division and are budgeted at the mid-point of the salary range which overall are higher than what was included in the 2012.

Partially offsetting the unfavorable variance is declines in consulting, outside services and office expenses. These reductions are a result of the 2012 budget having a significant number of decision packages that were for projects that are not on-going.

**Division of Dental Practice/Professional Affairs**

The Division of Dental Practice/Professional Affairs includes the Council on Dental Practice (CDP), the Council on Dental Benefit Programs (CDBP) and the Department on Dental Informatics (DDI).

Several advisory committees and subcommittees support the CDP, including the Center for Professional Success (CPS) Advisory Committee; the Subcommittee on the Dental Team; the Subcommittee on Practice Models and Economics; the Subcommittee on Teledentistry; and the Subcommittee on CDP Policy Revision. These committees are all are included in the Council's administrative budget. The Dental Wellness Advisory Committee also supports the CDP, which is included in the Council's Dentist Health and Wellness budget. The Council represents practicing dentists with the DDI and participates in the development of the Electronic Health Record (EHR) and other information technology solutions through its work with the Standards Committee on Dental Informatics (SCDI). The Council's primary focus involves the development and dissemination of dental practice management and marketing information to assist dentists in the efficient

operation of their dental practices. In 2013, the Council will provide oversight to the ADA Center for Professional Success, which will establish the American Dental Association as a world class source of dental practice management information through the development and delivery of practice management resources and continuing education.

The Council on Dental Benefit Programs is the ADA agency dedicated to promoting quality dental care through the development, promotion and monitoring of dental benefit programs for the public, as well as by development and maintenance of coding taxonomies and quality assessment and improvement tools and methodologies. The Council on Dental Benefit Programs is supported by the Quality Assessment and Improvement (QA&I), Dental Codes Maintenance and Development and the Dental Benefit Information Service (DBIS) program areas, which are displayed as separate budgets within the Council. The QA&I area provides staff support to the Dental Quality Alliance and advocates for effective professional review processes for use among dentists, patients and payers. CDBP, the lead agency that established the DQA as directed by a House of Delegates mandate, now manages the work of the Alliance and serves as one of the ADA representatives. *Working with all the stakeholders in the quality measurement arena, the DQA hopes to ensure that appropriate measures are developed and implemented in dentistry.* The Council's Subcommittee on the Code is concerned with maintaining the ADA's *Code on Dental Procedures and Nomenclature* and is responsible for developing, evaluation and disseminating information on coding taxonomies including diagnostic input codes-SNODENT. The DBIS area provides a resource on the vast array of dental benefit plans develops educational materials regarding dental benefits, including an online course and interacts with third-party payers advocating for the appropriate administration and financing of dental benefit programs.

The role of the Department of Dental Informatics (DDI) is to apply information technology to administrative and clinical workflows in dentistry. The primary objective of dental informatics is to improve patient care and increase administrative efficiency through the use of information technology. The DDI continues to serve as the primary resource to dental offices that have questions about all enacted and pending HIPAA regulations. The DDI works with many areas within the ADA, particularly the Council on Dental Benefit Programs and the Council on Dental Practice. The DDI is also supporting CDBP with the maintenance and distribution of the Systematized Nomenclature of Dentistry (SNODENT). In addition to the above, DDI now staffs the Dental Content Committee. The DDI advocates for the dental profession through active participation in the standards community and provides staff support to the ADA's Standards Committee on Dental Informatics (SCDI). Furthermore, the Department of Dental Informatics assists with coordinating ADA comments on legislation and regulations related to Health Information Technology (HIT), Administrative Simplification and Electronic Health Records (EHR) in order to protect the profession from the unnecessary application of standards that could adversely affect dental practice.

**The programs in this division are listed below and are in order of how they ranked utilizing the Decision Lens tool:**

#### **Dental Code Development and Maintenance**

This program supports the Council on Dental Benefit Programs fulfillment of its ADA Bylaws responsibility "To formulate and maintain dental coding taxonomies that dentists can use to document patient care and to explore applications and opportunities for new coding taxonomies."

#### **Department of Dental Informatics**

The DDI oversees the development of standards for electronic dental records, transactions and terminology (e.g., SNODENT) which are necessary for members to do business.

#### **CDBP Third-Party Issues**

The CDBP answers member questions, intervenes when possible and develops tools to address a top priority issue for our members.

**CDBP Dental Quality Alliance**

House of Delegates mandated development of quality measures for dentistry to support the appropriate measurement of health outcomes.

**The Center for Professional Success (CPS) Advisory Committee**

The CDP will provide oversight to the CPS and help establish the ADA as a world class source of dental practice management information, tools, education, and services.

**Subcommittee on Teledentistry**

The CDP formed a subcommittee to address Resolution 61H-2011, Practice Development of Teledentistry. A representative of dental practice attended the 2012 American Telemedicine Association Meeting, and the Subcommittee will report to the 2012 HOD.

**Subcommittee on the Dental Team**

This CPD subcommittee plays a critical role maintaining liaisons relationships with national organizations representing members of the dental team. These organizations include the American Dental Hygienists' Association, American Dental Assistants Association, American Association of Dental Office Managers, Dental Assisting National Board, National Association of Dental Laboratories, National Board for Certification of Dental Labs and the Dental Lab Summit.

**Subcommittee on Practice Models and Economics**

The CDP formed a Subcommittee on Practice Models and Economics to study changing trends in practice models, group practice configurations and the economy.

Natural account summary for the Division of Dental Practice/Professional Affairs is below:

**Dental Practice/Professional Affairs**

2013 Budget Summary by Natural Account

\$ 000

				2013 v 2012 Variance	
	2011 Actual	2012 Budget	2013 Budget	Fav / (Unfav)	
				\$	%
<b>Revenues</b>					
Publication & Product Sales	0	0	0	(0)	-50.0%
Meeting & Seminar Income	29	5	45	41	900.0%
Grants & Contributions	18	93	153	60	64.3%
Other Income	8	6	210	203	3280.4%
<b>Total Revenues</b>	<b>55</b>	<b>104</b>	<b>408</b>	<b>304</b>	<b>291.3%</b>
<b>Expenses</b>					
Total Salaries and Temporary Help	1,992	2,177	1,776	401	18.4%
Total Fringe Benefits	-	715	615	101	14.1%
Total Payroll Taxes	-	147	128	19	13.0%
Total Travel Expenses	346	508	498	10	2.1%
Printing, Publication & Marketing	8	7	182	(175)	-2502.3%
Meeting Expenses	18	22	26	(5)	-22.3%
Consulting and Outside Services	38	47	250	(203)	-432.7%
Professional Services	9	6	16	(11)	-194.5%
Bank & Credit Card Fees	1	0	1	(1)	-183.3%
Office Expenses	30	25	30	(5)	-18.3%
Other Expenses	-	3	-	3	100.0%
<b>Total Expenses</b>	<b>2,442</b>	<b>3,657</b>	<b>3,522</b>	<b>136</b>	<b>3.7%</b>
Net Budget Basis Operating Cash Flow	(2,387)	(3,553)	(3,114)	439	12.4%

1 This division 2013 budget shows a favorable variance of \$439k or 12.4% when compared to 2012. The  
 2 favorable revenue variance is largely due to new revenue associated with the implementation of Center for  
 3 Professional Success (CPS). (CPS) also adds expense budget which is the reason for the variances in print,  
 4 publications & marketing and consulting and outsider services expense categories.

5 Also contributing to the favorable expense variance is cost efficiencies.  
 6

**Health Policy Resources Center**

8 The Health Policy Resources Center (HPRC) is a central repository for information relating to the health policy  
 9 of the ADA. The main purpose of this area is to strengthen and contribute to ADA's policy and advocacy on  
 10 economic and technical issues. This is accomplished by identifying critical policy position development needs  
 11 of the Association in economic and technical areas for use by ADA councils, commissions and the Board; by  
 12 providing unbiased, scientifically valid information and analysis on priority economic issues of the Association  
 13 for staff and policy-making bodies; by determining and prioritizing the objective, and economic/technical  
 14 research needed for effective positioning and advocacy; by being responsible for oversight of activities of the  
 15 Dental Economic Advisory Group; and by providing management and interpretation of survey results  
 16 published by the Survey Center. In addition, HPRC also provides analytical and statistical services to other  
 17 agencies within the ADA.  
 18

HPRC is the central ADA source for collection, analysis, and publication of current statistics on dentistry. Surveys are conducted in response to mandates of the House of Delegates and directives of the Board of Trustees, as well as requests from the Association's councils, departments and commissions. In addition to making the reports available as free downloadable reports to members, salable materials to non-members and the public and providing internal survey research assistance, HPRC also provides survey research consultation to tripartite members. Furthermore, HPRC provides research samples and custom analysis of existing primary data for industry, dental organizations, and other related agencies (e.g., hospitals, educational institutions).

The programs in this division are listed below and are in order of how they ranked utilizing the Decision Lens tool:

#### Policy Research

Delivers critical data and policy analysis to inform decision making among ADA leadership and members.

#### Dental Economics Advisory Group

Provides input into HPRCs strategic policy research agenda and guidance on specific technical analysis issues.

Natural account summary for the Division of Health Policy Resources Center is below:

### Health Policy Resource Center

2013 Budget Summary by Natural Account

\$ 000

	2011 Actual	2012 Budget	2013 Budget	2013 v 2012 Variance	
				Fav / (Unfav)	
				\$	%
<b>Revenues</b>					
Publication & Product Sales	51	118	60	(58)	-49.1%
<b>Total Revenues</b>	<b>51</b>	<b>118</b>	<b>60</b>	<b>(58)</b>	<b>-49.1%</b>
<b>Expenses</b>					
Total Salaries and Temporary Help	1,161	1,355	1,358	(3)	-0.3%
Total Fringe Benefits	-	455	464	(9)	-2.1%
Total Payroll Taxes	-	97	97	(0)	-0.1%
Total Travel Expenses	23	27	18	9	33.2%
Printing, Publication & Marketing	5	2	1	1	45.5%
Meeting Expenses	2	4	3	0	2.8%
Consulting and Outside Services	204	462	424	39	8.3%
Office Expenses	189	168	167	1	0.5%
Facility & Utility Costs	0	0	0	(0)	-25.0%
Other Expenses	-	4	-	4	100.0%
<b>Total Expenses</b>	<b>1,584</b>	<b>2,574</b>	<b>2,534</b>	<b>40</b>	<b>1.6%</b>
Net Budget Basis Operating Cash Flow	(1,534)	(2,456)	(2,474)	(17)	-0.7%

This division does not show any significant variances when comparing the 2013 and 2012 budgets.

**Division of Education/Professional Affairs**

The Division of Education is made up of three agencies with *Bylaws* authority: the Council on Dental Education and Licensure, the Commission on Dental Accreditation and the Joint Commission on National Dental Examinations; and three departments: the Department of Testing Services and the Department of Library Services. Among its responsibilities, the Council on Dental Education and Licensure provides oversight for the Continuing Education Recognition Program (CERP) that evaluates and recognizes providers of continuing dental education and the Dental Admission Testing Program (DAT). Major areas of responsibility include the promotion of excellence and consistency in education, improving the quality of dental education and the quality and uniformity of licensure examinations. The Department of Library Services supports the Association's role as an information source.

Seminar Series, in conjunction with other Association divisions, develops markets and administers continuing education programs that support practicing dentists and the dental team. Additionally, the Center provides a resource on continuing education to other departments in order to enhance the consistency, quality and delivery of the Association's continuing education offerings and maintains the Association's CERP status.

**The programs in this division are listed below and are in order of how they ranked utilizing the Decision Lens tool:**

**The Joint Commission- National Board Dental Examinations**

National Boards Part I, Part II; Dental Hygiene National Board. Candidates need to pass these exams for licensure.

**CDEL-Dental Aptitude Test (DAT)-policy is the purview of CDEL; administration is the purview of Dental Testing Services**

Test for admission to dental school Testing Services (DTS)

**CODA (Accreditation)**

Accreditation of all dental and dental-related education programs in the US.

**CDEL-Continuing Education Recognition Program (CERP)**

CERP Committee evaluates and approves providers of CE programs based on established standards for CE quality. This is required for dentists to renew their state licenses. AGD PACE provides a very similar service.

**Testing services for outside clients-Optometry Admission Test (OAT)**

OAT and other testing services to other outside organizations.

**Center for Continuing Education and Lifelong Learning-Seminar Series**

A series of related courses that are available online.

**Library Services- Partial Funding**

Library service provided to members, non-members and the public. Maintain the archive of the ADA and provide inter-library loans.

Natural account summary for the Division of Education/Professional Affairs is below:

**Education**

2013 Budget Summary by Natural Account

\$ 000

				2013 v 2012 Variance	
	2011 Actual	2012 Budget	2013 Budget	Fav / (Unfav)	
				\$	%
<b>Revenues</b>					
Testing Fees & Accreditation	17,129	17,427	18,020	592	3.4%
Meeting & Seminar Income	610	977	711	(267)	-27.3%
Grants & Contributions	10	136	40	(96)	-70.6%
Royalties	41	45	18	(27)	-60.0%
Other Income	101	267	270	3	1.2%
<b>Total Revenues</b>	<b>17,892</b>	<b>18,853</b>	<b>19,058</b>	<b>206</b>	<b>1.1%</b>
<b>Expenses</b>					
Total Salaries and Temporary Help	4,997	5,223	4,439	784	15.0%
Total Fringe Benefits	-	1,939	1,646	292	15.1%
Total Payroll Taxes	-	399	332	67	16.7%
Total Travel Expenses	1,435	1,676	1,670	6	0.3%
Printing, Publication & Marketing	22	100	94	6	5.9%
Meeting Expenses	6	31	19	12	38.9%
Consulting and Outside Services	1,342	284	54	230	81.1%
Professional Services	4,238	5,219	5,316	(97)	-1.9%
Bank & Credit Card Fees	285	253	282	(29)	-11.3%
Office Expenses	233	247	157	89	36.3%
Grants and Awards	-	2	-	2	100.0%
Endorsement Costs	120	135	150	(15)	-11.1%
Other Expenses	3	21	16	5	25.3%
<b>Total Expenses</b>	<b>12,681</b>	<b>15,528</b>	<b>14,175</b>	<b>1,353</b>	<b>8.7%</b>
Net Budget Basis Operating Cash Flow	5,211	3,325	4,884	1,559	46.9%

1  
2  
3 Educations 2013 budget is favorable by \$1.6M or 46.9% on a net budget basis when compared to 2012. This  
4 variance is attributable to an increase in the fee structure in testing and accreditation fees. Meeting & seminar  
5 income and grants and contributions have declined as a result of eliminations of unprofitable product  
6 offerings. Expense reductions are primarily the result of a planned transition out of the costly in-house ADA  
7 library operation, resulting in savings in salaries expense, fringe benefit and payroll taxes categories. Further  
8 savings will be achieved in 2014 when the transition is completed, at which point it may also be possible to  
9 also generate new revenue by renting out the office space.

**Division of Science/Professional Affairs**

11 The Division of Science supports the Council on Scientific Affairs, which provides the House, the Board and  
12 other ADA agencies with the sound scientific basis for ADA policy. The Division manages the ADA Center  
13 for Evidence-Based Dentistry, the ADA Laboratories and other scientific research and product evaluation  
14 activities including the ADA Seal program and Professional Product Review research and publication.  
15 Through the ADA Laboratories, the Division assures the accuracy and reproducibility of safety and efficacy  
16 data submitted to the ADA Acceptance Program to gain the Seal of Acceptance and evaluates professional  
17 dental products that represent new technology or issues about safety and efficacy of concern to ADA  
18 members. The Division houses the Department of Standards Administration, which coordinates and

administers national and international dental standards for dental products and informatics. Through these programs, the Division of Science monitors emerging dental science and responds to critical issues that could have significant impact on practicing dentists and the oral health of the public. The primary focus is on clinical issues involving the health of the dental team. Emphasis is on provider, patient and public safety to assess, promote and advance effective clinical care. The Division provides the scientific content to ADA print and digital communications and provides member dentists, the dental healthcare team, and the public with timely and relevant information based upon sound scientific principles and evidence-based research.

**The programs in this division are listed below:**

**Standards and Guidelines**

Develops national and international standards and guidelines for dental products; includes related standards development and testing in ADA labs

**ADA Seal**

Americans recognize the ADA Seal of Acceptance as the gold standard when it comes to evaluating the safety and efficacy of dental products. Consumers look for the Seal when buying toothpaste, toothbrushes, mouthwash and even chewing gum. Families trust the ADA to research and test the scientific claims of consumer dental products.

**Center for Evidence-Based Dentistry**

Includes clinical guidelines, systematic reviews, critical summaries, EBD Website, Champions and Forsyth courses.

**ANSI Standards**

Fulfills ADA obligations as ANSI-recognized Standards Development Organization, including US SubTags, Dental Informatics and liaison with other SDOs affecting dentistry.

**Scientific Information and Guidance**

Critical appraisal of science literature and emerging trends to inform and guide ADA agencies, members and the public.

**Research**

Includes HSP data collection, management and analysis; project protocol development; invention of patentable instrumentation; scientific presentations and publication in peer reviewed journals; and educational collaborations.

**Professional Product Review**

Includes content generation, writing and editing. Content covers dental materials, equipment and devices; digital tech; therapeutics; and clinical techniques produced in ADA or labs or via clinical collaborations.

Natural account summary for the Division of Science/Professional Affairs is below:

**Science**

## 2013 Budget Summary by Natural Account

\$ 000

				2013 v 2012	
				Variance	
	2011	2012	2013	Fav / (Unfav)	
	Actual	Budget	Budget	\$	%
<b><u>Revenues</u></b>					
Publication & Product Sales	8	10	10	-	0.0%
Grants & Contributions	269	55	29	(26)	-47.5%
Royalties	3	2	3	0	25.0%
Other Income	609	646	646	1	0.1%
<b>Total Revenues</b>	<b>889</b>	<b>713</b>	<b>688</b>	<b>(25)</b>	<b>-3.5%</b>
<b><u>Expenses</u></b>					
Total Salaries and Temporary Help	3,654	4,216	3,628	587	13.9%
Total Fringe Benefits	-	1,324	1,258	66	5.0%
Total Payroll Taxes	-	278	260	19	6.7%
Total Travel Expenses	430	487	477	10	2.0%
Printing, Publication & Marketing	237	203	75	128	63.0%
Meeting Expenses	62	79	43	36	45.4%
Consulting and Outside Services	294	93	85	7	8.0%
Professional Services	39	164	98	66	40.4%
Bank & Credit Card Fees	3	1	1	(0)	-66.7%
Office Expenses	276	352	347	5	1.4%
Facility & Utility Costs	3	62	56	5	8.9%
Grants and Awards	-	5	5	-	0.0%
Depreciation/Amortization	-	37	80	(43)	-117.7%
Other Expenses	11	14	-	14	100.0%
<b>Total Expenses</b>	<b>5,009</b>	<b>7,314</b>	<b>6,415</b>	<b>900</b>	<b>12.3%</b>
Net Budget Basis Operating Cash Flow	(4,120)	(6,602)	(5,727)	875	13.2%

The division of Science's 2013 budget is favorable by \$875k or 13.2% on a net budget basis when compared to 2012. Expense reductions include net \$350 thousand for elimination of the Health Screening Program. The 2012 budget also anticipated hiring of new staff whereas the 2013 budget holds salaries expense at the 2011 actual levels. Additionally, the 2013 budget included the second year of a two-year consumer marketing program for the ADA Seal that was not financially viable and considered inconsistent with the Science Division's mission.

**Publishing Division**

The Publishing Division's mission is to produce credible, high quality ADA publications that inform the dental profession (in the US and globally) about the latest practical and scientific information as well as socioeconomic and political issues affecting oral health care. These publications are produced in print and electronic formats. The Division directs the editorial, business, and financial operations of ADA publications in print and electronic media—JADA, ADA News, and all catalog products. Responsibilities run the full gamut of

strategic planning, product and content development in print and on ADA.org, as well as business development (advertising sales, marketing, printing, distribution and fulfillment). Publishing also oversees the activities of JADA's scientific editor, editorial board, industry advisory board, and advertising sales representatives.

**The programs in this division are listed below and are in order of how they ranked utilizing the Decision Lens tool:**

### JADA

Flagship scientific journal of the ADA, revenue generating via advertising, paid subscriptions, licensing and ancillary products.

### ADA News

ADA News is the primary communications vehicle for members of the ADA, revenue generating primarily via advertising.

Natural account summary for the Division of ADA Publishing is below:

## ADA Publishing

2013 Budget Summary by Natural Account  
\$ 000

	2011 Actual	2012 Budget	2013 Budget	2013 v 2012 Variance	
				Fav / (Unfav)	
				\$	%
<b>Revenues</b>					
Advertising	7,766	10,213	8,620	(1,593)	-15.6%
Publication & Product Sales	956	1,269	853	(416)	-32.8%
Meeting & Seminar Income	-	-	40	40	NA
Grants & Contributions	-	-	351	351	NA
Royalties	108	157	156	(1)	-0.4%
<b>Total Revenues</b>	<b>8,831</b>	<b>11,639</b>	<b>10,020</b>	<b>(1,619)</b>	<b>-13.9%</b>
<b>Expenses</b>					
Total Salaries and Temporary Help	2,039	2,135	2,040	95	4.5%
Total Fringe Benefits	-	759	741	18	2.4%
Total Payroll Taxes	-	154	146	8	5.0%
Total Travel Expenses	52	75	67	8	11.0%
Printing, Publication & Marketing	4,897	5,862	5,171	691	11.8%
Meeting Expenses	14	13	50	(37)	-274.1%
Consulting and Outside Services	249	265	267	(3)	-1.0%
Professional Services	85	123	421	(298)	-243.3%
Bank & Credit Card Fees	47	5	47	(42)	-872.9%
Office Expenses	74	109	89	20	18.0%
Facility & Utility Costs	11	10	12	(2)	-20.0%
Other Expenses	82	65	60	4	6.9%
<b>Total Expenses</b>	<b>7,551</b>	<b>9,573</b>	<b>9,111</b>	<b>462</b>	<b>4.8%</b>
Net Budget Basis Operating Cash Flow	1,280	2,066	909	(1,157)	-56.0%

ADA Publishing's 2013 budget is unfavorable by (\$1,593k) or (56%) on a net budget basis when compared to 2012. On the revenue side, advertising revenue shows an unfavorable variance of (\$1,593k) due to a continued decline in ad sales in JADA and ADA News, however, this is projected to be partially offset by new revenue from online advertising which is reported in the Communication division budget. The increase in grants and contributions is due to a new program "JADA Live Seminar Series" being budgeted in 2013. This program will generate approximately \$54k in net revenue.

On the expense side, printing, publication & marketing expenses are declining, which is direct result of the decline in advertising revenue. The increase in professional service expense is due to the "JADA Live Seminar Series". There is a positive variance in salaries and benefits due to headcount reductions.

### **Product Development & Sales**

The Department of Product Development and Sales (PDS) produces patient education and professional resources for sale primarily to ADA member dentists. The 500+ PDS products include printed materials such as books, brochures and postcards, as well as DVDs, e-books, apps and web content. Major topic areas include dental disease prevention and treatment, dental coding, staff training and management, HIPAA and OSHA compliance, and practice marketing.

PDS handles the full spectrum of product activities from concept to distribution. Product ideas are gathered from ADA members, and content is vetted in focus groups and by experts within and outside the ADA. Going forward, PDS will be an active participant in the Business Development initiative across the ADA. PDS closely monitors design and production to ensure accurate, high-quality products. A robust multichannel marketing program consisting of direct mail, e-grams, websites and ads, print ads and tradeshow raises member awareness of PDS product benefits. Members order PDS products via the ADA Member Service Center and the PDS e-commerce site, [adacatalog.org](http://adacatalog.org). An outside warehouse fulfills the orders. To ensure products are meeting members' needs, PDS systematically surveys customers, compiles all product feedback and consults this data when revising or developing products. PDS has benefited from the 2012 conversion from Siebel to Aptify, in that on line sales are demonstrating a positive trend.

PDS generates significant additional revenue by licensing CDT codes and other content to U.S. and international licensees. Sales of the ADA member mailing list sales are also handled in this department.

**This division has only one program and the description of the program is detailed below:**

### **Product Development & Sales**

This department produces products primarily in education, practice management and patient information for the entire ADA, working with multiple divisions and Councils. More than 540 products are produced and sold through PDS, with annual revenues of approximately \$8 million.

Natural account summary for the Product Development and Sales is below:

**Product Development and Sales**2013 Budget Summary by Natural Account  
\$ 000

	2011 Actual	2012 Budget	2013 Budget	2013 v 2012 Variance	
				Fav / (Unfav)	
				\$	%
<b>Revenues</b>					
Publication & Product Sales	4,899	7,247	5,816	(1,431)	-19.7%
Royalties	2,536	2,179	2,398	220	10.1%
<b>Total Revenues</b>	<b>7,435</b>	<b>9,426</b>	<b>8,214</b>	<b>(1,211)</b>	<b>-12.9%</b>
<b>Expenses</b>					
Total Salaries and Temporary Help	771	799	807	(9)	-1.1%
Total Fringe Benefits	-	276	284	(7)	-2.7%
Total Payroll Taxes	-	60	60	(1)	-1.1%
Total Travel Expenses	16	19	21	(2)	-8.3%
Printing, Publication & Marketing	2,090	2,871	2,407	464	16.2%
Meeting Expenses	0	-	17	(17)	NA
Consulting and Outside Services	169	305	216	89	29.0%
Bank & Credit Card Fees	139	172	163	9	5.2%
Office Expenses	43	42	42	(0)	-1.2%
Facility & Utility Costs	0	1	1	-	0.0%
Endorsement Costs	2	-	-	-	NA
Other Expenses	39	45	30	15	32.6%
<b>Total Expenses</b>	<b>3,270</b>	<b>4,588</b>	<b>4,048</b>	<b>540</b>	<b>11.8%</b>
Net Budget Basis Operating Cash Flow	4,165	4,838	4,167	(671)	-13.9%

Product Development and Sales 2013 budget is unfavorable by (\$671k) or (13.9%) on a net budget basis when compared to 2012. The decline in net revenue is largely due to 2013 being a non-CDT product release year. 2012 is the last year that CDT sales were made on a 2 year cycle. Starting in 2013, CDT updates are sold on an annual basis and revenue should be consistent year to year thereafter. This accounts for the variance in publication and product sales on the revenue side and printing, publication and marketing on the expense side. The increase in royalty revenue is due to a projected increase in CDT licensing royalties.

**Division of Global Affairs**

This division's purpose is to enable all ADA international activities such as: the Committee on International Programs and Development, the International Development Subcommittee, the International Business Strategic Planning Team and the ADA's membership to and participation in the FDI World Dental Federation. The Division also assists other committees/workgroups, ADA staff and officers in maintaining and forming relationships with international organizations, colleagues and contacts, so that international initiatives reflect the ADA International Strategic Approach that was approved by the Board of Trustees.

The Committee on International Programs and Development (CIPD) advises the ADA Board of Trustees and ADA agencies regarding the ADA's international activities, the alignment of these activities with the International Strategic Approach, the Association's Strategic Plan, and the positioning of the ADA as an active partner in the global oral health arena, with the ultimate goal of improving global oral health.

The ADA International Development Subcommittee and the HVO Oral Health Initiative provides and promotes opportunities for global volunteer service to ADA members who wish to address clinical and patient needs

while sharing knowledge and expertise with local health-care workers and providers in order to improve dental skills, practice methodologies, and access to care for underserved populations.

The division manages the ADA's FDI World Dental Federation membership and promotes its international agenda, assuring the stature of the Association in the global dental community; facilitates the operations, planning, coordination and logistics of the ADA/FDI delegation who represent the ADA on governance, communications, dental practice, education, science and standards, dental development and health promotion at the FDI Annual World Dental Congress and within the North American Regional Organization (NARO). The international dental community depends heavily on ADA leadership, especially on issues related to environmental mercury (UNEP/WHO), access and standards.

The International Business Strategic Planning Team is responsible for developing an international business plan and thereafter, for implementing and executing the plan as approved by the CIPD, and consistent with the ADA's Constitution and Bylaws. The Division of Global Affairs assumes the lead role of the Team in order to facilitate a more uniform approach, enhance the ADA brand, and more efficiently allocate resources. It uses its international expertise to orchestrate various activities of the group which include evaluating external international opportunities that come into the Association, to provide guidance on international business practices and cultural norms, and to recommend best practices. This Planning team works to strengthen the ADA's fiscal position by identifying international business opportunities including continuing education, JADA, evidence based dentistry and affiliate membership that will bring in non-dues revenue for the Association.

**The programs in this division are listed below and are in order of how they ranked utilizing the Decision Lens tool:**

#### **FDI World Dental Federation**

Includes the FDI membership dues, all the expenses related to the ADA/FDI Delegation and general FDI activities. (ADA membership is critical in establishing international oral health policy that ultimately affects ADA members e.g. Mercury, NCDs etc.)

#### **Liaison to International Community**

Includes the major international initiatives of the ADA and all protocol for work within an international environment: by creating and fostering relationships with external organizations, international colleagues and contacts; aligning the ADA with the BOT approved International Strategic Approach; acting as a membership link to the international community; and activities including the Humanitarian Award; Certificate Program; international section of ADA.org, plus organizing meetings, receptions and hosting international guests.

#### **International Business Activities**

Activities include international marketing and promotion; business development via ADA booths at international meetings; and foreign language translations. (This program supports all Divisions with International business interests and in 2011 it realized a net income of over \$650,000).

#### **International Humanitarian Outreach**

Includes the expenses of the International Development Subcommittee and all its activities including fund raising for programs in developing countries, and the management of the International Volunteer Web page (2011 saw 50,000 + visits with average view time of 6 minutes/25 seconds)

#### **Convert Part Time Position to Full Time Decision Package**

Managing the ongoing objectives and activities of the CIPD in support of the International Strategic Approach and assistance in the expansion and implementation of the international business plan especially in China, as international engagement is now seen as a strategic priority by the BOT.

Natural account summary for the Division of Global Affairs is below:

**Division of Global Affairs**

2013 Budget Summary by Natural Account

\$ 000

	2011 Actual	2012 Budget	2013 Budget	2013 v 2012 Variance	
				Fav / (Unfav)	
				\$	%
<b>Revenues</b>					
Grants & Contributions	36	-	-	-	NA
<b>Total Revenues</b>	<b>36</b>	<b>-</b>	<b>-</b>	<b>-</b>	<b>NA</b>
<b>Expenses</b>					
Total Salaries and Temporary Help	395	403	425	(23)	-5.6%
Total Fringe Benefits	-	134	147	(12)	-9.2%
Total Payroll Taxes	-	29	31	(2)	-6.9%
Total Travel Expenses	179	304	240	63	20.8%
Printing, Publication & Marketing	51	79	74	6	7.4%
Meeting Expenses	52	63	63	1	0.8%
Consulting and Outside Services	2	5	5	-	0.0%
Professional Services	3	16	15	1	4.5%
Bank & Credit Card Fees	0	1	1	-	0.0%
Office Expenses	256	334	352	(17)	-5.2%
Grants and Awards	8	5	5	-	0.0%
Other Expenses	4	5	5	0	10.0%
<b>Total Expenses</b>	<b>951</b>	<b>1,377</b>	<b>1,361</b>	<b>16</b>	<b>1.2%</b>
Net Budget Basis Operating Cash Flow	(915)	(1,377)	(1,361)	16	1.2%

There are no significant variances to report for this division.

**Division of Communications and Marketing**

The Division of Communications and Marketing is a shared service resource working with all ADA divisions to meet the communications and marketing needs of the Association. With strategic guidance from the Council on Communications, the division advises the ADA on brand image and the usage and application of intellectual property in all communications and is charged with safeguarding the reputation of the Association. The division engages member, professional and public audiences in order to preserve and enhance the ADA's position as America's leading advocate for oral health. The division's responsibilities include media relations, public affairs and advocacy, the creation and production of all video media and public service announcements, executive communications, creation and management of all digital media assets, marketing research, marketing strategy, copywriting, design and printing services as well as environmental scanning.

The Marketing Department ensures that the ADA speaks with a unified voice, provides a point of integration for the effective application of communications plans and brings operating efficiencies to the development and production of all video and print materials. The Public Affairs Department, located in the Washington office, provides counseling and support to Leadership on access to care, workforce, scope of practice and other legislative and advocacy issues and strategic counsel to the State Public Affairs Program. Through the Public and Professional Communications Department all media relations and issues management activities are conducted in close collaboration with Leadership and the other Divisions, with primary responsibility for managing the reputation of the ADA. Additionally this department provides media training for ADA

spokespeople and Leadership and support for all executive communications needs. The Electronic Media Department responsibilities include oversight of ADA.org, MouthHealthy.org, ADA Intranet, ADA e-mail publications, and other electronic media. Electronic Media works closely with Information Technology to ensure the high functionality of the resources available electronically and that the user experiences are positive, impactful and fully consistent with the both the brand and image of the Association.

Natural account summary for the Division of Communications is below:

## Communications

2013 Budget Summary by Natural Account  
\$ 000

	2011 Actual	2012 Budget	2013 Budget	2013 v 2012 Variance	
				Fav / (Unfav)	
				\$	%
<b>Revenues</b>					
Advertising	-	-	688	688	NA
Meeting & Seminar Income	1	4	5	1	25.0%
Grants & Contributions	53	27	-	(27)	-100.0%
Other Income	1	-	-	-	NA
<b>Total Revenues</b>	<b>55</b>	<b>31</b>	<b>692</b>	<b>662</b>	<b>2162.9%</b>
<b>Expenses</b>					
Total Salaries and Temporary Help	2,259	2,484	2,373	111	4.5%
Total Fringe Benefits	-	837	817	20	2.4%
Total Payroll Taxes	-	178	170	8	4.7%
Total Travel Expenses	122	166	134	33	19.8%
Printing, Publication & Marketing	390	650	839	(189)	-29.2%
Meeting Expenses	108	55	52	3	6.0%
Consulting and Outside Services	68	67	162	(95)	-141.8%
Professional Services	1	7	249	(242)	-3585.0%
Office Expenses	74	47	40	7	14.5%
Other Expenses	-	1	-	1	100.0%
<b>Total Expenses</b>	<b>3,021</b>	<b>4,491</b>	<b>4,835</b>	<b>(344)</b>	<b>-7.7%</b>
Net Budget Basis Operating Cash Flow	(2,966)	(4,461)	(4,143)	318	7.1%

The division of Communications 2013 budget is favorable by \$318k or 7.1% on a net budget basis when compared to 2012. This division is launching a new Consumer Website (MouthHealthy.org) which is projected to generate \$688k in non-dues revenue. The Consumer Website has contributed to the increases in print, publications & marketing and professional services expenses. Overall this new program will generate net revenue of \$150k in 2013. Additional expense savings will be realized as a result of a divisional reorganization which will generate a net reduction in headcount.

## Capital Budget

House of Delegates Resolution 132H-1992 (*Trans.*1992:588) directs that a description of all proposed capital expenditures exceeding \$25,000 be incorporated into the report of the Board on financial matters. The schedule and explanatory narrative that follows are intended to comply with this requirement.

Individual expenditures below this \$25,000 threshold, when possible, have been aggregated into broad categories for presentation on the next page.

1

	<b>2013</b>
<b>Description</b>	<b>FUNDING</b>
<b>Building Related</b>	
LED Retrofit 2nd Floor	\$ 62,000
New Lutron Lighting System 2nd Floor Auditorium	68,000
New Floor System Lower Level	55,000
Induction Lighting Mechanical Rooms, Garage and Dock	33,000
Upgrades Main Cooling Tower	150,000
Waterproof 23rd Floor	127,000
Fan Shaft Replacement	53,000
Condenser Pump Motors	30,000
Cat Walk East Roof	43,000
Misc Projects	35,000
Leasehold Improvements related to vacant space	181,000
Common Area Interior and Exterior Repairs	30,000
2nd Floor Bathroom Renovation	215,000
<b>Total Building Related Items</b>	<b>1,082,000</b>
<b>Technology</b>	
Computer Hardware/Software	810,000
MS SharePoint Licenses for EBD Website	65,000
PeopleSoft Tools Upgrade Implementation	40,000
Aptify 6.0 Upgrade	25,000
ADA Connect Expansion & Taxonomy	35,000
ADA.org Website Re-Engineering	139,000
ePerformance Implementation & Training	91,000
Aptify Learning Management System (LMS)	185,000
<b>Total Technology</b>	<b>1,390,000</b>
<b>Scientific Equipment</b>	
Dual Mid IR / NIR spectrometer	33,000
<b>Total Scientific Equipment</b>	<b>33,000</b>
<b>Other</b>	
Exec Dinning Room Equipment/Furnishings	25,000
Audiovisual Equipment	25,000
Furniture (Association Wide)	40,000
Copiers, Fax Machines, Scanners & Water Coolers	30,600
Contingency Fund	230,000
<b>Total Other</b>	<b>350,600</b>
<b>Grand Total</b>	<b>\$ 2,855,600</b>

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3

**LED RETROFIT – 2<sup>ND</sup> FLOOR AUDITORIUM & CONFERENCE ROOMS:** The bulbs (135 watt) currently being used will no longer be made after 2013. The new LED bulbs will reduce maintenance and energy costs. The payback is 14 years.

**NEW LUTRON LIGHTING SYSTEM – 2<sup>ND</sup> FLOOR AUDITORIUM & CONFERENCE ROOMS:** This is the removal of the old Lutron system which is no longer supported by Lutron and installing a new lighting system for the 2<sup>nd</sup> floor auditorium and conference rooms. The old system is currently having issues and is very expensive to maintain at its current state.

**NEW FLOOR SYSTEM – LOWER LEVEL:** New floor system for the lower level. Due to the high dolly traffic the floor is failing in many areas and becoming a tripping hazard. New floor system that can take wear and tear is recommended.

**INDUCTION LIGHTING – MECHINCIAL ROOMS, GARAGE & DOCK:** This project consists of replacing all the metal halides in all the mechanical rooms, garage and dock areas. The new induction lighting system would give us better lighting in these areas and save us on energy and maintenance with a simple payback of around 1.7 years.

**UPGRADES – MAIN COOLING TOWER:** New filter system needs to be installed to keep tower clean, which helps extend the life of the cooling tower. This new system will also include a new caulk joint and a new rain installation in the middle of the tower, which will also help in extending its useful life.

**WATERPROOF 23<sup>RD</sup> MECHANICAL FLOOR:** We currently have leaking issues from the 23<sup>rd</sup> floor due to all the mechanical equipment on the floor. Waterproofing the floor like we did with the garage and dock areas will prevent water damage to lower floors when an issue arises saving the building in time and maintenance expense.

**FAN SHAFT REPLACEMENT:** After many years of wear and tear the shaft begins to be less efficient and a possible safety hazard if not replaced. Could cause more of an expense if not taken care of and will save on energy due to it being more efficient.

**CONDENSER PUMP MOTORS – MAIN CHILLER:** The current condenser pump is at the end of its useful life. New motor will also be more efficient which means less in electrical expense.

**CAT WALK EAST ROOF:** The cat walk would be installed in order to clean the 2 cooling towers that serve the 4<sup>th</sup> floor and second floor. Contractors and the engineers would use the catwalk to clean the towers instead of a ladder that could possibly fall and hurt someone or damage the roofing membrane.

**LEASEHOLD IMPROVEMENTS RELATED TO VACANT SPACE - DC:** When tenants sign new leases or renew current leases they are allocated an allowance for improvements to their leased space. The budgeted amount of \$181,000 is based upon the leases expiring in 2012 in the Washington DC building. The leasing fees are the paid to the management company upon tenants signing their contracts.

**COMMON AREA INTERIOR AND EXTERIOR REPAIRS – DC:** Exterior caulking of the joints between the exterior precast and window sections on the East and North side of the DC building.

**2<sup>ND</sup> FLOOR BATHROOM RENOVATIONS:** The bathrooms on the 2<sup>nd</sup> floor (there are four) have not been renovated over 25 years. The bathroom fixtures, wall and ceiling tile and partitions are in need of contemporary upgrades. This will help to improve the look of the 2nd Floor Conference Center, providing a competitive edge in relation to other meeting space offered in the immediate area. A better impression on potential customers maximizes our opportunity for non-dues revenue through the leasing opportunities of our Conference Center.

**COMPUTER HARDWARE & SOFTWARE:** It has been the Association's practice to replace and upgrade a portion of existing computer equipment on an annual basis in recognition of technical obsolescence and excessive repair. The rapid pace of technological improvements has caused the Association to cycle replacements every three years.

**MS SHAREPOINT LICENSES FOR EBD WEBSITE:** This request is to complete website enhancements in 2013.

**PEOPLESOFT TOOLS UPGRADE IMPLEMENTATION:** In 2013, an upgrade to the latest version of PeopleTools will be completed. People Tools is the software development environment used by IT developers to create and customize PeopleSoft applications. This upgrade will ensure developers are using the most current software development environment that is compatible with most recent upgrades to the Finance and HRMS systems.

**APTIFY 6.0 UPGRADE:** Travel is necessary for ADA staff to be on location of the scheduled site conversion and implementation. It is anticipated that 10-12 states and their local societies will be converted in 2013. Each conversion would require 1 IT staff person to be onsite for 2 full days. Travel is also included for the Chief Technology Officer (CTO) to be onsite to meet with State Executives and other staff as needed.

**ADA CONNECT EXPANSION & TAXONOMY:** The purpose is to obtain funding to retain outside IT consulting services to develop and implement a collaboration area and template on ADA Connect for the Board of Trustees.

**ADA.ORG WEBSITE RE-ENGINEERING:** The purpose is to obtain the funding to develop and implement the Sitecore web content management software onto ADA.org as a replacement for the Open Text Reddot web content management software. The vendor for Reddot has announced a plan to sunset Reddot in favor of their new product, Vignette. Vignette only works in UNIX environments where the ADA is a Microsoft environment. This upgrade will provide an improved navigation design for ease-of-use by ADA members and non-member dental professionals as well as greater efficiencies for the ADA's marketing and content production staff as compared to the Reddot product currently being used.

**ePERFORMANCE IMPLEMENTATION & TRAINING:** The purpose of this decision package is to request the necessary funding to retain outside IT consulting services to assist IT staff with the implementation of the PeopleSoft ePerformance module and to provide ADA staff with the necessary training to use this module. The ePerformance module would replace the ADA's current in-house developed Performance Management tool and would integrate into the Association's current PeopleSoft Human Resources Management system.

**APTIFY LEARNING MANAGEMENT SYSTEM:** The purpose is to obtain the funding to develop and implement the Aptify Education and eLearning/Learning Management System (LMS) modules to provide Continuing Education (CE) and Online Learning Management services that would replace the CE module within the Tripartite System; provide new functionality to allow online delivery of CE programs and to facilitate and manage the Tripartite's online CE activities and provide a variety of other learning activities for ADA members, non-members and ADA staff.

**DUAL MID IR/NIR SPECTROMETER: Dual Mid IR / NIR spectrometer:** Fourier transform infrared (FTIR) spectroscopy is an analysis technique that provides information regarding the molecular structure and chemical bonding of materials. These materials can be organic or inorganic. FTIR is used primarily in failure analysis (scientific process of collecting data for determining the cause of a particular failure) in order to identify unknown materials. Specifically, spectroscopy is used to determine the quantity, structure and identity of atoms, molecules and ions by analyzing the radiation emitted or absorbed by those molecules. FTIR is a technique which is used to obtain an infrared spectrum of absorption, emission, photoconductivity or Raman scattering of a solid, liquid or gas. An FTIR spectrometer simultaneously collects spectral data in a wide spectral range. As a result, FTIR spectroscopy is a very useful technique in identifying unknown components of a mixture.

1 **EXECUTIVE DINNING ROOM EQUIPMENT/FURNISHINGS:** Purchase new china and flatware due to  
2 broken or damaged inventory in order to maintain the EDR service levels. Replacement is needed for  
3 efficient food service operation in the Executive Dining Room kitchen. Catering equipment is old, broken and  
4 in need of replacement.

5  
6 **AUDIOVISUAL EQUIPMENT:** Purchase an array of upgraded Audio Visual equipment to improve service to  
7 both internal and external customers. Replace outdated equipment (camcorders) needed to conduct  
8 spokesperson training seminars, all employee videotaping and videotaping other events throughout the ADA  
9 as needed. Additional audio recorders are needed for the councils and committee meetings that must be  
10 recorded on a regular basis throughout the building.

11  
12 **FURNITURE:** This provides for standard Association-wide furniture replacement.

13  
14 **COPIERS, FAX MACHINES, SCANNERS:** This provides for the purchase of dual-line fax machines and 2  
15 filtered water replacements.

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17 **Contingency Fund:** The capital budget includes a contingency fund for unanticipated but necessary  
18 expenditures, just as the operating budget does. The Board will approve all expenditures from the capital  
19 contingency fund.

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**Appendices include the following:**

- Agency Programs
- Association Reserves
- 2011 Financial Results
- Headquarters Building Renovation and Valuation
- One-Time Activities

<b>American Dental Association 2013 Agency Programs</b>		
<b>Division</b>	<b>Program</b>	<b>Decision Lens Score</b>
Dental Practice/Professional Affairs	Dental Code Development & Maintenance ADA	0.745
Government & Public Affairs	Fluoridation and Prevention Administration	0.644
Government & Public Affairs	Passage of McCarran-Ferguson (antitrust legislation)	0.644
Government & Public Affairs	Passage of ERISA Bill	0.599
Government & Public Affairs	Eliminating/Reducing Harmful Regulations	0.590
Government & Public Affairs	State Non-Covered Services	0.590
Membership, Tripartite Relations & Marketing	Council on Membership Administration	0.588
Government & Public Affairs	FTC Related Issues	0.573
Government & Public Affairs	Fluoridation and Prevention Collaboration	0.566
Government & Public Affairs	CAPIR Administration	0.564
Government & Public Affairs	Health Information Technology	0.563
Education	The Joint Commission- National Board Dental Examinations Educ	0.555
Education	CDEL-Dental Aptitude Test (DAT) Educ	0.542
Government & Public Affairs	Community Outreach Cultural Competency Health Literacy Administration	0.535
Dental Practice/Professional Affairs	Department of Dental Informatics DentProfAffr	0.527
Government & Public Affairs	State Legislative Bill Tracking	0.510
Government & Public Affairs	State Public Affairs (SPA) Program	0.510
Science	Standards and Guidelines Sci	0.510
ADA Publishing	JADA ADAPub	0.509
Science	ADA Seal ADA	0.507
Government & Public Affairs	Access, Infrastructure and Capacity Administration	0.498
Government & Public Affairs	State Legislative Report	0.497
ADA Publishing	ADA News ADAPub	0.492
Science	Center for Evidence-Based Dentistry Sci	0.490
Health Policy Resource Center	Policy Research HealthPolResCntr	0.489
Government & Public Affairs	HCR Implementation	0.486
Science	ANSI Standards Sci	0.485
Government & Public Affairs	CAPIR Collaboration	0.479
Government & Public Affairs	Interprofessional Relations Admin/Accreditation	0.479
Science	Scientific Information and Guidance Sci	0.477
Government & Public Affairs	Give Kids A Smile Initiative	0.475
Government & Public Affairs	Workforce Demonstration Projects	0.474
Government & Public Affairs	ADPAC Marketing Campaign	0.467
Government & Public Affairs	Washington Leadership Conference	0.467
Government & Public Affairs	Access, Infrastructure, Capacity Collaboration	0.463
Membership, Tripartite Relations & Marketing	DMM Retention	0.461
Membership, Tripartite Relations & Marketing	Council on Members Insurance and Retirement Programs MbrTriMktg	0.459
Government & Public Affairs	Community Water Fluoridation (National/State)	0.458
Education	CODA (Accreditation) Educ	0.457
Government & Public Affairs	Community Outreach Cultural Competency Collaborations	0.457
Membership, Tripartite Relations & Marketing	Council Meeting Expense	0.453
ADA Publishing	Product Development & Sales ADAPub	0.452
Membership, Tripartite Relations & Marketing	Department of Dental Society Services	0.452
Dental Practice/Professional Affairs	CDBP Third-Party Issues	0.450
Government & Public Affairs	Interprofessional Relations Collaboration	0.442
Dental Practice/Professional Affairs	CDBP Dental Quality Alliance	0.440
Membership, Tripartite Relations & Marketing	Department of Membership Marketing	0.434
Government & Public Affairs	Amalgam Issues	0.433
Science	Research Sci	0.432
<i>Continued on Following Page</i>		

<i>Continued From Preceding Page</i>		
Government & Public Affairs	Geriatrics and Special Needs Collaborations	0.425
Government & Public Affairs	Lobbyist Conference	0.425
Membership, Tripartite Relations & Marketing	Marketing Collaborative	0.425
Membership, Tripartite Relations & Marketing	Tripartite Membership Growth Support	0.423
Science	Professional Product Review	0.414
Membership, Tripartite Relations & Marketing	DMM Research	0.413
Membership, Tripartite Relations & Marketing	Membership Program for Growth	0.412
Dental Practice/Professional Affairs	The Center for Professional Success (CPS)	0.410
Membership, Tripartite Relations & Marketing	Membership Initiative	0.407
Government & Public Affairs	Dental Student and New Dentist Issues	0.392
Government & Public Affairs	2013 Prevention Summit Decision Package	0.385
Membership, Tripartite Relations & Marketing	DMM Recruitment	0.369
Membership, Tripartite Relations & Marketing	Office of Student Affairs	0.366
Membership, Tripartite Relations & Marketing	ASDA Consultant Program	0.352
Membership, Tripartite Relations & Marketing	Recruitment and Retention Conference	0.352
Education	CDEL-Continuing Education Recognition Program (CERP) Educ	0.350
Government & Public Affairs	Funding for Federal Oral Health Programs	0.350
Government & Public Affairs	Special Care Dentistry Act (Medicaid coverage for underserved elderly)	0.343
Conference & Meeting Services	ADA Sessions	0.338
Membership, Tripartite Relations & Marketing	New Dentist Committee and New Dentist Programs	0.337
Dental Practice/Professional Affairs	Economic Issues DentProfAffr	0.322
Education	Testing services for outside clients Educ	0.315
Membership, Tripartite Relations & Marketing	FDS Membership	0.313
Dental Practice/Professional Affairs	The Dental Team Advisory Panel (DTAP)	0.304
Division of Global Affairs	FDI World Dental Federation	0.304
Government & Public Affairs	Federal Dental Services	0.301
Membership, Tripartite Relations & Marketing	DMM International	0.299
Dental Practice/Professional Affairs	Ergonomics and Disability Support Advisory Committee (EDSAC)	0.296
Science	Non-U.S. Activities	0.296
Dental Practice/Professional Affairs	Teledentistry DentProfAffr	0.294
Dental Practice/Professional Affairs	Future of Dental Laboratory Technology	0.292
Dental Practice/Professional Affairs	Practice Patterns and Transitions	0.290
Division of Global Affairs	Liaison to International Community	0.288
Division of Global Affairs	International Business Activities	0.280
Membership, Tripartite Relations & Marketing	Success Programs -speaker development & dental school MbrTriMktg	0.266
Dental Practice/Professional Affairs	Dental Well-Being Advisory Committee (DWAC)	0.262
Government & Public Affairs	Indian Health Issues	0.258
Education	Center for Continuing Education and Lifelong Learning-Seminar Series Ec	0.247
Division of Global Affairs	International Humanitarian Outreach	0.239
Membership, Tripartite Relations & Marketing	Institute for Diversity in Leadership	0.238
Division of Global Affairs	Convert Part Time Position to Full Time Decision Package	0.235
Membership, Tripartite Relations & Marketing	Leadership Inclusion network Decision Package	0.227

- 1
- 2 The agency programs that were not funded are listed below and sorted based on the corresponding decision
- 3 lens score.
- 4

<b>Proposed Decision Packages/Agency Programs</b>		
Not Funded in 2013 Budget		
<b>Division</b>	<b>Program</b>	<b>Decision Lens Score</b>
Government & Public Affairs	Community Outreach Cultural Competency Health Literacy Administration	0.535
Government & Public Affairs	Community Outreach Cultural Competency Collaborations	0.457
Government & Public Affairs	National Childrens Dental Health Month	0.433
Science	Pilot to Revitalize Seal Decision Package Sci	0.433
Government & Public Affairs	Geriatrics and Special Needs Administration(Partial Reduction)	0.432
Membership, Tripartite Relations & Marketing	Member Handbook	0.423
Science	EDB Clin Rec & Ed. Programs Decision Package Sci	0.393
Health Policy Resource Center	Dental Economics Advisory Group HealthPolResCntr	0.343
Science	ADEA/ADA EBD Workshop Decision Package Sci	0.291
Dental Practice/Professional Affairs	Emergency Preparedness and Disaster Recovery DentProfAffr	0.291
Education	CDEL-Hands-on Anesthesia and Airway Management Training Educ	0.281
Government & Public Affairs	American Indian/Alaska Native Volunteer Program	0.274
Education	Center for Continuing Education and Lifelong Learning-CE Online Educ	0.237
Education	Library Services-online and walk-in service Educ	0.228
Dental Practice/Professional Affairs	Hillenbrand Fellowship DentProfAffr	0.223
Education	CDEL-Career Guidance Educ	0.216
<b>Shared Services Decision Packages Not Funded in 2013</b>		
ePerformance Decision Package(Partial Reduction)		
LMS Decision Package		

**Descriptions of the Agency Programs that were not funded are detailed below:**

**Community Outreach Cultural Competency – Health Literacy Administration**

National Oral Health Literacy Advisory Committee (NOLAC), health literacy toolkit, Conferences, CE.

**Community Outreach Cultural Competency Collaborations**

American Public Health Association (APHA), National Rural Health Association (NRHA), Society of American Indian Dentists (SAID), Office of Minority Health, Cultural Competence.

**National Children's Dental Health Month**

Material Development and Promotion

**Pilot to Revitalize Seal Decision Package**

This is the second phase of a Seal 2-year marketing campaign to consumers to revitalize the Seal of Acceptance Program. The first phase was funded and initiated in 2012. The intention is to provide an incentive to manufacturers by providing tangible evidence to include the Seal on more OTC products.

**Geriatrics and Special Needs Administration**

National Elder Care Advisory Committee (NECAC) Symposia, Seminars, Publications and CE.

**Member Handbook**

Communicates the benefits of membership. The handbook is sent to all existing members and to tripartite dental societies to assist in their membership retention efforts. Includes all activities to develop and develop the piece, as well as the efforts necessary to generate sponsorship and advertising revenue to increase handbook value and offset production expense.

**EDB Clinical Recommendations & Educational Programs Decision Package**

In accordance with the EBD business plan which was previously approved this would add one staff person to increase the capacity of the ADA's EBD Center to develop clinical recommendations, address emerging professional needs, and increase the capacity for educational outreach programs to member dentists. This would enable the EBD Center to produce 2 additional clinical recommendations per year, pilot and implement the EBD educational program for dental schools, and develop translational resources to help dentists implement clinical recommendations in their practices to enhance patient care.

**Dental Economics Advisory Group**

Provides input into HPRCs strategic policy research agenda and guidance on specific technical analysis issues.

**ADEA/ADA EBD Workshop Decision Package**

The ADA's Center for Evidence-based Dentistry (EBD) and ADEA would like to collaborate in creating a workshop at the 2103 ADA annual meeting that would both build the capacity of dental school faculty to incorporate EBD into their curricula. As collaborators, both associations would equally contribute and leverage human and financial resources to develop programs on how to teach EBD to dental students.

**Emergency Preparedness and Disaster Recovery**

The subcommittee collaborates with external groups, including the American Medical Association, the National Disaster Life Support Education Consortium™, the Centers for Disease Control and Prevention and the U.S. Public Health Service towards developing appropriate ADA policies regarding the dentist's role in emergency response and disaster preparedness.

**CDEL-Hands-on, Anesthesia and Airway Management Training for General Practitioners**

A hands-on, CE courses for general practitioners that want to provide sedation services in their office. CDEL staff manage the course; content experts are hired to give the course. Unique to the ADA. Equipment/faculty/space limitations.

**American Indian/Alaska Native Volunteer Program**

Placement, Early Childhood Caries, Indian Health Service (IHS) update conferences, Indigenous Child Health conference, etc.

**Center for Continuing Education and Lifelong Learning-CE Online**

Many competitors in this arena. Courses that are available for free are the most popular.

**Library Services-online and walk-in service**

Library service provided to members, non-members and the public. Maintain the archive of the ADA. Inter-library loan.

**Hillenbrand Fellowship**

The purpose of the Hillenbrand Fellowship is to provide support for one year for one member dentist to develop leadership and association management skills while simultaneously working on a project of their choosing. The ADA benefits not only from the project itself and other duties performed by the Fellow during their year, but from the return on investment as the Fellow transitions from dental practice into a rewarding non-clinical career.

**CDEL-Career Guidance**

Information for prospective students for the entire range of dental careers.

**Association Reserves**

The Association's Reserve Division consists of a Capital Formation Account and an Investment Account. The former includes long-term capital investment in ADA Business Enterprises Inc., which is not easily liquidated and therefore not available for immediate situations.

On the other hand, the Investment Account represents liquid reserves that are more readily convertible to cash. The objectives of the liquid reserve fund are to sustain basic operations and core member services during a short- or long-term economic downturn, as well as to cover unbudgeted expenditures brought about by events or opportunities requiring immediate funding. Association leadership attempts to balance the need for liquid reserve funds against maintaining an affordable membership dues structure, recognizing that a strong reserve position is a key component keeping the ADA financial stable for the foreseeable future.

*Reserve Division Investment Account.* Investments in this account are currently allocated among mutual funds and managers with differing investment strategies. This approach diversifies the overall portfolio and distributes the risk.

The chart below provides a summary of the ADA's reserve position as of May 31, 2012.

RESERVES					
<b>Balance, May 31, 2012 before commitments</b>					<b>\$53,584,050</b>
<b>Pending Transfers of authorized commitments (from)/to Reserves</b>					
	Council on Dental Practice study			(156,255)	
	Workforce models (CDHC) pilot program			(529,343)	(685,598)
<b>Remaining Authorized Commitments</b>					
	Workforce models CDHC			(831,068)	
	National issues discussion on workforce			(18,803)	
	Remediation process			(70,000)	
	New IT security officer position			(85,250)	
	State public affairs program funding			(5,000,000)	
	Council on Dental Practice study			(28,245)	(6,033,366)
<b>Balance, May 31, 2012 adjusted for commitments</b>					<b>\$46,865,086</b>
<b>Percent of 2012 budgeted expenses of</b>				<b>\$120,139,667</b>	<b>39.0%</b>

The additional chart below provides a multi-year projection of the ADA's reserve position. This projection includes estimates of annual budget surpluses, the on-going impact of the \$30 dues increase being proposed for 2013, spending based on existing commitments against reserves, the Board of Trustees and House of Delegates approving additional commitments against reserves and investment returns which assumes a 7% return annually.

The chart also provides a projected calculation of the estimated reserve percentage based on year-end reserve balance and annual ADA operating expense budgets. For modeling purposes only, the ADA operating expense budget assumes a constant 3% annual increase. Based on all these rough assumptions, the reserve projection shows that the ADA could reach the targeted 50% level in 2015.

<b>ADA Reserve Account Projections</b>					
August 2, 2012					
\$ 000					
	2011 Act	2012	2013	2014	2015
<b>Net Uncommitted Reserves</b>					
Beginning of Year		47,118	48,789	54,192	59,972
Changes:					
Operating Surplus / (Deficit) Before Dues Increase		373	1,047	1,047	1,047
\$ 30 Dues Increase in 2013		-	2,940	2,940	2,940
Reserve Spending		(2,000)	(2,000)	(2,000)	(2,000)
Investment Returns		3,298	3,415	3,793	4,198
Total Changes		1,671	5,402	5,780	6,185
End of Year	47,118	48,789	54,192	59,972	66,157
Budget Expenses	120,148	120,642	118,427	121,980	125,639
Reserve % of Expenses	39.2%	40.4%	45.8%	49.2%	52.7%

Uncommitted Reserves exclude designated funds committed by Board or House resolutions. Commitments assume renewal of State Public Affairs program funding under resolution 37H-2011, which would otherwise expire on December 31, 2012.

Related to this reserve fund projection model, the Board also considered the needs for a designated capital fund for infrequent and extraordinary capital building projects at its June meeting. A subsequent review of the ADA's historical documentation revealed that the ADA Board had established a Capital fund in 1993, funded it as part of the annual budget process and continued its use until it was closed in 2005.

As a result, the Board also recommended a \$50 per year special assessment for the next two years (in 2013 and 2014) to establish, as outlined in the ADA's strategic plan and permitted by ADA Bylaws Chapter XVII Section 30, a Capital Improvement fund to support:

- Major building repair and replacement projects,
- Tenant improvements to secure long term lease agreements,
- Stability of long term reserves which would otherwise be impacted by spending for inevitable capital projects, and,
- An emergency fund in the event of a sudden, unforeseen capital equipment failure.

1 Looking at multi-year projection for the long term reserve fund above in relation to the building fund, some  
2 portion of the future surpluses generated by the continuation of the \$30 dues increase after the ADA reaches  
3 the 50% target reserve level in 2015 could be designated to continue funding of the capital replacement fund  
4 as part of the ongoing annual operating budgets. Based on ADA's history, it appears that similar budget  
5 funding of the capital improvement fund was approximately \$1.5 million per year from 1993 to 2004.  
6

7 **2011 Financial Results**

8 **ADA Operating Results:** The 2011 budget approved by the House of Delegates projected a net deficit of  
9 (\$1,041,600). Actual results yielded a net deficit of (\$1,623,502). This represents an unfavorable variance of  
10 approximately \$582k to budget.  
11

12 The actual operating deficit was primarily attributable to the following:  
13

<b>ADA Operating Results</b>					
<b>Explanation of Variance to Budget</b>					
<b>Budget Net ADA Operations</b>				<b>(\$1,041,600)</b>	
<u>Revenue variances</u>					
Favorable – Royalty revenue	1,314,000				
Unfavorable – short-term investment earnings	(1,852,000)				
Favorable – Dues revenue	347,000	(191,000)			
<u>Expense variances</u>					
Unfavorable – Pension	(1,980,000)				
Favorable - Open Positions	1,424,000				
Favorable – Travel expenses	471,000				
Unfavorable – ADA Foundation grant	(365,000)				
Unfavorable - Depreciation	(280,000)	(730,000)			
<u>Division variances (without salaries/travel - includes revenues)</u>					
Favorable – Education **	580,000				
Favorable – Govt/Public Affairs/SPA **	510,000				
Unfavorable – Product Sales **	(440,000)				
Unfavorable – Conference & Meeting**	(575,000)				
Favorable – Communications **	335,000				
Unfavorable –Publishing **	(1,000,000)				
Remainder of variances	199,098	(390,902)			
<u>Cash Item variances</u>					
Favorable – Capital Expenditures	450,000				
Favorable – Depreciation	280,000	730,000			
<b>Total Variances</b>				<b>(581,902)</b>	
<b>Actual Net Operating Results After Taxes</b>				<b>(1,623,502)</b>	
** Division variances do include revenues, but do not include favorable salaries/travel variances which are listed separately					

**Headquarters Building Renovation and Valuation**

The House adopted Resolution 69H-2002 (*Trans.*2002:372), directing that the estimated market value of the ADA headquarters building be included in Board Report 2. The two most likely uses of the ADA building by a purchaser would be as an office building or a conversion to a residential property. These are two very different uses and very different markets which yield different estimated valuations. Per discussion with real estate transaction professionals in Chicago, there has been no appreciable change in the market price determined for each of these potential uses in the last year. Thus, the estimated market values remain approximately \$41.5 million for sale to a residential developer and \$33 to \$39 million for office use. The value for office use assumes that the building would be occupied, meaning the ADA would commit to a long-term

lease as a tenant (an expense not now incurred) or find a replacement tenant and rent space in a different building.

These amounts represent gross selling price before any related sale and closing costs. These valuations reflect current conditions in the Chicago real estate market.

#### **One-Time Activities**

The following chart is in response to Resolution 86H-1999 (*Trans.* 1999:894). The resolutions listed below were approved at the 2011 House for spending in 2012 for one-time activities. These items are not included in the 2013 budget.

2011 House Resolution	Description	(Revenue)/ Expense
<b>Dental Education, Science &amp; Related Matters</b>		
40H	Funding Support for CODA Strategic Planning Efforts	\$ 23,750
41H	ADA Scientific Review of Alternative Dental Workforce Models	40,000
66H	Deflating the Dental Education Bubble	230,000
<b>Legal, Legislative &amp; Public Affairs Matters</b>		
38H	Proposal for ADA Governance	300,000
83H	Implications of the Affordable Care Act	100,000
Total one-time activities in the 2012 budget		<u>\$ 693,750</u>

#### **Resolutions**

See Resolution 57; Worksheet:2063

See Resolution 58; Worksheet:2064

Resolution No. 57 NewReport: Board Report 2 Date Submitted: July 2012Submitted By: Board of TrusteesReference Committee: Budget, Business and Administrative MattersTotal Net Financial Implication: \$117,272 (Revenue) Net Dues Impact:   
\$116,225 (Ongoing Expense)Amount One-time  Amount On-going  FTE ADA Strategic Plan Goal: Financial (Required)**APPROVAL OF 2013 BUDGET****Background:** (See Report 2 of the Board of Trustees to the House of Delegates: 2013 Budget, Worksheet:2000).**Resolution****57. Resolved,** that the 2013 Annual Budget of revenues and expenses, including net capital requirements be approved.**BOARD RECOMMENDATION: Vote Yes.****Board Vote: Resolution 57**

BLANTON	Yes	GOUNARDES	Yes	NORMAN	Yes	SUMMERHAYS	Yes
DOW	Yes	HAGENBRUCH	Yes	RICH	Yes	VIGNA	Yes
ENGEL	Yes	ISRAELSON	Yes	ROBERTS	Yes	WEBER	Yes
FAIELLA	Yes	KIESLING	Yes	SEAGO	Yes	VERSMAN	Yes
FEINBERG	Yes	LOW	No	STEFFEL	Yes	YONEMOTO	Yes

Resolution No. 58 NewReport: Board Report 2 Date Submitted: July 2012Submitted By: Board of TrusteesReference Committee: Budget, Business and Administrative MattersTotal Net Financial Implication: \$3,189,000 Net Dues Impact: \$30Amount One-time                      Amount On-going \$3,189,000 FTE                     ADA Strategic Plan Goal: Financial (Required)1 **ESTABLISHMENT OF DUES EFFECTIVE JANUARY 1, 2013**

2 **Background:** After careful review and consideration, the ADA Board took specific steps to deliver a balanced  
3 budget and position the organization to deliver member value and long-term financial stability. Final Board  
4 actions included recommendation of a \$30 dues increase intended to generate an additional surplus to fund  
5 reserves as part of a multi-year plan to get reserves to the 50% target level.

6 This \$30 dues increase is reported to the House in advance of the 90-day dues notice deadline as a bold step  
7 intended to support the ADA's financial stability. However, recognizing the long lead time and related  
8 potential for changes in budget assumptions, the Board will exercise its right to amend, and possibly reduce,  
9 this recommendation later if new information becomes available before the Annual Session.

10 **Resolution**

11 **58. Resolved,** that the dues of ADA active members shall be five hundred forty-two dollars (\$542.00),  
12 effective January 1, 2013.

13 **BOARD RECOMMENDATION: Vote Yes.**14 **Board Vote: Resolution 58**

BLANTON	Yes	GOUNARDES	Yes	NORMAN	Absent	SUMMERHAYS	Yes
DOW	Yes	HAGENBRUCH	Yes	RICH	Yes	VIGNA	Yes
ENGEL	Yes	ISRAELSON	Yes	ROBERTS	Yes	WEBER	No
FAIELLA	Yes	KIESLING	Yes	SEAGO	Yes	VERSMAN	Yes
FEINBERG	No	LOW	No	STEFFEL	Yes	YONEMOTO	Yes

Resolution No. 59 NewReport: NA Date Submitted: July 2012Submitted By: Board of TrusteesReference Committee: Budget, Business and Administrative MattersTotal Net Financial Implication: \$5,315,000 Net Dues Impact: \_\_\_\_\_Amount One-time \_\_\_\_\_ Amount On-going \$5,315,000 FTE \_\_\_\_\_ADA Strategic Plan Goal: Financial (Required)**SPECIAL ASSESSMENT: CAPITAL BUILDING FUND**

**Background:** At its June meeting, the Board considered the needs for a designated capital fund for infrequent and extraordinary capital building projects. A subsequent review of the ADA's historical documentation revealed that the ADA Board had established a Capital fund in 1993, funded it as part of the annual budget process and continued its use until it was closed in 2005.

As a result, the Board recommended a \$50 per year special assessment for the next two years to establish, as outlined in the ADA's strategic plan and permitted by ADA *Bylaws* Chapter XVII Section 30, a Capital Improvement fund to support:

- Major building repair and replacement projects,
- Tenant improvements to secure long term lease agreements,
- Stability of long term reserves which would otherwise be impacted by spending for inevitable capital projects, and,
- An emergency fund in the event of a sudden, unforeseen capital equipment failure.

**Resolution**

**59. Resolved,** that as provided in Chapter I, Section 50 and Chapter XVIII, Section 40 of the *Bylaws*, a special assessment be levied in the amount of \$50 for 2013 and \$50 for 2014 for the purpose of creating and funding a capital building fund, and be it further

**Resolved,** that all funds received from this assessment be maintained in a segregated account.

**BOARD RECOMMENDATION: Vote Yes.****Board Vote: Resolution 59**

BLANTON	Yes	GOUNARDES	Yes	NORMAN	Absent	SUMMERHAYS	Yes
DOW	Yes	HAGENBRUCH	Yes	RICH	Yes	VIGNA	Yes
ENGEL	Yes	ISRAELSON	Yes	ROBERTS	Yes	WEBER	Yes
FAIELLA	Yes	KIESLING	Yes	SEAGO	No	VERSMAN	Yes
FEINBERG	Yes	LOW	Yes	STEFFEL	Yes	YONEMOTO	Yes

Resolution No. 60 NewReport: NA Date Submitted: July 2012Submitted By: Board of TrusteesReference Committee: Budget, Business and Administrative MattersTotal Net Financial Implication: None Net Dues Impact: \_\_\_\_\_

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

ADA Strategic Plan Goal: Members (Required)**POSTING OF FINANCIAL INFORMATION**

**Background:** At its June 2012 meeting, the Audit Committee of the ADA Board of Trustees accepted the 2011 Audited Financial Statements for the ADA and its subsidiaries.

The transmission of this material to the House is notable for at least two reasons:

- First, this is the first time in three years that the Committee has been able to transmit audited financial statements to the House of Delegates on a timely basis.
- Second, and more importantly, the Consolidated 2011 Financial Statements for the ADA highlight some improvements in the financial position of the ADA at the end of 2011 compared to year-end 2010. Although the ADA's net assets decreased slightly due to lower investment values at December 31, 2011, changes made by the Board to the ADA's employee retirement benefit plans reduced total liabilities by over \$7 million. In addition, the significant cut in pension plan benefits reduced "normal" pension costs, for 1 year of service, from \$5.2 million in 2011 to \$1.9 million in 2012.

**Resolution**

**60. Resolved**, that the ADA policy on "Request to Post Information on ADA.org" (*Trans.2009:493*) be amended to read as follows (additions are underscored; deletions are stricken):

**Resolved**, that the ADA post in the delegates' section of ADA.org, ADA Connect, or the equivalent, copies of all audit reports and management letters associated with the audit report of the ADA and its subsidiaries within 30 days after Board of Trustees review, and be it further

**Resolved**, that the ADA post in the delegates' section of ADA.org, ADA Connect, or the equivalent, copies of the quarterly financial reports within 30 days after Board of Trustees review.

**BOARD RECOMMENDATION: Vote Yes.**

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

Resolution No. 65 NewReport: NA Date Submitted: July 2012Submitted By: Board of TrusteesReference Committee: Budget, Business and Administrative MattersTotal Net Financial Implication: None Net Dues Impact: \_\_\_\_\_

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

ADA Strategic Plan Goal: Financial (Required)1 **ADA RESERVES**

2 **Background:** At its June 2012 meeting, the Board received a report from the Finance Committee on reserves  
 3 and the need for an appropriate target level of long-term reserve funds. A proper level of long-term reserves  
 4 protects the ADA from unanticipated risks and maintenance of minimum funding levels is a fiduciary  
 5 duty. Reserves serve as both a safety net in the event of a catastrophe and a means to enable funding of  
 6 long-term strategic opportunities. A minimum reserve target of 40% of the ADA's budgeted annual operating  
 7 expense was recommended as a means to serve these purposes and is expected to weather normal market  
 8 volatility without reserves dropping to a dangerous level.

9 Because existing reserve policy also did not adequately address what actions should be taken in the event  
 10 that this 40% minimum reserve level is breached for more than a short period of time, it was recommended  
 11 that the policy be amended to authorize the Board to reduce expenses even if such cost reductions delay the  
 12 implementation of previously adopted House initiatives.

13 Recognizing that the actions called for in the proposed amended policy are extraordinary, the Board agreed  
 14 that the policy should not be invoked absent a finding by the Board that the drop in reserves below the 40%  
 15 level is more than transient. For example, although investment market fluctuations may temporarily cause  
 16 reserve levels to drop, the actions called for in the proposed new policy should only be taken if the Board  
 17 concludes by a majority vote that reserve levels are not likely to be restored to safe levels in the absence of  
 18 action.

19  
20 **Resolution**

21  
 22 **65. Resolved**, that Resolution 59-2007H-2008, "ADA Reserves" (*Trans.*2008:443), be amended to read  
 23 as follows (additions are underscoring; deletions are ~~stricken~~):

24  
 25 **Resolved**, that the Board be urged to target the ADA's liquid reserves at a level of 50% of the  
 26 Association's annual budgeted operating expenses, ~~and to consider any excess in developing the~~  
 27 ~~following year's annual operating budget consistent with the long term strategy of dues stabilization~~  
 28 ~~taking into consideration any known contingent use of reserves.~~ Liquid reserves are defined as the  
 29 total net uncommitted balance of the Reserve Division Investment Account, and be it further  
 30

31 **Resolved**, that upon a finding by the Board that a predicted drop in liquid reserves below 40% is  
 32 unlikely to be corrected absent action by the Association, the Board be urged to immediately reduce  
 33 expenses even if such reduction results in delay in implementation of previously adopted House  
 34 initiatives. ~~and be it further~~

35  
 36 **Resolved**, that Resolution 26H-2005, Association Reserve Policy (*Trans.*2005:294), be rescinded.

1  
2 **BOARD RECOMMENDATON: Vote Yes.**  
3  
4 **BOARD VOTE: UNANIMOUS. (BOARD OF TRUSTEES CONSENT CALENDAR ACTION—NO BOARD**  
5 **DISCUSSION)**

File 7: Res. 65; Pgs. 2067-2068

Resolution No. 66 NewReport: NA Date Submitted: July 2012Submitted By: Board of TrusteesReference Committee: Budget, Business and Administrative MattersTotal Net Financial Implication: None Net Dues Impact: \_\_\_\_\_

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

ADA Strategic Plan Goal: Financial (Required)**LONG-TERM FINANCIAL STRATEGY OF DUES STABILIZATION**

**Background:** ADA member dues revenue is, of course, a key component of the Association's annual operating budget. Dues revenue is the mathematical product of two factors:

- a) The number of members and
- b) The applicable dues rate – which may be discounted.

For example, because of multiple membership categories and various dues rate levels that apply to each category, the net "effective" ADA dues level is only \$313 in 2012 based on total dues revenue divided by the total number of ADA members, and not \$512, the "full dues rate" as established by the 2011 House of Delegates. This key fact – that the effective dues rate per member is less than the full dues rate – needs to be considered by the Board and House in implementing any financial strategy.

In addition, although the dues stabilization policy was intended to focus on the need to limit member dues increases to no more than the rate of inflation, the policy focuses on only one factor, dues rate, without consideration of the number of members or the change in the mix of members in the various discounted dues categories. The existing policy also assumes that other external factors that impact the Association's finances, such as the market rates of investment returns, remain static, when recent history clearly shows that such external factors can, in fact, fluctuate significantly. As a result, the existing dues stabilization policy as it is defined does not enable the ADA to manage through changing economic conditions and membership market rates to deliver programs and services for members and maintain the financial stability of the organization.

For these reasons, the Board proposes the following changes to the policy.

**Resolution**

**66. Resolved**, that Resolution 17H-2008, "Long-Term Financial Strategy of Dues Stabilization" (*Trans.*2008:421) be amended to read as follows (additions are underscored; deletions are ~~stricken~~):

**Resolved**, that the Board develop annual budgets and manage the Association's finances and reserves in accordance with the goal of long-term financial stability for the Association, taking into account the need to limit dues increases, as practical, the effective dues rate for members, external market conditions and other relevant factors such as ~~strategy of dues stabilization. The dues stabilization strategy seeks to achieve long term dues stability by keeping annual dues increases at or below the level of inflation, based upon the Chicago Consumer Price Index (CPI) average for the prior three years. The strategy does not call for automatic inflationary dues increases.~~

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2  
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**BOARD RECOMMENDATON: Vote Yes.**

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

Resolution No. 74 NewReport: Board of Trustees Date Submitted: July 2012Submitted By: Board of TrusteesReference Committee: Budget, Business and Administrative MattersTotal Net Financial Implication: \$64,000 Annual Savings Net Dues Impact: Amount One-time  Amount On-going \$64,000 FTE ADA Strategic Plan Goal: Members (Required)1 **TRANSITION TO AN ELECTRONIC HOUSE OF DELEGATES**

2 **Background:** The ADA has been investigating mechanisms to transition to an electronic House of Delegates  
3 over the past few years. Background on the steps to this migration is included in this report in addition to next  
4 steps to finalize the transition.

5 In 2008, the ADA commenced a process to incorporate electronic mechanisms to the House of Delegates  
6 session in an effort to improve the efficiency of the House and reduce the cost and risk involved in paper  
7 production processes. Resolution 13H-2008 was adopted:

8 **13H-2008. Resolved,** that distribution of House of Delegates materials be transitioned to an electronic  
9 format no later than 2012, pursuant to favorable study, and be it further

10 **Resolved,** that the Board of Trustees develop a timeline for the transition, identifying all appropriate  
11 details and issues, and be it further

12 **Resolved,** that printed materials will still be available for any delegate upon request, and be it further

13 **Resolved,** that an informational report be submitted to the 2009 House of Delegates on the transition and  
14 related issues.

15 In 2009, a study was submitted to the House of Delegates on the transition to an electronic House and related  
16 issues. In the interim, in keeping with the third resolving clause of Resolution 13H-2008, printed materials  
17 were still available for any delegate upon request. At the 2009 House of Delegates, the following resolution  
18 was adopted to move forward with the implementation of an electronic House:

19 **36H-2009. Resolved,** that \$32,800 be added to the 2010 Association budget to provide the following  
20 enhancements to the meetings of the House of Delegates and district caucuses: electrical power to every  
21 third delegate and alternate seat in the House of Delegates, electrical power to the head table for every  
22 post-reference committee district caucus meeting, and two support technicians during the meetings of the  
23 House of Delegates, and be it further

24 **Resolved,** that the Board be directed to study mechanisms for providing wireless internet or intranet  
25 access or other electronic mechanisms to provide efficient, updated information to the House of  
26 Delegates, and be it further

27 **Resolved,** that the transition to electronic meetings of the House of Delegates be completed for the 2012  
28 session.

29 In 2010 required power upgrades and technical support in keeping with the first resolving clause of Resolution  
30 36H-2009 were implemented. Also in 2010, planning began for software to automate the business processes

1 of the House of Delegates. This software is based on Microsoft SharePoint and has been branded as ADA  
2 Connect. ADA Connect was developed in 2011 under the leadership of a House of Delegates advisory team.  
3 ADA Connect, along with necessary wireless internet and intranet upgrades, were released to the House of  
4 Delegates for the 2011 session. In keeping with the third resolving clause of Resolution 13H-2008 printed  
5 materials were still available.

6 Printed materials for the House of Delegates include the first and second set of resolution worksheets,  
7 reference committee agendas and reports, any additional worksheets distributed at the session, the Report of  
8 the President, the Manual of the House of Delegates, and miscellaneous documents. After using ADA  
9 Connect to support the ADA House of Delegate session for 2011 and incorporating feedback received from  
10 the post-session delegate survey and the ADA Connect HOD Advisory team, it was concluded that all printed  
11 form of materials could be eliminated except Reference Committee agendas and Reference Committee  
12 reports. Reference Committee reports are the primary resource for completing the business of the House.  
13 Retention of paper Reference Committee agenda and reports was a recommendation of the HOD Advisory  
14 team and minimizes the amount of paper materials needed because these documents are relatively  
15 brief. The elimination of printed materials (with the exception of Reference Committee agendas and reports)  
16 and its subsequent expense for postage and mailing of worksheets would result in a \$64,000 estimated  
17 savings annually.

#### 18 **Proposed Resolution**

19 **74. Resolved**, that effective with the 2013 House of Delegates all materials for the meetings of the House  
20 of Delegates will be provided in an electronic format only with the exception of Reference Committee  
21 Reports and Agendas which will also be provided in paper format during the meeting, and be it further

22 **Resolved**, that Resolution 13H-2008 (*Trans.*2008:446) be rescinded.

23 **BOARD RECOMMENDATION: Vote Yes.**

24  
25 **BOARD VOTE: UNANIMOUS. (BOARD OF TRUSTEES CONSENT CALENDAR ACTION—NO BOARD**  
26 **DISCUSSION)**

Resolution No. 76 NewReport: Board Report 4 Date Submitted: July 2012Submitted By: Board of TrusteesReference Committee: Budget, Business and Administrative MattersTotal Net Financial Implication: None Net Dues Impact: \_\_\_\_\_Amount One-time \_\_\_\_\_ Amount On-going \_\_\_\_\_ FTE 0ADA Strategic Plan Goal: Members (Required)**REPORT 4 OF THE BOARD OF TRUSTEES TO THE HOUSE OF DELEGATES: ADAMEMBER.NET  
E-MAIL FORWARDING SYSTEM UPGRADE**

**Background:** ADAMember.net Electronic Mail forwarding service, implemented in 2005, has experienced very low utilization. The House of Delegates should have the opportunity to review the volume information and alternative solutions. This report includes this information in addition to a Board recommendation on how to eliminate this service.

In 2005, an ADAMember.net E-mail Forwarding System was implemented to provide a service that allows ADA members to connect their existing electronic mail address to an electronic mail address with their own domain name and with the address completed with "@ADAMember.net". The 2011 Special Assessment Fund for Information Technology Infrastructure projects included funding in the amount of \$130,300 to complete a system upgrade for the E-mail Forwarding System. This upgrade is necessary so Microsoft will continue to provide support and to ensure system security and dependability so this member benefit can continue to be offered. At the December 2011 Board meeting, Resolution B-192-2011 was adopted as follows:

**B-192-2011. Resolved,** that the upgrade of the ADA member e-mail forwarding system be postponed pending submission to the House of Delegates of the relevant volume utilization data, based on which the House of Delegates can make an informed decision as to whether to go forward with the needed upgrade.

**ADAMember.net E-mail Forwarding Volume Data.** In September 2011, a close examination of the monthly electronic mail use statistics was done by staff in Membership, with help from staff in IT. At that point in time, there were 802 users who had signed up for the ADAMember.net E-mail Forwarding System since it was deployed in 2005. Of those 802 user accounts, 783 user accounts are members and 72 user accounts could be classified as "leaders". "Leaders" are user accounts that have the following classification code:

Del-11	Delegates
Alt-11	Alternates
100	Officers & Trustees
105	Past Presidents
130	Council chairs & council members
200	Constituent Society Presidents
201	Constituent Society Presidents Elect
230	Component Society Presidents

Of the 804 user accounts, 184 user accounts showed activity receiving electronic mail through the service offering. Of the "leaders", 22 user accounts showed activity receiving electronic mail through the service offering.

1 Additionally, a snapshot was taken of detailed volume statistics for the month of September 2011. During  
2 that period, 17 users received more than 300 emails (the three largest users received 981, 1045, and 1615  
3 messages); 29 users received between 100 and 300 emails; 31 users received between 30 and 99 emails;  
4 42 users received between 10 and 29 emails; and 49 users received between 1 and 9 emails.

5 During 2011, ADA IT collected 9 months of detailed use statistics for the system. During those 9 months,  
6 the maximum numbers of users who received 1 or more messages per month was 185. In other words,  
7 there were 185 or fewer active users per month, measured on a monthly basis over a 9 month period.

8 In May 2012, ADA IT examined the electronic mail addresses listed in Find a Dentist to see how many used  
9 an ADAMember.net address. Of all members listed, 38 listed their ADAMember.net address as their  
10 primary address, 150 listed their ADAMember.net address as their secondary address.

11 The low utilization of this service is consistent with changes in the electronic mail offerings in the  
12 commercial market. In 2005 and earlier, it was not unusual for electronic mail users to change their  
13 electronic mail service providers regularly. At the time, electronic mail service was just starting to mature as  
14 a utility. New and improved free electronic mail services were competing for users. Users would change  
15 electronic mail addresses regularly. Users started to maintain separate electronic mail addresses for  
16 business and personal use. By 2008 or later, electronic mail service offerings in the commercial market  
17 have matured. Established users seem to have settled on one vendor or another, and electronic mail  
18 address changes are unusual.

19 The original cost to upgrade the existing e-mail forwarding service as included in the 2011 Assessment for  
20 IT Infrastructure was \$130,300 for a one time upgrade that would likely need to be upgraded again  
21 approximately every 4 years. The annualized cost of this solution then would be \$32,575.

22 Utilizing the Universal Assessment Criteria established by the Board of Trustees, due to the very low  
23 utilization, the Board of Trustees recommends that the service offering be discontinued. A 90-day  
24 transition period will be offered to the existing users and after that time the service would be eliminated.  
25 Any places where the ADAMember.net address is utilized by the users, such as on the users' website or  
26 any communications that are received at the ADAMember.net addresses would need to be edited or  
27 replaced by the users.

28 Due to the low utilization of the ADAMember.net Electronic Mail forwarding service and the cost to maintain  
29 this service, the Board of Trustees is recommending discontinuation of this service and place the remaining  
30 funds to be returned to the 2012 IT Budget to resolve open audit points for Payment Card Industry standard  
31 (PCI) Compliance.

### 32 Resolution

33 **76. Resolved**, that the @ADAMember.net Electronic Mail Forwarding service be discontinued due to  
34 low utilization, and be it further

35 **Resolved**, that the service will be supported by the ADA for 90 days after the 2012 House of Delegates  
36 meeting assuming House approval of the discontinuation of the service, and be it further

37 **Resolved**, that the remaining funds from the 2011 Special Assessment for IT Infrastructure be returned  
38 to the 2012 IT Budget and used to resolve open audit points for Hyperion and Payment Card Industry  
39 standard (PCI) Compliance.

40 **BOARD RECOMMENDATION: Vote Yes.**

41  
42 **BOARD VOTE: UNANIMOUS. (BOARD OF TRUSTEES CONSENT CALENDAR ACTION—NO BOARD**  
43 **DISCUSSION)**

Resolution No. 83 NewReport: NA Date Submitted: July 2012Submitted By: Board of TrusteesReference Committee: Budget, Business and Administrative MattersTotal Net Financial Implication: None Net Dues Impact: Amount One-time  Amount On-going  FTE 0ADA Strategic Plan Goal: Members (Required)**POLICIES TO BE MAINTAINED AS RECOMMENDED BY THE BOARD OF TRUSTEES**

**Background:** In accord with Resolution 111H-2010, Regular Comprehensive Policy Review, the Board identified the following policies that should be maintained as written. The full text of each policy is included in appended.

**Resolution****83. Resolved,** that the following policies be maintained:

Payment of President's and/or President-elect's Expenses by Host Organizations (*Trans.*1989:519)  
Funding of Visits to Constituent and Component Societies by ADA Officers (*Trans.*1988:456)  
Review of Reports and Studies by the ADA Board of Trustees (*Trans.*1995:652)  
Joint Meeting Approval (*Trans.*1985:610)  
Availability of ADA House Materials to Members (*Trans.*1991:606)  
Availability of House of Delegates Transcripts (*Trans.*1990:570)  
ADA Intellectual Property Licensing Protocol (*Trans.*2008:495)  
Annual Session Dress Code (*Trans.*1999:981)

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

**Appendix 1****Policies to be Maintained****Payment of President's and/or President-elect's Expenses by Host Organizations (*Trans.1989:519*)**

**Resolved**, that all host dental organizations that request the presence of the ADA President and/or President-elect at their meetings be required to pay all expenses related to that visit, except transportation expenses.

**Funding of Visits to Constituent and Component Societies by ADA Officers (*Trans.1988:456*)**

**Resolved**, that constituent and component societies, when inviting ADA officers to their functions, be urged to fund those visits in whatever manner possible.

**Review of Reports and Studies by the ADA Board of Trustees (*Trans.1995:652*)**

**Resolved**, that all council and committee reports and studies requested by the House of Delegates or the ADA Board of Trustees be reviewed and acted upon by the ADA Board of Trustees before any dissemination to "communities of interest."

**Joint Meeting Approval (*Trans.1985:610*)**

**Resolved**, that Association agencies obtain prior approval from the Board of Trustees for conduct of joint or co-sponsored conferences, programs or meetings on topics or issues not in accord with Association policy or current program activity.

**Availability of ADA House Materials to Members (*Trans.1991:606*)**

**Resolved**, that all nonconfidential ADA House of Delegates reports and proposed resolutions, including reference committee reports, be made available to ADA members upon request and that the charge for these materials shall be commensurate with the cost to provide the service, and be it further

**Resolved**, that the dates, times and locations of ADA House of Delegates' sessions and reference committee meetings be circulated in advance to all members and be publicly posted at the ADA Annual Scientific Sessions.

**Availability of House of Delegates Transcripts (*Trans.1990:570*)**

**Resolved**, that the official transcript of the American Dental Association House of Delegates be made available in toto to any active, life or retired member of the Association, and be it further

**Resolved**, that the cost of this transcript be borne by the individual or constituent requesting said transcript.

**ADA Intellectual Property Licensing Protocol (*Trans.2008:495*)**

**Resolved**, that the ADA Board of Trustees, in connection with any proposed non-de minimus grant by the ADA of rights in or to ADA intellectual property, require the ADA council(s) having substantive knowledge of the intellectual property to be involved from the beginning in discussions concerning the proposed grant, to review the terms of such proposed grant and to make recommendation(s) to the Board of Trustees on the proposed grant, and be it further

1           **Resolved**, that the ADA Board of Trustees, after having considered the recommendations of the  
2           appropriate ADA council(s), when appropriate, make a determination concerning the proposed grant.

3   **Annual Session Dress Code (*Trans.1999:981*)**

4           **Resolved**, that the House of Delegates adopt business casual attire.

5

Resolution No. None NewReport: Board Report 6 Date Submitted: July 2012Submitted By: Board of TrusteesReference Committee: Budget, Business and Administrative MattersTotal Net Financial Implication: None Net Dues Impact: Amount One-time  Amount On-going  FTE 0ADA Strategic Plan Goal: Members (Required)

**REPORT 6 OF THE BOARD OF TRUSTEES TO THE HOUSE OF DELEGATES: INFORMATION TECHNOLOGY INITIATIVES, EXPENDITURES AND ESTIMATED COSTS, AND ANTICIPATED FUTURE PROJECTS**

**Background:** This report to the House of Delegates on the ADA's Information Technology initiatives, expenditures and future projects is submitted as required by Resolution 30H-2003 (*Trans.2003:334*), which urged the Board to provide an annual report summarizing technology initiatives, expenditures, estimated costs, anticipated projects and their sources of funding.

The Division of Information Technology (IT) uses an established plan to provide technology staff with the goals and objectives necessary to support the ADA Strategic Plan. This plan allows the IT division to address immediate issues and the opportunity to provide quality information technology operations to service ADA members and the tripartite.

**Overview:** This executive summary is organized into two sections. The first section provides a final update on the projects included within the 2011 Special Assessment Fund for IT Initiatives. The second section provides an overview on select projects that are included in the 2012 Division of Information Technology base budget as well as planned projects for 2013. Further details on all projects can be found in the detailed report. This report is informational only; there are no resolutions.

**2011 Special Assessment Fund:** The following projects were funded by the 2011 Special Assessment Funds for IT Initiatives:

- **Association Management System.** In 2010, IT facilitated a process with a cross-divisional working team to analyze the options of whether to continue to invest in Siebel for eCommerce and case management or to sunset Siebel in favor of an Association Management System platform. This working team recommended that an Association Management System should be purchased to replace Siebel. Aptify was the selected software system. In 2011, Aptify software was purchased with an unlimited user license environment. Outside IT consulting services were retained with Aptify to assist ADA staff with the system implementation. The system requirements documentation and definition process were completed in June 2011 and defined not only commerce, order management and customer relationship management processes, but also defined ways to deliver solutions to improve the Tripartite System, online continuing education, online meeting registration, fundraising, advertising and subscriptions. The system went into production in mid-December 2011. Additionally, an experienced Aptify Senior Application Developer was hired as part of a two-year plan to reduce the reliance on outside consulting services.
- **Data Warehouse.** Business Objects is the Association's data warehouse application, which allows for the creation of data marts, reporting tools and an Electronic Dashboard. In order to deploy the Electronic Dashboard functionality to all senior staff, additional software licenses were purchased along with annual software maintenance and support. Software licenses were purchased and implemented by year end.

- 1 • *Content Management Bridge Software.* This software allows the automation of documents into the  
2 Content Management System (CMS) for the ADA.org website, the Evidence-Based Dentistry (EBD)  
3 website and all other websites managed via the CMS. It allows configuration of the CMS to  
4 automatically load text data from the ADA's document management system into the CMS. This  
5 project was postponed and funding was unspent since a decision was made to replace the existing  
6 CMS in 2012. This CMS Replacement project is currently underway and will be deployed with the  
7 new consumer website ([www.mouthhealthy.org](http://www.mouthhealthy.org)). The ADA is also planning to replace the CMS on  
8 ADA.org in 2013.
- 9 • *eMail Forwarding.* In 2005, an Email Forwarding System was implemented to provide ADA members  
10 with the functionality to forward their email using the ADAMEMBER.NET email address to a personal  
11 email address using this system. The technology that currently supports this system will not be  
12 supported by Microsoft beyond 2012. An upgrade to a supported Microsoft .NET technology platform  
13 is needed to ensure system security and dependability so this member benefit can continue. To date,  
14 about 850 members have accounts on the system and only 184 regularly utilize this system. The  
15 Board has submitted a recommendation to the House for discontinuing this service after reviewing  
16 alternatives. It was decided to postpone the upgrade until a decision is made.
- 17 • *Hyperion Planning System.* In 2010, the Board supported a supplemental request to implement  
18 Hyperion software for zero-based budgeting. This supplemental request included licenses for  
19 developers and outside IT consulting expertise to configure the product. The Hyperion Expansion  
20 project was the 2011 work effort to deploy the software to the budgeting representatives in the ADA  
21 Divisions, provide training and the technical support they need to use the software to prepare the  
22 budget and provide budget forecasts. This project was completed at the end of May. A report road  
23 show was held in December to train Hyperion users on report writing.
- 24 • *PeopleSoft.* The upgrade of all seven PeopleSoft financial software applications from version 8.9 to  
25 version 9.1 was necessary to ensure that the software used to create Financial Statements for the  
26 ADA remains supported by the vendor and keeps the software maintenance agreement current. The  
27 move to the most current version, v9.1, ensured compatibility with interfacing applications and  
28 Microsoft software used in conjunction with PeopleSoft for another four to five years. Additional  
29 functionality and features were also included in the current version to assist with efficiencies such as  
30 the type-ahead feature, and quick look-up. The upgrade included: General Ledger, Accounts  
31 Payable, Billing, Accounts Receivable, Asset Management, Purchasing, and Workflow approvals.  
32 This project was completed in mid-August. The first phase of the Human Resources Management  
33 System (HRMS) upgrade began in September 2011 and was completed by year end. As with the  
34 Financial System upgrade, this upgrade ensures that the system remains supported by the vendor  
35 and keeps the software maintenance agreement current; ensures critical software bundles, tax  
36 updates and patches and fixes are received; and ensures compatibility with third-party applications.  
37 The second phase is currently underway and is scheduled to be completed by October 2012. The  
38 funding for Phase II was approved and included in IT's 2012 base budget.

39 All project work was completed in 2011 and was fully-funded by the Special Assessment Fund for Information  
40 Technology.  
41

1 The following table details the spending against the 2011 Special Assessment Fund for IT Initiatives through  
2 December 31, 2011:

Project	Approved Funding	Final Spending	Difference
Association Management System	\$1,600,000	\$1,618,132	(\$18,132)
Business Objects Software Licenses & Support	\$20,050	\$20,014	\$36
Content Management Data Bridge Software	\$18,900	\$0.00	\$18,900
Email Forwarding System	\$130,300	\$0.00	\$130,300
Hyperion Planning Tool Expansion	\$201,800	\$199,605	\$2,195
PeopleSoft Financial System Upgrade	\$489,400	\$488,865	\$535
PeopleSoft HR System Upgrade	\$40,000	\$39,348	\$652
Totals	\$2,500,450	\$2,365,964	\$134,486

3 **Year 2012 Projects and Expenditures:** In 2012, the IT division continues to move forward with projects in  
4 its core areas. As of this report, the following projects are completed and others are currently in the working  
5 stages with a completion goal by the end of the year.

- 6 • *Document Management (FileWeb).* The Association implemented Open Text Livelink as its  
7 document management system in 2002. This system, which was branded “ADA FileWeb” allows  
8 ADA staff to efficiently store and share documents. In 2011, an upgrade began to improve the user  
9 interface as well as provide new user functionalities and features. This upgrade was completed in  
10 March 2012. Later this year, an outside IT consulting firm will be retained to assist staff with  
11 completing a planning effort for the migration away from Open Text Livelink to ADA Connect. A  
12 cross-divisional Work Team will be established to define system requirements documentation and  
13 define business processes. The information obtained in this phase will be used to select features and  
14 functionality that will be implemented into the new system. The migration to the new environment is  
15 planned for 2014.
- 16 • *Data Warehouse.* In 2012, work continues on enhancing and expanding the Electronic Dashboard.  
17 Enhancement work will also continue on existing data marts and new data marts will be implemented  
18 as needed upon request. Any requests for new data marts or enhancements to existing data marts  
19 are completed using existing staff.
- 20 • *Internet.* In 2012, the following internet projects have been completed:
  - 21 ○ ADA.org enhancements including improvements to the Find-A-Dentist area.
  - 22 ○ Evidence-Based Dentistry (EBD) website enhancements.
  - 23 ○ Implemented Search Engine Optimization (SEO) friendly URLs for online Dental Buyers’  
24 Guide so it appears higher on search return lists on Google, Yahoo and other web search  
25 engines resulting in more traffic to the site and makes participation more appealing to  
26 advertisers.
  - 27 ○ The 2012 Annual Session mobile application for the iPhone, Android and Blackberry  
28 platforms was developed and deployed. Session attendees can use this app to locate  
29 exhibitors, find continuing education class times and locations and other relevant session  
30 information.
  - 31 ○ A mobile application was also developed and deployed for the 2012 New Dentists’  
32 Conference. Similar to the annual session app, conference attendees will be able to locate  
33 exhibitors and search for continuing education course logistics.

- 1           ○ SiteCore, the ADA's new web content management software was purchased and replaces  
2           OpenText RedDot. This software was used on the new consumer website,  
3           [www.mouthhealthy.org](http://www.mouthhealthy.org). In 2013, a decision package was submitted to retain outside  
4           consulting services to move ADA.org from Open Text RedDot to the new SiteCore software.
- 5       • *Consumer Website.* In 2012, outside IT consulting services were retained to assist IT and COMM  
6       staff with the development and implementation of a new consumer website, [www.mouthhealthy.org](http://www.mouthhealthy.org).  
7       This new website is consumer-focused and provides consumers with a dedicated site to obtain dental  
8       information pertaining to their needs. The consumer-based content that currently resides on ADA.org  
9       will be moved to this new website. It includes features such as a Symptom Checker Slideshow and a  
10      public-version of Find-A-Dentist. The current ADA.org website will focus on the needs of ADA  
11      members and other dental professionals. The new site is scheduled to launch at the end of June. In  
12      addition, the ADA's new content management system, SiteCore was implemented on this site.
- 13     • *Center for Professional Success.* A project is underway to develop a web resource to support the  
14     Center for Professional Success. The project scoping and planning are currently underway.
- 15     • *ADA Connect.* A decision package was submitted and approved in the 2011 budget to purchase a  
16     software solution to replace the Association's current collaboration software application (SiteScape)  
17     and to address Resolution 36H-2009 (*Trans.*2009:406;409), which was adopted at the 2009 annual  
18     session to study electronic mechanisms to provide the ADA House of Delegates (HOD) with efficient  
19     and updated information and that the identified mechanism be implemented by the 2012 annual  
20     session. An ADA cross-divisional Work Team was established, which included HOD members and  
21     ADA volunteers to review a number of solutions and participate in vendor demonstrations. In the end,  
22     it was decided that a Microsoft (MS) SharePoint environment would be implemented. An outside IT  
23     consulting firm was retained to assist ADA staff with the development and implementation of the ADA  
24     Connect environment. This environment went into production on August 1, 2011 to the HOD.  
25     Training was conducted with HOD members with the goal to have them ready to use ADA Connect at  
26     the 2011 House of Delegates. Work also began on the developing and deploying ADA Connect  
27     areas for ADA Councils, Committees and Standards Committees previously using the collaboration  
28     software SiteScape to manage their day-to-day business activities. These deployments were  
29     completed in June 2012. Site-owners have been trained and are now actively using the new tool. A  
30     Balloting and Voting system will also be available via ADA Connect and used by ADA Councils,  
31     Committees and Standards committees to administer voting activities. Rollouts of this new  
32     functionality are underway and users are currently being trained. Upon completion of the balloting  
33     system rollout, work will begin to expand this environment to provide stability, enhance collaboration  
34     services and provide broader access to other groups such as Committees, Workgroups and program  
35     participants. This expansion includes purchasing MS SharePoint software licenses for additional  
36     users and funding to retain outside IT consulting services to assist staff with the development and  
37     implementation of the enhancements and fixes needed. In 2013, a decision package has been  
38     submitted to retain outside IT consulting services to assist IT staff with developing an ADA Connect  
39     area for the Board of Trustees.
- 40     • *PeopleSoft.* The Human Resources Management System (HRMS) upgrade is underway and  
41     scheduled to be completed in October 2012. Similar to the Financial System upgrade that was  
42     completed in 2011, this upgrade is necessary to maintain compliance with the software maintenance  
43     agreement and will ensure that updates and security patches are received and installed in a timely  
44     manner to keep the system current. In 2013, an upgrade to the latest version of PeopleTools will be  
45     completed. People Tools is the software development environment used by IT developers to create  
46     and customize PeopleSoft applications. This upgrade will ensure developers are using the most  
47     current software development environment that is compatible with most recent upgrades to the  
48     Finance and HRMS systems. A decision package was submitted in 2013 to fund the purchase of a  
49     Talent Management solution that tightly integrates with the HRMS as they are both Oracle-owned  
50     products. This software as a service will improve many aspects of the eRecruitment operation by  
51     providing HR recruiters the flexibility to have extra resources without hiring additional staff. It

consolidates key activities such as posting jobs and searching for candidates into a single action and reduces the need for repetitive tasks. It reduces manual entries and time spent on reviewing resumes. This service provides features that quickly link applicants' skills to posted job descriptions. It also reduces the applicants' time filling out multiple pages of web forms thus giving them a more modern, less burdensome and more positive experience as they interact with the technology.

- *Hyperion Plan Tool.* In 2012, outside IT consulting services were retained to provide system support and maintenance while IT actively recruited for a full-time staff person to manage these activities. A person was hired and training completed to transition this work to the staff person. Consulting services were also retained to work with Finance staff to identify system enhancements and to develop and document business processes around budgeting and forecasting activities. In 2013, system enhancements, fixes and support will be completed by ADA staff. No additional funding has been requested for this project.
- *Tripartite System.* A system upgrade was released in September 2011, which included enhancements and fixes that were identified by the current upgrade process. A total of ten TS deployments were completed between 2010 and 2011. With these additions, 40 states, 68 components and the ADA are actively using TS. No additional funding has been requested for TS and all current work is completed by internal staff. In 2012, work is underway to begin transitioning from TS to Aptify. This conversion will be completed in 2013. Once the ADA conversion is completed, a plan will be developed to begin converting states and local societies currently using TS as their membership management system to Aptify. The ADA purchased enterprise licensing, which allows all current TS sites to move to Aptify as well as any new sites to come on to Aptify if they so choose.
- *Infrastructure Hardware/Software Licenses.* The expenditures reflected in 2011, 2012 and 2013 are primarily for hardware and software licenses to maintain the Association's network infrastructure as well as provide end-user equipment such as desktops, laptops and printers. In addition, funding is budgeted annually for a manufacturer-certified on-site technician. As part of the network server and printer maintenance agreement, this technician is available on-site to fix hardware under warranty instead of depending on "depot warranty service." This on-site service minimizes downtime for users. In 2011, the ADA purchased Microsoft Office 2010, which includes new versions of Microsoft Word, Excel, PowerPoint and Outlook. MS Access users and some MS Visio and Project users will also be upgraded. The upgrade was delayed due to compatibility issues with ADA FileWeb. An upgrade to ADA FileWeb has to be completed first before MS Office could be deployed. That upgrade was completed in early 2012. Staff training for MS Office was completed in March and all users have now been upgraded. Core system upgrades will be completed on the Chicago and Washington DC telephone systems. These upgrades are required to keep these systems current. An upgrade of the Call Pilot software will also be completed in 2012. This software allows users to manage their voice mail through their computer.
- *Aptify.* In 2012, work is underway to replace the Tripartite System (TS) at the ADA with Aptify. A cross-divisional Work Team has been developed and work is underway to gather system requirements and to complete the technical design. This work is scheduled to be completed in August. System development and configuration work is scheduled to begin later this year with testing and implementation planned to be completed in 2013. In addition to the TS conversion, planning will begin for the Events module implementation. This module will replace the hard-coded online meeting registrations on ADA.org. ADA departments scheduling meetings will have the ability to develop their meeting registrations with this module, which will eliminate the need for IT staff to develop them. Also in 2012, a second experienced Sr. Application Developer was hired as part of a two-year plan to have highly trained, knowledgeable ADA staff dedicated to this system whereby significantly reducing the need for outside IT consulting services. This person will maintain, support and enhance the system. Once the TS conversion project is completed, a plan will be developed to being converting state and local societies currently using TS as their membership management system to Aptify. A decision

1 package has been submitted in 2013 to fund travel expenses for IT staff to travel to the sites and  
2 assist with the conversions.

- 3 • *Aptify/Learning Management System.* A decision package is submitted in the 2013 budget to retain  
4 outside IT consulting services to assist with implementing the Aptify Education and  
5 eLearning/Learning Management System (LMS) modules to provide Continuing Education (CE) and  
6 Online Learning Management services that would replace the CE module within the Tripartite  
7 System. This system provides new functionality to allow online delivery of CE programs and to  
8 facilitate and manage the Tripartite's online CE activities and provide a variety of other learning  
9 activities for ADA members, non-members and ADA staff. This program will provide a standardized  
10 software platform that leverages existing technology investments to create and distribute learning  
11 activities. The decision package also includes funding for ADA staff to attend Aptify training to  
12 support the system ongoing both from the technical and business side. Finally, this decision package  
13 includes funding for one (1) new IT staff resource to be responsible day-to-day system maintenance;  
14 new system programming; software configuration; development and testing. This person will also  
15 support the development and maintenance of online web applications to support the delivery of  
16 Continued Education content. When the original Aptify implementation plan was presented in 2011,  
17 three (3) new incremental headcount were requested (one in 2011, one in 2012 and one in 2013) and  
18 approved to ensure appropriate IT staff resourcing for ongoing system support and enhancements.  
19 The new position in this decision package is that one new position for 2013.
- 20 • *SAS to Aptify Conversion.* In 2011, a project began to convert SAS (Statistical Analysis Software)  
21 applications used by the Department of Testing Services to a more current system. The applications  
22 used within SAS have been over-developed through the years and the system is slow and antiquated.  
23 The original plan was to convert these applications to a Microsoft .NET platform. However, since that  
24 solution was identified, Aptify was purchased. IT staff working with Aptify consultants determined that  
25 Aptify's Education module could be used to maintain these applications for DTS and thus leveraging  
26 an existing technology investment. Outside IT consulting was retained and the work completed in  
27 2011 was funded by the Division of Education. This project is currently in the data validation phase is  
28 planned to be completed by September 2012.

29

The table below outlines actual expenditures in the core areas in 2011; projected spending in 2012 and planned spending in 2013. Also disclosed is spending related to infrastructure hardware and major projects.

IT Core Area	2011 Actual Spending	2012 Projected Spending	2013 Planned Spending
FileWeb	13,090	200,555	10,000
Data Warehouse	0	0	0
Internet	1,500	368,495	263,565
ADA Connect	437,382	241,083	131,000
PeopleSoft	0	435,600	112,800
Hyperion Budgeting Plan Tool	0	168,500	0
Tripartite System	0	0	0
Infrastructure Hardware/Licenses	1,232,271	1,162,151	970,000
Siebel	58,154	0	0
Aptify	0	233,208	474,250
Total Project Spending	1,742,397	2,809,592	1,961,615
Balance of IT Operating Budget	5,605,949	8,733,436	9,736,576
Total IT Spending	7,348,346	11,543,028	11,698,191

The tables below summarize the previous information based on the source of funding. The IT division continues to maintain and upgrade its current core areas while also providing ongoing support and completing various IT-related projects for ADA divisions.

#### IT Core Area

	Operating Budget	Capital Budget	Total
<b>2011 Spending</b>			
FileWeb (1)	\$13,090	0	13,090
Data Warehouse	0	0	0
Internet (2)	1,500	0	1,500
ADA Connect (3)	157,362	280,020	437,382
PeopleSoft	0	0	0
Hyperion Budgeting Plan Tool	0	0	0
Tripartite System	0	0	0
Infrastructure Hardware/ Licenses (4)	106,534	1,125,737	1,232,271
Siebel (5)	46,088	12,066	58,154
Aptify	0	0	0
Total Project Spending	324,574	1,417,823	1,742,397
Balance of IT Operating Budget	5,605,949	0	5,605,949
Total IT Spending	\$5,930,523	1,417,823	7,348,346

<b>2011 Consulting Projects</b>	<b>Total Spending</b>	<b>Operating Budget</b>	<b>Capital Budget</b>
FileWeb Upgrade	13,090.00	13,090.00	0.00
<b>FileWeb Totals (1)</b>	<b>13,090.00</b>	<b>13,090.00</b>	<b>0.00</b>
<b>Data Warehouse Totals</b>	<b>0.00</b>	<b>0.00</b>	<b>0.00</b>
Mobile Application	1,500.00	1,500.00	0.00
<b>Internet Totals (2)</b>	<b>1,500.00</b>	<b>1,500.00</b>	<b>0.00</b>
MS SharePoint & Anti-Virus/Security Software	65,461.00	0.00	65,461.00
ADA Connect Site Development & Implementation	291,160.00	93,905.00	197,255.00
Balloting Software, Development & Implementation	24,472.00	7,168.00	17,304.00
Educational Session	4,500.00	4,500.00	0.00
Post implementation environment support	51,789.00	51,789.00	0.00
<b>ADA Connect (3)</b>	<b>437,382.00</b>	<b>157,362.00</b>	<b>280,020.00</b>
<b>PeopleSoft Totals</b>	<b>0.00</b>	<b>0.00</b>	<b>0.00</b>
<b>Hyperion Budget Module Totals</b>	<b>0.00</b>	<b>0.00</b>	<b>0.00</b>
<b>Tripartite System Totals</b>	<b>0.00</b>	<b>0.00</b>	<b>0.00</b>
Warranty Technician	71,016.00	71,016.00	0.00
Telephone Upgrades	64,747.00	4,067.00	60,680.00
Network Infrastructure	53,845.00	0.00	53,845.00
Network Security	200.00	200.00	0.00
Operating Software	31,251.00	31,251.00	0.00
Capital Hardware	717,035.00	0.00	717,035.00
Capital Software	294,177.00	0.00	294,177.00
<b>Infrastructure Totals (4)</b>	<b>1,232,271.00</b>	<b>106,534.00</b>	<b>1,125,737.00</b>
Personalized Products fix for PDS	58,154.00	46,088.00	12,066.00
<b>Siebel Totals (5)</b>	<b>58,154.00</b>	<b>46,088.00</b>	<b>12,066.00</b>
<b>Grand Totals</b>	<b>1,742,397.00</b>	<b>324,574.00</b>	<b>1,417,823.00</b>

2012 Planned Spending	2012 Operating Budgeted Spending	2012 Capital Budget	Total 2012 Budgeted Spending
FileWeb (1)	\$173,740	26,815	200,555
Data Warehouse	0	0	0
Internet (2)	131,945	236,550	368,495
ADA Connect (3)	88,676	152,407	241,083
PeopleSoft (4)	130,680	304,920	435,600
Hyperion Budgeting Module (5)	168,500	0	168,500
Tripartite System	0	0	0
Infrastructure Hardware/Licenses (6)	186,600	975,551	1,162,151
Aptify (7)	201,608	31,600	233,208
Total Project Spending	1,081,749	1,575,436	2,809,592
Balance of IT Operating Budget	8,733,436	0	8,733,436
Total IT Spending	9,815,185\$	1,575,436	11,543,028

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<b>2012 Consulting Projects</b>	<b>Total Projected Spending</b>	<b>Operating Budget</b>	<b>Capital Budget</b>
FileWeb Upgrade	3,740.00	3,740.00	26,815.00
FileWeb Replacement Planning	170,000.00	170,000.00	0.00
<b>FileWeb Totals (1)</b>	<b>200,555.00</b>	<b>173,740.00</b>	<b>26,815.00</b>
<b>Data Warehouse (DW) Totals</b>	<b>0.00</b>	<b>0.00</b>	<b>0.00</b>
Mobile Application	3,000.00	3,000.00	0.00
Mobile Application	36,000.00	10,000.00	26,000.00
Consumer Website	196,000.00	84,000.00	112,000.00
SiteCore Software	98,550.00	0.00	98,550.00
Evidence-Based Dentistry website	9,945.00	9,945.00	0.00
Center for Professional Practice	25,000.00	25,000.00	0.00
<b>Internet Totals (2)</b>	<b>368,495.00</b>	<b>131,945.00</b>	<b>236,550.00</b>
ADA Connect	32,338.00	5,546.00	26,792.00
ADA Connect	6,000.00	6,000.00	0.00
ADA Connect	39,600.00	39,600.00	0.00
ADA Connect	163,145.00	37,530.00	125,615.00
<b>ADA Connect Totals (3)</b>	<b>241,083.00</b>	<b>88,676.00</b>	<b>152,407.00</b>
HRMS Upgrade - Phase II	435,600.00	130,680.00	304,920.00
<b>PeopleSoft Totals (4)</b>	<b>435,600.00</b>	<b>130,680.00</b>	<b>304,920.00</b>
Hyperion Plan Tool System Support	76,800.00	76,800.00	0.00
Hyperion Plan Tool System Enhancements	91,700.00	91,700.00	0.00
<b>Hyperion Budget Module Totals (5)</b>	<b>168,500.00</b>	<b>168,500.00</b>	<b>0.00</b>

<b>Tripartite System (TS) Totals</b>	<b>0.00</b>	<b>0.00</b>	<b>0.00</b>
Warranty Technician	75,000.00	75,000.00	0.00
Telephone Upgrades	93,000.00	20,000.00	73,000.00
Network Infrastructure	376,600.00	6,600.00	370,000.00
Network Security	10,000.00	10,000.00	0.00
Operating Software	75,000.00	75,000.00	0.00
Capital Hardware	524,041.00	0.00	524,041.00
Capital Software	8,510.00	0.00	8,510.00
<b>Infrastructure Totals (6)</b>	<b>1,162,151.00</b>	<b>186,600.00</b>	<b>975,551.00</b>
Aptify Upgrade	76,600.00	45,000.00	31,600.00
Aptify/DTS Conversion	27,808.00	27,808.00	0.00
Aptify/TS Conversion/Events Implementation	128,800.00	128,800.00	0.00
<b>Aptify Totals (7)</b>	<b>233,208.00</b>	<b>201,608.00</b>	<b>31,600.00</b>
<b>Grand Totals</b>	<b>2,809,592.00</b>	<b>1,081,749.00</b>	<b>1,727,843.00</b>

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## IT Core Area

<b>2013 Planned Spending</b>	<b>Operating Budget</b>	<b>Capital Budget</b>	<b>Total</b>
FileWeb	\$10,000	0	10,000
Data Warehouse	0	0	0
Internet (1)	59,565	204,000	263,565
ADA Connect (2)	96,000	35,000	131,000
PeopleSoft (3)	72,800	40,000	112,800
Tripartite System	0	0	0
Infrastructure Hardware/ Licenses (4)	160,000	810,000	970,000
Hyperion Budgeting Module	0	0	0
Aptify (5)	69,350	25,000	94,350
Aptify/Learning Management (6)	194,900	185,000	379,900
Total Project Spending	662,615	1,299,000	1,961,615
Balance of IT Operating Budget	9,736,576	0	9,736,576
Total IT Spending	<u>\$10,399,191</u>	<u>1,299,000</u>	<u>11,698,191</u>

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<b>2013 Consulting Projects</b>	<b>Total Projected Spending</b>	<b>Operating Budget</b>	<b>Capital Budget</b>
FileWeb Support	10,000.00	10,000.00	0.00
<b>FileWeb Totals (1)</b>	<b>10,000.00</b>	<b>10,000.00</b>	<b>0.00</b>
<b>Data Warehouse Totals</b>	<b>0.00</b>	<b>0.00</b>	<b>0.00</b>
ADA.org Re-Engineering - DP	198,565.00	59,565.00	139,000.00
MS SharePoint for EBD website	65,000.00	0.00	65,000.00
<b>Internet Totals (2)</b>	<b>263,565.00</b>	<b>59,565.00</b>	<b>204,000.00</b>
ADA Connect - DP	116,000.00	81,000.00	35,000.00
MS SharePoint Environment Support	15,000.00	15,000.00	0.00
<b>ADA Connect/KM Totals (3)</b>	<b>131,000.00</b>	<b>96,000.00</b>	<b>35,000.00</b>
People Tools Upgrade	56,800.00	16,800.00	40,000.00
Talent Generation SaaS - DP	56,000.00	56,000.00	0.00
<b>PeopleSoft Totals (4)</b>	<b>112,800.00</b>	<b>72,800.00</b>	<b>40,000.00</b>
<b>Tripartite System Totals</b>	<b>0.00</b>	<b>0.00</b>	<b>0.00</b>
Warranty Technician	75,000.00	75,000.00	0.00
Telephone Upgrades	10,000.00	10,000.00	0.00
Network Security	25,000.00	25,000.00	0.00
Operating Software	50,000.00	50,000.00	0.00
Capital Hardware	810,000.00	0.00	810,000.00
Capital Software	0.00	0.00	0.00
<b>Infrastructure Totals (5)</b>	<b>970,000.00</b>	<b>160,000.00</b>	<b>810,000.00</b>
Aptify 6.0 Upgrade	25,000.00	0.00	25,000.00
Aptify/TS Rollouts - DP	69,350.00	69,350.00	0.00
Aptify/Learning Management System - DP	379,900.00	194,900.00	185,000.00
<b>Aptify Totals (6)</b>	<b>474,250.00</b>	<b>264,250.00</b>	<b>210,000.00</b>
<b>Grand Totals</b>	<b>1,961,615.00</b>	<b>662,615.00</b>	<b>1,299,000.00</b>
<b>DP = Decision Package in 2013 Budget</b>			

1  
2**Resolutions**

3 This report is informational and no resolutions are presented.

4 **BOARD RECOMMENDATION: Vote Yes to Transmit.**5 **BOARD VOTE: UNANIMOUS. (BOARD OF TRUSTEES CONSENT CALENDAR ACTION—NO BOARD**  
6 **DISCUSSION)**

Resolution No. None NewReport: Board Report 7 Date Submitted: July 2012Submitted By: Board of TrusteesReference Committee: Budget, Business and Administrative MattersTotal Net Financial Implication: None Net Dues Impact: Amount One-time  Amount On-going  FTE 0ADA Strategic Plan Goal: Collaboration (Required)**REPORT 7 OF THE BOARD OF TRUSTEES TO THE HOUSE OF DELEGATES: COMPENSATION AND CONTRACT RELATING TO THE EXECUTIVE DIRECTOR**

**Background:** In June, 2012, the Board of Trustees executed a second three-year employment agreement with the current Executive Director, which expires on March 31, 2015. As in the initial contract, either party may terminate the agreement without cause by giving the other party written notice of termination at least 60 days prior to the termination date. The Executive Director is the only member of the ADA staff with a written employment contract. The contract provides that the Executive Director's performance is to be reviewed by the Board on an approximately annual basis or more frequently, as deemed appropriate by the Board, at the Board's sole discretion.

**Compensation and Benefits:** The Executive Director's current annual base salary is \$450,000 and is paid in accordance with the Association's standard payroll schedule and policies. The Board of Trustees reviews the Executive Director's salary on an approximately annual basis, and may, in its sole discretion, increase her compensation based upon a performance review by the Board. In addition, she is eligible to receive an annual bonus ranging from 0%-3% of her base salary, as determined by the Board, based upon criteria jointly approved by the Executive Director/COO and the Board, and subject to the availability of funds. The Executive Director is entitled to all of the fringe benefits offered during the term of this Agreement to all other similarly situated Association employees having her length of service in the employ of the Association; provided, however, that such fringe benefits do not include "Severance Pay" under the ADA Employee Handbook or any other ADA policy or procedure relating to severance pay.

The Executive Director participates in the Executive Parity Plan, a non-qualified retirement plan that restores the value of lost benefits to senior ADA executives who otherwise would suffer significant benefit reductions (20% to 60% reduction) because of the tax laws. This non-qualified plan is funded via a specified cash amount the Board sets aside annually to be paid upon vesting. The set asides are strictly restorative and are funded from the savings in the qualified pension plan contributions which result because of the reduction in executive covered benefits under the qualified plan. Like many for-profit corporations and other Chicago-based professional associations, the Board recompenses the Executive Director and other affected senior executives for this reduction in pension plan benefits.

The Executive Director also receives a \$5,000 annual contribution to the Great-West Variable Annuity Plan; a parking space in the Association Headquarters building; the reimbursement of reasonable, substantiated expenses incurred to purchase and maintain a membership in one city or athletic club in the Chicago area; one cellular telephone, spousal travel to the Association's annual session; and membership dues in professional associations (except the dues of the American Dental Association and its constituent and component dental societies). The Board collects data from outside consultants and various published reports in order to compare the compensation and benefits package of the Executive Director to other similarly sized non-profit organizations.

1 **Resolutions**

2 This report is informational and no resolutions are presented.

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

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

Resolution No. None N/AReport: Board Report 9 Date Submitted: September 2012Submitted By: Board of TrusteesReference Committee: Budget, Business and Administrative MattersTotal Net Financial Implication: None in 2013 Net Dues Impact: \_\_\_\_\_Amount One-time None Amount On-going \$100,000 - \$200,000 FTE 0ADA Strategic Plan Goal: Financial (Required)**REPORT 9 OF THE BOARD OF TRUSTEES TO THE HOUSE OF DELEGATES: RESPONSE TO  
RESOLUTION 68H-2011: PARITY PLAN EVALUATION**

**Background:** This report is in response to House of Delegates Resolution 68H-2011 (*Trans.*2011:450). The Parity Plan currently offers retirement income benefits to some ADA officers. This is an informational report for the House of Delegates confirming the evaluation and actions taken by the Board of Trustees.

Resolution 68H-2011 reads as follows:

**68H-2011. Resolved,** that the House of Delegates urges the Board of Trustees to evaluate the parity plan, take such action as is appropriate, and report back to the 2012 House of Delegates.

**Evaluation Process:** The Board appointed its Compensation Committee to perform an evaluation of the Parity Plan. Following a Request for Proposal, Benefits and Compensation Resources (BCR) was selected and engaged by the Compensation Committee as the external consulting experts to perform a competitive market evaluation of the Parity Plan. This evaluation determined current common practice among similar associations for offering senior executives and Board officers the types of benefit coverage offered through the Parity Plan.

The external market competitive evaluation examined retirement plan benefits offered by 11 large not-for-profit organizations considered potentially similar in size and/or national operating scope with the ADA. The information was obtained from publicly available 2010 Form 990 reports from the following entities:

<b>Not-for-Profit Organizations for Benchmarking ADA Parity Plan</b>	
<b>Professional Membership Orgs.</b>	<b>Charitable or Research Orgs.</b>
American Bar Association	Alzheimer's Association
American Dietetic Association*	American Cancer Society
American Hospital Association	American Diabetes Association
American Medical Association	American Heart Association
American Osteopathic Association	
Joint Commission	
National Association of Realtors	

\*name recently changed to Academy of Nutrition and Dietetics.

The Compensation Committee reviewed the background of the ADA Parity Plan, the competitive market findings, and subsequent information provided by the ADA's pension plan actuary to develop a set of recommendations. Such recommendations were submitted to the Board during its July 2012 meeting.

**Background of the Parity Plan:** The Parity Plan was begun in 1994 as a 457(f) non-qualified deferred compensation arrangement set up as an extension of the ADA Employee Pension Plan. The Parity Plan's purpose was to restore to eligible staff executives that portion of pension benefits lost due to the compensation and benefit caps enforced by IRC 401(a)(17) and 415 on Pension Plan benefits. For example, for 2012, the IRC cap is \$250,000 and the Parity Plan would therefor provide a retirement benefit to eligible staff executives based only on the present value of that portion of salary in excess of \$250,000. Staff executives complete five years of service to vest in and begin receiving payment of any accrued benefits. Thereafter each year's benefit allocation can be paid out immediately after allocation. Currently, six (6) ADA executives plus the Executive Director of the ADA Foundation would be eligible for a year-end 2012 Parity Plan benefit.

The Parity Plan was amended in 2000 to extend eligibility for retirement benefits to three ADA officers – President, President-elect and Treasurer. Prior to 2000, the ADA did not provide officers with any retirement benefit opportunity. ADA records indicate the change was made to enable key officers to restore a portion of the retirement savings lost due to their service to the ADA with its resulting diminishment of eligible wages earned from their personal practices that could be used to fund their solo retirement plans.

At amendment, the ADA officers were designated as employees and became eligible to accrue service under the Parity Plan to mirror service under the Pension Plan. Because these officers are not regular employees, they may not participate in the Pension Plan. Unlike ADA staff executives, all of the officers' calculated present value of retirement benefits must be paid from the Parity Plan (not just a portion of benefits tied to stipend compensation paid in excess of \$250,000).

The ADA officers vest in any accrued benefits and payment is made immediately at the end of eligible service time. Payment is made to each President at the end of his/her 2-year term based on service in both the president-elect and president roles; and payment is made to a Treasurer at the end of his/her 3-year term [or may be delayed until the end of service if extended through a subsequent term as Treasurer or election as President-elect].

All participants are also eligible for the Parity Plan's 20% tax gross-up benefit. This gross up in effect reimburses the participants for the loss of favorable tax treatment because the Parity Plan is a non-qualified plan and benefit payments are subject to normal taxation when paid.

**Historical and Projected 2012 Benefits:** A history of recent and projected benefit payouts is shown below (note the President's payout in 2008 included benefits related to his also serving as ADA Executive Director; the Treasurer's projected payout covers a 6-year term in the Treasurer role).

	2006	2007*	2008*	2009	2010	2011	Est. 2012**
<b>Payouts:</b>							
Staff	\$ 56,990	\$ 424,237	\$183,466	\$24,307	\$ 118,378	\$ 98,641	\$ 2,745
Officer - President	\$123,100	\$ 130,200	\$253,269	\$205,563	\$ 169,038	\$ 144,844	\$ 78,769
Officer - Treasurer							\$ 130,539
<b>TOTAL</b>	<b>\$180,090</b>	<b>\$ 554,437</b>	<b>\$436,735</b>	<b>\$229,870</b>	<b>\$ 287,416</b>	<b>\$ 243,485</b>	<b>\$ 212,053</b>

\* Note: 2007 payout included payment to ED whose employment terminated. 2008 payout comprised of the President payout and Treasurer payout which also included his role as Treasurer for two terms.

\*\* Amounts projected by actuary. Amounts are less than in prior years due to 1/1/12 Pension Plan changes.

Projected payouts for 2012 reflect amounts that will be vested and eligible for distribution at year end. A total of approximately \$49,000 is projected to be earned by the six (6) ADA executives plus the ADAF Executive Director for 2012 while the Board Officers are projected to earn approximately \$65,000 of benefits for 2012. The 2012 benefits reflect a decrease that corresponds to the reduction in the related Pension Plan formula which changed in 2012 from 2.135% to only 1% of covered compensation multiplied by years of service.

**Findings from the Competitive Market Evaluation:** The competitive market evaluation conducted by the external consultant offered these findings.

- Five of the 11 potential peers offer some form of nonqualified retirement replacement plan to top executives and / or officers who are also bona fide employees. Two charitable organizations – Alzheimers and American Heart – still offer a 457(f) plan. A more common type of plan, a SERP (supplemental employee retirement plan) is offered to Executive (i.e., bona fide employee) Officers by American Diabetes; American Hospital; and the Joint Commission.
- None of the potential peer organizations offer retirement benefits to non-employees such as the ADA officers.
- Only two peer associations also offer a tax gross up. Providing a tax gross up for benefit or perquisite payments is in fact no longer a common practice.

**Board Actions:** Based on the findings of the competitive market study, the Compensation Committee recommended to the Board that the ADA Parity Plan be discontinued because it is no longer consistent with competitive market practice. At the July 2012 meeting, the Board adopted Resolution B-108 which is provided in full below.

**B-108-2012. Resolved,** that the ADA Executive Parity Plan as currently designed is no longer consistent with current competitive market practice and should be changed as follows:

- the Plan be frozen effective July 31, 2012 so that no future staff executives or Board Officers of the ADA, ADAF or ADABEI become eligible to participate under the Plan if not already a participant as of that effective date
- that restoration benefits continue to be provided per the terms of the Plan to the currently participating staff executives until and through December 31, 2013 after which date no further new restoration benefits amounts would be provided
- that restoration benefits continue to be provided per the terms of the Plan to the currently participating Board Officers until and through the earlier of the expiration of their current terms of service as an eligible Board Officer or November 5, 2013
- that the Plan shall continue in frozen operation until such time as all vested benefits have been distributed to the eligible participants. At which time the Plan shall be terminated with all due legal process by the ADA Human Resources Department.

### 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)**

\*Dr. Faiella was absent.

Resolution No. N/A N/AReport: Board Report 10 Date Submitted: September 2012Submitted By: Board of TrusteesReference Committee: Budget, Business and Administrative MattersTotal Net Financial Implication: None Net Dues Impact: Amount One-time  Amount On-going  FTE 0ADA Strategic Plan Goal: Financial (Required)**REPORT 10 OF THE BOARD OF TRUSTEES TO THE HOUSE OF DELEGATES: RESPONSE TO  
RESOLUTION 77H-2011: ADA PENSION PLANS****Background:** This report is in response to House of Delegates Resolution 77H-2011 (*Trans.*2011:444).

Resolution 77H-2011 reads as follows:

**77H-2011. Resolved,** that the Board of Trustees provide to the House of Delegates an annual executive summary on the status of the Pension Plan as reflected in the annual ADA audit reports and the annual actuarial certification of the pension plan funding status.

The ADA reviewed its employee benefits as part of a larger project to assess total compensation in 2011 and made significant changes to retiree benefits effective January 1, 2012 that reduced both future costs and risks while still providing a market competitive total compensation package.

To summarize, that decision was based on the following facts which still apply to the plan:

- The new terms of the pension plan reduce future costs and risks by more than 60% compared to the old plan terms.
- Supplemental pension funding is not optional and represents payment of prior service costs under the old pension plan. This funding is the majority of the ADA's annual budget cost and is required even if the plan is terminated.
- If the pension plan were terminated completely, the ADA would not have access to plan assets to reduce costs in future periods.
- A "hard freeze" plan termination would come at a high price because conservative accounting rules lock in the value of the liability based on an assumed liquidation of pension benefits as of the termination date using current, historic low interest rates. This liability can only be reduced by the future payment of those plan's liabilities.
- The long term economic costs of the plan are ultimately tied to the payout of future benefits over many years, in fact, decades into the future. ADA contributions that go into the plan do not come out except to pay plan benefits. Because pension benefits, since 1993, are only paid as a monthly annuity to retirees, cash flows are predictable and plan assets are invested to balance long term returns, risks, and costs in relation to the maturity of the long term pension liabilities.

Resolution 77H-2011 asks for reporting on the ADA Pension Plan using two sources of information that provide two perspectives of plan status based on two different actuarial calculations of the future pension benefit liability:

- a. the accrual basis liability included in the ADA's 12/31/11 balance sheet (based on FAS 158 accounting rules), and

- 1       b. the "cash basis" liability, percent funded status and funding requirements included in the ADA's 1/1/12  
2       Adjusted Funding Target Attainment Percentage ["AFTAP"] Range Certification Report (based on  
3       ERISA calculation rules).

4       Although these two liability calculation methods differ, in general terms the net Pension liability represents the  
5       amount of projected total pension funds needed to cover "100% funding" of future benefits less the value of  
6       actual funds invested in pension plan assets. In each case, this "100% funded" liability is an amount  
7       calculated by our actuary based on a formula that uses certain interest rates determined by either government  
8       or accounting rules. When interest rates go down the amount needed to reach 100% funded status goes up.

9       The pension liability, under both methods, accrual basis and cash basis, is recalculated by our actuary as of  
10      the end of every plan year, December 31.

11      **Accrual Basis Pension Liability (included in the ADA's 12/31/11 audited balance sheet):** The following  
12      roll-forward analysis of the ADA's 12/31/11 balance sheet liability shows all the changes in the net accrual  
13      basis liability since the beginning of the year compared to an original estimate based on actuarial estimates in  
14      June 2011.

15      There are four major types of changes that affect the ADA's net pension liability:

- 16      1. The ADA's contribution of cash to the plan assets which reduces the liability includes two parts:

17          a. The funding of "normal service" costs for current employees of the ADA who earn benefits during the  
18          plan year; and

19          b. The funding of supplemental payments to help get the plan to 100% funded status which represent  
20          "catch up" funding of benefits earned in prior periods as defined by government funding rules initially  
21          introduced by the pension protection act ("PPA") of 2006; and

- 22      2. The increase in the net plan liability due to the accrual of the "normal service" benefit costs plus interest  
23      on the unfunded pension liability; and

- 24      3. The decrease in the net pension liability due to the increase in the value of the plans investment assets;  
25      and

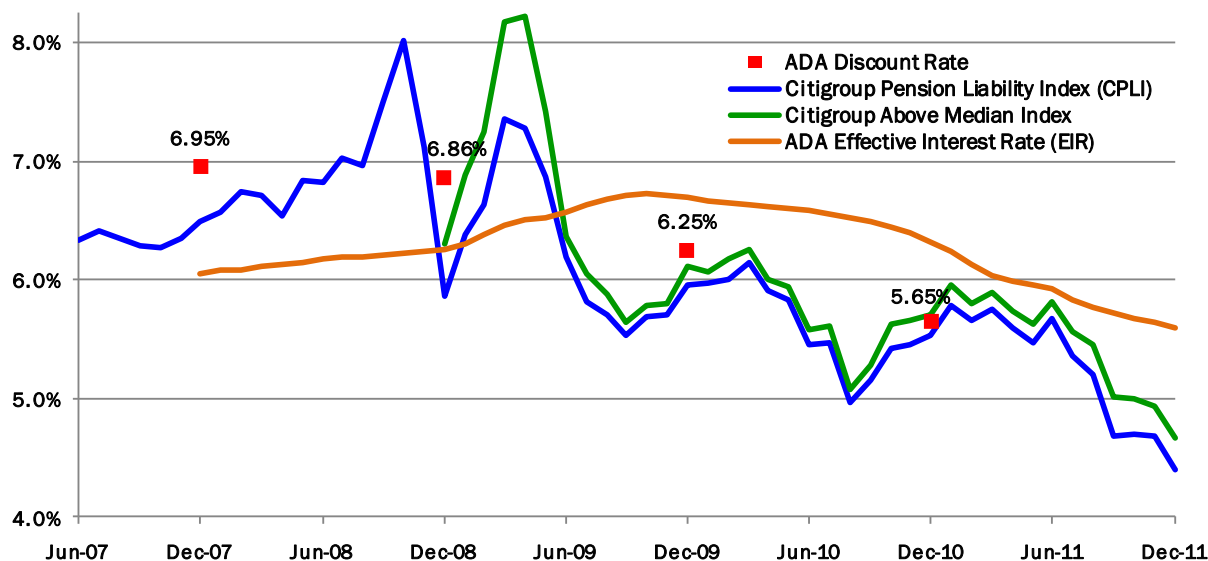
- 26      4. The impact of an increase or decrease in the net pension liability due to the decrease or increase in the  
27      "spot rate" of interest used to calculate the actuarial present value of those future retirement benefits at  
28      December 31 each year.

29      In addition to these changes to the pension liability, the ADA also made the "one time" change to future  
30      employee benefits effective January 1, 2012 that significantly reduced the ADA's accrual basis pension  
31      liability as well as its ongoing pension expense. This one change reduced the liability by \$8.9 million at  
32      12/31/2011 and will reduce "normal service costs" annually in 2012 and future years by over \$3 million or 60%  
33      compared to 2011.

34      The following roll-forward analysis chart shows that the biggest differences between the Forecast of the Net  
35      Pension Liability and the Actual results at the end of 2011 were caused by lower than planned interest rates  
36      and investment values. Unfortunately, these unfavorable impacts more than offset the \$8.9 million of savings  
37      generated by the big, one time reduction in employee benefits but this illustrates the impact that low "spot"  
38      interest rates can have on the year end valuation of future benefit liabilities. Of course, had the Association  
39      not achieved the \$8.9 million of savings in 2012, the funding status of the Plan would have been markedly  
40      worse.

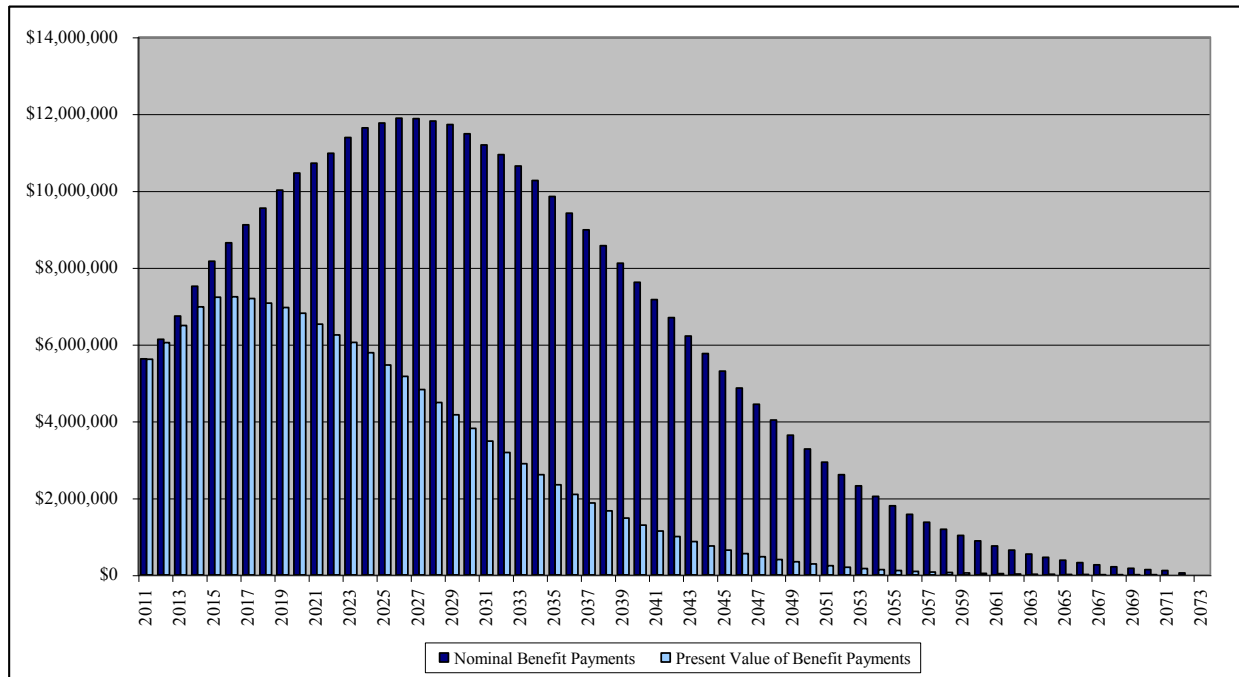
<b>ADA Consolidated</b>				
<b>Pension Liability Analysis</b>				
Millions of Dollars; Increase / (Decrease) in Liability				
Audited as of December 31, 2011				
	Forecast Model as of July 2011	Actual	Favorable/ (Unfavorable) Variance	Notes
Beginning Balance December 31, 2010	48.8	48.8	-	
Contributions (Cash):				
<i>Normal Service Cost Funding</i>	(5.2)	(5.2)	-	Funding under old pension plan formula; 2012 cost is \$1.8 M.
<i>Supplemental/Catch-up Funding of Prior Service</i>	(8.9)	(7.6)	(1.3)	Required contributions of prior service costs on path to 100% status
Expected Obligation Increase	13.4	13.4	-	Service Cost (benefit accrual) and Interest Cost (interest on obligation).
Net Investment (Gains)/Losses	(8.2)	(2.9)	(5.3)	Actual based portfolio at 12/31/2011 market values; all assets held to maturity
Actuarial (Gain)/Loss	2.6	2.1	0.5	Update based on latest participant population, salaries, and mortality data
Reduction in Benefits	(8.1)	(8.9)	0.8	Final plan slightly less costly than assumed in July 2011 model.
Annual FAS 158 Actuarial Valuation Adjustment Discount Rate	-	10.0	(10.0)	Actuarial impact of 5.16% effective discount rate approved by KPMG
Supplemental Benefit Trust	-	1.4	(1.4)	Existing ADA liability as reported in annual audit reports, but not in model.
<b>Ending Balance December 31, 2011</b>	<b>34.4</b>	<b>51.1</b>	<b>(16.7)</b>	Actual balance includes accrued liability using 5.16% discount rate

Low interest rates, more than any other factor, have been increasing the year end valuations of Retirement Benefit Obligations. The next graph show the downward trend of the rates used to calculate these long term liabilities.



It is important to note that although the use of year end "spot rates" determines the value of the liabilities and can also drive higher contribution rates to plan assets, it is the actual cash payout of the retirement benefits that will only happen over many decades that represents the true economic cost of the plan. All cash

contributed to the plan stays in the plan until all benefits are paid. And the actual payout of the 12/31/11 pension plan liability through monthly benefits to retirees will only happen over the next 30 to 40 years with the final payment expected in the year 2072. The following graph shows these expected annual payments to plan participants from plan assets:



**Pension Relief:** As a result, many actuaries questioned the use of “spot rates” to value pension liabilities and suggested to legislators that a longer 25 year average interest rate be used to calculate the requirements for cash contributions to pension plans. This “pension relief” was intended to reduce the funding burden on pension plan sponsors caused by the current, low interest rate environment and was signed into law as part of the MAP-21 Act to fund highway and student loan interest programs. While the exact impact of MAP-21 is not known because the Treasury is drafting regulations to implement pension stabilization, the ADA’s actuaries have estimated savings will be at least \$2 million in 2013 and this assumption was built into the 2013 budget as reported in Board Report 2.

**Cash Basis Pension Liability (included in the annual actuarial certification of the pension plan funding status):** The other pension liability recalculated by our actuary each year is the Cash Basis Pension Liability which is published in the ADA’s annual Adjusted Funding Target Attainment Percentage [“AFTAP”] Range Certification Report (based on ERISA calculation rules). This report is significant because it includes the annual funded status of the plan. In addition, as this “cash basis” liability increases, the amount of annual cash contributions required from the next year’s Operating Budget will also increase.

The following chart shows the Cash Basis Pension Liability based on the AFTAP certification report:

American Dental Association					
Employees' Retirement Trust					
Adjusted Funding Target Attainment Percentage ("AFTAP") Funding Status					
as of January 1, 2012 (valuation date)					
		Year End 2010		Year End 2011	
		amount	%	amount	%
	AFTAP Net Effective Interest Rate	6.32%		7.05%	
	Cash Basis Target Liability (= 100% status)	\$ 133,828,104	100.0%	\$ 131,579,775	100.0%
	Less: Plan Assets	(108,809,888)	81.3%	(112,255,102)	85.3%
	Net AFTAP Report Unfunded Plan Liability	\$ 25,018,216	18.7%	\$ 19,324,673	14.7%

The data in this chart show, in simple format, how the 2011 year end valuation of investments also contributes to the funded status of the plan.

**Conclusions:** Although the use of "spot" rates of interest, in effect at the end of each year, determine the GAAP accounting basis of the liabilities and, although the annual cash basis valuation can drive higher contributions to the plan's assets, the final cost of the plan is ultimately tied to the payment of these benefits to plan participants.

Because the ADA stopped lump sum payments for benefits earned after 1993, the pension plan operates as a simple annuity plan which greatly reduces transactions other than normal portfolio management and the payment of monthly benefits to participants. This results in very predictable cashflows.

Once the ADA contributes cash into the plan, it stays in plan investments to generate long term returns until benefits are paid out. Under this plan structure, the ADA's actuaries and investment advisors have explained that temporary investment valuation and interest rate volatility have minimal impact on the long term economics of the pension plan.

Board changes to retirement benefit plans helped reduce total liabilities by over \$7 million at 12/31/11 (plan changes actually account for \$21.8 million of direct reduction which was partially offset by the impact of interest and investment).

In addition, the significant cut in pension plan benefits reduced "normal" pension costs, for 1 year of service, from \$5.2 million in 2011 to \$1.9 million in 2012.

Although the historic low "point in time" interest rate as of December 31, 2011 resulted in higher pension liability, expected long term higher interest rates will turn this liability into an asset in the future. Pension relief intended to reduce the funding burdens on pension plan sponsors caused by the current, low interest rate environment was signed into law as part of the MAP-21 Act is expected to reduce ADA contributions in 2013.

The continuation of the pension plan at reduced levels is expected to pay for itself with limited risk once 100% funded status is reached.

While the impact of low interest rates has increased the amount of retirement liabilities measured at December 31, 2011, over the long term the plan will provide the ADA with a valuable benefit to attract and retain employees critical to its mission based on an asset that will eventually pay for itself once 100% funded status is reached.

Without any continuing pension plan in place, there would be a long term risk of an overfunded pension plan, with the ADA being unable to utilize any portion of the resulting overfunded asset balance.

- 1 With a continuing pension plan, any overfunding that may occur due to fluctuating interest rates can be used  
2 to help minimize annual plan contributions going forward.
- 3 On a related topic, the Board's action in 2011 to reduce retiree health benefits resulted in an immediate \$10  
4 million improvement in the ADA's financial position at December 31, 2011. That reduction also eliminated the  
5 ADA's exposure to escalating health care costs by capping the future maximum annual cost per retiree.

6 **Resolutions**

- 7 This report is informational and no resolutions are presented.

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

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

- 10 \*Dr. Faiella was absent.

Resolution No. N/A N/AReport: Board Report 12 Date Submitted: September 2012Submitted By: Board of TrusteesReference Committee: Budget, Business and Administrative MattersTotal Net Financial Implication: None Net Dues Impact: \_\_\_\_\_Amount One-time \_\_\_\_\_ Amount On-going \_\_\_\_\_ FTE 0ADA Strategic Plan Goal: Financial (Required)**REPORT 12 OF THE BOARD OF TRUSTEES TO THE HOUSE OF DELEGATES: UPDATE ON 2010  
COMMERCE FEASIBILITY STUDY**

**Background:** This informational report provides an update to the House of Delegates on the achievements to the business case for implementing Aptify and demonstrates a commitment to achieving the business case.

The goals and objectives of the feasibility study were to identify a commerce/order management solution that met the following criteria:

- Unified commerce/order management experience
- Integrated order management
- Improved receipt, tracking of revenue
- Reduced and/or eliminated manual and redundant processes
- Reduced and/or eliminated errors
- Improve the quality of the order process

In order to manage the migration of the standalone ADA operational systems to an integrated association management software package, each functional area has been prioritized into a software implementation plan that spans a 3 year period. This period began in 2011 and will extend into 2014.

As of 2012 the ADA has purchased and implemented the Aptify Association Management Software package and migrated existing Siebel applications to Aptify. The Siebel Systems have all been decommissioned as of 2012.

Below is an updated financial summary that compares the estimated cost savings and revenue projections initially developed for the 2010 Commerce Feasibility Study to the actual achievements as August of 2012.

The following costs were identified in this summary as follows:

- Cost to Migrate – Consulting dollars necessary to configure and move function to Aptify.
- Hard Cost Savings – Current expenses that will be eliminated.
- Soft Cost Savings – Elimination or reduction of manual and redundant processes.

[illegible]

In Service Year	Functional Area	Cost to Migrate	Hard Cost Savings	Soft Cost Savings	Additional Revenue	2010 Proposed Net Savings/ Revenue	To Date Actual Savings/ Revenue
	and Publishing to calculate cost for PDS products. Aptify is now used to manage all product cost used to generate net revenue calculations.						
2012	Survey Management	0	0	\$8,400	0	\$8,400	0
	<p>The original study proposed cost saving by eliminating weekly member surveys, taking orders by phone and eliminating redundant posting of content to ADA.org for free surveys.</p> <p>As of 2012, the Survey Center has not realized these cost savings. The Survey Center will realize cost savings by eliminating weekly member surgery and taking orders via the phone, in 2013, when the survey module in Aptify is implemented.</p> <p>As of 2012, the Survey Center continues to post free members surveys online and has kept free PDF files on the ADA.org website, as well as via the new eCatalog. The Survey Center plans to review this business process in 2013 as the division determines what products will be developed by the Survey Center. These cost savings will be realized in 2013.</p>						
		<b>Cost to Migrate</b>	<b>Hard Cost Savings</b>	<b>Soft Cost Savings</b>	<b>Additional Revenue</b>	<b>2010 Proposed Net Savings/ Revenue</b>	<b>To Date Actual Savings/ Revenue</b>
<b>Total as of 2012</b>				<b>\$255,800</b>	<b>\$620,000</b>	<b>\$875,800</b>	<b>\$506,129</b>

1 As of 2012, the following functional areas are scheduled to be implemented in the "In Service Year" noted in  
2 the first column. Cost savings will be reported based on each applications implementation period.  
3

In Service Year	Functional Area	Cost to Migrate	Hard Cost Savings	Soft Cost Savings	Additional Revenue	2010 Proposed Net Savings/ Revenue	To Date Actual Savings/ Revenue
2013	Meetings/Events	\$98,000	0	\$386,450	0	\$288,450	
2013	CERP	0	\$650	\$5,450	0	\$6,100	
2014	Accreditation (CODA)	0	0	0	0	0	
On hold pending study	CELL	\$196,000	0	0	0	-\$196,000	
2013	Testing Services	0	0	\$52,000	\$985,250	\$1,076,250	
2014	Fundraising	0	\$13,395	\$66,000	0	\$79,395	
2013	Online Giving	0	0	\$1,700	0	\$1,700	
2014	Advertising Sales	0	0	0	0	0	
2013	Subscriptions	0	\$1,464	\$3,000	0	\$4,464	

<b>2010 Proposed Totals</b>		\$294,000	\$15,509	\$770,400	\$1,605,250	\$2,136,159	
<b>2012 Actuals as of 8/28</b>				<b>\$255,800</b>	<b>\$620,000</b>	<b>\$875,800</b>	<b>\$506,129</b>
<b>To Date Totals</b>		\$294,000	\$15,509	\$514,000	\$985,250	\$1,260,359	\$506,129

1 Efficiencies that were not included in the 2010 Commerce Feasibility Study but could possibly be realized are  
2 any efficiencies garnered by the Tripartite system operations team when the older Tripartite system is replaced  
3 by Aptify starting in July 2013. As these are better understood, this report will include an estimate of those  
4 efficiencies realized.

5 Please note, that actual cost savings and revenue in this report are only reflective savings and additional  
6 revenue as of August 2012. Currently online eCatalog sales have increased in 2012 over 2011 by 28% as of  
7 August, 2012. As of August 2012 soft cost savings have exceeded expectations by \$10,000. Full proposed  
8 savings and additional revenue will be realized over 2013 and 2014 with the implementation of Aptify  
9 functionality.

10 Revenue and cost savings realized from September 1, 2012 through December 31, 2012 will be included in  
11 the Commerce Feasibility study progress report to the House of Delegates in 2013.

## 12 **Resolutions**

13 This report is informational and no resolutions are presented.

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

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

16 \*Dr. Faiella was absent.

17 File 4: Board Rpt. 12; Pgs. 2100-2103

Resolution No. 169 NewReport: N/A Date Submitted: October 2012Submitted By: Fifth Trustee DistrictReference Committee: Budget, Business and Administrative MattersTotal Net Financial Implication: \$50,000 Net Dues Impact: .47Amount One-time \$50,000 Amount On-going  FTE 0ADA Strategic Plan Goal: Financial (Required)**EVALUATION OF ADA PROPERTIES**

The following resolution was submitted by the Fifth Trustee District and transmitted on September 29, 2012, by Dr. Lew Mitchell, chair, Fifth District.

**Background:** Resolution 59 (Worksehet:2065) requests that a special assessment of \$50 per member for two years be implemented for a net financial impact of \$10,630,000. This assessment is to be used to re-establish a capital building fund for "major building repair and replacement projects" after closing of the previous capital fund in 2005 resulted in a shortage of available monies for such projects.

The ADA owns and maintains two very expensive office buildings in two major markets within the United States. Maintaining these properties has become increasingly problematic and expensive and leasing of space to outside entities has become necessary to offset the high maintenance costs. This situation raises the question of whether the American Dental Association should continue to own office buildings in two very expensive locations or whether the ADA should seek to divest itself of such a commitment to insure the stability of long term reserves, which would otherwise be impacted by spending for inevitable capital projects.

**Resolution**

**169. Resolved,** that the Board of Trustees be urged to engage professional consultants for the expressed purpose of evaluating the concept of the American Dental Association divesting itself of ownership in the office buildings in both Chicago, IL and Washington, DC and the ramifications, both pro and con, of such a divestiture, and be it further

**Resolved,** that the Board of Trustees present a report of the results of their findings to the House of Delegates at the 2013 annual session.

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

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## Membership and Related Matters

Resolution No. 50 NewReport: N/A Date Submitted: July 2012Submitted By: Council on MembershipReference Committee: Membership and Related MattersTotal Net Financial Implication: None Net Dues Impact: Amount One-time  Amount On-going  FTE 0ADA Strategic Plan Goal: Members (Required)**DOWNLOADABLE ADA MEMBER LOGOS****Background:** (*Reports.171*)

**Member Recognition Through Logo Utilization:** Currently, an inequity exists between the general ADA member logo and the logo that is available to ADA member dental specialists. The Council believes that in order to provide equitable member value, a member should be allowed access to the member logo that allows for greater usage and proposes the following action

**Resolution**

**50. Resolved,** that the downloadable ADA member logos, without the year of issue, be made available for all active and retired and life member dentists.

**BOARD RECOMMENDATION: Vote Yes.****Board Vote: Resolution 50**

BLANTON	Yes	GOUNARDES	Yes	NORMAN	Yes	SUMMERHAYS	Yes
DOW	Yes	HAGENBRUCH	Yes	RICH	Yes	VIGNA	Yes
ENGEL	Yes	ISRAELSON	Yes	ROBERTS	Yes	WEBER	Yes
FAIELLA	Absent	KIESLING	Yes	SEAGO	Yes	VERSMAN	Yes
FEINBERG	Yes	LOW	Yes	STEFFEL	Yes	YONEMOTO	Yes

Resolution No. 51 NewReport: N/A Date Submitted: July 2012Submitted By: Council on MembershipReference Committee: Membership and Related MattersTotal Net Financial Implication: \$1,951,104 (Revenue)\*Total Net Financial Implication: \$2,597,632 (Revenue) Net Dues Impact: \_\_\_\_\_Amount One-time \_\_\_\_\_ Amount On-going \_\_\_\_\_ FTE 0ADA Strategic Plan Goal: Members (Required)**AMENDMENT OF ADA BYLAWS REGARDING THE DUES OF ACTIVE LIFE MEMBERS****Background:** (*Reports:171*)

**Active Life Membership:** At its February 2012 meeting, the Council on Membership discussed the potential impact that the projected growth of the life and active life membership categories could have for the ADA. Based on historical data, it is expected that between 2012 and 2016, 11,794 active members will transition from active membership to active life membership. As these individuals move from paying 100% to 50% of full active dues, the projected impact to the Association is a reduction in dues revenue of \$3,343,616. The Council determined that if this same group were to pay 75% of current full active dues, over this same time period, \$4,528,896 in revenue could be gained, thus minimizing the effect of the reduction and adding nearly \$1.2 million in additional revenue over the five-year time period.

The Council also discussed the potential impact of raising dues for existing active life members. Not accounting for attrition, increasing dues to 75% of full active dues would generate an additional \$128 from each of the 12,814 current active life members. This equates to an annual increase of \$1.6 million. With respect to attrition, each year, over the past four years, attrition nationally for this group has averaged 2%. In 2010, the Illinois State Dental Society (ISDA) implemented a dues increase for its active life members that raised dues from 50% to 100% of full dues. Over the first year, 17 of the existing ISDA active life members, or 3.5%, did not renew. The Council also considered the option of grandfathering in existing active life members. Doing so would maintain the Association's existing relationship with current life members as well as minimize the potential for increased attrition. However, doing so could foster dissatisfaction among those active life members who pay a different dues amount moving forward. It would also increase the complexity of dues collection for constituents who would need to track and collect two separate dues amounts within one category of membership.

The Council carefully weighed the importance of serving long-standing members who continue to actively practice dentistry, with the recognition that costs continue to increase to provide existing benefits. In addition, future value through offerings such as the ADA's Center for Professional Success may increase costs further. If active life member dues are raised to cover those costs, market share could be impacted by the level of attrition that may occur. This natural tension creates a fine line between covering expense and providing the greatest value for the membership dollar. As a result of this discussion, the Council recommends that the following *Bylaws* resolution be forwarded to the 2012 House of Delegates for consideration

\*The financial impact was incorrectly stated and has been revised because the financial impact of adding 2,429 active life members (\$621,824) was already included in the proposed 2013 budget.

**Resolution**

**51. Resolved**, that the ADA *Bylaws*, Chapter I. MEMBERSHIP, Section 20. QUALIFICATIONS, PRIVILEGES, DUES AND SPECIAL ASSESSMENTS, Section B. LIFE MEMBER, Subsection c. DUES AND SPECIAL ASSESSMENTS, paragraph 1, be amended as follows (new language underscored; deletions ~~stricken~~):

(1) ACTIVE LIFE MEMBERS. The dues of life members who have not fulfilled the qualifications of retired membership pursuant to Chapter I, Section 20C of these *Bylaws* with regard to income related to dentistry shall be ~~fifty percent (50%)~~ seventy-five percent (75%)\* of the dues of active members, due January 1 of each year. In addition to their annual dues, active life members shall pay ~~fifty percent (50%)~~ seventy-five percent (75%)\* of any active member special assessment, due January 1 of each year.

\*The dues and special assessment percentage for those members who attained active life membership classification prior to the adjournment *sine die* of the 2012 House of Delegates shall remain at the same percentage as they had upon entry into this category, and until such time that they move to another membership category.

**BOARD COMMENT:** The Board appreciates the difficult decision made by the Council on Membership in recommending this course of action. On one hand, the association recognizes and values its longest standing members. On the other, it continues to provide services to all practicing dentist members at a time when fiscal challenges prevail. In order to be fair and equitable across all those who receive benefit, while ensuring the long term financial stability of the association, the Board recommends increasing active life membership dues consistent with the Council's recommendation, *i.e.* seventy-five percent (75%) of those of active members without grandfathering. In addition, the Board recommends that other forms of recognition for active life members be investigated and provided at each tripartite level. Doing so will provide continued support and recognition of these valued members while increasing the financial viability of the ADA and to ensure further achievement of the ADA's mission.

**51B. Resolved**, that the ADA *Bylaws*, Chapter I. MEMBERSHIP, Section 20. QUALIFICATIONS, PRIVILEGES, DUES AND SPECIAL ASSESSMENTS, Section B. LIFE MEMBER, Subsection c. DUES AND SPECIAL ASSESSMENTS, paragraph 1, be amended as follows (new language underscored; deletions ~~stricken~~):

(1) ACTIVE LIFE MEMBERS. The dues of life members who have not fulfilled the qualifications of retired membership pursuant to Chapter I, Section 20C of these *Bylaws* with regard to income related to dentistry shall be ~~fifty percent (50%)~~ seventy-five percent (75%) of the dues of active members, due January 1 of each year. In addition to their annual dues, active life members shall pay ~~fifty percent (50%)~~ seventy-five percent (75%) of any active member special assessment, due January 1 of each year.

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

**Board Vote: Resolution 51B**

BLANTON	Yes	GOUNARDES	Yes	NORMAN	Yes	SUMMERHAYS	Yes
DOW	Yes	HAGENBRUCH	No	RICH	No	VIGNA	Yes
ENGEL	Yes	ISRAELSON	Yes	ROBERTS	Yes	WEBER	Yes
FAIELLA	Yes	KIESLING	Yes	SEAGO	Yes	VERSMAN	Absent
FEINBERG	No	LOW	Yes	STEFFEL	Yes	YONEMOTO	Yes

Resolution No. 67, 69, 70, 71, 72 and 73 NewReport: CM Supplemental Report 1 Date Submitted: July 2012Submitted By: Council on MembershipReference Committee: Membership and Related Matters

Total Net Financial Implication: \_\_\_\_\_ Net Dues Impact: \_\_\_\_\_

Amount One-time \_\_\_\_\_ Amount On-going \_\_\_\_\_ FTE 0ADA Strategic Plan Goal: Members (Required)**COUNCIL ON MEMBERSHIP SUPPLEMENTAL REPORT 1 TO THE HOUSE OF DELEGATES:  
RECENT COUNCIL ACTIVITIES**

**Background:** Since its annual report was submitted in May 2012, the Council on Membership met June 15-16, 2012. This report addresses the subjects and resolutions for the 2012 House of Delegates brought forth at that meeting as well as the Council's recommendations to ADA policies and updates on the 2011 House of Delegates assignments: Resolutions 17H-2011 *Amendment of ADA Bylaws Regarding Creation of a 25% Dues Waiver* (Trans.2011:000); 16H-2011 *Amendment of ADA Bylaws Regarding Humanitarian Membership Category* (Trans.2011:000); 20H-2011 Funding of the Student Block Grant Program (Trans.2011:000); 46H-2011 Revision of ADA Specialty Logo (Trans.2011:000); and 2009 House of Delegates assignment Resolution 92H-2009, *Five-Year Projected Dues Revenue Impact From Members Transitioning to Life Membership* (Trans.2009:415).

**Introduction:** The Council on Membership continues to use the ADA Strategic Goals as a guide when addressing its *Bylaws* responsibilities, focusing its efforts on increase ADA member value, member count, member dues revenue and membership market share. As a result, the Council has considered future strategies through review and analysis of current and forecasted market trends. The Council's agendas and subsequent actions and resolutions fully align with the ADA's vision, mission and strategic plan.

**Meetings:** The Council met on June 15-16, 2012, at the ADA Headquarters Building in Chicago.

**Membership Category Study:** The Council has been performing a study of the ADA membership categories and dues structure since its June 2011 meeting. The study has been centered on two objectives; the first was to analyze the current dues contribution by membership category with the intent to assess dues amounts for other categories beyond full active dues. The second objective is to evaluate membership that supports group practice and/or international dentistry. The intent of the Council was to determine the potential of developing new or modifying existing membership categories to meet the evolving needs of international dentists and/or those working in a practice consisting of 20 or more dentists.

**Affiliate Membership:** To maintain the U.S. dental profession's global leadership role, the ADA can heighten its participation and presence in international oral health activities. One key opportunity is to build the capacity for the ADA to respond to unique global market needs by taking a flexible approach to offering and delivering ADA affiliate membership, those dentists who are not licensed in the U.S. and practice dentistry abroad. Since its inception, this not fully privileged category of membership has been a "goodwill" category of membership. The Council considered how the category might change in order to continue to be a part of the dental profession globally as well as provide a foundation for non-dues revenue growth and position ADA for the future. Such flexibility would allow the Association to meet the unique needs of individuals and groups practicing dentistry outside the United States, while generating revenue that increases overall ADA fiscal

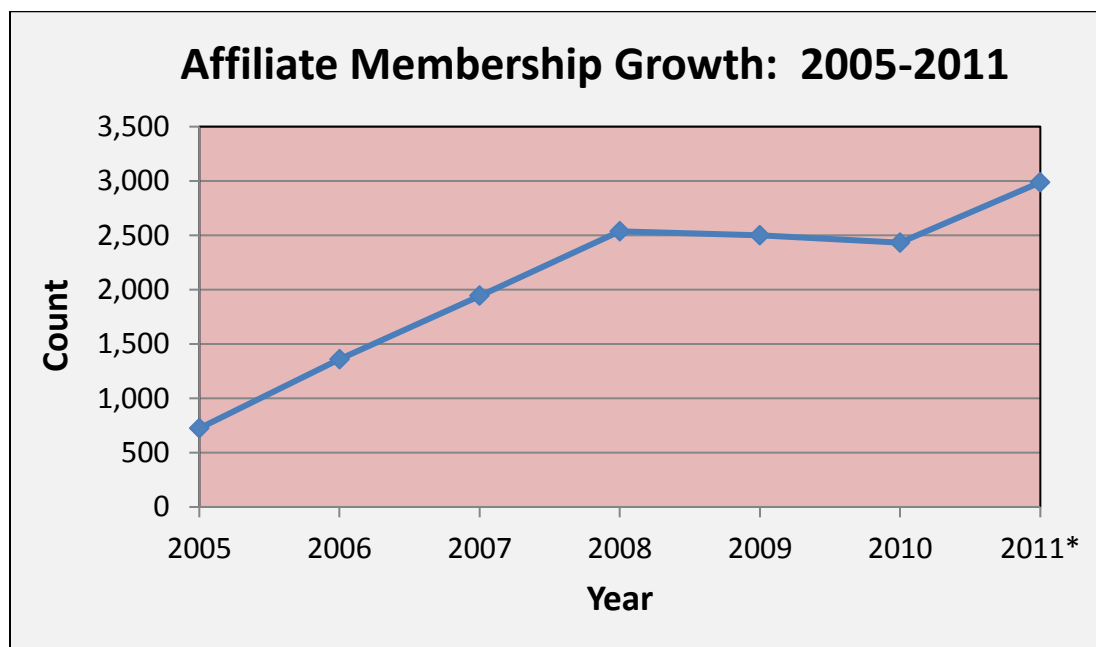
1 solvency, enhances the image of the Association, improves relationships with international associations and  
2 attains the goals of the ADA Strategic Plan and International Business Plan.

3 The 2005 House of Delegates passed Resolution 31H-2005 Amendment of ADA *Bylaws* Regarding Affiliate  
4 Dues. This resolution was initiated by the Council on Membership and established a reasonable flat dues rate  
5 of \$75 (\$12 for individuals in least developed countries as determined by the FDI) for affiliate members.  
6 Doing so created an electronic membership that offered electronic access to ADA publications and the  
7 member rate for the annual session. However, the specificity of the *Bylaws* limits the ADA's ability to bundle  
8 services that meet unique needs of countries and/or organizations that desire something specific and are  
9 willing to pay for it.

10 At that time, the Council on Membership carefully considered information and data related to dentists who  
11 practice outside the U.S. as part of its membership study. It considered whether or not waivers should be  
12 expanded to include affiliate members, but this also was not pursued.

13 Affiliate membership stands at almost 3,000 members and represents dentists from more than 125 countries.  
14 The largest numbers of affiliate members are from Brazil, Canada, Mexico, India, the Philippines and the  
15 United Arab Emirates. Despite the global economic slump, this category has grown steadily (725 members in  
16 2005 to 2,993 in 2011) in large part due to a change in dues structure and associated increased efforts to  
17 recruit and retain them as reflected in the following graph (Graph 1):

18 Graph 1



19 It should be noted that the dues rate for this category in 2005 and the years prior was 50% of full active dues  
20 and assessments (\$233 in 2005) and included ADA's publications in print format, prior to change to the flat  
21 dues amount of \$75 a year (\$12 for members in a "least developed" country) which went into effect in 2006. In  
22 addition to the lower dues rate, the ability to effectively promote a flat amount of dues that was not tied to an  
23 annual fluctuating rate, allowed for increased effectiveness in recruiting and retaining these members.

Additional retention tactics implemented in 2011 have also helped to increase the affiliate member retention rate by 8.9% from 2010 to 2011, accounting for 179 more renewed members. In 2009 and 2010, the retention rate averaged just 56.5%; in 2011, the renewal rate has increased to 64.9%.

One overarching issue the Council has considered through a series of workgroups, which included representation from the Board of Trustees' Committee on International Programs and Development (CIPD,) is whether ADA affiliate membership needs to be more flexible to achieve ADA international business plan goals.

Recently, the Association has been involved in several discussions with other national dental associations regarding the offering of ADA affiliate membership to its members. In all instances, the other national dental association had requested a reduced dues rate (lower than \$75) in exchange for marketing or paying for affiliate membership to all its members, which can number in the thousands. The current ADA *Bylaws* do not allow for such exceptions and the ADA has been unable to respond to these emerging international opportunities.

More flexible affiliate membership arrangements with foreign dental associations could present the Association with unique opportunities to connect with the global dental community in light of the growing globalization of the dental profession while, simultaneously, generating a potentially substantial stream of revenue. Leveraging this opportunity, the ADA can serve as the association model for other countries; stimulate growth of private dental practice globally; dramatically increase affiliate membership; provide information, products and services to a global market of dental professionals and their patients; and generate incremental revenue that can be used to support the ADA Strategic Plan overall.

Eligibility and dues for affiliate membership is set by the House of Delegates in the ADA *Bylaws*. While the Board may set interim policy when such policies are essential to the management of the association (which must then be ratified at the next meeting of the House of Delegates), only the House of Delegates can amend the *Bylaws*. This lack of ability to respond in a flexible manner is a significant barrier for affiliate membership growth the Council on Membership and CIPD have addressed strategically. Several recent opportunities (Canada, China, and special considerations in Iraq and other countries) have been brought to the ADA this year and due to the current *Bylaws*, the ADA has been unable to act quickly to respond to them. It is anticipated that future opportunities will confront many of the same barriers unless there is more flexibility to negotiate affiliate Membership benefits and dues based on a country or international association's needs.

It is also important to note that the benefits a affiliate members receive were not created based upon defined member needs or considering an international scope. That is to say, the ADA did not create a value proposition specifically for the member practicing outside of the United States. For example, subject matter has not been developed specifically addressing situations experienced in other countries. Content has not been routinely translated. Rather, existing member benefits have been harvested and repackaged, then delivered to dentists practicing outside of the United States.

As a result of the review of international membership, the following *Bylaws* resolution is offered for consideration of the House of Delegates:

**67. Resolved**, that the ADA *Bylaws*, *Chapter I. MEMBERSHIP*, Section 20. QUALIFICATIONS, PRIVILEGES, DUES AND SPECIAL ASSESSMENTS I. AFFILIATE MEMBER, b. PRIVILEGES be amended as follows: (additions are underscored; deletions are ~~stricken~~).

b. PRIVILEGES. An affiliate member in good standing shall receive ~~annually a membership card, have access to the members only content areas of ADA.org, be entitled to attend any scientific session of this Association, purchase items through the ADA Catalog at the member rate and receive such other~~ a set of products and services as are authorized by the Board of Trustees in collaboration with the Council on Membership.

c. DUES AND SPECIAL ASSESSMENTS. The dues of affiliate members shall be established by the Board of Trustees. The Board of Trustees shall be authorized to deviate from the established affiliate member dues rate to: (1) promote affiliate memberships in a selected jurisdiction, and (2) to recognize economic circumstances in least developed countries eligible for special fee criteria as established by the FDI World Dental Federation. Affiliate member dues shall be twelve dollars (\$12.00) for those members practicing in least developed and low income countries eligible for special fee criteria as established by the Fédération Dentaire Internationale and seventy five dollars (\$75.00) for other such members, due January 1 each year. Affiliate members shall be exempt from the payment of any special assessment.

**ADA Dues Structure:** When an individual considers joining the American Dental Association, they must navigate through eleven membership categories and 28 separate dues rates in order to determine what their dues will be at a national level. If they qualify for tripartite membership, at that point, the person contacts their constituent dental society, who will then determine their state and local dues rates. This can take up to a day for the dental society to determine the rate and then to respond to the member. At that point, the individual may be required to wait another period of time before the constituent society's Board meets and approves the application. The Council recognizes that these barriers to membership can have a negative impact on an individual's decision to join.

In addition, the ADA is currently moving through a significant transition in its business model. The governance study is underway. The ADA is looking to reconstitute its value proposition to address the demographic shift in organized dentistry. The association is looking to gain efficiencies while it maximizes revenue streams. And it is using a business development process to add value through bundling and unbundling of products and services

The chart below (Chart 1) outlines the 11 categories, their associated dues rate, and the volume of members that pay each rate. In addition, the revenue contribution associated with each category is also identified (2012 dues x EOY 2011 membership count = potential 2012 revenue contribution). As noted, there are 28 various dues rates due to waiver and reduced dues structures.

Chart 1

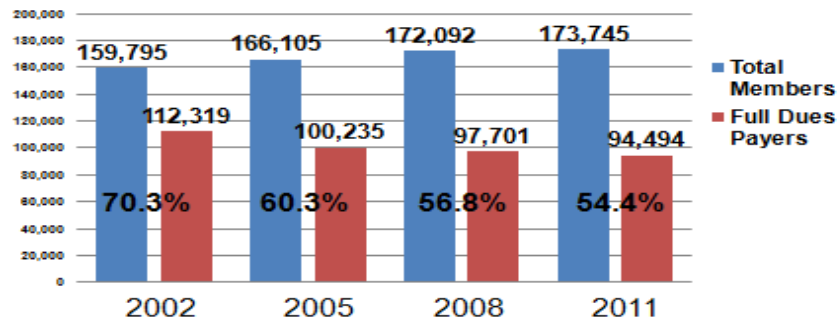
<b>Member Category</b>	<b>2012 Dues</b>	<b>2011 EOY Count</b>	<b>Potential 2012 Revenue Contribution</b>
Active Life Member (50% of full active dues)*	\$256	12,814	\$3,280,384
Active Member*	\$512	94,494	\$49,892,832
Affiliate Member – Developed Country	\$75	2,360	\$177,000
Affiliate Member – Least Developed Country (per FDI)	\$12	633	\$7,596
Associate Member (25% of full active dues)	\$128	41	\$5,453
Graduate Student Member	\$30	3,225	\$96,750
Honorary Member	\$0	181	\$0
Non-practicing Dentist Member (50% of full active dues)	\$256	70	\$18,550
Provisional Member	\$128	1	\$128
Retired Life Member (0% of full active dues)*	\$0	23,027	\$0
Retired Member (25% of full active dues)*	\$128	2,028	\$269,724
Student Member	\$5	17,600	\$88,000

\*fully privileged membership status

The following graph (graph 2) shows the proportion of full dues paying members to those of other membership categories.

Graph 2

### Full Dues Payers as a Percentage of All ADA Members



As the Council works through an approach to encourage constituent societies to work with the ADA to remove these barriers, it is taking action to manage dues strategically and seek opportunities to increase dues revenues. With that end in mind, it is the Council's intention to 1) develop a philosophy for dues, 2) create intention around dues-setting relative to the value offered, and 3) to create a road map that streamlines the processes to join, reinstate and renew membership, with dues determination being a simple step within each process.

Of the 11 categories of membership, the Council has identified four categories in particular, in addition to active member, as offering the greatest potential to increase revenue contribution:

- Active Life Member
- Graduate Student Member
- Student Member
- Affiliate Member (for individuals from both developed and least developed countries)

The Council then used the existing information from the ADA *Bylaws* to determine the following on each of the four dues categories:

- 1) If increasing the dues rate for the category is warranted; and
- 2) If so, to what extent should the rate be modified; or
- 3) If not, what would need to change for the Council to consider changing the rate?

**Nomination of Chair and Election of Vice Chair:** The Council nominated Dr. Mark Bauman, second district representative, Saratoga Springs, New York, as chair of the Council on Membership for 2012-2013. The Council elected Dr. Thomas Kelly, seventh district representative, Beachwood, Ohio, as vice chair of the Council on Membership for 2012-2013.

**Response to Assignments from the House of Delegates:****ADA Policy Review**

In accordance with Resolution 111H-2010, Regular Comprehensive Policy Review, the Council on Membership reviewed ADA policies and presents a series of resolutions with recommendations to maintain, rescind or amend those policies. Due to the number of policies, the complexity of many policy issues and the variability in the number of policies for which each council/agency is responsible, it was recommended that agencies be given flexibility to develop individual three-year reporting plans. The first series of policy reviews is to be presented to the 2012 House of Delegates.

In total, the Council on Membership has 38 policies to review. The policies have been sorted by last year of adoption or amendment and have been scheduled for review with approximately 1/3 of the policies to 2012, 2013 and 2014. The cycle will repeat in 2015. New policies will be assigned to a given year based upon subject matter.

At its June 2012 meeting the Council reviewed the first 12 of its 38 policies and made recommendations for the policies to remain unchanged; amend to update the policies to make relevant to the processes of 2012 or to defer a recommendation until its February 2013 meeting in order to gather additional background information on the policy to make an educated recommendation on the policy. Of the 12 policies reviewed, three have been referred back to the Council for additional information. The Council made recommendations on the remaining nine policies and the recommendations below are offered to the 2012 House of Delegates for its consideration. The full text of each policy is included in Appendix 1.

**Recommendations—Policies to be Maintained**

The Council concluded that the following policies should be maintained as written. The full text of each policy is included in Appendix 2.

**69. Resolved**, that the following ADA policies be maintained:

State Associations of the Professions (*Trans.*1964:263)  
Registration Fees for Members (*Trans.*1989:537)  
Application Process for Direct ADA Membership (*Trans.*1989:539)  
Diversity in Association Membership Marketing and Consumer-Related Materials (*Trans.*1995:606)  
Nonmember Utilization of ADA Member Benefits (*Trans.*1990:532)

**Recommendations—Policies to be Amended**

The Council believes that the policy “Alternate Methods of Dues Payment” should be changed to reflect encouragement of constituent and component dental societies to offer alternate methods of dues paying for its members.

**70. Resolved**, that the ADA policy “Alternate Methods of Dues Payment” (*Trans.*1988:456) be amended as follows (additions are underscored; deletions are ~~stricken~~):

**Resolved**, that ~~these~~ constituent and/or component societies ~~that have not offered their membership an alternative method of dues payment, be urged to do so as soon as possible, be urged to offer an~~ alternative method of dues payment, and be it further

**Resolved**, that the Association offer its assistance in recommending such a plan to those constituent and/or component societies that request such assistance.

The Council believes that the policy “Consumer Directories” should be amended to improve the accuracy of the statement that the constituent and component dental societies are encouraged to produce and maintain their own directory of dentists in their area.

**71. Resolved**, that the ADA policy “Consumer Directories” (*Trans.*1976:930) be amended as follows (additions are underscored; deletions are ~~stricken~~):

**Resolved**, that constituent and component dental societies be encouraged to ~~produce or cooperate in producing~~ produce, develop, maintain and update ethical “consumer directories” of dentists in their areas which will provide appropriate information to the public, and be it further

**Resolved**, that constituent and component societies consider cooperating with responsible state or local consumer organizations in the production of such directories.

The Council believes that the policy “New Dentist Representation” adopted in 1990 should be rescinded. The House of Delegates adopted Resolution 71H-2011 (*Trans.*2011:000) which duplicates the intent of the earlier resolution.

**71H-2011. Resolved**, that the American Dental Association encourage each state dental association to bring at least one new dentist as a delegate or alternate delegate to the annual American Dental Association’s House of Delegates, and be it further

**Resolved**, that each association be urged to report to each House of Delegates their respective new dentist delegates or alternates.

**72. Resolved**, that the ADA policy on New Dentist Representation (*Trans.*1990:576) be rescinded.

The Council believes that the policy “Requirement for Membership Maintenance in ADA for Fellows of the American College of Dentists, the USA Section of the International College of Dentists and the Pierre Fauchard Academy” be amended to reflect the current way the ADA shares its data with other dental societies that require ADA membership as a qualification for their membership.

**73. Resolved**, that the ADA policy “Requirement for Membership Maintenance in ADA for Fellows of the American College of Dentists, the USA Section of the International College of Dentists and the Pierre Fauchard Academy” (*Trans.*1989:538) be amended as follows (additions are underscored; deletions are ~~stricken~~):

**Resolved**, that the American College of Dentists, the USA Section of the International College of Dentists and the Pierre Fauchard Academy be ~~formally~~ advised upon request on an ~~annual~~ on-going basis when a member is dropped from the roster of the ADA, and be it further

**Resolved**, that the ACD, USA Section of the ICD and the Pierre Fauchard Academy be encouraged, when legally feasible, to require continuing membership in the ADA for those members in good standing.

**2009 House of Delegates:** Resolution 92H-2009 (*Trans.*2009:415) calls for the appropriate ADA agency to report yearly to the House of Delegates the five-year anticipated (projected) dues revenues impact from members’ transition to life membership. This information is reported out through the Council on Membership and is included as Appendix 2 to this report.

**Response to Assignments from the 2011 House of Delegates:**

*Creation of a 25% Dues Waiver.* The House of Delegates adopted Resolution 17H-2011 that created a financial hardship dues waiver of 25% of member dues. The resolution approved a change in the *Bylaws* to allow for this waiver, the resolution states:

**17H-2011. Resolved,** that the ADA *Bylaws, Chapter I. MEMBERSHIP, Section 50. DUES OR SPECIAL ASSESSMENT RELATED ISSUES B. FINANCIAL HARDSHIP WAIVERS* be amended by adding the words “twenty-five percent (25%)” before the words “fifty percent (50%)” in line 660 as follows: (new language underscored).

Those members who have suffered a significant financial hardship that prohibits them from payment of their full dues and/or any special assessment may be excused from the payment of twenty-five percent (25%), fifty percent (50%), seventy-five percent (75%) or all of the current year’s dues and/or any special assessment as determined by their constituent and component dental societies. The constituent and component societies shall certify the reason for the waiver, and the constituent and component societies shall provide the same proportionate waiver of their dues as that provided by this Association.

As a result of this resolution, the *Bylaws* were updated and the option of a 25% dues waiver was available beginning with the 2012 membership year. As of June 25, 2012, there are currently 22 members on the 25% dues waiver.

*Humanitarian Membership Category.* The House of Delegates adopted Resolution 16H-2011 that updated the *Bylaws* to change the language of the charitable dues waiver to humanitarian dues waiver to include those who engage in full-time international humanitarian relief efforts under the scope of those eligible to receive the dues discount. The resolution states:

**16H-2011. Resolved,** that the ADA *Bylaws, Chapter I. MEMBERSHIP, Section 50. DUES OR SPECIAL ASSESSMENT RELATED ISSUES, Subsection D. WAIVERS FOR ACTIVE MEMBERS WORKING FOR A CHARITABLE ORGANIZATION* be amended by striking the word “charitable” and substituting in its place the word “humanitarian” as outlined below (new language underscored; deletions stricken through).

D. WAIVERS FOR ACTIVE MEMBERS WORKING FOR A ~~CHARITABLE~~ HUMANITARIAN ORGANIZATION. An active member who is serving the profession by working full-time for a ~~charitable~~ humanitarian organization and is receiving neither income nor a salary for such ~~charitable~~ humanitarian service other than a subsistence amount which approximates a cost of living allowance shall be exempt from the payment of dues and any special assessment then in effect through December 31 following completion of such service provided that such ~~charitable~~ humanitarian service is being performed continuously for not less than one (1) year and provided further that such member does not supplement such subsistence income by the performance of services as a member of the faculty of a dental or dental auxiliary school, as a dental administrator or consultant, or as a practitioner of any activity for which a license to practice dentistry or dental hygiene is required.

As a result, the *Bylaws* were updated and the Humanitarian Organization dues waiver became available beginning with the 2012 membership year. As of June 25, 2012, there are currently 64 members who are utilizing the humanitarian organization dues waiver; this is the same number of members that were on the charitable dues waiver as of June 25, 2011.

*Funding of the Student Block Grant Program.* In 2011, funding for the Student Block Grant program was cut from the 2012 budget. Due to the Council’s proposed resolution to reinstate funding at 75% of the amount and the support the resolution received at the 2011 House of Delegates the following resolution was adopted:

1 **20H-2011. Resolved**, that the Student Block Grant program be funded at \$126,750 for 2012, and be it  
2 further

3 **Resolved**, that additional metrics be integrated into the application and reporting mechanisms by the  
4 Council on Membership beginning with the 2012 Student Block Grant program, and be it further

5 **Resolved**, that findings derived from these metrics be made available to ADA and tripartite agencies with  
6 yearly reports to the ADA House of Delegates for sunset review.

7 The student block grant application has been updated to include a section for reporting metrics on the  
8 programs. Due to the deadline for submission to submit the reports on 2012 student block grant activities  
9 being December 31, 2012, results of the impact of the student block grants on student conversion for 2012  
10 will be available to report in 2013.

11 *Revision of the ADA Specialty Logo.* At the 2011 House of Delegates the following resolution regarding the  
12 removal of the membership year from the ADA specialty logo for members was adopted and referred to the  
13 Council on Membership for implementation and follow-up. As a result, the date has been removed from the  
14 member ADA specialty logo.

15 **46H-2011. Resolved**, that the date be removed from the ADA specialty logo.

16 **Resolutions**

17 (Resolution 67:Worksheet:3016)

18 (Resolution 69:Worksheet:3017)

19 (Resolution 70:Worksheet:3019)

20 (Resolution 71:Worksheet:3020)

21 (Resolution 72:Worksheet:3021)

22 (Resolution 73:Worksheet:3023)

23  
24

**Appendix 1****ADA Policies to be Maintained****State Associations of the Professions (*Trans.1964:263*):**

**Resolved**, that the constituent dental societies be urged to take a leadership role in the formation of state Associations of the Professions to provide a vehicle for interprofessional cooperation in those areas where united activity of the various professions can be of great benefit.

**Registration Fees for Members (*Trans.1989:537*):**

**Resolved**, that as a membership benefit, the American Dental Association urges its constituent and component societies and other dental meetings to charge a lesser registration fee to other constituent and component ADA members than to nonmembers.

**Application Process for Direct ADA Membership (*Trans.1989:539*):**

**Resolved**, that the American Dental Association verify eligibility of direct members on an annual basis and urge constituent societies to assist in the verification of employment status of direct members, and be it further

**Resolved**, that the American Dental Association encourage constituent societies to promote tripartite membership to federally employed.

**Diversity in Association Membership Marketing and Consumer-Related Materials (*Trans.1995:606*):**

**Resolved**, that the American Dental Association is committed to promoting an inclusive environment that values and embraces the diversity of its membership, and be it further

**Resolved**, that the Association reflect this diversity in its membership marketing and consumer-related materials.

**Nonmember Utilization of ADA Member Benefits (*Trans.1990:532*):**

**Resolved**, that the ADA Board of Trustees review the policies pertaining to nonmember utilization of ADA member benefits and take whatever action is necessary to insure that a nonmember cannot utilize ADA member benefits to imply membership and/or promote his or her practice to the public, and be it further

**Resolved**, that the pricing differential for ADA products and/or services between members and nonmembers be at the maximum the law will allow in order to increase the tangible benefits of being a member of the ADA. Nonmember Utilization of ADA Member Benefits.

**ADA Policy to Rescinded****New Dentist Representation (*Trans.1990:576*)**

**Resolved**, that the American Dental Association encourage constituent societies to consider new dentists when electing delegates and alternate delegates to the American Dental Association House of Delegates.

1 **APPENDIX 2**2 **RESPONSE TO RESOLUTION 92H-2009—FIVE-YEAR PROJECTED DUES REVENUE IMPACT**  
3 **FROM MEMBERS TRANSITIONING TO LIFE MEMBERSHIP**

4 **Overview:** The Council on Membership is providing this informational report to the House of Delegates in  
5 response to Resolution 92H-2009:

6 **Resolved,** that the appropriate ADA agency report yearly to the House of Delegates the five-year  
7 anticipated (projected) dues revenues impact from members transition to life membership.

8 **Background:** The Health Policy Resources Center, in conjunction with the Division of Membership, Tripartite  
9 Relations and Marketing, developed projections of the dues revenue impact from members' transition to life  
10 membership. The projections were developed through statistical modeling and extensive review of retirement  
11 trends among dentists. It should be noted that retirement rates among dentists have dropped slightly both as  
12 a result of the economic downturn and also as part of a longer term trend. The most significant component of  
13 the drop in retirement rates took place in 2009. Accordingly, the projections are more likely to overstate than  
14 understate the financial impact. Finally, these projections do not include the added dues revenues associated  
15 with new members and dental students transitioning from student status to member status and the associated  
16 dues increases.

17 Based on historical patterns and the current age and member longevity, it is estimated that the dues revenue  
18 impact from members transitioning to life membership will be as follows (Table 1):

**Table 1**

Year	Dues Impact From Members Transitioning to Life Membership
2012	(\$639,232)
2013	(\$690,048)
2014	(\$659,584)
2015	(\$675,584)
2016	(\$679,168)

19 At the end of 2011, there were 12,992 active life members and 23,027 retired life members. Although the ADA  
20 should be mindful about the anticipated transition of baby boom dentists into different membership categories  
21 and also into retirement, it also is appropriate for the ADA to recall that current workforce projections indicate  
22 that the dental workforce will continue to grow continuously through 2030, and this projection does not  
23 incorporate potential graduates from dental schools that have not opened their doors (Table 2).

1

**Table 2 Census Counts and Projections, 1993-2030**

Year	Professionally Active Dentists	Active Private Practitioners	Applicants to Dental School	Applicant Rate	First-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>1</sup>	171,110 <sup>12</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*.

- 2 Table 3 shows the number of projected members who will become eligible for life membership from 2012 to  
3 2016. This projection assumes that there will be no dues increase during the next five years and that all  
4 members will retain membership. There is also an assumption that the retirement rate will remain the same  
5 during the same time period.
- 6 Table 4 shows the number of members who begin paying in the life membership dues rates over the next five  
7 years is expected to increase from 2,786 in 2012 to 2,963 by 2016. It should be noted that the further out in  
8 the projection, the less accurate the forecast.

<sup>1</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 3 Forecast to Become Life Members 2012-2016**

Year Paying Life Dues for First Time	2012	2013	2014	2015	2016
Expected Retired Life	514	580	555	568	571
Expected Active Life	2,272	2,429	2,323	2,378	2,392
Total Projected to Become Life Members	<b>2,786</b>	<b>3,009</b>	<b>2,878</b>	<b>2,946</b>	<b>2,963</b>

**Table 4**

Reduction from Prior Year	2012	Estimated Reduction from Prior Year	2013	Estimated Reduction from Prior Year	2014	Estimated Reduction from Prior Year	2015	Estimated Reduction from Prior Year	2016	Estimated Reduction from Prior Year
2.3% who paid full active dues (\$512) to retired life(\$0)	65	(\$33,280)	70	(\$35,840)	66	(\$33,792)	68		68	(\$34,816)
9.9% who paid retired dues (\$128) to retired life(\$0)	276	(\$35,328)	297	(\$38,016)	285	(\$36,480)	292	(\$37,376)	294	(\$37,632)
Paid full dues and expected to pay active life dues (80.0% of estimated total elected)(\$256)	2,229	(\$570,624)	2,407	(\$616,192)	2,302	(\$589,312)	2,357	(\$603,392)	2370	(\$606,720)
Total estimated reduction in dues revenue		(\$639,232)		(\$690,048)		(\$659,584)		(\$675,584)		(\$679,168)

**Note:**

Total elected to life membership for 2012 as of 1-31-12

Assumes no dues increase and no assessment in years 2012-2016.

Full dues in 2012 are \$512

In 2012, 81.6% (2,278) of those elected to life status (50% of full dues) the rest on \$0 waivers.

19.3% (521) of those who were elected to life membership for 2012 were retired life.

Assumes retired rate will remain the same in future years.

Assumes no deaths.

Numbers do not add up to total expected to pay life dues because some members paid \$0 in the previous year and are expected to pay \$0 the next year. Only dues payers were figured in these calculations.

Resolution No. 67 NewReport: CM Supplemental Report 1 Date Submitted: July 2012Submitted By: Council on MembershipReference Committee: Membership and Related MattersTotal Net Financial Implication: None Net Dues Impact: \_\_\_\_\_Amount One-time \_\_\_\_\_ Amount On-going \_\_\_\_\_ FTE 0ADA Strategic Plan Goal: Members (Required)**AMENDMENT OF ADA BYLAWS REGARDING BENEFITS OF AFFILIATE MEMBERS****Background:** (See CM Supplemental Report 1 to the House of Delegates, Worksheet:3003)**Resolution**

**67. Resolved**, that the ADA *Bylaws*, Chapter I. MEMBERSHIP, Section 20. QUALIFICATIONS, PRIVILEGES, DUES AND SPECIAL ASSESSMENTS I. AFFILIATE MEMBER, b. PRIVILEGES be amended as follows: (additions are underscored; deletions are ~~stricken~~).

b. PRIVILEGES. An affiliate member in good standing shall receive ~~annually a membership card, have access to the members-only content areas of ADA.org, be entitled to attend any scientific session of this Association, purchase items through the ADA Catalog at the member rate and receive such other~~ a set of products and services as are authorized by the Board of Trustees in collaboration with the Council on Membership.

c. DUES AND SPECIAL ASSESSMENTS. The dues of affiliate members shall be established ~~by the Board of Trustees. The Board of Trustees shall be authorized to deviate from the established affiliate member dues rate to:~~ (1) promote affiliate memberships in a selected jurisdiction, and (2) to recognize economic circumstances in least developed countries eligible for special fee criteria as established by the FDI World Dental Federation. Affiliate member dues shall be twelve dollars (\$12.00) for those members practicing in least developed and low income countries eligible for special fee criteria as established by the Fédération Dentaire Internationale and seventy five dollars (\$75.00) for other such members, due January 1 each year. Affiliate members shall be exempt from the payment of any special assessment.

**BOARD RECOMMENDATION: Vote Yes.****Board Vote: Resolution 67**

BLANTON	No	GOUNARDES	No	NORMAN	Yes	SUMMERHAYS	Yes
DOW	Yes	HAGENBRUCH	No	RICH	Yes	VIGNA	Yes
ENGEL	Yes	ISRAELSON	Yes	ROBERTS	Yes	WEBER	Yes
FAIELLA	Yes	KIESLING	Yes	SEAGO	Yes	VERSMAN	Yes
FEINBERG	No	LOW	No	STEFFEL	Yes	YONEMOTO	Yes

Resolution No. 69 NewReport: CM Supplemental Report 1 Date Submitted: July 2012Submitted By: Council on MembershipReference Committee: Membership and Related MattersTotal Net Financial Implication: None Net Dues Impact: Amount One-time  Amount On-going  FTE 0ADA Strategic Plan Goal: Members (Required)**ASSOCIATION POLICIES TO BE MAINTAINED RECOMMENDED BY THE COUNCIL ON MEMBERSHIP**1 **Background:** (See CM Supplemental Report 1 to the House of Delegates, Worksheet:3003)2 **Resolution**

3

4 **69. Resolved,** that the following ADA policies be maintained:5 State Associations of the Professions (*Trans.*1964:263)6 Registration Fees for Members (*Trans.*1989:537)7 Application Process for Direct ADA Membership (*Trans.*1989:539)8 Diversity in Association Membership Marketing and Consumer-Related Materials (*Trans.*1995:606)9 Nonmember Utilization of ADA Member Benefits (*Trans.*1990:532)10 **BOARD RECOMMENDATION: Vote Yes.**11 **BOARD VOTE: UNANIMOUS.**

**WORKSHEET ADDENDUM  
COUNCIL ON MEMBERSHIP  
ADA POLICIES TO BE MAINTAINED**

**1 State Associations of the Professions (*Trans.1964:263*):**

**2 Resolved**, that the constituent dental societies be urged to take a leadership role in the formation of state  
**3 Associations of the Professions** to provide a vehicle for interprofessional cooperation in those areas where  
**4 united activity of the various professions** can be of great benefit.

**5 Registration Fees for Members (*Trans.1989:537*):**

**6 Resolved**, that as a membership benefit, the American Dental Association urges its constituent and  
**7 component societies and other dental meetings** to charge a lesser registration fee to other constituent and  
**8 component ADA members** than to nonmembers.

**9 Application Process for Direct ADA Membership (*Trans.1989:539*):**

**10 Resolved**, that the American Dental Association verify eligibility of direct members on an annual basis and  
**11 urge constituent societies** to assist in the verification of employment status of direct members, and be it  
**12 further**

**13 Resolved**, that the American Dental Association encourage constituent societies to promote tripartite  
**14 membership** to federally employed.

**15 Diversity in Association Membership Marketing and Consumer-Related Materials (*Trans.1995:606*):**

**16 Resolved**, that the American Dental Association is committed to promoting an inclusive environment that  
**17 values and embraces the diversity of its membership**, and be it further

**18 Resolved**, that the Association reflect this diversity in its membership marketing and consumer-related  
**19 materials**.

**20 Nonmember Utilization of ADA Member Benefits (*Trans.1990:532*):**

**21 Resolved**, that the ADA Board of Trustees review the policies pertaining to nonmember utilization of ADA  
**22 member benefits** and take whatever action is necessary to insure that a nonmember cannot utilize ADA  
**23 member benefits** to imply membership and/or promote his or her practice to the public, and be it further

**24 Resolved**, that the pricing differential for ADA products and/or services between members and nonmembers  
**25 be at the maximum the law will allow** in order to increase the tangible benefits of being a member of the ADA.  
**26 Nonmember Utilization of ADA Member Benefits**.

Resolution No. 70 NewReport: CM Supplemental Report 1 Date Submitted: July 2012Submitted By: Council on MembershipReference Committee: Membership and Related MattersTotal Net Financial Implication: None Net Dues Impact: Amount One-time  Amount On-going  FTE 0ADA Strategic Plan Goal: Members (Required)1 **AMENDMENT OF ADA POLICY ON ALTERNATE METHODS OF DUES PAYMENT**2 **Background:** (See CM Supplemental Report 1 to the House of Delegates, Worksheet: 3003)3 **Resolution**4 **70. Resolved**, that the ADA policy "Alternate Methods of Dues Payment" (*Trans.*1988:456) be amended  
5 as follows (additions are underscored; deletions are ~~stricken~~):6 **Resolved**, that ~~these~~ constituent and/or component societies ~~that have not offered their~~  
7 ~~membership an alternative method of dues payment, be urged to do so as soon as possible, be~~  
8 urged to offer an alternative method of dues payment, and be it further  
910 **Resolved**, that the Association offer its assistance in recommending such a plan to those  
11 constituent and/or component societies that request such assistance.12 **BOARD RECOMMENDATION: Vote Yes.**13 **BOARD VOTE: UNANIMOUS.**

Resolution No. 71 NewReport: CM Supplemental Report 1 Date Submitted: July 2012Submitted By: Council on MembershipReference Committee: Membership and Related MattersTotal Net Financial Implication: None Net Dues Impact: Amount One-time  Amount On-going  FTE 0ADA Strategic Plan Goal: Members (Required)**AMENDMENT OF POLICY ON CONSUMER DIRECTORIES**1 **Background:** (See CM Supplemental Report 1 to the House of Delegates, Worksheet: 3003)2 **Resolution**3 **71. Resolved**, that the ADA policy "Consumer Directories" (*Trans.*1976:930) be amended as follows  
4 (additions are underscored; deletions are ~~stricken~~):5 **Resolved**, that constituent and component dental societies be encouraged to ~~produce or cooperate~~  
6 ~~in producing~~ produce, develop, maintain and update ethical "consumer directories" of dentists in their  
7 areas which will provide appropriate information to the public, and be it further8 **Resolved**, that constituent and component societies consider cooperating with responsible state or  
9 local consumer organizations in the production of such directories.10 **BOARD RECOMMENDATION: Vote Yes.**11 **BOARD VOTE: UNANIMOUS.**

Resolution No. 71S-1 SubstituteReport: N/A Date Submitted: October 2012Submitted By: Fifth Trustee DistrictReference Committee: Membership and Related MattersTotal Net Financial Implication: None Net Dues Impact: \_\_\_\_\_Amount One-time \_\_\_\_\_ Amount On-going \_\_\_\_\_ FTE 0ADA Strategic Plan Goal: Members (Required)**SUBSTITUTE FOR RESOLUTION 71: AMENDMENT OF POLICY ON CONSUMER DIRECTORIES**

The following substitute for Resolution 71 (Worksheet:3020) was adopted by the Fifth Trustee District and transmitted on October 4, 2012, by Ms. Connie Lane, executive director, Mississippi Dental Association.

**Background:** Many other national, state and local entities, including consumer organizations and businesses, develop and maintain dentist directories for consumers. For profit entities sell directory services to dentists to potentially drive patients to dentists who have paid for their services. While this business model may serve many dentists in a positive manner, there are also directory services that rank or inappropriately portray dental practices.

ADA members have the right to expect that their association will provide an accurate and current dentist directory based on membership information routinely gathered and maintained on dentists. It is the responsibility of the profession, on the national, constituent and component levels, to provide a trustworthy dentist directory reference for consumers. Furthermore, this compiled information should be promoted as a resource of choice for consumers. The provision and promotion of this dentist reference information serves as an important member benefit as well as a service to the public.

**Resolution**

**71S-1. Resolved**, that the ADA policy "Consumer Directories" (*Trans.*1976:930) be amended as follows (additions are underscored; deletions are ~~stricken~~):

**Resolved**, that constituent and component dental societies be encouraged to ~~produce or cooperate in producing~~ produce, develop, maintain and update ethical "consumer directories" of dentists in their areas which will provide appropriate information to the public, and be it further

**Resolved**, that constituent and component societies ~~consider cooperating~~ be urged to actively communicate with responsible state or local consumer organizations ~~in the production~~ the availability of such directories on component, constituent and ADA Web sites.

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

Resolution No. 72 NewReport: CM Supplemental Report 1 Date Submitted: July 2012Submitted By: Council on MembershipReference Committee: Membership and Related MattersTotal Net Financial Implication: None Net Dues Impact: Amount One-time  Amount On-going  FTE 0ADA Strategic Plan Goal: Members (Required)**1 RESCISSION OF POLICY ON NEW DENTIST REPRESENTATION****2 Background:** (See CM Supplemental Report 1 to the House of Delegates, Worksheet:3003)**3 Resolution****4 72. Resolved,** that the ADA policy on New Dentist Representation (*Trans.* 1990:576) be rescinded.**5 BOARD RECOMMENDATION: Vote Yes.****6 BOARD VOTE: UNANIMOUS.**

**WORKSHEET ADDENDUM  
COUNCIL ON MEMBERSHIP  
ADA POLICY TO BE RESCINDED**

- 1 **New Dentist Representation (*Trans.1990:576*)**
- 2 **Resolved**, that the American Dental Association encourage constituent societies to consider new dentists when
- 3 electing delegates and alternate delegates to the American Dental Association House of Delegates.

Resolution No. 73 NewReport: CM Supplemental Report 1 Date Submitted: July 2012Submitted By: Council on MembershipReference Committee: Membership and Related MattersTotal Net Financial Implication: None Net Dues Impact: Amount One-time  Amount On-going  FTE 0ADA Strategic Plan Goal: Members (Required)

1 **AMENDMENT OF POLICY ON REQUIREMENT FOR MEMBERSHIP MAINTENANCE IN ADA FOR**  
2 **FELLOWS OF THE AMERICAN COLLEGE OF DENTISTS, THE USA SECTION OF THE INTERNATIONAL**  
3 **COLLEGE OF DENTISTS AND THE PIERRE FAUCHARD ACADEMY**

4 **Background:** (See CM Supplemental Report 1 to the House of Delegates, Worksheet:3003)

5 **Resolution**

6 **73. Resolved**, that the ADA policy "Requirement for Membership Maintenance in ADA for Fellows of the  
7 American College of Dentists, the USA Section of the International College of Dentists and the Pierre  
8 Fauchard Academy" (*Trans.* 1989:538) be amended as follows (additions are underscored; deletions are  
9 ~~stricken~~):

10 **Resolved**, that the American College of Dentists, the USA Section of the International College of  
11 Dentists and the Pierre Fauchard Academy be ~~formally~~ advised upon request on an annual on-going  
12 basis when a member is dropped from the roster of the ADA, and be it further

13 **Resolved**, that the ACD, USA Section of the ICD and the Pierre Fauchard Academy be encouraged,  
14 when legally feasible, to require continuing membership in the ADA for those members in good  
15 standing.

16 **BOARD RECOMMENDATION: Vote Yes.**

17 **BOARD VOTE: UNANIMOUS.**

Resolution No. 77, 78, 80 and 81 NewReport: Board Report 5 Date Submitted: July 2012Submitted By: Board of TrusteesReference Committee: Membership and Related MattersTotal Net Financial Implication: None Net Dues Impact: Amount One-time  Amount On-going  FTE 0ADA Strategic Plan Goal: Members (Required)**REPORT 5 OF THE BOARD OF TRUSTEES TO THE HOUSE OF DELEGATES: ANNUAL REPORT OF THE DIVISION OF GLOBAL AFFAIRS**

**Introduction:** The following report reflects the activities of the division of Global Affairs and the Board of Trustees Standing Committee on International Programs and Development (CIPD). The Board is providing this report to the House to keep it informed of the scope of ADA's international activities.

**Background:** The 2012 Committee on International Programs and Development is comprised of the following individuals: Kathryn Kell, Davenport, IA (2012) – Chair, Edward Brown, Allston, MA (2014), Christopher Fox, Alexandria, VA (2014), David Frost, Durham, NC (2013), Martin Hobdell, Norfolk, UK (2014), Jamie Just, Denver, CO (2015), Gary Leff, Arlington, VA (2012), Madeline Monaco, Morris Plains, NJ (2012), Ken Rich, Dry Ridge, KY (2012), William Calnon, Rochester, NY – Ex-Officio, and Robert Faiella, Osterville, MA – Ex-Officio. The staff for this committee in the Division of Global Affairs is Helen Cherrett – Senior Director and Sarah Knight – Coordinator.

**Mission and Purpose:** To advise the ADA Board of Trustees and ADA agencies regarding the ADA's international activities, the alignment of these activities with the International Strategic Approach, the Association's strategic plan, and the positioning of the ADA as an active partner in the global oral health arena, with the ultimate goal of improving global oral health.

**Supporting the Strategic Plan: Activities, Results and Accomplishments**

- The Association made \$638,300 of net income from international business activities in 2011 which are managed and directed by the Division of Global Affairs through collaboration with other ADA agencies.
- The Division of Global Affairs assisted in the recruitment and retention of approximately 3,000 ADA affiliate members in 2011.
- 1,925 international attendees and 21 international exhibitors were recruited for attendance to the 2011 ADA Annual Session in Las Vegas.
- The Division of Global Affairs participated in four international dental shows (Brazil, Dubai, Mexico, and Germany) to promote the ADA brand, Affiliate Membership, Annual Session, CE Online, E-books, JADA, and to investigate potential business opportunities.
- The ADA Division of Global Affairs raised over \$62K for the Japan Dental Association following the March 2011 earthquake and nuclear disaster by collecting funds from ADA staff, ADA members, dental organizations, and dental industry.

- 1 • The Division of Global Affairs continued to manage the Adopt-a-Practice: Rebuilding Dental  
2 Offices in Haiti Campaign, which has collected over \$123K to rebuild dental offices that were  
3 damaged or destroyed by the 2010 earthquake. Four offices were rebuilt in 2011 with a portion of  
4 the funds collected and the rebuilding continues into 2012.
- 5 • The Division of Global Affairs secured more than \$58K for international humanitarian and  
6 education programs (Southeast Asia Dental Public Health Program, the Kenyan Dental  
7 Association Outreach Program and The Oral Health Panel at the 2011 Global Health  
8 Conference).
- 9 • The ADA Division of Global Affairs managed the 2012 ADA Humanitarian Award and which will  
10 be presented to Dr. Ronald Lamb in October 2012 at the ADA Annual Session
- 11 • The ADA Division of Global Affairs managed the content of the ADA International Volunteer  
12 webpage which welcomed over 50,000 visitors in 2011 with an average view time of over 6  
13 minutes per visit.
- 14 • In 2011, there were 28 ADA/HVO volunteers who went to Cambodia, Honduras, Laos, Rwanda,  
15 St Lucia and Vietnam. In the first four months of 2012, placements increased to 25 assignments  
16 to date, including Nicaragua, Peru and Tanzania in addition to the already listed locations.
- 17 • The ADA is taking a key role in its collaborations with the FDI World Dental Federation, working  
18 to dissuade the United National Environmental Programme (UNEP) from developing a mandate  
19 that includes a ban on dental amalgam. It is also seeking inclusion in the agreement of an  
20 increase in prevention and research work, so that the demand for all restoratives will eventually  
21 decrease.
- 22 • The ADA also played a role in supporting the United Nations (UN) High-level meeting on  
23 Prevention and Control of Non-Communicable Diseases. And with other key countries,  
24 successfully lobbied respective governments to include oral disease in the UN-mandated  
25 initiatives. With the support of the ADA the FDI is now tracking the progress of the targets and  
26 indicators put in place by the UN through the WHO.
- 27 • The Division managed the ADA/FDI Delegation's participation in the 2011 FDI Annual World  
28 Dental Congress in Mexico City which led to the election of Dr. Kathryn Kell (Iowa) as FDI  
29 treasurer.

30 In December 2011, the ADA Board of Trustees approved a resolution recognizing that international  
31 engagement is a strategic priority for the Association:

32 **B-210-2011. Resolved**, that the ADA Board of Trustees recognizes that international  
33 engagement is a strategic priority for the Association and that this engagement is necessary in  
34 order to fully accomplish the strategic objectives of the Association, and furthermore that the Division  
35 of Global Affairs will coordinate the integration of these activities with the appropriate ADA agencies.

## 36 Emerging Issues and Trends

37 Oral health issues are being viewed on a global scale as research, education, standards, and new  
38 advancements that happen in the U.S. and other countries have an effect on dentistry worldwide. Dental  
39 communities abroad ask the ADA for assistance and support with science, intellectual property, leadership  
40 and technology opening new doors to international opportunities and collaborations and global engagement  
41 give the ADA an opportunity to learn from other countries of which there is much to collaborate. Continuing

1 education is in strong demand and with the use of technology dentists from all over the world can be  
2 connected at the same time to learn about techniques, procedures, and advancements.

3 The United Nations (UN) High-Level Meeting on Prevention and Control of Non-Communicable Diseases,  
4 held in New York on September 19-20, 2011, was a historic occasion both for global health and specifically  
5 for global oral health. It was only the second time in history that Heads of State discussed and acted upon a  
6 health issue: the first was in 2001 when HIV/AIDS was the topic. For the first time, oral diseases were  
7 recognized when 193 Member States signed a Political Declaration to prevent and control the major non-  
8 communicable diseases: heart, cancer, diabetes, respiratory diseases as well as renal, oral and visual  
9 diseases. The FDI World Dental Federation (FDI) had worked with member national dental associations to  
10 lobby their respective governments to include oral diseases in the UN-mandated initiative and the President of  
11 Tanzania had hosted, with the collaboration of the governments of Australia and Sweden and the World  
12 Health Organization (WHO), a side event on September 19<sup>th</sup> 2011, held at NYU College of Dentistry, called  
13 "Putting Teeth Into NCDs: Encouraging Priority Actions for Non-Communicable Disease". Subsequent to  
14 issuing the Political Declaration, the UN directed WHO to set targets and indicators for the global monitoring  
15 framework dealing with those diseases as well as the common risk factors (tobacco, alcohol, diet and physical  
16 activity) and the FDI, with ADA support, is actively tracking this activity with the WHO in Geneva and, in  
17 particular, with the Pan American Health Organization (PAHO) regional effort for the Americas. This process  
18 and the attempt to integrate oral health targets and indicators is continuing and reports of such are being  
19 made by the WHO as well as its regional arm, PAHO, and the FDI.

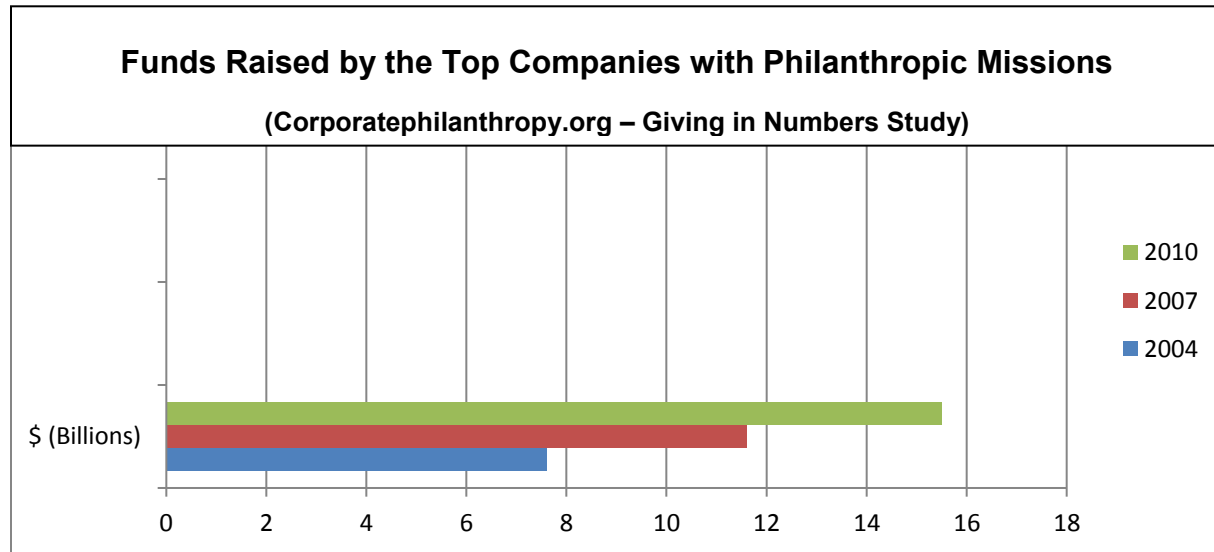
20 Since 2010 the United Nations Environmental Programme (UNEP) has held four meetings seeking a globally  
21 binding mandate on the use of mercury. Dental amalgam is one segment of mercury use under review. A  
22 number of delegations and activists seek to use these negotiations to effectuate a ban on dental  
23 amalgam. The ADA was asked to support the FDI World Dental Federation in its fight to maintain the  
24 availability of dental amalgam as one restorative option. The ADA now plays a leading role in supporting the  
25 FDI as it fights a mercury ban using sound scientific-based strategies to support the availability of  
26 amalgam. The ADA has been working with the U.S. State Department so that the U.S. delegation to these  
27 negotiations has a complete understanding of the position of organized dentistry. As this struggle continues,  
28 the ADA maintains its position and is working for some form of phase down approach, premised on reduced  
29 demand through increased prevention efforts. The ADA opposes any date by which amalgam use must be  
30 discontinued.

31 For those dentists outside the U.S. that would like to be members of the American Dental Association, a  
32 category of membership, called Affiliate Membership is highly promoted by the Division of Global Affairs. The  
33 ADA Committee on International Programs and Development (CIPD) has long supported a growth in this  
34 category and at its February 2012 meeting the Council on Membership also discussed the potential impact  
35 that the growth of the affiliate membership category could have for the ADA. A workgroup was formed, that  
36 includes representation from the CIPD.

37 Current trends show more students and dentists broadening their horizons beyond "traditional" private  
38 practice dentistry and opening up to international aid and volunteer work. The ADA sponsors and manages  
39 nine programs through the NGO Health Volunteers Overseas, Oral Health Initiative which include: the Adopt-  
40 a-Practice: Rebuilding Dental Offices in Haiti campaign; the Southeast Asia Dental Public Health Training  
41 programs; advanced education at the Muhimbili University in Dar Es Salaam, Tanzania sponsored by Henry  
42 Schein Cares Foundation, as well as programs in Honduras, Nicaragua, Peru, Rwanda, Samoa and St. Lucia.  
43 The ADA International Volunteer Webpage highlights these programs and numerous other international  
44 volunteer opportunities and nonprofit organizations involved in oral health.

45 More U.S. based nonprofit organizations and dental schools are now offering volunteer programs for dentists  
46 and students than ever before. In May of 2010, students at the Arthur A. Dugoni School of Dentistry at the  
47 University of the Pacific started their own international humanitarian organization which focuses on oral  
48 health. Stating that volunteering is a "fulfilling and important part of dentistry," these students have started  
49 from a young age to inspire and encourage their fellow dentists and dental students to contribute to the needs

of underserved communities. International assistance is becoming increasingly popular among all branches of dentistry. As a result of greater interest, more for-profit and non-profit organizations are providing opportunities to volunteer internationally as well as support dentists, students and the dental industry through their programs. The chart below illustrates that companies with philanthropic missions have raised significantly more funds in 2010 than they did in 2004 – nearly double the amount.



“Infectious diseases know no borders; fighting global disease directly protects the United States. And improving the health of people in the developing world drives economic growth, fights poverty, and strengthens communities, which in turn reduces the instability that can fuels war and conflict,” said Rajiv Shah, USAID Administrator, in recognition of World Health Day 2011.

## Policy Review

In accord with Resolution 111H-2010, Regular Comprehensive Policy Review, the CIPD reviewed Association policies related to International issues.

The CIPD concluded that the following policies should be maintained as written. The full text the policy is included in the appendix.

## Policy to be Maintained

**77. Resolved**, that the following policy be maintained:

Need of Dental Public Health Education and Oral Health Services in Underserved Countries  
(*Trans.*1999:906)

The CIPD believed that the following policies should be amended to include more pertinent language:

## Policy to be Amended

**78. Resolved**, that the ADA policy on Donation of ADA Library Materials (*Trans.*1993:684) be amended as follows (deletions are ~~stricken~~):

1 **Resolved**, that the ADA donate its appropriate excess ~~and outdated~~ library materials to ~~Medical~~  
2 ~~Books for China International or any other organizations that is~~ in need of these materials, and be it  
3 further

4 **Resolved**, that the ADA encourage its allied dental organizations to also donate their excess  
5 materials.

6 The CIPD also concluded that the following policies be rescinded due to irrelevance. The full text of the  
7 policies is included in the appendix.

8 **Policies to be Rescinded.**

9 **80. Resolved**, that Resolution 21-1963-H Membership in FDI World Dental Federation (*Trans.*1963:264)  
10 be rescinded.

11 **81. Resolved**, that Resolution 69-1975-H Actions Taken by UNESCO (*Trans.*1975:740) be rescinded.

12 **Resolutions**

13 (Resolution 77:Worksheet:3029)

14 (Resolution 78:Worksheet:3031)

15 (Resolution 80:Worksheet:3032)

16 (Resolution 81:Worksheet:3034)

17 **Committee Minutes**

18 <https://www.ada.org/members/1293.aspx#cipd>

Resolution No. 77 NewReport: Board Report 5 Date Submitted: July 2012Submitted By: Board of TrusteesReference Committee: Membership and Related MattersTotal Net Financial Implication: None Net Dues Impact: \_\_\_\_\_Amount One-time \_\_\_\_\_ Amount On-going \_\_\_\_\_ FTE 0ADA Strategic Plan Goal: Members (Required)

1 **ADA POLICY TO BE MAINTAINED ON NEED OF DENTAL PUBLIC HEALTH EDUCATION AND ORAL**  
2 **HEALTH SERVICES IN UNDERSERVED COUNTRIES AS RECOMMENDED BY THE DIVISION OF**  
3 **GLOBAL AFFAIRS**

4 **Background:** (See Report 5 of the Board of Trustees to the House of Delegates, Worksheet:3024)

5 **77. Resolved,** that the following policy be maintained: Need of Dental Public Health Education and Oral  
6 Health Services in Underserved Countries (*Trans.*1999:906).

7 **BOARD RECOMMENDATION: Vote Yes.**

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

**WORKSHEET ADDENDUM  
DIVISION OF GLOBAL AFFAIRS  
ADA POLICY TO BE MAINTAINED**

- 1 **Need of Dental Public Health Education and Oral Services in Underserved Countries** (*Trans.* 1999:906)
- 2 **Resolved**, that the ADA recognizes the need for the education of providers of dental care in the underserved
- 3 world and of its responsibility to support the efforts of legitimate organizations to assist in providing this
- 4 service, and be it further,
- 5 **Resolved**, that the ADA remain proactive in creating higher visibility and sensitivity in the needs of the
- 6 underserved nationally and internationally with regard to oral health care.

Resolution No. 78 NewReport: Board Report 5 Date Submitted: July 2012Submitted By: Board of TrusteesReference Committee: Membership and Related MattersTotal Net Financial Implication: None Net Dues Impact: Amount One-time  Amount On-going  FTE 0ADA Strategic Plan Goal: Members (Required)**1 AMENDMENT OF ADA POLICY ON DONATION OF ADA LIBRARY MATERIALS****2 Background:** (See Report 5 of the Board of Trustees to the House of Delegates, Worksheet:3024)**3 78. Resolved,** that the ADA policy on Donation of ADA Library Materials (*Trans.* 1993:684) be amended  
**4 as follows (deletions are ~~stricken~~):****5 Resolved,** that the ADA donate its appropriate excess ~~and outdated~~ library materials to ~~Medical~~  
**6 Books for China International or any other organizations that is in need of these materials, and be it  
**7 further******8 Resolved,** that the ADA encourage its allied dental organizations to also donate their excess  
**9 materials.****10 BOARD RECOMMENDATION: Vote Yes.****11 BOARD VOTE: UNANIMOUS. (BOARD OF TRUSTEES CONSENT CALENDAR ACTION—NO BOARD**  
**12 DISCUSSION)**

Resolution No. 80 NewReport: Board Report 5 Date Submitted: July 2012Submitted By: Board of TrusteesReference Committee: Membership and Related MattersTotal Net Financial Implication: None Net Dues Impact: Amount One-time  Amount On-going  FTE 0ADA Strategic Plan Goal: Members (Required)**1 RESCISSION OF ADA POLICY ON MEMBERSHIP IN FDI WORLD DENTAL FEDERATION****2 Background:** (See Report 5 of the Board of Trustees to the House of Delegates, Worksheet:3024)**3 80. Resolved,** that Resolution 21-1963-H Membership in FDI World Dental Federation (*Trans.*1963:264)  
**4 be rescinded.****5 BOARD RECOMMENDATION: Vote Yes.****6 BOARD VOTE: UNANIMOUS. (BOARD OF TRUSTEES CONSENT CALENDAR ACTION—NO BOARD**  
**7 DISCUSSION)**

**WORKSHEET ADDENDUM  
DIVISION OF GLOBAL AFFAIRS  
ADA POLICY TO BE RESCINDED**

- 1 **Membership in FDI World Dental Federation** (*Trans.*1963:264)
- 2 **Resolved**, that members of the Association be encouraged to consider the advantages of supporting
- 3 membership in the FDI World Dental Federation which provides a direct means for furthering international
- 4 good will through the dental profession and for broadening personal interests through the Federations
- 5 publications and meetings.

Resolution No. 81 NewReport: Board Report 5 Date Submitted: July 2012Submitted By: Board of TrusteesReference Committee: Membership and Related MattersTotal Net Financial Implication: None Net Dues Impact: Amount One-time  Amount On-going  FTE 0ADA Strategic Plan Goal: Members (Required)

1 **RESCISSION OF ADA POLICY ON MEMBERSHIP IN FDI WORLD DENTAL FEDERATION—ACTIONS**  
2 **TAKEN BY UNESCO**

3 **Background:** (See Report 5 of the Board of Trustees to the House of Delegates, Worksheet:3024)

4 **81. Resolved,** that Resolution 69-1975-H Actions Taken by UNESCO (*Trans.* 1975:740) be rescinded.

5 **BOARD RECOMMENDATION: Vote Yes.**

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

**WORKSHEET ADDENDUM  
DIVISION OF GLOBAL AFFAIRS  
POLICY TO BE RESCINDED**

1 **Actions Taken by UNESCO** (*Trans.1975:740*)

2 **Resolved**, that the American Dental Association express its strong opposition to the recent actions of  
3 UNESCO with regard to a member state, Israel, and urge that body to rescind those decisions and take  
4 appropriate steps to assure that future actions will be consistent with its role as an educational, scientific and  
5 cultural organization, and be it further,

6 **Resolved**, that organized dental groups in the United States and abroad be encouraged to take similar or  
7 other appropriate action.

Resolution No. 82 NewReport: NA Date Submitted: July 2012Submitted By: Board of TrusteesReference Committee: Membership and Related MattersTotal Net Financial Implication: None Net Dues Impact: \_\_\_\_\_Amount One-time \_\_\_\_\_ Amount On-going \_\_\_\_\_ FTE 0ADA Strategic Plan Goal: Members (Required)1 **AMENDMENT OF ADA POLICY ON CHANGES IN ADA STRATEGIC PLAN**

2 **Background:** In accord with Resolution 111H-2010, Regular Comprehensive Policy Review, the Board  
 3 identified that the following policy, Changes in ADA Strategic Plan" (*Trans.* 1997:714), be amended to read as  
 4 follows (additions are underscored; deletions are ~~stricken~~):

**Resolution**

5 **82. Resolved**, that the ADA policy on "Changes in ADA Strategic Plan" (*Trans.* 1997:714) be amended  
 6 to read as follows (additions are underscored; deletions are ~~stricken~~):

7 **Resolved**, that the ADA Board of Trustees be urged to establish a mechanism for seek input  
 8 from communities of interest, including representatives from the House of Delegates, in the  
 9 development of to any substantive changes to the ADA Strategic Plan, after the initial review by  
 10 the Board of Trustees, and be it further

11 **Resolved**, that any comments resulting from this review be referred to the Board of Trustees for  
 12 consideration or possible action

13 **BOARD RECOMMENDATION: Vote Yes.**14 **BOARD VOTE: UNANIMOUS.**

Resolution No. 82S-1 SubstituteReport: N/A Date Submitted: October 2012Submitted By: Fifth Trustee DistrictReference Committee: Membership and Related MattersTotal Net Financial Implication: None Net Dues Impact: \_\_\_\_\_Amount One-time \_\_\_\_\_ Amount On-going \_\_\_\_\_ FTE 0ADA Strategic Plan Goal: Members (Required)**1 AMENDMENT OF ADA POLICY ON CHANGES IN ADA STRATEGIC PLAN**

2 The following substitute for Resolution 82 (Worksheet:3036) was adopted by the Fifth Trustee District and  
3 transmitted on October 4, 2012 by Ms. Connie Lane, executive director, Mississippi Dental Association.

4 **Background:** The ADA Strategic Plan is a very broad and all-encompassing document that drives  
5 organization policy and determines budgetary requirements. While confidence in elected ADA leaders and  
6 board members is noted and gratefully acknowledged, significant input from the ADA House of Delegates, the  
7 body of the Association that is the most representative of the membership, should also be a significant part in  
8 the final approval process of this plan.

**9 Resolution**

10 **82S-1. Resolved**, that the ADA policy on "Changes in ADA Strategic Plan" (*Trans.*1997:714) be  
11 amended to read as follows (additions are underscored; deletions are ~~stricken~~):

12 **Resolved**, that the ADA Board of Trustees be urged to establish a mechanism for seek input  
13 from communities of interest, including representatives from the House of Delegates, in the  
14 development of to any substantive changes to the ADA Strategic Plan, after the initial review  
15 by the Board of Trustees, and be it further

16 **Resolved**, that the Board of Trustees of the ADA be urged to seek final approval of the ADA  
17 Strategic Plan from the ADA House of Delegates.

18 **Resolved**, that any comments resulting from this review be referred to the Board of Trustees  
19 for consideration or possible action.

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

Resolution No. 160 NewReport: NA Date Submitted: September 2012Submitted By: First Trustee DistrictReference Committee: Membership and Related MattersTotal Net Financial Implication: None Net Dues Impact: Amount One-time  Amount On-going  FTE 0ADA Strategic Plan Goal: Financial (Required)**EXTENDING NEW DENTIST DISCOUNT PROGRAM**

The following resolution was adopted by the First Trustee District and transmitted on September 16, 2012, by Dr. Judith M. Fisch, caucus chair, First Trustee District.

**Background:** According to the ADA Survey Center's "2009 Survey of Dental Graduates: Workforce," dental students graduate with an average debt of \$253,419. This debt level affects a new dentist's decision on where and how to practice, and is also a factor on whether or not to join and/or renew membership in organized dentistry. In states that have private dental schools, such as in Massachusetts, the debt levels are higher and the impact on membership is even greater.

Currently, the ADA's Reduced Dues Program offers five years of reduced dues. However, with the rising costs of dental education and the practice of dentistry, dentists need more time to realize the benefits of organized dentistry. There are many benefits offered by the tripartite, especially for dentists in their first ten years out of school. Extending the number of years of reduced dues would increase member retention by reducing the financial barrier to membership and better allow dentists to realize the benefits of membership. In addition, retaining a dentist for 30 or more years has a tremendous value to all levels of the tripartite, paid not just in dues but in products purchased, continuing education events attended, and volunteer positions accepted.

**Resolution**

**160. Resolved,** the ADA Council on Membership be requested in its annual report to the ADA 2014 House of Delegates to report on the benefits and the financial impact of extending the reduced dues period for the New Dentist Dues Discount Program.

**BOARD RECOMMENDATION: Vote Yes.**

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

\*Dr. Faiella was absent.

Resolution No. 167 NewReport: CMIRP Supplemental Report 1 Date Submitted: September 2012Submitted By: Council on Members Insurance and Retirement ProgramsReference Committee: Membership and Related MattersTotal Net Financial Implication: None Net Dues Impact: Amount One-time  Amount On-going  FTE 0ADA Strategic Plan Goal: Financial (Required)

**COUNCIL ON MEMBERS INSURANCE AND RETIREMENT PROGRAMS SUPPLEMENTAL REPORT 1  
TO HOUSE OF DELEGATES: RESCISSION OF POLICY ON SPONSORSHIP OR ENDORSEMENT OF A  
NATIONAL PROFESSIONAL LIABILITY INSURANCE PROGRAM**

**Background:** The Council on Members Insurance and Retirement Programs has one policy in *Current Policies* related to the Sponsorship or Endorsement of a National Professional Liability Insurance Program.

**78H-1995. Resolved,** that prior to considering the sponsorship or endorsement of any national professional liability insurance program, the Board of Trustees shall present said program to the House of Delegates for consideration and approval.

Resolution 78H-1995 is more appropriately considered a directive of the House, rather than a policy. The authority to implement new insurance plans, make changes to plan provisions, terminate existing plans and approve contracts, rests with the Board of Trustees.

Although the ADA has no immediate plans to pursue a National Professional Liability Insurance Program, the Council recommends the House rescind the policy to clarify the Board's responsibility and future obligations to the House.

**Resolution**

**167. Resolved,** that the ADA policy on Sponsorship or Endorsement of a National Professional Liability Insurance Program (*Trans.*1995:603) be rescinded.

**BOARD RECOMMENDATION: Vote Yes.**

**Board Vote: Resolution 167**

BLANTON	Yes	GOUNARDES	Yes	NORMAN	Yes	SUMMERHAYS	Absent
DOW	Yes	HAGENBRUCH	Yes	RICH	Yes	VIGNA	Yes
ENGEL	Yes	ISRAELSON	Yes	ROBERTS	Yes	WEBER	Yes
FAIELLA	Absent	KIESLING	Yes	SEAGO	Yes	VERSMAN	Yes
FEINBERG	Yes	LOW	Yes	STEFFEL	Yes	YONEMOTO	Yes

Resolution No. NA NewReport: Board Report 8 Date Submitted: September 2012Submitted By: Board of TrusteesReference Committee: Membership and Related MattersTotal Net Financial Implication: None Net Dues Impact: Amount One-time  Amount On-going  FTE 0ADA Strategic Plan Goal: Members (Required)**REPORT 8 OF THE BOARD OF TRUSTEES TO THE HOUSE OF DELEGATES: ANNUAL REPORT OF STRATEGIC PLANNING ACTIVITIES**

**Background:** This report to the House of Delegates on the American Dental Association's (ADA) annual strategic planning activities is submitted to report to the House on the status of strategic planning activities.

**2012 Strategic Planning Committee (SPC):** Drs. McKinley Price (chair), Evis Babo, Todd Cubbon, Jeffrey Dow, Dennis Engel, Robert Faiella, Daniel Klemmedson, Charles Norman, Kathleen O'Loughlin, Danielle Ruskin, J. Ted Sherwin, Adam Shisler and Carol Summerhays.

**Overview:** During 2012 the SPC supported the Board by monitoring the implementation of the 2011-2014 Strategic Plan and the associated 2012 Operating Plan. The Strategic Plan may be found here [https://www.ada.org/members/sections/about/doc\\_strategic\\_2011.pdf](https://www.ada.org/members/sections/about/doc_strategic_2011.pdf). The Committee also evaluated its own operations and proposed to the Board of Trustees that the committee be disbanded so that the Board could take a more direct role in strategic planning. At the June Board meeting, this proposal was adopted by the Board. The Board expresses its thanks to the Committee members for their work and will seek their expertise in development of the next strategic plan. In addition, House input will be actively sought during the planning phase for each new three year strategic plan by the appointment of members of the House to the Board's strategic planning workgroup.

In furtherance of the suggestion of the SPC, the Board currently monitors progress toward achievement of the Strategic Plan and will continue to do so. The Board believes that this evolution in strategic planning is very positive. It follows closely on the new emphasis in the budgeting process on linking budget decisions with the strategic plan. The Association is moving from a culture focusing on activities to one which will focus on results. This work is in progress and we expect our new strategic plan will continue this shift. The Board intends to hold a planning meeting in December to prepare for the development of a new strategic plan.

**Results:** Beginning this year a combined quarterly management report was compiled that includes an executive summary of divisional activity, the Strategic Dashboard, Operating Plans and financial statements. The quarterly management report is available on ADA.org at <http://www.ada.org/4022.aspx>. This report allows delegates and the Board to quickly monitor ADA activities and performance against the current strategic/operating plan.

The existing strategic plan includes a series of "outcomes/objectives" for each of the four strategic goals. Of course, our ultimate objective is to create a unique and powerful value for members, nonmembers and the public while creating a powerful and influential ADA brand. The remainder of this report will provide information on progress towards reaching these desired outcomes. Review of the outcomes and the specific outcome measures called for has demonstrated a need to refine some of those metrics going forward. This is a task the Board will be undertaking and is noted where appropriate, below. In the following section of the report, the Goals and Outcomes/objectives are taken directly from the Strategic Plan.

**Goal 1: Provide support to dentists so they may succeed and excel throughout their careers**

## Outcomes/objectives:

1. *Professional competency and ethical standards:* The “Measure” for this outcome as stated in the strategic plan is utilization of online and annual session CE. Utilization of CE remains strong. During 2011, the Association delivered 453 CE offerings, to 46,248 dentists and 24,234 dental team members awarding 178,117 continuing education units. 2012 data is not yet available.

Although this Measure is clearly defined, the Board believes that additional information is useful in assessing progress towards this objective:

- The Association provided 10,987 ADA CE Online users with peer reviewed quality online continuing education; 15,302 courses were taken during 2011 of peer reviewed quality online continuing education. By the end of 2011, CE Online had more than 28,000 users; 6,512 registered in 2011 (an increase of 15% from 2010). Projections for 2012 are growing the user base by 7,489 new registrants and having 16,832 courses taken.
  - In 2011, 15,749 annual session dental professionals occupied 46,800 individual seats or 3.0 courses per dental professional (7.7 hours of cutting edge dental continuing education on average). This was an increase of 0.2 courses per professional attendee over 2010 and 0.8 over 2009. The average number of courses per dental professionals: 2011: 3.0; 2009: 2.3; 2008: 2.9.
  - The Association provided effective knowledge translation by launching new content through CE Online and Seminars course offerings, in order to improve members’ ability to provide patient care, and manage their businesses.
  - The Association is maintaining its practice of producing best in class licensure examinations to further the reputation of dental professionals by supporting the JCNDE's Committee for an Integrated Examination (CIE) in constructing a highly innovative, Integrated National Board Dental Examination (INBDE) that is more closely aligned with modern practice in dental education.
  - The Association conducted 107 Success dental school programs at 46 dental schools, providing practice management, financial, ethics and other subjects to enrich the dental school experience and provide information on real world topics from practicing dentists.
  - Publishing produced the two best-read publications in the dental profession – *ADA News* and *JADA* – in both print and digital formats and introduced new mobile versions.
  - The Association relaunched the ADA's online catalog using the Aptify system, with the number of orders exceeding last year's usage by 40%.
  - Through its Legal Division, the Association continues to provide members with informational and educational materials relating to their legal obligations in such areas as statutory and regulatory compliance, as for example HIPPA, data security compliance and federal employment law.
  - The Association successfully held its New Dentist Conference that provided leadership and clinical CE offerings to 260 attendees.
2. *Professional autonomy:* This outcome focuses on keeping the doctor-patient relationship free from outside interference. The “Measure” for this outcome as stated in the strategic plan is a member survey on perception of professional autonomy. In retrospect, reliance on perception is a poor way to assess progress towards this outcome. Sources of potential interference are well known: third-party payors and government regulation. The following summarizes achievements made toward reaching this objective.
    - Third-Party Payors
      - The Association created an information management system to promote the autonomy of members dealing with third-party payors. One measure of the success of this effort is a decrease in number of complaints from members about third-party payor interference. A baseline for tracking this information was developed which runs from April 1, 2011 to November 30, 2011. The reason an eight month baseline is

being used is that Aptify did not become fully functional for this purpose until May 1, 2012. We will be comparing the eight month baseline to the data we collect from May 1, 2012 to December 31, 2012

- Federal Issues

- Through the Washington Office, the Association continues to work to repeal the Affordable Care Act excise tax on dental devices that is scheduled to go into effect on January 1, 2013. On May 7 the ADA submitted comments to the Internal Revenue Service on a proposed rule for "Taxable Medical Devices" along with a coalition of other dental provider groups, the Dental Trade Alliance and the National Association of Dental Laboratories. This is the rule that applies the 2.3% excise tax on medical and dental devices under the terms of the ACA.
- The Association has increased the number of co-sponsors, which now stands at 4 Republicans and 6 Democrats, for federal legislation to enact ERISA reforms as provided in the "Dental Insurance Fairness Act of 2012" (H.R. 4818). H.R. 4818, introduced by Rep. Paul Gosar (R-AZ), would require all health plans that offer dental benefits to provide uniform coordination of benefits and would also require them to permit assignment of benefits. Additional coalition building and grassroots efforts underway should also help generate support for the bill.

- State Issues

- Through the ADA Washington Office and through the SPA program, the Association developed tool kits to assist state dental societies and individual dentists with understanding and complying with the Affordable Care Act – particularly the State Health Exchanges. At present, the tool kits have been made available to the constituent societies and a national issues call with state leaders was held to review this important tool. There are no outcomes from these efforts yet because the exchanges are still being developed.
- In cooperation with constituent societies, the Association continues to work on the state level to pass third party payer ERISA reform legislation, particularly with regard to coordination of benefits and assignment of benefits provisions
- Non-covered services laws (NCS laws) generally restrict or prevent dental plans from placing limits on what contracted dentists may charge for services the plans do not cover. Since the issue was launched in 2009, the ADA has worked closely with states to assist with NCS issue advocacy. Forty-three states have filed an NCS bill with 28 of them becoming law. Success was rapid; half of the states enacted their NCS law within two years of the first law in June of 2009.

3. *Financial health*: This outcome focuses on the financial health of members, as defined by each member. The "Measure" as stated in the strategic plan is member perception of well-being. Below is the latest dentists' economic confidence measure from the Q3 2012 Dentists' Economic Confidence Survey. The report has not been published yet.

Dentists' economic confidence is down from last quarter. Today's economic confidence index score for Q3 is -28, a drop of 11 points from Q2. Dentists are more positive about the future, but their confidence level about future conditions has also dropped from a score of 3 in Q2 to a score of -17 in Q3. Dentists' economic confidence index scores reflect dentists' feelings about their net income, gross billings, open appointment times, and treatment acceptance rates, on a scale from -100 (pessimistic) to 100 (optimistic).

In addition, because the outcome explicitly recognizes that each member may define success under this outcome differently, the following actions are offered as key examples of action taken to meet this outcome:

- The Association developed a business plan creating a Center for Professional Success (CPS) to serve as a "world class" source of dental practice management applications,

information and continuing education. The goal of the CPS is to strengthen the value of ADA membership by meeting the practice management needs of dentists regardless of career stage or path. The launch of the CPS web-based portal is anticipated in the first quarter of 2013.

- Through the Council on Members Insurance and Retirement Plans, the Association is conducting an audit of the insurance program and seeking new product offerings in insurance and retirement plans for our members.
- The Association conducted the 7th ADA Kellogg program (34 participants) enhancing the understanding of standard business school curriculum of participating member dentists.

4. *Positive public image of the profession:* This outcome focuses on how the profession is viewed by the public. The stated "Measure" is an ADA Consumer survey. This is an example of the type of measure the Board would like to revisit in order to develop more concrete data. In the meantime, it is useful to understand the actions taken to achieve this outcome through the promotion of the profession. The Association has taken the following steps to achieve this outcome:

- Through the Communications Division, the Association launched a new, consumer focused web site, MouthHealthy.org, on June 25, 2012. Initial traffic is just beginning to be measured but its projected that MouthHealthy will reach 1.2 million visitors by year end. The launch featured public relations outreach with delivered a television audience of over 7 million news viewers seeing interviews with ADA spokesperson Dr. Maria Lopez Howell.
- The Ad Council public service campaign conducted on behalf of the Partnership for Healthy Mouths, Healthy Lives will contribute to the positive perception of the profession, however its impact can only be measured indirectly based on the public response to the messages and growing awareness of preventive behaviors. The campaign was just launched in July so there is no data available at this time.
- The Association is participating in the healthcare site, Sharecare.com. The Association's traffic and participation on Sharecare.com now exceeds 2 million visitors and over 3,000 oral health questions answered.
- In June 2012 the Board of Trustees unanimously endorsed the ADA's participation as a partner in the Million Hearts Campaign (<http://millionhearts.hhs.gov/index.html>). The ADA's commitments in support of the Campaign are now posted online with other public and private organization partners (<http://millionhearts.hhs.gov/aboutmh/partners.html>). Although it is anticipated that ADA participation will positively impact its public image, the primary reasons for participation are to support public health and the important role that dentists play in the overall health of their patients. No data are available on the impact of this program presently given its recent implementation.
- The Association has issued a series of statements featuring solutions to "Breaking Down Barriers to Oral Health for All Americans" which articulates the profession's commitment to oral health leadership.
- Over 40,000 dental team members, including nearly 10,000 dentists participated in 1600 GKAS events throughout the nation.
- The ADA and the National Association of Community Health Centers finalized an initiative whereby local CHCs can contract with local dentists to extend access to care opportunities.

5. *Member health, wellness and professional satisfaction throughout their career(s):* This outcome focuses on the health and wellness of individual members. The stated "Measure" is a member survey. In retrospect, it is not clear how this particular measure would work in practice. The Board intends to revisit an appropriate metric for this outcome.

- The Association produced three webinars and sponsored one CE course delivered at the 2012 ADA annual session on topics related to opioid analgesia, addiction and the prevention of prescription drug abuse. These courses were supported by a three-year grant received

from Substance Abuse and Mental Health Services Administration and the American Academy of Addictive Psychiatry.

- Content related to establishing healthy habits in the dental office, ergonomics, stress management, career burnout, disability support and promoting initiatives related to women's health is currently being developed and will be included in the future Center for Professional Success.

**Goal 2: Be the trusted resource for oral health information that will help people be good stewards of their own oral health.**

**Outcomes/objectives:**

1. *Oral health literacy*: This outcome focuses on the public's knowledge of oral health. The stated "Measure" is an ADA consumer survey. There is not a regularly scheduled or budgeted consumer survey; however a consumer survey was fielded for the MouthHealthy communications and website initiative and as part of the Ad Council effort there is a baseline tracking study which will be followed by annual reports of selected oral health behavior changes and literacy measures. Both of these efforts will permit tracking over time, although they will rely on self-reported data. Another appropriate metric is measurement of how many members of the public are reached through various initiatives. In particular:
  - Through the Communications Division, the Association launched a new, consumer focused web site, MouthHealthy.org on June 25, 2012. Initial traffic is just beginning to be measured but its projected that MouthHealthy will reach 1.2 million visitors by year end. The launch featured public relations outreach which delivered a television audience of over 7 million news viewers seeing interviews with ADA spokesperson Dr. Maria Lopez Howell.
  - The Association is a leading partner in the Ad Council coalition to promote prevention efforts in the home. ADA MouthHealthy oral health videos are featured on the campaign website. The extensive multi-media public service campaign launch was featured on approximately 50 television stations and news networks reaching an audience of more than 14 million that day.
  - The Association is now participating in the healthcare site, Sharecare.com. The Association's traffic and participation on Sharecare.com now exceeds 2 million visitors and over 3,000 oral health questions answered.
  - Work continues on revitalizing the ADA's trusted Seal of Acceptance brand by presenting new consumer friendly content on MouthHealthy.org. The Seal pages on MouthHealthy have been some of the most viewed on the site, ranking just behind Find-a-Dentist and the home page. Seal pages have been viewed nearly 11,500 times in the first 50 days of the MouthHealthy launch. Traffic to Seal pages on ADA.org continues to be strong with just a 10% decrease in page views since the launch of MouthHealthy. Seal pages on ADA.org are viewed nearly 20,000 times each month. A project is also underway to determine how better knowledge of the Seal is likely to affect consumer purchasing decisions. The project involves exposing dentists and 125,000 patients in 250 dental offices to information about Accepted products. Dentist and consumer attitudes will be tested at the end of the activity in 2013 and compared with baseline data.
2. *Shared responsibility*: The focus of this outcome is the respective roles of both the patient and doctor in managing oral health. The stated "Measures" largely focus on the data provided above with respect to oral health literacy.

**Goal 3: Improve public health outcomes through a strong collaborative profession; including effective collaboration across the spectrum of stakeholders outside of dentistry**

Outcomes/objectives:

1. *Effective dental professional collaboration:* The focus of this outcome is the entire profession working together to improve oral health. The stated "Measure" for this outcome is poorly focused on individual initiatives rather than on the outcome itself. Accordingly, the Board intends to revisit this metric. Nevertheless, this is an area of intense activity within the Association, including:
  - The Association partnered with over 35 other oral health organizations, resulting in the Ad Council campaign on prevention.
  - Work is underway on the 4<sup>th</sup> annual conference in January 2013 of the National Roundtable for Dental Collaboration. This conference provides a venue for 23 dental associations and dental specialty organizations to identify and assess common challenges in the delivery of oral health care, and to work collaboratively to address those challenges towards improving oral health and overall health.
  - The Association welcomed the 10th ADA Institute for Diversity in Leadership class and participated in a Joint Leadership session w/National Dental Association, Hispanic Dental Association and Society of American Indian Dentists.
  - ADA Connect has been implemented to improve collaboration among ADA leadership, ADA Tripartite leadership, Commissions and standards organizations.
  - Collaborating with the Health Resources and Services Administration (HRSA), the Association developed a perinatal consensus statement with American Congress of Obstetricians and Gynecologists (ACOG).
  - The Association entered into a formal partnership with the U.S. National Oral Health Alliance to provide a platform for a diverse network of stakeholders to harness opportunities and create viable solutions for improved oral health through prevention and treatment for vulnerable populations.
  - Through engagement with the American Academy of Pediatrics Section on Oral Health, the Association developed an oral health risk assessment tool and made available to 60,000 pediatric physicians.
2. *The public has access to effective prevention and to a quality focused delivery system:* This outcome focuses on prevention strategies and availability of a quality driven delivery system, with the public system mirroring the efficiencies of the private system. The "Measure" is not specified.
  - The ADA developed a tool kit titled "Fluoridation: Tap in to Your Health" which is available to dental societies via ADA Connect. The tool kit includes: 1) materials for building a fluoridation campaign; 2) materials for public distribution; 3) advocacy materials and 4) press statements and policies from the ADA. Launched at the ADA Management Conference on July 19, 2012, the tool kit was a first edition with additional items to be added in the months ahead.
  - In addition, fluoridation technical assistance has been provided to dental societies and members in many states, including Alaska, Arizona, Arkansas, California, Kansas, Montana, New Mexico, New York, Oregon, Pennsylvania, Texas, Washington and Wisconsin. On June 11, 2012, a letter was sent to Howard K. Koh M.D., M.P.H., Assistant Secretary for Health, U.S. Department of Health and Human Services, requesting that Surgeon General Regina Benjamin issue a formal statement in support of water fluoridation as previous Surgeons General have done. The letter was signed by nearly 100 organizations, including national dental and medical organizations, state dental associations, oral health coalitions, and health foundations.
  - The ADA was well "ahead of the curve" (beginning in January 2012) in providing constituent dental societies with the tools they need to effectively advocate for dentistry and dental patients with regard to the establishment of health benefit exchanges under

the new health care reform law, the Affordable Care Act (ACA). Now that the U.S. Supreme Court upheld the constitutionality of the ACA, including the requirement that health care exchanges be in place in each state by January 1, 2014, millions more children and adults will have dental coverage from private and public sector health plans, unless federal action changes things. The primary activity regarding implementation remains at the state level, however. The advocacy materials provided to constituent dental societies (on ADA Connect) have been updated accordingly and monthly calls to share "best practices" with constituent society staff continues.

- The Association obtained Centers for Medicaid and Medicare Services (CMS) assistance in promotion of Incurred Medical Expense (IME) to state Medicaid agencies to facilitate dentist's use of this reimbursement mechanism for dental care provided to nursing home residents on Medicaid.
- A comprehensive advocacy, communications and public affairs toolkit has been developed and provided to all states for use in efforts to promote and defend community water fluoridation. It provides presentations, press materials, and an extensive collection of positioning facts and documentation for use by the state organization or individual dentists.
- Concerning efforts to head off creation of two tier delivery system, on July 18, 2012, the House Appropriations subcommittee on Labor, Health and Human Services, Education, and Related Agencies passed a funding bill for fiscal year 2013 that included an explicit prohibition on funding of the Alternative Dental Provider Demonstration Program.

**Goal 4: Ensure that the ADA is a financially stable organization that provides appropriate resources to enable operational and strategic initiatives**

**Outcomes/objectives:**

1. *Increase the reserves of the Association so that a reserve level of 50% of the Association's annual budgeted operating expenses is achieved, as urged by HOD Resolution 59-2007H-2008:*  
The purpose of this outcome is self-explanatory, as is the Measure. At present, the Association's reserve levels do not meet this outcome, but following actions have been taken:
  - The Board has forwarded to the House a proposed revision to existing policy on this point and has included a plan to raise reserves to this level and to sustain them at this level.
  - The Association has established a business development function to review and help launch, when appropriate, proposed new business opportunities generated either internally—staff and members—or via outside sources.
  - Supporting constituent and component membership recruitment and retention efforts through the Membership Program for Growth, the Association dispersed \$500,000 in funding in July of 2011. As of August 14, 2012, 53 of the 54 2011-program recipients have reported their results from the past twelve months. At least 884 new or reinstated members can be attributed directly from funded MPG efforts equaling \$446,420 in ADA membership revenue. In addition, at least 2,506 additional renewing members can be attributed directly to MPG funded efforts resulting in \$1,160,995 in dues revenue. In total, at least 3,390 members joined, reinstated or renewed through the first year effort generating \$1,607,415 in dues -- a \$1,107,415 return on the original \$500,000 investment. It is important to note that many participating societies were able to find efficiencies and perform under their proposed budget. These figures do not take into account the lifetime value of the member that resulted from the program.
  - Through three national collaborative campaigns, other membership marketing efforts, focus on member segments and supportive tripartite membership outreach efforts, the Association gained more than 5,500 new members (including 3,000 through conversion of the class of 2011) and a 5.2% non-renew rate for full dues-paying members through June 2012. With an overall active membership of 119,133 (versus 119,571 for the same

period in 2011), membership market share stands at 63% versus 64.2% for the same time last year, due to the fact that the market is growing faster than membership.

- The Board is proposing changes to active, life dues in order to address demographic shifts that are profoundly affecting overall membership dues revenues.
- The Board continues to monitor and manage areas of legal risk to the Association, including the review and maintenance of appropriate insurance coverage and attentiveness to defending or asserting the ADA's legal rights in judicial and regulatory settings.
- Through action by the House, the Association adopted reductions to the ADA Employees' Pension Plan which reduced annual normal costs of funding by over \$3 million per year (equivalent to cash savings of +/-2.5% of annual operating expenses), and reductions to the retiree medical benefit plan that eliminated almost \$13 million in projected liability that had depressed net asset balances.
- Through diligent cost containment and vendor management, the Association generated the highest total net to date from annual session, \$4,007,627, and the highest average net per attendee, \$148.29 per, while maintaining satisfaction. (unaudited figures)

2. *Establish, as permitted by the ADA Bylaws Chapter XVII, Section 30, and annually fund a Capital Improvement Fund that can be carried over each year:* The Board has forwarded to the House a resolution to create such a fund.

- The Board has proposed establishment of such a fund in a resolution to the 2012 House.

## 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)**

\* Dr. Faiella was absent.

Resolution No. NA NewReport: Board Report 11 Date Submitted: September 2012Submitted By: Board of TrusteesReference Committee: Membership and Related MattersTotal Net Financial Implication: None Net Dues Impact: Amount One-time  Amount On-going  FTE 0ADA Strategic Plan Goal: Members (Required)**REPORT 11 OF THE BOARD OF TRUSTEES TO THE HOUSE OF DELEGATES: ANNUAL REPORT OF NEW DENTIST COMMITTEE**

**Background:** The New Dentist Committee (NDC) is a standing committee of the ADA Board of Trustees. The Mission of the ADA New Dentist Committee is to serve as the voice of the new dentist within the American Dental Association, representing new dentists' views to the ADA Board of Trustees and other agencies; to monitor and anticipate new dentist needs and advocate for the development of member benefits, services, and resources to facilitate professional and practice success; and to foster the next generation of leadership within organized dentistry by building community and facilitating new dentist leadership development at all three levels of the tripartite. Therefore, the Board of Trustees submits the following report regarding the New Dentist Committee to the 2012 House of Delegates.

**Committee Composition:** The following individuals served as members of the Standing New Dentist Committee in 2011-2012: Dr. Danielle Ruskin, Michigan, chair; Dr. Christopher Salierno, New York, vice chair; Dr. Dan Bruce, Idaho; Dr. Madalyn Davidson, Illinois; Dr. Jennifer Enos, Arizona; Dr. Michael LeBlanc, Kansas; Dr. Irene Marron-Tarrazzi, Florida; Dr. Heather Maupin, Indiana; Dr. Keri Miller, Alabama; Dr. Matthew Niewald, Missouri; Dr. Timothy Oh, Maine; Dr. Sarah Poteet, Texas; Dr. Edgar Radjabli, Maryland; Dr. Brian Schwab, Pennsylvania; Dr. Eric Unkenholz, South Dakota; Dr. Shamik, Vakil, Virginia; and Dr. Rex Yanase, California.

**Supporting the Strategic Plan: Activities, Results and Accomplishments:** Committee activities support many of the objectives of the *ADA Strategic Plan*, primarily those related to Goal 1: Provide support for dentists so that they may succeed and excel throughout their careers. The Success Dental Student Programs, the *ADA New Dentist News* and the New Dentist Conference are the primary New Dentist Committee programs that directly support the ADA strategic plan.

**Success Dental Student Programs:** To help dental students achieve professional success and position the ADA as a valuable resource, volunteer dentist members present the Success programs to dental students at no charge to the school. Since the 2008-2009 academic year, Success has offered four programs, one for each year of dental school to help students prepare for life as a dentist at every stage. All programs are available to every school every year. In the 2011-2012 academic year, the ADA presented 107 Success programs, reaching about 40% of all dental students. The educational focus of the programs is key as an increasing number of schools limit or prohibit outside programs with a marketing focus. Program evaluations from students, speakers and schools are consistently positive, with results in the top quintile. Twenty-one of the 37 speakers participated in a one-day speaker development session at the ADA in July of this year to discuss ways to enhance the program and to participate in public speaking training to prepare for the 2012-2013 academic year. Committee members are encouraged to become Success program speakers and currently there are three NDC members on the corps as well as several Committee alums. The Committee is currently undertaking a strategic review of the Success Dental Student Programs and more information will be available in 2013.

**ADA New Dentist News:** *ADA New Dentist News* is distributed quarterly to new dentists and dental students as a wrap on the *ADA News* to help new dentists succeed professionally across a wide variety of practice settings. The publication includes feature stories about new dentists in real-life situations, such as looking for an associate position, as well as informational articles, such as tips for choosing an accountant. To reinforce the value of ADA membership, *ADA New Dentist News* also highlights relevant resources and continuing education. Wells Fargo Practice Finance, an ADA Business Resources provider offering practice acquisition, start-up and expansion loans; sponsors this publication.

**New Dentist Conference:** One of the Committee's most valuable programs is the annual New Dentist Conference, whose mission is to foster and develop leadership skills and camaraderie, offer updates on current issues and provide continuing education at a good value to new dentists. This year, the Committee undertook a strategic review of the New Dentist Conference, addressing the goals and objectives of the conference, reviewing the current conference model and discussing three alternatives, including an option to co-locate with Annual Session. After a thorough discussion, the Committee chose to maintain the Conference as a stand-alone meeting as the best way to achieve the Committee's *Bylaws* responsibilities and support its strategic goals.

The 2012 Conference was held June 22-24 in Washington D.C. and offered up to 13 hours of CE. With its D.C. location, advocacy was frequently featured, including in the keynote address on the impact of politics on the dental profession, a breakout session on grassroots advocacy as well as an ADPAC VIP reception held at the ADA Washington Office. ADPAC staffed a booth at the Conference and sponsored the social event at The Park at Fourteenth. This year's Conference also featured a new emerging speakers track and CE by nationally known speakers. ADA President, Dr. William Calnon, gave welcoming remarks during the leadership programming and spoke about ADA's goal to help dentist's succeed and shape the future in dentistry. Twelve members and officers of the ADA Board of Trustees participated in the Conference, discussing the hot topics and engaging in discussions with new dentists. The New Dentist Conference Facebook group holds 770 members and continues to be active after the Conference. The final Conference registration closed at 263 attendees. While registration was lower than past years, the Conference was able to easily exceed its goal to be revenue-neutral due to increased sponsorships and gained cost efficiencies. Attendees gave positive evaluations of the Conference and speakers.

**Additional Member Value Contributions:** The Committee contributes to a number of other programs that demonstrate value to members to help them be successful dentists, including the *Practice & Thrive* e-publication, podcasts and webinars on topics of interest to new dentists as well as contributions to American Student Dental Association publications. The Committee offers and facilitates leadership development at the state and local level as well.

**Emerging Issues and Trends:** As the voice of the new dentist, the New Dentist Committee is the key agency to monitor professional issues and trends for the newest dental practitioners. In this role, the Committee reviews and makes recommendations regarding financial and debt issues, licensure information, practice patterns and other emergent issues. Additionally, it is important for the Committee to understand the needs and concerns of new dentists across the country so that the ADA can continue to help dentists succeed in early career stages. Making sure the new dentist voice is heard throughout the ADA and in the tripartite is critical and a top priority for the Committee. Through the *ex officio* appointments, an NDC member participates in 11 ADA councils and the ADPAC Board, offering the new dentist perspective and reporting relevant topics back to the Committee. In 2011-2012, NDC participation in council meetings has helped to identify key insights and set the stage for future collaborations and valuable outcomes. Examples include contributions to annual session courses, elevated interest in new dentist participation in Washington Leadership Conference and ADPAC and identification of large group practice trends, among others.

Additionally, the Committee is interested in continuing to strengthen its relationship with the Board of Trustees to fulfill its responsibilities as a standing committee of the Board. To report on Committee activities, the New Dentist Committee chair attended one day of the July 2012 Board meeting, while the vice chair attended one day of the March meeting and the Committee wished to continue this participation and expand it in 2013. At

its June meeting, the Committee passed a recommendation for the Board to consider a pilot program to increase Committee participation in the 2012-2013 year. The Board discussed this opportunity at its July meeting and decided to implement a pilot, inviting the New Dentist Committee chair or vice chair to participate in two full Board meetings.

**Membership Trends:** As part of the NDC *Bylaws* responsibility to enhance member value and encourage involvement of new dentists in organized dentistry, the Committee demonstrates the relevance of ADA membership and supports resources at all three levels of the tripartite through the ADA New Dentist Committee Network. At the end of 2011, a total of 66.9%, or nearly 30,000, of new dentists are members of the ADA, which is slightly below membership market share overall at 67.3%. The level of membership participation among new dentists has increased over the last decade, reaching a high of 69.7% in 2006, with a decrease of 2.8 percentage points between 2006 and 2011 (66.9%), and down a half percent from 2010. The 0.4 point gap between new dentists and the rest of the membership at the end of 2011 was the narrowest since the ADA began reporting the figure. The continuation of the reduced dues program, increased marketing communications as well as new dentist outreach at the local level helps to recruit and retain this segment.

**Leadership Development and Recognition:** Fostering leadership is one of the Committee's primary goals and they work towards this goal in a number of ways. Through the New Dentist Committee Network, new dentists represent new dentist committees across the tripartite. There is new dentist representation by 42 constituent and 160 component societies in the New Dentist Committee Network. The ADA communicates with the network through its bi-monthly e-publication, *Network Update*, which helps the community stay in touch and shares pertinent news and information. The Network also receives targeted communications regarding the Conference and other issues and an ADA Connect site is in development, which will help foster greater communication and interaction among new dentist leaders.

The ADA offers training workshops to support the development and advancement of new dentist committees at the state and local level. Since the last annual report, three full-day workshops were conducted, one for the Kentucky Dental Association New Dentist Committee, one for the Texas Dental Association New Dentist Committee along with several Texas component societies and another for the Missouri Dental Association. Workshops are free of charge and evaluations have been positive and encouraging.

A full day of leadership programming was open to all attendees at the 2012 New Dentist Conference and included a keynote address on leadership, sessions on getting involved, small group discussions, grassroots advocacy, Parliamentary procedure, among others, as well as the highly interactive Network Idea Exchange and Hop Topics session with ADA Leaders. The opportunity to connect at social events, breaks and receptions is also viewed as a highly valuable aspect of the Conference, and the all-inclusive pricing model further underscores the importance of networking. Additionally, many districts get together for dinners to socialize and discuss issues in their areas.

Beyond the Conference, the Committee continues to offer virtual training at no charge through the *Understanding the Associations Series* on ADA CE Online, which offers three hours of CE credit.

The inclusion of new dentists in tripartite leadership continues to be a topic of interest. At the 2011 House of Delegates, Resolution 71H-2011 (*Trans.2011:546*) was adopted to encourage state societies to increase new dentist representation in the House. Evaluation of the 2011 House of Delegates reveals that a total of 14 delegates and alternate delegates were new dentists, which is roughly 3% of the entire House. At its January 2012 meeting the Committee reviewed the *ADA New Dentist Committee Survey of Constituent and Component Societies* which showed that few states had made firm plans to include new dentists. In June, the NDC adopted a resolution to further study state level representation to better understand the advancement of new dentist leaders from local and state to national roles.

This year, the Committee recognized Dr. C. Brad Adams of the North Carolina Dental Society with the Golden Apple Award for New Dentist Leadership; Dr. David White of the Nevada Dental Association with the Golden

Apple Award for Outstanding Leadership in Mentoring; and, in collaboration with ADPAC, Dr. Ross Bennett of the Missouri Dental Association with the Golden Apple Award for New Dentist Legislative Leadership. The Colorado Dental Association New Dentist Committee program, "Surviving The First Ten Years" was the 2012 recipient of the New Dentist Committee Outstanding Program Award of Excellence. The Arkansas State Dental Society New Dentist Committee was awarded the Outstanding New Dentist Committee Award for overall achievement. The Golden Apple Award for Dental School/Dental Student Involvement in Organized Dentistry will be announced September 2012.

**Advocacy:** New dentist participation in advocating for the dental profession is another area of high interest and importance. The Committee promotes ADPAC membership for new dentists and also strives to participate at 100% each year as well. ADPAC donations at the 2012 conference totaled \$9,650. Committee involvement in ADPAC supports the Committee's *Bylaws* responsibility to advocate the perspective of the new dentists to the Board and other agencies as they develop programs and policies. The Committee will work jointly with ADPAC to focus on increasing new dentist participation in Washington Leadership Conference and further collaborating with the constituent societies on advocacy initiatives.

**New Media:** The Committee values the opportunity to communicate with students and new dentists using the most relevant mechanisms. The New Dentist Conference Facebook Group has been successful and will continue as will the Twitter feed. Through the *ex officio* appointment to the Council on Communications, the Committee provided insights and suggestions regarding social media and other communications channels. The Committee passed a resolution at its June meeting to explore a new dentist blog. Additionally, a new podcast on PPO's will be posted to ADA.org in September 2012.

**Transition to Practice:** The Committee continues to monitor new dentist practice trends as well as the factors that can influence that decision, such as high levels of student debt and licensure options. Debt for new graduates has more than tripled since 1990, is more than \$180,000 on average, and more than \$218,000 for those in private dental education as reported by the American Dental Education Association (ADEA) Survey of Dental School Seniors. ADEA also indicates that the trend of about 50% of graduates going into private practice continues, while 36% of the 2011 class selected advanced dental education and the remaining graduates pursued government service and other options. To help new graduates navigate the many options in the dental profession, the Committee is developing a new resource *Roadmap to Dental Practice*, which will replace the *Starting Your Dental Practice* CD-ROM. The most relevant components of *Starting Your Dental Practice* are expected to be updated and repurposed for potential use on the Center for Professional Success in 2013.

One of the most relevant and timely discussions regarding new graduate practice options is the trend of large group practices, which the ADA Health Policy Resource Center has reported to be the fastest growing model of dental practice today. The Committee held a mega-issue discussion at its January meeting with the framing question "*What are the opportunities and challenges of corporate dentistry for new dentists today?*" In its follow-up discussion in June 2012, the Committee observed that many other agencies were also studying these issues, but noted that there was a lack of cohesion in the approach and little resulting action. As a standing Committee of the Board, it suggested that a task force be formed to create a unified approach to addressing the next steps for the ADA regarding large group practice. At its July meeting, the Board decided to postpone definitely consideration of this recommendation until March 2013, as emerging ADA research on large group practice could influence and clarify the role of such a task force.

As the Center for Professional Success develops, the new dentist voice will be considered as a new dentist representative serves on the Volunteer Oversight Committee. Additionally, a content area on the site will be targeted to the needs of new dentists.

**Ethics:** The Committee is committed to fostering ethics and raising awareness of ethical issues that new dentists face. The Council on Ethics, Bylaws and Judicial Affairs (CEBJA) is collaborating with the New Dentist Committee on the development of a new ethics mentoring program designed to offer support to dentists who have questions or concerns with ethical implications. CEBJA expects to debut this program in

2013, first piloting it with the new dentist audience. The Committee heard a presentation on the new program at its June meeting, asked questions and offered suggestions. They were supportive of the idea and looked forward to ongoing collaborations with CEBJA. The Committee also held a mega-issue discussion on ethics at its June meeting with the framing question, *How can the ADA support new dentists in making ethical decisions?* A summary of the suggestions from the discussion will be communicated to CEBJA.

**Response to House of Delegates Resolutions:** The New Dentist Committee discussed Resolution 71H-2011 (*Trans.*2011:546) at its January 2012 meeting and did not take further action.

**71H-2011. Resolved,** that the American Dental Association encourage each state dental association to bring at least one new dentist as a delegate or alternate delegate to the annual American Dental Association's House of Delegates, and be it further

**Resolved,** that each association be urged to report to each House of Delegates their respective new dentist delegates or alternates.

In response to the resolution, the New Dentist Committee will continue to encourage dental societies to foster new dentist leadership with the intent of bringing new dentist delegates to annual session. The resolution was brought up again at the Committee's June 2012 meeting in the context of understanding the depth of leadership participation at every level in the tripartite. The Committee adopted a resolution to further explore new dentist involvement in governance at the constituent and component societies.

**Resolved,** that the American Dental Association encourages constituent societies to consider new dentists when electing delegates and alternate delegates to the American Dental Association House of Delegates.

Additional information regarding administrative implementation of Resolution 71H-2011 is included in the Addendum to Board Report 1.

**Policy Review:** The New Dentist Committee does not have any policy review changes at this time. The Committee will identify and review policies in accordance with Resolution 111H-2010 and recommend action to maintain, amend, rescind, or remove from *Current Policies* at its January 2013 meeting. The results will be reported in the 2013 report to the House of Delegates.

**Committee Minutes:** For more information on Committee activities, review the full minutes posted on ADA.org: <https://www.ada.org/members/1293.aspx#newdentist>

## 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)**

\*Dr. Faiella was absent.

Resolution No. 171 NewReport: N/A Date Submitted: October 2012Submitted By: Fifth Trustee DistrictReference Committee: Membership and Related MattersTotal Net Financial Implication: None Net Dues Impact: \_\_\_\_\_Amount One-time \_\_\_\_\_ Amount On-going \_\_\_\_\_ FTE 0ADA Strategic Plan Goal: Members (Required)

1 **ADA MEMBERSHIP LOGO**

2 The following resolution was submitted by the Fifth Trustee District on September 29, 2012 and transmitted  
3 by Dr. Lew Mitchell, chairman, Fifth Trustee District.

4 **Background:** ADA affiliate members currently may download the ADA member logo as a member benefit.  
5 This logo can then be displayed and utilized in marketing a dental practice as an ADA member dentist.  
6 Allowing affiliate members to download and utilize the ADA logo in marketing efforts can promote 'dental  
7 tourism' and convey to unsuspecting consumers that the affiliate member dentist is adhering to the same  
8 practice standards as ADA members, which may or may not be true.

9 **Resolution**

10 **171. Resolved**, that the ADA *Bylaws*, Chapter I. MEMBERSHIP, *Section 20. QUALIFICATIONS,*  
11 *PRIVILEGES, DUES AND SPECIAL ASSESSMENTS, Subsection I. AFFILIATE MEMBER,*  
12 *subsection b. PRIVILEGES,* be amended as follows (new language underscored):

13 b. PRIVILEGES. An affiliate member in good standing shall receive annually a  
14 membership card, have access to the members-only content areas of ADA.org except for  
15 the ADA member logo be entitled to attend any scientific session of this Association,  
16 purchase items through the ADA Catalog at the member rate and receive such other  
17 services as are authorized by the Board of Trustees.

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

Resolution No. 173 NewReport: N/A Date Submitted: October 2012Submitted By: Sixth Trustee DistrictReference Committee: Membership and Related MattersTotal Net Financial Implication: TBD Net Dues Impact: \_\_\_\_\_

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

ADA Strategic Plan Goal: Members (Required)**COLLABORATION WITH DENTAL SCHOOLS TO PROMOTE PRIVATE PRACTICE OF DENTISTRY**

The following resolution was adopted by the Sixth District Caucus and transmitted on October 1, 2012, by Ms. Vicki Wilburs, executive director, Missouri Dental Association.

**Background:**

“Learn from the mistakes of others. You can’t live long enough to make them all yourself.”

—Oliver Wendell Holmes

It is widely agreed that the model of medical care delivery has changed drastically in the last three decades. The number of physicians that own their practices has declined drastically during this time. According to a 2011 Chicago Tribune report, in 2010 the American Medical Association lost 12,000 full dues paying members; down to 216,000 members from 228,000. Some of these physicians cited AMA’s endorsement of the federal Affordable Care Act. They felt that the AMA position no longer reflected the views of private practice physicians. [http://articles.chicagotribune.com/2011-06-19/business/ct-biz-0620-ama-meeting-20110619\\_1\\_ama-delegate-individual-mandate-ama-members](http://articles.chicagotribune.com/2011-06-19/business/ct-biz-0620-ama-meeting-20110619_1_ama-delegate-individual-mandate-ama-members)

The market share of the American Medical Association is reportedly at 17%. <http://www.medpagetoday.com/MeetingCoverage/AMA/33320> This decline in membership and market share of AMA parallels the decline in physician-owned medical practices and decline in the influence of private practice physicians. Front line physicians employed by hospital corporations and other entities seldom join or are active in AMA. However, physicians employed in management positions in hospital corporations and pharmaceutical companies are AMA members as part of their job responsibilities. This increases the influence of this group of physicians within AMA. Their goals may not coincide with those of private practice physicians.

ADA has a market share of 67.3% of the active licensed dentists in 2011. From 71.8% in 2006, the market share has steadily declined each year, according to the ADA National Recruitment and Retention Report for Active Licensed Dentists, end of year 2011 (Appendix 1). Additionally, noted in this same report, the ADA had 128,719 active members out of 191,167 (67.3%) leaving 62,448 non-members. This growing number of non-members must not be ignored.

Many corporate-owned dental practices known as Dental Service Organizations (DSO) reportedly have policies against ADA membership. Many front line dentists that are employed by Federally Qualified Health Centers (FQHC) typically are not ADA members either, yet the true numbers are unknown as we do not currently have data on number of dentists employed by FQHC’s, number of dentists doing dental research, or numbers of dentists as practice owners versus employees. Additionally, from speaking to many dental

1 students, these entities—DSOs and FQHCs—along with the military services, actively recruit new dental  
2 graduates for employment.

3 Currently, there is not an effective mechanism in place to promote or facilitate dentists to join existing privately  
4 owned practices or start their own practices. If the number and percentage of dentists in private practices  
5 continue to decline, dentistry may very well follow the declining trend of AMA. That could negatively affect the  
6 quality of dental care delivered in USA.

7 **Resolution**

8 **173. Resolved,** that the ADA Board of Trustees formulate and institute an action plan to collaborate  
9 with schools of dentistry to promote the private practice dentistry, and be it further

10 **Resolved,** that the Board of Trustees formulate and institute an action plan to collect membership  
11 data that accurately reflects practice ownership and employment by entities, and be it further

12 **Resolved,** that the Board of Trustees report progress made in this regard through ADA publications  
13 and make a report to the 2013 House of Delegates.

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

**REPORT OF PRESIDENT**

Mr. Speaker and all gathered in this House...

Good afternoon...

"A mind that is stretched by a new experience can never go back to its old dimensions."

The words of Oliver Wendall Holmes

I totally agree with Justice Holmes...the past two years, especially this last year as president, have changed my life forever. I look at the world through a totally different lens.

As my term as President of the American Dental Association draws to a close, I am often asked about my experience.

A commonly posed question is "Has it been all you thought it would be?"

Let me answer that in the best way I know how...As a ten year old boy, I discovered a special place on our farm...a stand of pine trees in the middle of a hardwood forest.

It became my "secret place"...a place I would run to when things didn't go well in my life. I would lie on the needles and look up at the sky and think...and think...and try to make sense of things.

Those trees calmed me...they inspired me...they gave me strength.

I vowed that someday, after I did something very special with my life, I would go back and plant ten seedlings so that someone else might experience the same feelings.

The farm has long since been sold, but I still own 22 acres that contain that forest.

Many great things have happened to me in my life...and those have been celebrated in very special ways...but the opportunity to serve as your ADA President...50 years later...finally gives me a reason to plant those trees!

Only a small handful of people here today know what I mean when I say that it has been a once in a lifetime experience.

I thank you for the unbelievable opportunity!

I certainly did not get to stand in front of you this afternoon without the love and support of many special people in my life. Please allow me a moment to showcase some of them here today.

First, my brother, Dr. Tom Calnon...an ADA member from Connecticut and a member of the CSDA House of Delegates.

Joining Tom is my sister-in-law, Suzanne, a speech pathologist back home in Norwalk.

Thanks for being here guys...it means a lot to me...

The next two people are the heart and soul of our office team...

Cari Mannillo, my lead hygienist ...

1 And Cheryl Ennis, my lead assistant and office manager

2  
3 These two are each celebrating anniversaries with the office this year...Cheryl...25 years and Cari....30  
4 years.

5  
6 To ensure my safe return back to my office, I should disclose that they both were 12 years old when they  
7 started working for me!

8  
9 Next, my son Tim, a fourth year dental student at the University at Buffalo. During his third year, Tim was the  
10 District 2 Trustee to the American Student Dental Association and is here this week as a Delegate from  
11 ASDA.

12  
13 With Tim is his girlfriend, Becky, a fourth year student at the New York College of Optometry in Manhattan.

14  
15 Next is my son, Chris and daughter-in-law JJ. Both are general dentists. I have the pleasure of working side-  
16 by-side with Chris in our office and he was just elected Vice-president of our local component...the same job  
17 that started me in my career.

18  
19 Last year, JJ completed her Fellowship at the University of Rochester in Geriatric Dentistry and now works for  
20 the Veteran's Administration.

21  
22 These two are the proud parents of our two grandchildren...two-year old Erin and two-month old Ryan.

23  
24 And now, someone who for years has been the glue that kept our family together when I was doing "my  
25 thing"....my best supporter and at times the person who offered me the most constructive criticism...

26  
27 And someone who it was fun sharing this special year with...

28  
29 My wonderful wife...Mary Kay

30  
31 I would be totally remiss if I didn't thank my colleagues...my friends....my family of the 2<sup>nd</sup> District who have  
32 supported me and inspired me over the years...Thank you so much.

33  
34 This successful year was also made possible by the people who I had the great fortune to be surrounded by  
35 at the ADA...

36  
37 our Executive Director, Kathy O'Loughlin...

38  
39 our Speaker, Tom Soliday...

40  
41 our Treasurer, Ed Leone...

42  
43 my fellow officers...Bob Faiella, Pat Blanton and Ken Versman.

44  
45 These folks along with an unbelievably talented and engaged Board of Trustees...

46  
47 and a loyal and dedicated ADA Staff that I consider truly best of class...made my year so special.

48  
49 A special acknowledgement goes to this House...just a few years ago the House and the Board were very  
50 polarized.

51  
52 Many of you have gone out of your way to work closely with me this year and we are all in a much better  
53 place.

54

1 Thank you all!

2  
3 Two years ago, I made the commitment to learn as much as I possibly could about our profession and our  
4 Association.

5  
6 As an officer, I have had first-hand interaction at all levels of our tri-partite structure. But, I quickly learned  
7 that if I really wanted to understand the complexities of our profession...that I needed to experience the true  
8 grassroots around this country.

9  
10 I often shared with you, in my presentations, that I viewed my role as ADA President as more than simply  
11 coming into your backyards and telling you all the great things the ADA was doing. Sure, that was important,  
12 but I also told you that I was there to listen...and to learn...and to feel the pulse of the dentists in your area if I  
13 was to do my job as best as I could.

14  
15 Over the course of last year, as President-Elect...and this year, as President, I have visited 41 states, some  
16 as many as six times.

17  
18 You have extended unbelievable hospitality to Mary Kay and me and you have shared with us the things that  
19 you are most proud of. We have had so many special experiences...

20  
21 You have shown us so much...far too many things to mention...and you have given me so many reasons to  
22 be proud...

23  
24 proud to be an ADA member...

25  
26 proud to be your ADA President...

27  
28 and proud to be an American . . .

29  
30 Ladies and Gentlemen...I am pleased to tell you that the pulse of our grassroots members...the very pulse of  
31 this Association... is strong ...it's pace is rapid...it gives me...and I know it gives you renewed energy to  
32 move this Association forward....so that every member can take pride in belonging to the ADA.

33  
34 When I make bold statements like that...some people call me an optimist...I take that as a compliment...but I  
35 suppose I am consistent with their label...for example...the other morning I looked in the bathroom  
36 mirror...was a little surprised...but, instead of thinking that I looked older...I decided that I had just invented  
37 the 51<sup>st</sup> shade of grey!

38  
39 I truly am optimistic, however, about our membership. Included in our mission statement are the words "a  
40 diverse membership".

41  
42 I can honestly tell you that until I fulfilled my role as an officer...I did not fully appreciate the breadth of that  
43 word "diverse". Even though there are many commonalities that connect all dentists, there are even more  
44 silos defined by factors that range from color and ethnicity to practice model and specialty.

45  
46 When we talk about membership, we often talk in terms of recruitment and retention...we tend to lump those  
47 two words together as if they are one. Whereas they are both components of membership initiatives, during  
48 my year I saw how independently they can be viewed and implemented.

49  
50 At the recent Multi-cultural Summit in Boca Raton Florida this past July, the MC for the opening ceremony, Dr.  
51 Joseph S. Gray, a very highly respected former NDA President and a life member of the ADA offered a very  
52 powerful statement....

53

1 that everyone in the room should be a member of his/her own organization...but that he felt it mandatory that  
2 everyone must be also an active member of the ADA. He received a lengthy standing ovation.

3  
4 Recruitment at its best!

5  
6 The importance of retention was evident in discussions at so many of my visits, especially visits to  
7 organizations that may not frequently have the opportunity to hear an ADA officer address them.

8  
9 Although Membership percentages are often high, there is also a common feeling of being somewhat  
10 disenfranchised.

11  
12 Earlier this month I had a chance to address one of those groups.

13  
14 Following the meeting, a member from Michigan approached me privately. After she introduced herself, her  
15 eyes filled with tears. She told me she had been a member for more than 30 years and lately had been  
16 having difficulty telling her younger dentists that they should also join. She felt forgotten by the ADA.

17  
18 She told me that my words gave her renewed reason for pride in being a member and that upon her return  
19 home, she was going to encourage membership from all of her dentists.

20  
21 Nelson Mandela once said: "If you talk to a man in a language he understands, that goes to his head. If you  
22 talk to him in his own language, that goes to his heart."

23  
24 Retention is all about maintaining that relationship to the heart...to show value...so I encourage all of you,  
25 when you go home; spread the word to reach out to members who might feel sidelined and unwelcome.

26  
27 Learn about what they do...in essence learn their language...extend your hand...invite them to a local  
28 meeting...and ask them to bring with them the uniqueness of themselves. Your members and your societies  
29 will all benefit.

30  
31 One of the roles as President is to be the outward voice and face of the Association. This meant being able  
32 to frequently step outside my comfort zone and in front of microphones and cameras. Media requests were  
33 common...sometimes multiple per day when major issues arose.

34  
35 I thank the ADA staff both in Washington and Chicago in our Governmental Affairs, Public Relations and  
36 Communications divisions for their patience...their direction...and their advice in preparing me for those  
37 interviews.

38  
39 During my year of meeting the press, an unfortunate theme surfaced... a theme that was not totally new, but  
40 one that demanded a new approach. Several of the reporters demonstrated obvious bias against the ADA,  
41 especially when the topic was Americans attaining adequate oral care. The ADA had a black eye...before we  
42 had even entered the fight.

43  
44 The most extensive interview I had was for PBS Frontline. The interview and taping lasted for multiple hours  
45 with a full range of topics covered. I was astounded when the one hour show finally aired, that my responses  
46 were given only one minute and four seconds of air time.

47  
48 The incident that pushed me over the brink, however, was a request to do a phone interview with the LA  
49 Times. The reporter was very polite, but started the interview by telling me she had already gotten the facts  
50 from other sources, but thought she should at least have a quote from the ADA.

51  
52 I took my anger back to the ADA Board and staff. The time had come to draw a new line in the sand and to  
53 do that we needed to totally reframe the issue surrounding the access debate.

1 The Board, our Divisions of Communication and Governmental Affairs as well as our entire Professional  
2 Services Group worked diligently to come up a plan to reframe the debate and change how we portray  
3 ourselves to the public...to policymakers and to the media.

4  
5 Basically, the ADA needs to position itself as a knowledge broker and as an indispensable part of the solution.  
6 It needs to be a provider of actionable policy interventions to improve the oral health of the public. Those  
7 interventions need to be perceived as objective...evidence based...credible...reliable...and trustworthy.  
8 At our September meeting, the Board reviewed the plan and gave its approval to proceed. You will be  
9 hearing more details from Dr. Faiella in his address to you next Tuesday.

10  
11 I was equally dismayed to have two high profile reporters; one from the Wall Street Journal and one from the  
12 Washington Post challenge the reasons for the ADA to be so involved politically...especially when it comes to  
13 ADPAC.

14  
15 The perception was one of the ADA being a self-serving trade association with our main purpose to be  
16 protection of our turf and benefiting our bottom line.

17  
18 They seemed bewildered when I told them that this involvement is a sense of enormous pride...because as  
19 dentists we need to be involved. We want to part of the solution...not the problem.

20  
21 I told them that ADPAC educates and supports legislators, on both side of the aisle, who have demonstrated  
22 a willingness to really impact the problems of oral health in this country and those who benefit the most from  
23 our involvement are the citizens of this country.

24  
25 Please join me in this pride and visit the ADPAC booth and help support their vital mission for our profession.

26  
27 This 2012 House of Delegates has been given a unique task...I prefer to characterize it as a unique  
28 opportunity. You have been handed a gift.

29  
30 ...the gift tag is marked "Governance."

31  
32 When you open it, the box will contain multiple pieces of a jigsaw puzzle. Those pieces can fit together in  
33 many, many ways.

34  
35 By the actions that this House takes over the next few days, you will put together those various components  
36 and you will form a picture of what this Association will look like in the future.

37  
38 In your deliberations in your caucuses...in your testimony to the Reference Committee...in the discussions on  
39 the floor of this body...I ask you all to remember that all of us are here for the same reason...to act in the best  
40 interest of this Association.

41  
42 We all have roots...very strong roots...and with those come regional preferences and differences. That  
43 creates a paradox for some.

44  
45 In my own experience, I have had numerous times where I would learn new information or hear a compelling  
46 statement from another member of my board...something that made sense to me....although it somehow  
47 didn't agree with my original stance. I considered it my duty to do what I thought would best help the ADA.

48  
49 I was always bolstered by the words of Winston Churchill: "You have enemies? Good!! That means you've  
50 stood up for something."

51  
52 I have had eight somewhat formal contacts with you over the course of this study...whether by e-mail or via  
53 documents placed on ADA Connect...my intention has always been to educate and inform....never to lobby.

54

1 In my first message to you, I said that I would try my best to be transparent and inclusive. This study has  
2 garnered opinion, feedback and advice from an extensive array of members, staff and stakeholders.

3  
4 I cannot imagine a process that could have been more inclusive. I thank the ADA Board Governance  
5 Committee, our unbelievably dedicated ADA staff, our consultants, the Westman Group, your Board of  
6 Trustees....and all of you for your commitment to this process.

7  
8 At the February meeting of the Trustees, I challenged the Board with a two-hour session in which I asked  
9 them to remove themselves from the present and place themselves in 2018...I asked them to review their  
10 actions of the past and to consider the position they now found themselves in.

11  
12 The questions of the new moment were...

13  
14 Did we envision the future adequately?

15  
16 Did we place the Association to be in the best possible position of strength?

17  
18 What if we knew then what we now know?

19  
20 The Board embraced this approach and we had two-hour carve outs for strategic thinking at each of the  
21 remaining Board meetings this year and I think they have yielded remarkable dividends.

22  
23 As you deal with the governance issues this week, I invite you to take the same trip to the future...place  
24 yourselves in 2018...think what the environment might be...and ask yourself the question...

25  
26 **What must the ADA look like if it is going be able to be responsive, nimble and influential?**

27  
28 The suggestions forwarded to this House are not based on finances...they are not a means to save  
29 resources. If that is an outcome, all the better...but the main objective has always been to improve.

30  
31 The University of Rochester, with which I am affiliated, has as its motto the Latin word "Meliora"...which  
32 translates to "Ever Better." I ask you to please make decisions that strive to make the ADA ever better.

33  
34 A few moments ago, I mentioned your President-elect...Bob Faiella.

35  
36 Bob and I have worked closely together this year and it has been an absolute honor to have him as a fellow  
37 officer.

38  
39 Bob will come into the presidency with an unparalleled understanding of how the ADA works...he takes his  
40 role very seriously.

41  
42 He possesses remarkable skills, but most importantly...he has the passion it takes to be a great President. I  
43 look forward to watching him next year.

44  
45 Soon, I will add the words "Immediate-Past" to my title...and I ask the Past Presidents seated right in front of  
46 me...to please save me a nice seat for next year when I join your club. I prefer window to aisle.

47  
48 As I prepare to leave this chapter of my life, I am reminded of the words of Mark Twain...

49  
50 "A man who carries a cat by the tail learns something he can learn in no other way".

51  
52 From my becoming "Billy Bob" at the GKAS/NASCAR event on my very first day as President to eating  
53 Jellyfish last month in China...this year provided me with that ability to learn and experience so much...much  
54 more than I ever dreamed possible.

1 Again... thank you for believing in me and for the opportunity to be your President.

2

3 I am So proud to call you all my colleagues!!

4

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## Dental Benefits, Practice and Health

Resolution No. 1 NewReport: N/A Date Submitted: July 2012Submitted 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 \_\_\_\_\_ FTE 0ADA Strategic Plan Goal: Members (Required)**POLICIES TO BE MAINTAINED AS RECOMMENDED BY THE COUNCIL ON DENTAL BENEFIT PROGRAMS****Background:** (*Reports:41*)**Recommendations—Policies to be Maintained:** The CDBP concluded that the following policies should be maintained as written.**Resolution****1. Resolved,** that the following policies be maintained:

- Real-Time Claims Adjudication (*Trans.2007:419*)
- Payment for Temporary Procedures (*Trans.1999:922*)
- Monitoring and Resolution of Code Misuse (*Trans.2007:419*)
- Proposal for the ADA Dental Claim Form to be Maintained in a Form That Coincides With the HIPAA-Required ANSI X12 837—Dental Transaction Set (*Trans.2001:434*)
- Itemization of Dental Charges (*Trans.1979:634*)
- Supporting Constituents With Third-Party Payer Issues (*Trans.2004:307*)
- Definitions of Fraudulent and Abusive Practices in Dental Benefits Plans and Claims (*Trans.1998:701; 2001:428; 2010:551*)
- Definitions of “Usual Fee” and “Maximum Plan Benefit” (*Trans.2010:545; 2011:452*)
- Review of Evidence-Based Reports Denying Reimbursement (*Trans.2002:423*)
- Government-Sponsored Dental Programs (*Trans.1998:705*)
- Guidelines on Coordination of Benefits for Group Dental Plans (*Trans.1996:685; 2009:423*)
- Opposition to Dental Benefit Plans or Programs Conflicting With ADA Policies (*Trans.1995:620*)
- Evaluation of Dental Care Programs (*Trans.1989:548*)
- Standards for Dental Benefit Plans (*Trans.1988:478; 1989:547; 1993:696; 2000:458; 2001:428; 2008:453; 2010:546*)
- Education of Prospective Purchasers of Dental Benefit Programs (*Trans.1986:515*)
- Direct Reimbursement Concept (*Trans.1982:518*)
- Programs in Conflict With ADA Policies (*Trans.1979:638*)
- Limitations in Benefits by Dental Insurance Companies (*Trans.1997:680*)
- Guidelines on the Use of Images in Dental Benefit Programs (*Trans.1995:617; 2007:419*)
- Eligibility and Payment Dates for Endodontic Treatment (*Trans.1994:674*)
- Extending Dental Plan Coverage to Dependents of Beneficiaries (*Trans.1993:694*)
- Plan Coverage for Treatment of Teeth Needing Restoration Due to Attrition, Wear and Abrasion (*Trans.1993:693*)
- Appropriate Use of Dental Benefits by Patients and Third-Party Payers (*Trans.1993:688*)

1 Preauthorization of Benefits (*Trans.*1992:597)  
2 Qualifications of Participating Dentists (*Trans.*1991:639)  
3 Least Expensive Alternative Treatment Clauses (*Trans.*1991:634)  
4 Pre-Existing Condition Exclusion (*Trans.*1991:634)  
5 Audits of Private Dental Offices by Third-Party Payers (*Trans.*1990:540; 2005:325)  
6 Coverage for Treatment of Temporomandibular Joint Dysfunction (*Trans.*1989:549)  
7 Payment for Prosthodontic Treatment (*Trans.*1989:547)  
8 Benefits for Services by Qualified Practitioners (*Trans.*1989:546)  
9 Equitable Dental Benefits for Relatives of Dentists (*Trans.*1987:502)  
10 Identification of Claims Reviewer (*Trans.*1985:584)  
11 Frequency of Benefits (*Trans.*1983:548)  
12 Maximum Fees for Non-Covered Services (*Trans.*2010:616)  
13 Statement on Reporting Fees on Dental Claims (*Trans.*2009:419)  
14 Statement on Determination of Maximum Plan Benefit (Formerly "Customary Fees") by Third Parties  
15 (*Trans.*1991:633; 2010:545; 2011:453)  
16 State No Fault and Workers' Compensation Programs (*Trans.*2008:460)  
17 Coordination of Benefits Reform (*Trans.*2008:496)  
18 Dental Claims Processing (*Trans.*1999:930)  
19 Third-Party Payers Overpayment Recovery Practices (*Trans.*1999:930)  
20 ERISA Reform (*Trans.*1998:738)  
21 Legislative Recognition of the Patient's Right to Assign Payment (*Trans.*1997:708)  
22 Prohibition of Contract Provisions Permitting the Automatic Assignment of Participating Dentist  
23 Agreements Among Entities Engaged in the Business of Insurance (*Trans.*1995:648)  
24 Update on Dental Tourism (*Trans.*2008:454)  
25 Responsibility for the Oral Health of Patients (*Trans.*2004:334)  
26 Community Rating, Risk Pools and Portability for Health Benefit Coverage Plans (*Trans.*1995:648)  
27 Statement on Dental Consultants (*Trans.*2010:555)

28 **BOARD RECOMMENDATION: Vote Yes.**

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

## 1 WORKSHEET ADDENDUM

## 2 COUNCIL ON DENTAL BENEFIT PROGRAMS

## 3 POLICIES TO BE MAINTAINED

4 **Real-Time Claims Adjudication (*Trans.2007:419*)**

5 **Resolved**, that the appropriate ADA agencies monitor any new real-time claims adjudication initiatives to  
6 determine the impact on dentists, and be it further

7 **Resolved**, that the appropriate ADA agencies communicate to dental plans, employers and patients the  
8 concerns about current payment issues, while encouraging the dental benefits industry to move towards  
9 real-time claims adjudication, and be it further

10 **Resolved**, that the appropriate ADA agencies educate dentists about the complexities of claims  
11 adjudication and third-party payment processes to enable them to more efficiently manage their practices,  
12 and be it further

13 **Resolved**, that the appropriate ADA agencies work with the national organizations responsible for  
14 developing electronic standards for electronic data interchange (EDI) to encourage the development of  
15 real-time claims adjudication standards.

16 **Payment for Temporary Procedures (*Trans.1999:922*)**

17  
18 **Resolved**, that provisional or interim restorations and prostheses are valid treatment modalities that  
19 should be reimbursable, and be it further

20 **Resolved**, that the American Dental Association urge third-party payers to accept this policy.

21 **Monitoring and Resolution of Code Misuse (*Trans.2007:419*)**

22  
23 **Resolved**, that the ADA educate members on the appropriate use of the *Code on Dental Procedures and*  
24 *Nomenclature* and encourage them to report misuse by third-party payers, and be it further

25 **Resolved**, that the ADA actively pursue violations of the third-party licensing agreement for use of the  
26 *Code on Dental Procedures and Nomenclature*.

27 **Proposal for the ADA Dental Claim Form to be Maintained in a Form that Coincides with the HIPAA-**  
28 **Required Ansi X12 837—Dental Transaction Set (*Trans.2001:434*)**

29  
30 **Resolved**, that the appropriate Association agencies endeavor to coordinate modifications to both the  
31 ADA Dental Claim Form and the Health Insurance Portability and Accountability Act of 1996 standard  
32 837, electronic dental claim for consistency and location of data content.

33 **Itemization of Dental Charges (*Trans.1979:634*)**

34  
35 **Resolved**, that the American Dental Association is opposed to legislation which would mandate that  
36 patient invoices contain an itemization of charges related to the dental treatment, including separation of  
37 commercial dental laboratory fees, because of the ensuing confusion it would certainly create.

38 **Supporting Constituents with Third-Party Payer Issues (*Trans.2004:307*)**

1 **Resolved**, that the ADA actively solicit information regarding third-party payer problems from members  
2 and all tripartite data sources, and be it further

3 **Resolved**, that the appropriate ADA agencies identify these third-party trends and critical issues and  
4 proactively use this analysis to facilitate efforts by constituent societies to address and resolve these  
5 issues with state and regional regulatory authorities.

6 **Definitions of Fraudulent and Abusive Practices in Dental Benefits Plans and Claims (*Trans.1998:701;***  
7 **2001:428; 2010:551)**

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

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

13 **Bad Faith Insurance Practices:** The failure to deal with a beneficiary of a dental benefit  
14 plan fairly and in good faith; or an activity which impairs the right of the beneficiary to receive  
15 the appropriate benefit of a dental benefits plan or to receive them in a timely manner.  
16 Some examples of potential bad faith insurance practices include: evaluating claims based  
17 on standards which are significantly at variance with the standards of the community; failure  
18 to properly investigate a claim for care; and unreasonably and purposely delaying and/or  
19 withholding payment of a claim.

20 **Inappropriate Fee Discounting Practices:**

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

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

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

35 **Bundling of Procedures:** The systematic combining of distinct dental procedures by third-party  
36 payers that result in a reduced benefit for the patient/beneficiary. and be it further

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

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

41 **Overcoding:** Reporting a more complex and/or higher cost procedure than was actually performed.

**Unbundling of Procedures:** The separating of a dental procedure into component parts with each part having a charge so that the cumulative charge of the components is greater than the total charge to patients who are not beneficiaries of a dental benefit plan for the same procedure

#### **Definitions of “Usual Fee” and “Maximum Plan Benefit” (*Trans.2010:545; 2011:452*)**

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

##### **Definitions of “Usual Fee” and “Maximum Plan Benefit”**

**Resolved**, that the following definitions of “usual fee” and “maximum plan benefit” 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* is the reimbursement 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

**Resolved**, that the ADA should communicate these definitions to insurance regulators, consumer advocacy groups, and dental benefits administrators to encourage the proper use of these terms.

#### **Review of Evidence-Based Reports Denying Reimbursement (*Trans.2002:423*)**

**Resolved**, that all complaints reported to the ADA between third-party payers and ADA members regarding interpretation of evidence-based reports be referred to the Council on Dental Benefit Programs with input from the appropriate Association agencies for review.

#### **Government-Sponsored Dental Programs (*Trans.1998:705*)**

**Resolved**, that the ADA strongly encourage all government-sponsored dental programs to support the concept of patient/enrollee freedom of choice in selection of dental benefit plans, and be it further

**Resolved**, that all government-sponsored programs allow for patient/enrollee selection of dental benefits plans independently from their selection of other health/medical benefit plans, and be it further

**Resolved**, that all government-sponsored dental benefit programs include a fee-for-service dental benefit option, where the patient/enrollee may use the services of any licensed dentist of their choice.

#### **Guidelines on Coordination of Benefits for Group Dental Plans (*Trans.1996:685; 2009:423*)**

When a patient has coverage under two or more group dental plans the following rules should apply:

a. The coverage from those plans should be coordinated so that the patient receives the maximum allowable benefit from each plan.

b. The aggregate benefit should be more than that offered by any of the plans individually, allowing duplication of benefits up to the full fee for the dental services received.

and be it further

**Resolved**, that third-party payers, representing self-funded as well as insured plans, should be urged to adopt these guidelines as an industry-wide standard for coordination of benefits, and be it further

**Resolved**, that constituent societies are encouraged to seek enactment of legislation that would require all policies and contracts that provide benefits for dental care to use these guidelines to determine coordination of benefits, and be it further

**Resolved**, that all third parties providing or administering dental benefits should adopt a unified standardized formula for determining primary or secondary coverage and that the formula should be readily applied by dental providers based on information easily obtained from the patient, and be it further

**Resolved**, that the ADA seek federal legislation requiring that third parties comply with a standardized formula for determining primary and secondary coverage, and be it further

**Resolved**, that the ADA, through its appropriate agencies, urge the National Association of Insurance Commissioners (NAIC) to amend their model legislation to conform with ADA policy.

#### **Opposition to Dental Benefit Plans or Programs Conflicting with ADA Policies (*Trans.1995:620*)**

**Resolved**, that the American Dental Association is opposed to any dental benefit plan or program and any financing mechanism for the delivery of dental care which conflicts with the policies or mission of the ADA.

#### **Evaluation of Dental Care Programs (*Trans.1989:548*)**

**Resolved**, that the American Dental Association recognizes the propriety of providing group dental care as a benefit of employment, and urges that the methods of financing and administering such programs be in keeping with the policies and principles of the Association, and be it further

**Resolved**, that the Association and its constituent and component societies maintain active communication with all groups interested in the development and operation of group programs for dental care, providing them with the Association's guidelines for dental benefit coverage, and be it further

**Resolved**, that the policy on "Evaluation of Dental Care Programs" (*Trans.1954:279*) and on "Labor Union Dental Programs" (*Trans.1954:279*) be rescinded.

#### **Standards for Dental Benefit Plans (*Trans.1988:478; 1989:547; 1993:696; 2000:458; 2001:428; 2008:453; 2010:546*)**

1. Organized dentistry at all levels should be regularly consulted by third-party payers with respect to the development of dental benefit plans that best serve the interests of covered patients.

2. Joint efforts should be made by organized dentistry and third-party payers to promote oral health with emphasis on preventive treatment.

3. Plan purchasers should be informed that oral conditions change over time and, therefore, "maximum lifetime benefit" reimbursement restrictions should not be included in dental plans. Dental plans should be designed to meet the oral health needs of patients.

4. Patients should have freedom of choice of dentist and all legally qualified dentists should be eligible to render care for which benefits are provided.

5. Plans that restrict patients' choice of dentists should not be the only plans offered to subscribers. In all instances where this type of plan is offered, patients should have the annual option to choose a plan that affords unrestricted choice of dentist, with comparable benefits and equal premium dollars.

6. The provisions and promotion of the program should be in accordance with the *Principles of Ethics* of the American Dental Association and the codes of ethics of the constituent and component societies involved.

7. The design of dental benefits plans differs from that of medical plans:

- Dental disease does not heal without therapeutic intervention, so early treatment is the most efficient and least costly.
- The need for dental care is universal and ongoing, rather than episodic.
- The need for dental care is highly predictable and does not have the characteristics of an insurable risk.
- The dental needs of individuals in an insured group vary considerably.
- Patient cooperation and post-treatment maintenance is critical to the success of dental treatment and the prevention of subsequent disease.

Therefore, the American Dental Association recommends that for preventive, diagnostic and emergency services, dental benefit plans should not contain deductibles or patient copayments, because they discourage patients from entering the system. Patient participation in the cost of complex care should be sufficient to motivate patients to adequately maintain their oral health.

Rather than excluding categories of services, the Association believes that cost containment is best achieved by varying the patient participation in the costs of treatment and imposing annual limitations on benefits.

8. In order that the patient and dentist may be aware of the benefits provided by a dental benefit plan, the extent of any benefits available under the plan should be clearly defined, limitations or exclusions described, and the application of deductibles, copayments and coinsurance factors explained to the patients by the third-party payers and employers. This should be communicated in advance of treatment.

The patient should also be reminded that he or she is fundamentally responsible to the dentist for the total payment of services received. In those instances where the plan makes partial payment directly to the dentist, the remaining portion for which the patient is responsible should be prominently noted in the Explanation of Benefits Statement (EOB) provided to the patient.

9. Each dentist should have the right to determine whether to accept payment directly from a third-party payer.

10. Third-party payers should make use of dental society peer review mechanisms as the preferred method for the resolution of differences regarding the provision of professional services. Effective peer review of fee disputes, quality, and appropriateness of treatment should be made available by the dental profession.

11. Procedures for claims processing should be efficient and reimbursement should be prompt. The third-party payer should use or accept the American Dental Association's "ADA Dental Claim Form" and the *Code on Dental Procedures and Nomenclature* that the Council on Dental Benefit Programs has approved after appropriate consultation with representatives of nationally recognized dental benefit organizations and the ADA recognized dental specialty organizations.

12. Dentists should comply with reasonable requests from third-party payers for information regarding services provided to patients covered under a plan.

13. Third-party payers' administrative procedures should be designed to enhance the dentist-patient relationship and avoid any interference with it.

14. When patient eligibility is certified through the predetermination process, the third-party payer shall be committed to reimburse on the basis of that initial certification within the provisions of that plan, unless and until written notification is provided in a timely manner to the dentist and the patient by the payer that change in eligibility status has occurred.

15. When such a change in eligibility occurs, a period of not less than 30 days should be allowed for continuation and, when possible, completion of treatment.

16. The treatment plan of the attending dentist, as agreed upon by the patient, shall remain the exclusive prerogative of the dentist and should not be unilaterally interfered with by third-party administrators or payers, or their consultants.

17. The American Dental Association opposes any abuse of the "Least Expensive, Professionally Acceptable Treatment" concept and will inform the public of the barrier such abuse represents to the attainment of quality dental care. When an insoluble dispute occurs between an attending dentist and third party regarding a treatment plan, peer review should be accepted by all parties involved as the mechanism for solution. Peer review should be entered into prior to the third-party payer's determination of reimbursable benefits in such cases.

18. A dental benefit plan should include the following procedures:

A. *Diagnostic*. Provides the necessary procedures to assist the dentist in evaluating the conditions existing and the dental care required.

B. *Preventive*. Provides the necessary procedures or techniques to assist in the prevention of dental abnormalities or disease.

C. *Emergency Care*. Provides the necessary procedures for treatment of pain and/or injury. It should also cover the necessary emergency procedures for treatment to the teeth and supporting structures.

D. *Restorative*. Provides the necessary procedures to restore the teeth.

E. *Oral and Maxillofacial Surgery*. Provides the necessary procedures for extractions and other oral surgery including preoperative and postoperative care.

F. *Endodontics*. Provides the necessary procedures for pulpal and root canal therapy.

G. *Periodontics*. Provides the necessary procedures for treatment of the tissue supporting the teeth.

H. *Prosthodontics*. Provides the necessary procedures associated with the construction, replacement, or repair of fixed prostheses, removable partial dentures, complete dentures and maxillofacial prostheses.

I. *Orthodontics*. Provides the necessary treatment for the supervision, guidance and correction of developing and mature dentofacial structures.

19. The financial reserves of the plan should be adequate to assure continuity of the program.

20. Reimbursement schedules and claim documentation requirements should be based on procedures performed by the dentist and not on the specialty status of the dentist performing them.

21. The methodology used by plan administrators to set reimbursement schedules should rely on current, geographic and other relevant data and be readily available to patients, plan purchasers and dentists.

22. Profiling to establish a different rate of reimbursement for the provider should not be used as a means of cost control by the plan administrators.

23. The data, calculations and methodology used for practice profiling of individual dentists should be made available to those dentists upon request.

24. Information on the possibility of post-payment utilization review, and any consequences of same, must be provided to both participating and nonparticipating dentists.

#### **Education of Prospective Purchasers Of Dental Benefit Programs (*Trans.1986:515*)**

**Resolved**, that the Association engage in an aggressive program to educate prospective purchasers to the advantages of dental benefit programs that are compatible with private practice, fee-for-service dentistry and freedom of choice, and be it further

**Resolved**, that in this effort, promotion of the direct reimbursement model is preferable, but other models may be acceptable.

#### **Direct Reimbursement Concept (*Trans.1982:518*)**

**Resolved**, that the ADA recognizes that the direct reimbursement concept can be an efficient, economical and cost-effective method of reimbursing the patient for dental expenses, and be it further

**Resolved**, that the Council on Dental Benefit Programs continue to present the direct reimbursement concept to both the public and the business community.

#### **Programs in Conflict with ADA Policies (*Trans.1979:638*)**

**Resolved**, that the Association does not advocate programs that are in conflict with ADA policies.

#### **Limitations in Benefits by Dental Insurance Companies (*Trans.1997:680*)**

**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 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 preexisting 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.

**Guidelines on the Use of Images in Dental Benefit Programs (*Trans.*1995:617; 2007:419)**

**Resolved**, that the following Guidelines on the Use of Images in Dental Benefit Programs be adopted as policy of the Association:

**Guidelines on the Use of Images in Dental Benefit Programs**

The American Dental Association's recommendations on selection criteria for images states that diagnostic imaging should be used only after clinical evaluation, review of the patient's history, and consideration of the dental and general health needs of the patient. The type, frequency and extent of diagnostic images necessary for each individual patient will be provided in accordance with the dentist's professional judgment. Federal and state laws regarding patient privacy are subject to change and may supersede these guidelines.

The Association believes that the following guidelines should be applied in the use of images in dental care plans:

1. Images should be generated only for clinical reasons as determined by the patient's dentist. Clinical images may be used as part of a system for determining those benefits to which the patient is entitled under the terms of a contract. Third-party payers should not request that images be generated solely for administrative purposes. If a third party requests an image which was not generated as part of the dentist's clinical treatment, dentists should consider the clinical necessity of the image in connection with the request.

2. When a dentist determines that it is appropriate to comply with a third-party payer's request for images, it is recommended that a duplicate set be submitted and the originals retained by the dentist. All images, including duplicates, except those submitted in digital or other electronic form, and whether or not it has been requested, should be returned to the dentist.

3. There are many instances in which a determination of care cannot be made solely on the basis of images and it is improper for third-party payers to deny authorization for payment or make determinations about treatment based solely on images.

4. Third-party payers should not use images to infringe upon the professional judgment of the treating dentist or to interfere in any way with the dentist-patient relationship. All questions of interpretation of images must be reviewed by a dentist consultant.

5. Clinical images should only be requested when they will be reviewed by a dentist to make a determination regarding the patient's entitlement to benefits. Dentists reviewing images for this purpose should be licensed in the U.S., preferably within the jurisdiction of the dentist providing the images in accordance with applicable state law.

6. Patients should be exposed to radiation only when clinically necessary, as determined by the treating dentist. Postoperative images should be required only as part of dental treatment.

7. It is important that images be correctly identified and be of diagnostic quality.

8. Third-party payers, except those in digital or other electronic form, should protect the confidentiality of all records, including images, which are submitted to them by dental offices. All images submitted to third-party payers should be returned to the treating dentist within fifteen (15) working days. Images received in an electronic form should be permanently deleted within 30 days of the completion of claims adjudication.

9. Images held by parties other than the treating dentist should not be transmitted to any agency or entity without written consent of the dentist or patient.

10. Where a claim or predetermination request indicates that images are provided, the third-party payer should immediately notify the submitting dentist's office if the images are missing.

11. A patient's predetermination request or claim should not be prejudiced by the third-party payer's loss or misplacement of images.

12. Images are an integral part of the dentist's clinical records and, as such, should be considered the property of the dentist where consistent with state law. Because it is necessary for a dentist to maintain accurate and complete records, third-party payers should accept copies of images in lieu of originals.

13. Any additional costs incurred by the dentist in copying images and clinical records for claims determination should be reimbursed by the third-party payer or the patient. and be it further

**Resolved**, that the Guidelines on the Use of Radiographs in Dental Care Programs (*Trans.1990:540*) be rescinded.

#### **Eligibility and Payment Dates for Endodontic Treatment (*Trans.1994:674*)**

**Resolved**, that the American Dental Association, through its Council on Dental Benefit Programs, encourages all third-party payers to recognize the date that endodontic therapy is begun as the eligibility date for coverage for endodontic therapy, and be it further

**Resolved**, that the Association, through its Council on Dental Benefit Programs, encourages all third-party payers to recognize the completion date as the date of service, that is, the payment date, for endodontic therapy.

#### **Extending Dental Plan Coverage to Dependents of Beneficiaries (*Trans.1993:694*)**

**Resolved**, that dental plan purchasers be encouraged to extend coverage to the dependents of beneficiaries, and be it further

**Resolved**, that the term "dependent" include spouse, children, and other members of the household who are financially dependent on the beneficiary as defined by the Internal Revenue Service (IRS).

#### **Plan Coverage for Treatment of Teeth Needing Restoration Due to Attrition, Wear and Abrasion (*Trans.1993:693*)**

**Resolved**, that dental benefit plans should provide coverage for restoration of teeth that have structural loss due to attrition, abrasion and/or erosion.

#### **Appropriate Use of Dental Benefits by Patients and Third-Party Payers (*Trans.1993:688*)**

**Resolved**, that the American Dental Association supports the appropriate use of dental benefits by patients and third-party payers, and be it further

**Resolved**, that in order for patients to receive the benefits to which they are entitled, the ADA opposes the practice by third-party payers of reclassifying treatment in such a way as to reduce or limit the patient's rightful dental benefit coverage.

**Preauthorization Of Benefits (*Trans.1992:597*)**

**Resolved**, that the American Dental Association is opposed to any dental benefit clause that would deny or reduce payment to the beneficiary, to which he or she is normally entitled, solely on the basis of lack of preauthorization, and be it further

**Resolved**, that Resolution 14H-1990 (*Trans.1990:539*), Preauthorization Requirements, be rescinded.

**Qualifications of Participating Dentists (*Trans.1991:639*)**

**Resolved**, that the American Dental Association supports the position that all dentists licensed in their state shall be eligible to participate in all public and private third-party programs, and be it further

**Resolved**, that Resolutions 38-1966-H (*Trans.1966:347*), Qualifications of Participating Dentists, as amended by Resolution 120H-1976 (*Trans.1976:865*), be rescinded.

**Least Expensive Alternative Treatment Clauses (*Trans.1991:634*)**

**Resolved**, that the use of a clause in a dental plan which restricts benefits to those for the least expensive alternative treatment as defined by the third-party payer can be misleading to the plan purchaser and the dental patient, and be it further

**Resolved**, that plans which contain this clause should make the limitations of this clause understood to the plan purchaser and the dental patient, and be it further

**Resolved**, that to best educate the public as to the application of this clause when it is applied to limit benefit coverage, the plan should inform the plan purchaser of that application and should provide the patient and treating dentist with the name and qualifications of the individual making the determination, along with the basis for determination that another treatment is in the best interests of the patient and appropriate for the patient's condition, and be it further

**Resolved**, that the ADA Council on Dental Benefit Programs be directed to inform consumer groups of the potential problems involved in accepting a contract that will pay only for the least expensive alternative treatment as determined by the third-party payer, and be it further

**Resolved**, that Resolution 58-1972-H (*Trans.1972:676*), Least Expensive Adequate Treatment (LEAT) Clause, be rescinded.

**Pre-Existing Condition Exclusion (*Trans.1991:634*)**

**Resolved**, that the American Dental Association, along with its constituent and component societies, urge inclusion of coverage in all dental benefits plans for preexisting conditions which would otherwise be covered, including replacement of missing teeth, and to provide coverage for the continuation of treatment plans already in progress when the patient first becomes enrolled in the plan.

**Audits of Private Dental Offices by Third-Party Payers (*Trans.1990:540; 2005:325*)**

**Resolved**, that where the dentist is under no direct contractual obligation with a third-party payer, the decision to comply with requests for in-office audits should be made independently by the individual dentist after consulting with his or her attorney for a determination of the legal implications of such decision, and be it further

**Resolved**, that in those instances where the dentist has expressly agreed in a contract to comply with office audit procedures, and in the event of an audit, the dentist is encouraged to obtain a written description and scope of the audit procedures and should seek the advice of his or her legal counsel, in order to be informed of his or her rights and potential liabilities regarding such audit, and be it further

**Resolved**, that dentists should consider their potential legal liability under applicable state and federal privacy laws in consultation with their attorneys when negotiating contracts that oblige them to allow third-party payer audits of the practices.

#### **Coverage for Treatment of Temporomandibular Joint Dysfunction (*Trans.1989:549*)**

**Resolved**, that the American Dental Association encourage all third-party payers to offer benefit coverage for diagnosis and treatment of bone and joint disorders without discrimination, and be it further  
**Resolved**, that the ADA strongly recommends that all third-party payers coordinate the coverage between medical and dental plans to eliminate any disparity in benefits coverage and reimbursement for such disorders, and be it further

**Resolved**, that the ADA strongly encourages constituent dental societies to seek legislation and/or a ruling from the state insurance commissioner that health benefit plans offer coverage for diagnosis and treatment for bone or joint disorders without discrimination, and be it further

**Resolved**, that Resolutions 111H-1981 (*Trans.1981:583*) and 27H-1982 (*Trans.1982:526*) be rescinded.

#### **Payment for Prosthodontic Treatment (*Trans.1989:547*)**

**Resolved**, that the Council on Dental Benefit Programs encourages all third-party payers to recognize the preparation date as the date of service, that is, payment date, for fixed prosthodontic treatment, and be it further

**Resolved**, that the Council on Dental Benefit Programs encourages all third-party payers to recognize the final impression date as the date of service, that is, payment date, for removable prosthodontic treatment, and be it further

**Resolved**, that Resolution 46H-1981 (*Trans.1981:579*) be rescinded.

#### **Benefits for Services by Qualified Practitioners (*Trans.1989:546*)**

**Resolved**, that beneficiaries of a health benefits plan are entitled to benefits for covered treatment if that treatment is provided by a legally qualified dentist or physician operating within the scope of his or her training and licensure, and be it further

**Resolved**, that benefits that would otherwise be payable should not be denied solely on the basis of the professional degree and licensure of the dentist or physician providing treatment, if that treatment is provided by a legally qualified dentist or physician operating within the scope of his or her training and licensure, and be it further

**Resolved**, that in those states that do not have such a law, constituent dental societies be urged to seek legislation that would prohibit discrimination in benefit payments based on the professional degree and licensure of the dentist or physician providing treatment, and be it further

**Resolved**, that all constituent dental societies be encouraged to monitor the way in which these laws are enforced in their states, and to bring to the attention of the state legislatures and the public any efforts that are clearly too inadequate to succeed, and be it further

**Resolved**, that Resolution 45-1957-H (*Trans.1957:390*), Resolution 44-1957-H (*Trans.1957:390*) and Resolution 19-1974-H (*Trans.1974:635*) be rescinded.

#### **Equitable Dental Benefits for Relatives of Dentists (*Trans.1987:502*)**

**Resolved**, that group benefit plan contracts should not contain exclusions for reimbursement for treatment based on the familial relationship of the treating dentist and the beneficiary, and be it further

**Resolved**, that such existing exclusions be deleted from all dental benefit plan contracts as they are renewed, and be it further

**Resolved**, that carriers, service corporations, other third-party payers and state insurance regulatory agencies be informed of this policy.

### Identification Of Claims Reviewer (*Trans.1985:584*)

**Resolved**, that in all correspondence between a third-party carrier and a dentist regarding a patient or a claim, the carrier should provide the name of a specific individual with whom to make contact in reference to that claim, and be it further

**Resolved**, that the patient's full name, the claim number and a toll-free telephone number should also be provided.

### Frequency of Benefits (*Trans.1983:548*)

**Resolved**, that the Council on Dental Benefit Programs continue to recommend to insurance firms, service plans, prospective purchasers and policyholders that, where considered necessary and appropriate, contract limitations on frequency of providing benefits for certain services be stated as "twice in a calendar (or contract) year" rather than "once in every six months."

### Maximum Fees for Non-Covered Services (*Trans.2010:616*)

**Resolved**, that, as a matter of policy, the American Dental Association opposes any third party contract provisions that establish fee limits for non-scheduled dental services, and be it further

**Resolved**, that the American Dental Association continue to actively pursue passage of federal legislation to prohibit ERISA covered plans from applying such provisions, and be it further

**Resolved**, that the American Dental Association encourage constituent dental societies to work for the passage of state legislation to prohibit insurance plans from applying such provisions.

### Statement on Reporting Fees on Dental Claims (*Trans.2009:419*)

**Resolved**, that the following Statement on Reporting Fees on Dental Claims be adopted.

#### Statement on Reporting Fees on Dental Claims

1. A full fee is the fee for a service that is set by the dentist, which reflects the costs of providing the procedure and the value of the dentist's professional judgment.

2. A contractual relationship does not change the dentist's full fee.

3. It is always appropriate to report the full fee for each service reported to a third-party payer.

### Statement on Determination of Maximum Plan Benefit (Formerly "Customary Fees") by Third Parties (*Trans.1991:633; 2010:545; 2011:453*)

**Resolved**, that the Statement on Determination of Customary Fees by Third Parties (*Trans.1991:633; 2010:545; 2011:453*) be amended by deleting the word "customary" (except in the title of the Statement where the word "formerly" was added to facilitate search capabilities; and the word "Fees" was placed inside the parentheses) and adding the words "Maximum Plan Benefit"; and removing the word "Fee" in the fifth and sixth bullet points (additions are shown by double underscoring; deletions are shown by double 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  
(Formerly "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 Screens
- Require carriers to use sufficient data when determining Maximum Plan Benefit 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

**State No Fault and Workers' Compensation Programs (*Trans.2008:460*)**

**Resolved**, that the American Dental Association, together with its constituent and component societies, urge state no fault and workers' compensation programs to include dental coverage for workplace and motor vehicle injuries, and be it further

**Resolved**, that the ADA supports application of the following principles in legislation governing no-fault and workers' compensation programs:

1. that the objective of such programs should be to restore to health those patients requiring treatment as the result of a workplace or motor vehicle injuries

2. that such programs should allow patients the freedom to choose their own dentist

3. that coverage for treatment include or take into account the need for present and future treatment needed as result of workplace or motor vehicle injuries

4. that treatment of pre-existing medical or dental conditions should be covered when the injury exacerbated the condition, or treatment of the condition is necessary as part of the final therapy to restore the patient's oral and maxillofacial health

5. that such programs should accept and use the ADA *Code on Dental Procedures and Nomenclature* and the ADA Dental Claim Form when processing dental claims for workplace and motor vehicle injuries

6. that the timeframes for reimbursement or payment on claims for dental treatment resulting from workplace and motor vehicle injuries be in accordance with the state prompt payment laws where applicable

7. that the patient should bear no financial loss for treatment costs as a result of receiving treatment resulting from workplace or motor vehicle injuries

1 8. that the dentist should be compensated for care rendered in accordance with the dentist's  
2 treatment plan and existing fee schedule

3 9. that such programs should make available an appeals process to patients and dentists for  
4 benefits determinations made on claims resulting from workplace or motor vehicle injuries

5 **Coordination of Benefits Reform (*Trans.2008:496*)**

6 **Resolved**, that the American Dental Association work with government agencies and dental carriers to  
7 enact coordination of benefit laws requiring that when a premium is paid and a claim submitted, that each  
8 benefit plan will pay the same amount they would allow if no other coverage was applicable up to 100% of  
9 the total claim, and be it further

10 **Resolved**, that the ADA encourage states to enact similar laws, and be it further

11 **Resolved**, that the ADA use its staff and resources to assist states in this process.

12 **Dental Claims Processing (*Trans.1999:930*)**

13 **Resolved**, that the American Dental Association seek or support legislation, and/or a directive through  
14 agency rules and/or regulations, that requires the purchaser of a dental benefit program to also provide a  
15 means, other than dental offices, through which the recipient of the benefit can process a claim.

16 **Third-Party Payers Overpayment Recovery Practices (*Trans.1999:930*)**

17 **Resolved**, that the American Dental Association seek or support legislation opposing all inappropriate  
18 third-party payer overpayment recovery practices, and be it further

19 **Resolved**, that the American Dental Association encourage state dental societies to seek or support  
20 legislation to prevent third-party payers from withholding fully assigned benefits to a dentist when an  
21 incorrect payment has been made to the dentist on behalf of a previous patient with the same third-party  
22 payer.

23 **ERISA Reform (*Trans.1998:738*)**

24 **Resolved**, that the ADA seek federal legislation and/or regulation that would prohibit ERISA and all  
25 health benefit plans from excluding coverage of general anesthesia and/or hospital or outpatient surgical  
26 facility charges incurred by covered persons who receive dental treatment under anesthesia, due to a  
27 documented physical, mental or medical reason as determined by the treating dentist(s) and/or physician.

28 **Legislative Recognition of the Patient's Right to Assign Payment (*Trans.1997:708*)**

29 **Resolved**, that the American Dental Association seek, and constituent societies be urged to seek,  
30 appropriate relief through legislation and/or administrative process to require third-party payers to  
31 recognize the right of patients to authorize payment directly to the dentist, without changing and without  
32 regard to the participation status of the dentist.

33 **Prohibition of Contract Provisions Permitting the Automatic Assignment of Participating Dentist**  
34 **Agreements Among Entities Engaged in the Business of Insurance (*Trans.1995:648*)**

35 **Resolved**, that the appropriate Association agencies initiate legislative and/or regulatory actions to  
36 prohibit PPO brokers and third-party payers in contractual relationships with dentists from selling and/or

1 using the discount rate information about those dentists to any other third-party payers and/or extended  
2 managed care networks, and be it further  
3 **Resolved**, that the Association encourage state dental societies to initiate legislative and/or regulatory  
4 action to prohibit these practices on a state level.

#### 5 **Update on Dental Tourism (*Trans.2008:454*)**

6 **Resolved**, that the following definition of dental tourism be adopted:

7 Dental tourism is the act of traveling to another country for the purpose of obtaining dental treatment.

8 and be it further

9 **Resolved**, that the appropriate agencies of the ADA continue to promote the importance of a dental  
10 home while working for increased affordable access to dental care and freedom of choice so that every  
11 American who needs dental care can receive it, and be it further

12 **Resolved**, that the appropriate agencies of the ADA establish a repository of information relevant to  
13 dental tourism, that the information be collected in a manner that protects patient confidentiality and that  
14 the information is used in a lawful manner, and be it further

15 **Resolved**, that the appropriate agencies of the ADA increase efforts to provide patients, insurance  
16 companies and plan purchasers with credible information and resources about quality dental care,  
17 including follow-up, delivered by professionals with accredited education, and be it further

18 **Resolved**, that in keeping with the ADA position on freedom of choice, patients seeking dental care  
19 outside of the U.S. should do so voluntarily, and that prior to travel, be urged to arrange for local follow-up  
20 care to ensure continuity of care upon return to the U.S., and be it further

21 **Resolved**, that patients who have insurance coverage for dental care performed outside the U.S. should  
22 confirm with their insurer and/or employer that follow-up treatment is covered upon return to the U.S., and  
23 be it further

24 **Resolved**, that patients choosing to travel outside the U.S. for dental care should seek information about  
25 the potential risks of combining certain procedures with long flights and vacation activities, and be it  
26 further

27 **Resolved**, that the transfer of patient records to-and from facilities outside the U.S. should be consistent  
28 with current U.S. privacy and security guidelines.

#### 29 **Responsibility for the Oral Health of Patients (*Trans.2004:334*)**

30 **Resolved**, that a dentist must have the primary responsibility for the oral health care of each patient,  
31 regardless of the provision of some preventive or education services by non-dentists.

#### 32 **Community Rating, Risk Pools and Portability for Health Benefit Coverage Plans (*Trans.1995:648*)**

33 **Resolved**, that the Association endorses appropriate legislative initiatives establishing the concept of  
34 community rating for health benefit coverage plans, and be it further

35 **Resolved**, that the Association endorses appropriate legislative initiatives establishing the concept of risk  
36 pools for small employers and individuals to facilitate the purchase of health benefit coverage plans, and  
37 be it further

38 **Resolved**, that the Association endorses appropriate legislative initiatives intended to facilitate the  
39 portability of health benefit coverage plans.

#### 40 **Statement on Dental Consultants (*Trans.2010:555*)**

41 **Resolved**, that the following Statement on Dental Consultants be adopted.

**Statement on Dental Consultants**

Third-party payers and plan purchasers have used dental consultants in order to streamline the claims review process for many years.

The American Dental Association initially saw a positive potential in the use of dental consultants by third-party payers as a means of receiving professional advice on certain aspects of dental benefits plans. While the ADA still believes that there is value to third-party payers' use of dental consultants, it also believes that some clear distinctions must be made between dental consultants and dental claims reviewers.

Dental claims reviewers work under supervision. They do not necessarily have, or need, clinical dental or dental practice background, and are trained specifically by the third-party payer to review dental claims that are uncomplicated and require straightforward processing.

Dental consultants are licensed dentists who, even if not currently practicing, have many years of experience in practice and can and should:

- Offer a professional opinion regarding complicated dental treatment
- Provide their name, degree, license number and direct phone number to the treating dental office
- Request consultations from specialists for certain specialty-related cases, when necessary
- Provide advice to third-party payers regarding the merit and value of dental benefits plan designs
- Educate plan purchasers regarding the impact alternative, less costly treatment may have on the life of a tooth, overall oral health, etc.
- Alert third-party payers when dentists' treatment patterns are changed by cost containment strategies to the detriment of the patients
- Provide guidance to third-party payers regarding the importance of the dentist/patient relationship
- Inform third-party payers, plan sponsors and subscribers about the availability and value of the profession's peer review system
- Initiate dialogue with organized dentistry regarding questionable treatment modalities
- Inform the dental profession of those treatment procedures on which questions of judgment between the dentist and the dental consultant are most likely to result in areas of disagreement
- Discuss treatment decisions with dentists on a professional level
- Explain clearly to practicing dentists the provisions of particular contracts and the benefit limitations of those contracts
- Demonstrate knowledge of contract interpretation, and laws and regulations governing dental practice in those jurisdictions affected by their consulting activities, as well as accepted standards of administrative procedure within the dental benefits industry
- Dentists reviewing claims submissions must be licensed in the United States, preferably within the jurisdiction of the dentist treating the patient in accordance with applicable state law

Dentists have a fundamental obligation to serve the best interests of the public and their profession. This obligation can never be abrogated for any reason. In order to maintain independent thought and judgment regarding dental matters, dental consultants should be competent with regard to current clinical procedures and practice through such mechanisms as continuing education, or have been in practice for a minimum of ten years immediately preceding employment as a dental consultant, and remain involved in the continuing dental education process in order to stay current with clinical procedures and changing technology.

1 It is strongly recommended that dental consultants be members of the American Dental Association.

2 and be it further

3 **Resolved**, that the American Dental Association distribute copies of this Statement to all third-party  
4 payers, and be it further

5 **Resolved**, that third-party payers, including dental consultants to payers, should not exceed their  
6 legitimate role in the processing of dental benefit claims, and specifically, third-party payers and dental  
7 consultants should not:

- 8
- 9 • Change code numbers as submitted without written permission of the attending dentist
  - 10 • Redefine code numbers, nomenclatures or descriptors except as provided for in their CDT license
  - 11 agreements
  - 12 • Disapprove complex cases without seeking the advice of appropriately trained consultants
- 13

14 and be it further

15 **Resolved**, that the ADA urge third-party payers and administrators to identify dental consultants by name  
16 in any correspondence to attending dentists, and be it further

17 **Resolved**, that the policies on Disclosure of Dentist Consultants Upon Request (*Trans.*1984:531;  
18 1985:583), Statement on Dental Consultants (*Trans.*1989:542) and Identifying Dental Consultants  
19 (*Trans.*2002:412) be rescinded.

Resolution No. 2 NewReport: N/A Date Submitted: July 2012Submitted 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 \_\_\_\_\_ FTE 0ADA Strategic Plan Goal: Members (Required)1 **AMENDMENT OF THE POLICY, DENTAL BENEFIT PLAN TERMINOLOGY**2 **Background:** (*Reports:42*)

3 **Recommendations—Policies to be Amended:** The CDBP believes that the policy “Dental Benefit Plan  
4 Terminology” should be amended to better reflect that definitions will be supported in the glossary on ADA.org  
5 and not in the *CDT Manual* or as part of Association policy.

6 **Resolution**

7 **2. Resolved**, that the ADA policy on “Dental Benefit Plan Terminology” (*Trans.1991:634*) be  
8 amended as follows (additions are underscored; deletions are ~~stricken~~):

9 **Resolved**, that all parties involved with dental benefits be encouraged to use dental benefit  
10 plan terminology consistent with definitions included in ~~Association policy and the current~~  
11 edition of the ~~publication entitled *Current Dental Terminology (CDT)*~~; Glossary of Dental  
12 Clinical and Administrative Terms on ADA.org, and be it further

13 **Resolved**, that the American Dental Association support continued development and use of  
14 consistent and accurate terms relating to dental benefits.  
15

16 **BOARD RECOMMENDATION: Vote Yes.**

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

19 Resolution 02

Resolution No. 3 NewReport: N/A Date Submitted: July 2012Submitted 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 \_\_\_\_\_ FTE 0ADA Strategic Plan Goal: Members (Required)**RESCISSION OF THE POLICY, PARTICIPATION IN PUBLIC AGENCY SPONSORED PROGRAMS INVOLVING DENTAL HEALTH BENEFITS****Background:** (*Reports:42*)

**Recommendations—Policies to be Rescinded:** The CDBP reviewed the policy “Participation in Public Agency Sponsored Programs Involving Dental Health Benefits” and recommends rescission because constituent and component societies actively participate in the planning and preparation of these programs and there is no need to keep this as policy.

**Resolution**

**3. Resolved,** that Resolution 113H-1995, “Participation in Public Agency Sponsored Programs Involving Dental Health Benefits” (*Trans.1995:648*), be rescinded.

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

1 WORKSHEET ADDENDUM  
2 COUNCIL ON DENTAL BENEFIT PROGRAMS  
3 POLICY TO BE RESCINDED

4 **Participation in Public Agency Sponsored Programs Involving Dental Health Benefits (*Trans.*1995:648)**

5 **Resolved**, that the American Dental Association urges constituent and component societies to participate  
6 actively in planning and preparation of all programs involving dental health benefits which may be  
7 sponsored by public agencies at any level, and be it further  
8 **Resolved**, that Resolution 33H-1966 (*Trans.*1966:336), Dental Society Participation in Program  
9 Planning, be rescinded.

Resolution No. 4 NewReport: N/A Date Submitted: July 2012Submitted 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 \_\_\_\_\_ FTE 0ADA Strategic Plan Goal: Members (Required)**1 RESCISSION OF THE POLICY, SUPPORT FOR INDIVIDUAL PRACTICE ASSOCIATIONS (IPAs)****2 Background:** (*Reports:43*)

**3 Recommendations—Policies to be Rescinded:** The CDBP reviewed the policy “Support for Individual  
**4 Practice Associations (IPAs)”** and recommends rescission because of the lack of interest and requests for  
**5 information from dentists regarding dental individual practice associations.**

**6 Resolution**

**7 4. Resolved,** that Resolution 38H-1988 and Resolution 2H-1994, “Support for Individual Practice  
**8 Associations (IPAs)”** (*Trans.1988:475; 1994:655*), be rescinded.

**9 BOARD RECOMMENDATION: Vote Yes.****10 BOARD VOTE: UNANIMOUS.****11**

Resolution 04

1 WORKSHEET ADDENDUM  
2  
3 COUNCIL ON DENTAL BENEFIT PROGRAMS  
4  
5 POLICY TO BE RESCINDED

6 **Support for Individual Practice Associations (IPAs) (*Trans.*1988:475; 1994:655)**

7 **Resolved**, that the American Dental Association provide information to members and plan  
8 purchasers about dental individual practice associations (IPAs) that are established and/or directed  
9 by organized dentistry and that conform to Association policy, and be it further

10 **Resolved**, that discussion of IPAs be included in the Purchaser Information Service Program.

Resolution No. 5 New

Report: N/A Date Submitted: July 2012

Submitted By: Council on Dental Benefit Programs

Reference Committee: Dental Benefits, Practice and Health

Total Net Financial Implication: None Net Dues Impact:

Amount One-time	Amount On-going	FTE	0
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ADA Strategic Plan Goal:      Members      (Required)

1       **RESCISSION OF THE POLICY, REPRESENTATION OF PARTICIPATING DENTISTS IN DENTAL**  
2       **SERVICE CORPORATIONS**

### 3 Background: (*Reports:43*)

4 **Recommendations—Policies to be Rescinded:** The CDBP reviewed the policy “Representation of  
5 Participating Dentists in Dental Service Corporations” and recommends rescission because the policy is  
6 outdated and no longer relevant today.

## 7 Resolution

8 **5. Resolved**, that Resolution 51H-1978, "Representation of Participating Dentists in Dental Service  
9 Corporations" (*Trans.*1978:511), be rescinded.

**10 BOARD RECOMMENDATION: Vote Yes.**

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

1 WORKSHEET ADDENDUM

2 COUNCIL ON DENTAL BENEFIT PROGRAMS

3 POLICY TO BE RESCINDED

4 **Representation of Participating Dentists in Dental Service Corporations (*Trans.1978:511*)**

5 **Resolved**, that the American Dental Association urges all dentists who are participating in dental service  
6 plans to take an active role in the organizational, administrative and professional affairs of their respective  
7 plans.

8

Resolution No. 6 NewReport: N/A Date Submitted: July 2012Submitted 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 \_\_\_\_\_ FTE 0ADA Strategic Plan Goal: Members (Required)**1 RESCISSION OF POLICY, DIRECT REIMBURSEMENT MECHANISM****2 Background:** (*Reports:43*)

**3 Recommendations—Policies to be Rescinded:** The CDBP reviewed the policy “Direct Reimbursement  
**4 Mechanism”** and recommends rescission because direct reimbursement has already achieved its goal of  
**5 being a recognized dental benefits program by plan purchasers and brokers.**

**6 Resolution**

**7 6. Resolved,** that Resolution 50H-1978, “Direct Reimbursement Mechanism” (*Trans.1978:510*), be  
**8 rescinded.**

**9 BOARD RECOMMENDATION: Vote Yes.**

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

**12** Resolution 06

1 WORKSHEET ADDENDUM  
2 COUNCIL ON DENTAL BENEFIT PROGRAMS  
3 POLICY TO BE RESCINDED

4 **Direct Reimbursement Mechanism (*Trans.1978:510*)**

**Resolved**, that the Direct Reimbursement mechanism, a method of assistance in which beneficiaries are reimbursed by the employer or benefits administrator for any dental expenses, or a specified percentage thereof, upon presentation of a paid receipt or other evidence that such expenses were incurred, is a recognized dental benefits approach available to purchasers of dental assistance plans.

Resolution No. 7 NewReport: N/A Date Submitted: July 2012Submitted 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 \_\_\_\_\_ FTE 0ADA Strategic Plan Goal: Members (Required)**1 RESCISSION OF THE POLICY, PRINCIPLES FOR BUDGET PAYMENT PLANS FOR DENTAL CARE****2 Background:** (*Reports:43*)

**3 Recommendations—Policies to be Rescinded:** The CDBP reviewed the policy “Principles for Budget  
4 Payment Plans for Dental Care” and recommends rescission because the policy is outdated and no longer  
5 relevant today.

**6 Resolution**

**7 7. Resolved,** that Resolution 41-1957-H, “Principles for Budget Payment Plans for Dental Care”  
8 (*Trans.1957:93, 389*), be rescinded.

**9 BOARD RECOMMENDATION: Vote Yes.**

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

12

Resolution 07

## 1 WORKSHEET ADDENDUM

## 2 COUNCIL ON DENTAL BENEFIT PROGRAMS

## 3 POLICY TO BE RESCINDED

4 **Principles for Budget Payment Plans for Dental Care (*Trans.1957:93, 389*)**

5 1. The most desirable method of making a budget payment plan available to all of the people in a state is  
6 through a plan operated on a state-wide basis. It is desirable, therefore, that budget payment plans be  
7 developed by the state society or that plans which are developed at the component level be expanded or  
8 associated in order to provide state-wide coverage as rapidly as possible.

9 2. The plan should be administered by the sponsoring dental society in accordance with regulations  
10 established by the society through the agency to which it has assigned responsibility for operating the  
11 plan.

12 3. The disposition of complaints arising from the financial operation of the plan should be the  
13 responsibility of the plan's governing body.

14 4. The disposition of complaints arising from the dentist-patient relationship should be the responsibility of  
15 the dental society's mediation or counseling committee which normally handles all such complaints. The  
16 availability of mediation or counseling service is essential to the successful operation of a budget  
17 payment plan.

18 5. The plan should include a continuing program of education for the membership in order to effect  
19 maximum utilization and to avoid the unnecessary burden of improper use.

20 6. The policies governing the management of the loss reserve of the plan should have the approval of a  
21 majority of the participating dentists and should be developed and adopted only with the advice and  
22 assistance of competent legal and tax counsel.

23 7. The plan should make provision for semiannual audits and such additional statistical evaluations as  
24 may be necessary to determine appropriate adjustments or alterations of the plan in the interest of the  
25 public, the dentists and the bank.

26 8. The promotion of the plan to the public should be in keeping with the *Principles of Ethics* of the  
27 American Dental Association and the codes of ethics of the sponsoring constituent and component dental  
28 societies. The promotional information should follow the highest standards of dental health educational  
29 concepts.

30 9. All members of the sponsoring society should be eligible to participate in the plan within the agreed  
31 limitations of the plan.

32 10. The maximum success of the plan depends on maximum participation by the membership of the  
33 sponsoring society.

Resolution No. 8 NewReport: N/A Date Submitted: July 2012Submitted 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 \_\_\_\_\_ FTE 0ADA Strategic Plan Goal: Members (Required)**RESCISSION OF THE POLICY, REQUEST FOR INSURANCE COMPANIES TO RETAIN DENTISTS' SOCIAL SECURITY NUMBERS****Background:** (*Reports:43*)**Recommendations—Policies to be Rescinded:** The CDBP reviewed the policy "Request for Insurance Companies to Retain Dentists' Social Security Numbers" and recommends rescission because the Council is opposed to insurance companies requesting the Social Security number from a dentist as there are other provider identifier numbers in use now.**Resolution****8. Resolved,** that Resolution 98H-2001, "Request for Insurance Companies to Retain Dentists' Social Security Numbers" (*Trans.2001:428*), be rescinded.**BOARD RECOMMENDATION: Vote Yes.****BOARD VOTE: UNANIMOUS. (BOARD OF TRUSTEES CONSENT CALENDAR ACTION—NO BOARD DISCUSSION)**

1 WORKSHEET ADDENDUM

2 COUNCIL ON DENTAL BENEFIT PROGRAMS

3 POLICY TO BE RESCINDED

4 **Request for Insurance Companies to Retain Dentists' Social Security Numbers (*Trans.2001:428*)**

5 **Resolved**, that the ADA, through the appropriate agency, urge insurance companies to keep on file the  
6 Social Security numbers of those dentists who accept assignment of benefits, and cease requesting them  
7 on claim forms or walkout statements.

Resolution No. 9 NewReport: N/A Date Submitted: July 2012Submitted 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 \_\_\_\_\_ FTE 0ADA Strategic Plan Goal: Members (Required)**1 RESCISSION OF THE POLICY, FREEDOM OF CHOICE OF DENTISTS****2 Background:** (*Reports:43*)

**3 Recommendations—Policies to be Rescinded:** The CDBP reviewed the policy “Freedom of Choice of  
**4 Dentists” and recommends rescission because this is not policy. It is a directive that should have been carried**  
**5 out in the early 1980s.**

**6 Resolution**

**7 9. Resolved,** that Resolution 51H-1983, “Freedom of Choice of Dentists” (*Trans.1983:582*), be rescinded.

**8 BOARD RECOMMENDATION: Vote Yes.**

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

1 WORKSHEET ADDENDUM  
2 COUNCIL ON DENTAL BENEFIT PROGRAMS  
3 POLICY TO BE RESCINDED

4 **Freedom of Choice of Dentists (*Trans.1983:582*)**

5 **Resolved**, that constituent dental societies be urged to support enactment of legislation that would allow  
6 any dentist the right to participate as a contracting provider for a dental prepayment plan, provided the  
7 dentist is licensed to furnish the dental care services offered by said plan.

Resolution No. 10 NewReport: N/A Date Submitted: July 2012Submitted 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  FTE 0ADA Strategic Plan Goal: Members (Required)**1 RESCISSION OF THE POLICY, MATHEMATICAL ANALYSIS OF HEALTH CARE RELATED DATA****2 Background:** (*Reports:43*)

**3 Recommendations—Policies to be Rescinded:** The CDBP reviewed the policy “Mathematical Analysis of  
**4 Health Care Related Data”** and recommends it be rescinded because the policy is outdated and no longer  
**5 relevant today with the advent of evidence-based dentistry.**

**6 Resolution**

**7 10. Resolved,** that Resolution 119H-1999, “Mathematical Analysis of Health Care Related Data”  
**8 (*Trans.1999:922*), be rescinded.**

**9 BOARD RECOMMENDATION: Vote Yes.**

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

1 WORKSHEET ADDENDUM  
2 COUNCIL ON DENTAL BENEFIT PROGRAMS  
3 POLICY TO BE RESCINDED

4 **Mathematical Analysis of Health Care Related Data (*Trans.1999:922*)**

5 **Resolved**, that the American Dental Association supports the concept for documentation of methods,  
6 data and supporting analysis that may be performed on health care related data, and which may affect  
7 the delivery or practice of health care, and be it further  
8 **Resolved**, that such analysis must be made public and reviewed by interested parties to ensure the  
9 quality, integrity and validity of such analysis methodology.

Resolution No. 11 NewReport: N/A Date Submitted: July 2012Submitted 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 \_\_\_\_\_ FTE 0ADA Strategic Plan Goal: Members (Required)**1 RESCISSION OF THE POLICY, PATIENT AND PROVIDER ADVISORY PANEL****2 Background:** (*Reports:43*)

**3 Recommendations—Policies to be Rescinded:** The CDBP reviewed the policy “Patient and Provider  
**4 Advisory Panel”** and recommends it be rescinded because this is a directive that should have been carried  
**5 out in the early 2000s. To our knowledge, advisory panels made up of covered patients never gained**  
**6 popularity.**

**7 Resolution**

**8 11. Resolved,** that Resolution 64H-1997, “Patient and Provider Advisory Panel” (*Trans.1997:704*) be  
**9 rescinded.**

**10 BOARD RECOMMENDATION: Vote Yes.****11 Board Vote: Resolution 11**

BLANTON	Yes	GOUNARDES	Yes	NORMAN	Yes	SUMMERHAYS	Yes
DOW	Yes	HAGENBRUCH	No	RICH	Yes	VIGNA	Yes
ENGEL	Yes	ISRAELSON	Yes	ROBERTS	Yes	WEBER	Yes
FAIELLA	Yes	KIESLING	Yes	SEAGO	Yes	VERSMAN	No
FEINBERG	Yes	LOW	Yes	STEFFEL	Yes	YONEMOTO	Abstain

WORKSHEET ADDENDUM

COUNCIL ON DENTAL BENEFIT PROGRAMS

POLICY TO BE RESCINDED

**Patient and Provider Advisory Panel (*Trans.1997:704*)**

**Resolved**, that the Association seek, and the constituent societies be urged to seek, legislation or regulation at the federal or state level, respectively, that would require any entity that offers coverage of dental benefits through a network of participating dentists to establish an advisory panel made up of covered patients and an advisory panel made up of participating dentists, and be it further

**Resolved**, that these panels would provide meaningful input to the plan, on an ongoing basis, on its design and policies.

Resolution No. 12 NewReport: N/A Date Submitted: July 2012Submitted 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 \_\_\_\_\_ FTE 0ADA Strategic Plan Goal: Members (Required)**RESCISSION OF THE POLICY, DISPUTES CONCERNING DENTAL TREATMENT PROVIDED UNDER DENTAL BENEFITS PROGRAMS****Background:** (*Reports:44*)**Recommendations—Policies to be Rescinded:** The CDBP reviewed the policy “Disputes Concerning Dental Treatment Provided Under Dental Benefits Programs” and recommends it be rescinded because this has been incorporated into the ADA’s Guidelines for the Peer-Review Process.**Resolution****12. Resolved,** that Resolution 4H-1992, “Disputes Concerning Dental Treatment Provided Under Dental Benefits Programs” (*Trans.1992:600*), be rescinded.**BOARD RECOMMENDATION: Vote Yes.****BOARD VOTE: UNANIMOUS. (BOARD OF TRUSTEES CONSENT CALENDAR ACTION—NO BOARD DISCUSSION)**

WORKSHEET ADDENDUM

COUNCIL ON DENTAL BENEFIT PROGRAMS

POLICY TO BE RESCINDED

**Disputes Concerning Dental Treatment Provided Under Dental Benefits Programs (*Trans.1992:600*)**

**Resolved**, that disputes concerning dental treatment provided under dental benefits programs be referred to the treating dentist's constituent dental society peer review process, and be it further  
**Resolved**, that in those states where peer review is not available, the review should be conducted by the peer review committee based in the third-party payer's and/or the dentist consultant's state of record.

Resolution No. 13 NewReport: N/A Date Submitted: July 2012Submitted 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 \_\_\_\_\_ FTE 0ADA Strategic Plan Goal: Members (Required)

1 **RESCISSION OF THE POLICY, USE OF PEER REVIEW PROCESS BY PATIENTS AND THIRD-PARTY**  
2 **PAYERS**

3 **Background:** (*Reports:44*)

4 **Recommendations—Policies to be Rescinded:** The CDBP reviewed the policy “Use of Peer Review  
5 Process by Patients and Third-Party Payers” and recommends it be rescinded because this has been  
6 incorporated into the ADA’s Guidelines for the Peer-Review Process.

7 **Resolution**

8 **13. Resolved,** that Resolution 4H-1990, “Use of Peer Review Process by Patients and Third-Party  
9 Payers” (*Trans.1990:534*), be rescinded.

10 **BOARD RECOMMENDATION: Vote Yes.**

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

WORKSDHEET ADDENDUM

COUNCIL ON DENTAL BENEFIT PROGRAMS

POLICY TO BE RESCINDED

**Use of Peer Review Process by Patients and Third-Party Payers (*Trans.1990:534*)**

**Resolved**, that patients and third-party payers be encouraged to use the dental profession's peer review process to address issues or disputes concerning dental treatment provided under dental benefits programs, and be it further

**Resolved**, that the Council on Dental Benefit Programs work with third-party payers, plan purchasers, benefits consultants and government agencies to include the following paragraph in the "claim appeals" section of the

Summary Plan Description provided to dental benefits plan subscribers: State and local dental societies provide an impartial means of dispute resolution regarding your dental treatment. This process, called Peer Review, may be available to you in addition to the (*insert name of benefit plan or benefit administrator*) appeal process. For more information about Peer Review, contact your local dental society, and be it further

**Resolved**, that Resolution 79H-1987 (*Trans.1987:502*), Utilization of Peer Review Process, be rescinded.

Resolution No. 14 NewReport: N/A Date Submitted: July 2012Submitted 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  FTE 0ADA Strategic Plan Goal: Members (Required)**RESCISSION OF THE POLICY, REASSIGNMENT OF THE DEVELOPMENT AND MAINTENANCE OF DENTAL PRACTICE PARAMETERS****Background:** (*Reports:44*)**Recommendations—Policies to be Rescinded:** The CDBP reviewed the policy “Reassignment of the Development and Maintenance of Dental Practice Parameters” and recommends it be rescinded because this policy was updated in 2010.**Resolution****14. Resolved,** that Resolution 34H-1999, “Reassignment of the Development and Maintenance of Dental Practice Parameters” (*Trans.1999:932*), be rescinded.**BOARD RECOMMENDATION: Vote Yes.****BOARD VOTE: UNANIMOUS. (BOARD OF TRUSTEES CONSENT CALENDAR ACTION—NO BOARD DISCUSSION)**

WORKSHEET ADDENDUM

COUNCIL ON DENTAL BENEFIT PROGRAMS

POLICY TO BE RESCINDED

**Reassignment of the Development and Maintenance of Dental Practice Parameters (*Trans.*1999:932)**

**Resolved**, that the Dental Practice Parameters Committee be continued as established by Resolution 62H-1993 (*Trans.*1993:697), Board Report 9 to the 1993 House of Delegates (*Supplement* 1993:392) and Board Report 20\* to the 1996 House of Delegates (*Supplement* 1996:502), and be it further

**Resolved**, that the Dental Practice Parameters Committee meet by conference call, or other electronic means, except when significant issues or challenges to the parameters process arise, as determined by the Committee, and be it further

**Resolved**, that in addition to computer software systems, publications and presentations, the parameters documents be made available in the "Members Only" section of ADA ONLINE, and be it further

**Resolved**, that the Dental Practice Parameters Committee develop ways and means to educate the dental community regarding the value of parameters and their use.

\*The Impact and Use of Dental Practice Parameters" as presented in Board Report 20 was amended by the 2003 House of Delegates (*Trans.*2003:361).

Note: The Dental Practice Parameters are available online at <https://www.ada.org/members/1945.aspx>.

Resolution No. 15 NewReport: N/A Date Submitted: July 2012Submitted 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 \_\_\_\_\_ FTE 0ADA Strategic Plan Goal: Members (Required)**RESCISSION OF THE POLICY, MONITORING THE USE AND APPLICATION OF DENTAL PRACTICE PARAMETERS****Background:** (*Reports:44*)**Recommendations—Policies to be Rescinded:** The CDBP reviewed the policy “Monitoring the Use and Application of Dental Practice Parameters” and recommends it be rescinded because it is outdated and no longer relevant today with the advent of evidence-based guidelines/recommendations.**Resolution****15. Resolved,** that Resolution 12H-1993, “Monitoring the Use and Application of Dental Practice Parameters” (*Trans.* 1993:697), be rescinded.**BOARD RECOMMENDATION: Vote Yes.****BOARD VOTE: UNANIMOUS. (BOARD OF TRUSTEES CONSENT CALENDAR ACTION—NO BOARD DISCUSSION)**

WORKSHEET ADDENDUM

COUNCIL ON DENTAL BENEFIT PROGRAMS

POLICY TO BE RESCINDED

**Monitoring the Use and Application of Dental Practice Parameters (*Trans.1993:697*)**

**Resolved**, that the appropriate agencies of the ADA monitor practice guidelines developed by the Agency for Health Care Policy and Research and, as appropriate, seek representation of dentists on review panels selected by AHCPH on conditions involving dental treatment, and be it further

**Resolved**, that the appropriate agencies of the American Dental Association monitor federal and state mandates for, and application of, practice parameters in health care systems, and be it further

**Resolved**, that the Association make every effort to influence federal legislative and/or regulatory activities with regard to dental practice parameters, including the development of model legislation, and be it further

**Resolved**, that constituent societies be encouraged to conduct similar efforts in their states, and be it further

**Resolved**, that when the Association becomes aware of any activity with regard to the development of dental practice parameters in any state, the constituent society will be offered the assistance of the Association to support that constituent society's efforts.

Resolution No. 33 NewReport: N/A Date Submitted: July 2012Submitted By: Council on Dental PracticeReference Committee: Dental Benefits, Practice and HealthTotal Net Financial Implication: None Net Dues Impact: \_\_\_\_\_Amount One-time \_\_\_\_\_ Amount On-going \_\_\_\_\_ FTE 0ADA Strategic Plan Goal: Members (Required)**1 POLICIES TO BE MAINTAINED AS RECOMMENDED BY THE COUNCIL ON DENTAL PRACTICE****2 Background:** (*Reports:139*)**3 Recommendations—Policies to be Maintained:** The Council concluded that the following policies should  
**4** be maintained as written. The full text of each policy is included in Appendix 1.**5 Resolution****6 33. Resolved,** that the following policies be maintained:**7** Definition of Cosmetic Dentistry (*Trans.1976:850*)**8** Definition of Oral Diagnosis (*Trans.1978:499*)**9** Definition of Treatment Plan (*Trans.1978:499*)**10** Definition of Dental Care (*Trans.1996:688*)**11** Primary Dental Care Provider (*Trans.1994:668; 2010:548*)**12** Definition of Denturist and Denturism (*Trans.1976:868; 2001:436*)**13** Amendment of Policy on Opposition to "Denturist Movement" (*Trans.2001:436*)**14** Dental Identification Efforts (*Trans.1985:587*)**15** Statement on the Use of Opioids in the Treatment of Dental Pain (*Trans.2005:327*)**16** Statement on Substance Abuse Among Dentists (*Trans.2005:328*)**17** Statement on Provision of Dental Treatment for Patients With Substance Use Disorders  
**18** (*Trans.2005:329*)**19** Statement on Alcohol and Other Substance Use by Pregnant and Postpartum Patients**20** (*Trans.2005:329*)**21** Statement on Dentist Health and Wellness (*Trans.2005:321*)**22** Statement on Substance Abuse Among Dental Students (*Trans.2005:328*)**23 BOARD RECOMMENDATION: Vote Yes.****24 BOARD VOTE: UNANIMOUS. (BOARD OF TRUSTEES CONSENT CALENDAR ACTION—NO BOARD**  
**25 DISCUSSION)**

## 1 WORKSHEET ADDENDUM

## 2 COUNCIL ON DENTAL PRACTICE

## 3 POLICIES TO BE MAINTAINED

4 **Definition of Cosmetic Dentistry (*Trans.1976:850*)**

5 **Resolved**, that cosmetic dentistry be defined as encompassing those services provided by dentists solely  
6 for the purpose of improving the appearance when form and function are satisfactory and no pathologic  
7 condition exist.

8 **Definition of Oral Diagnosis (*Trans.1978:499*)**

9 **Resolved**, that the following definition of “oral diagnosis” be adopted:

10 The determination by a dentist of the oral health condition of an individual patient achieved through  
11 the evaluation of data gathered by means of history taking, direct examination, patient conference,  
12 and such clinical aids and tests as may be necessary in the judgment of the dentist.

13 **Definition of Treatment Plan (*Trans.1978:499*)**

14 **Resolved**, that the following definition of “treatment plan” be adopted:

15 The treatment plan is the sequential guide for the patient’s care as determined by the dentist’s  
16 diagnosis and is used by the dentist for the restoration to and/or maintenance of optimal oral health.

17 **Definition of Dental Care (*Trans.1996:688*)**

18 **Resolved**, that the following definition of professional dental care be adopted.

19 Professional dental care is the diagnosis, treatment planning and implementation of services directed  
20 at the prevention and treatment of diseases, conditions and dysfunctions relating to the oral cavity  
21 and its associated structures and their impact upon the human body.

22 The implementation of professional dental care, which includes diagnostic, preventive, therapeutic,  
23 restorative, oral and maxillofacial surgical, endodontic, orthodontic, periodontic, prosthodontics and  
24 aesthetic (cosmetic) services shall be provided to dental patients by a legally qualified dentist or  
25 physician operating within the scope of his or her training.

26 **Primary Dental Care Provider (*Trans.1994:668; 2010:548*)**

27  
28 **Resolved**, that the definition of Primary Dental Care Provider (*Trans.1994:668*) be amended to read as follows:

29 *Primary Dental Care Provider.* A licensed dentist who accepts the professional responsibility for delivering  
30 primary dental care.

31 **Definition of Denturist and Denturism (*Trans.1976:868; 2001:436*)**

**Resolved**, that when the words “denturist” or “denturism” and all synonymous terms are used in American Dental Association publications, the terms should be accompanied by a brief but prominent footnote indicating that a “denturist” is a person who is educationally unqualified to practice dentistry in any form on the public, and be it further

**Resolved**, that constituent and component societies act in concert with the American Dental Association.

**Amendment of Policy on Opposition to “Denturist Movement” (*Trans.2001:436*)**

**Resolved**, that the Association vigorously opposes denturism, the denturism movement, and all other similar activities, regardless of how they are designated, in this country.

**Dental Identification Efforts (*Trans.1985:587*)**

**Resolved**, that the ADA encourage dental societies, related dental organizations and the membership to participate in efforts designed to assist in identifying missing and/or deceased individuals through dental records and other appropriate mechanisms.

**Statement on the Use of Opioids in the Treatment of Dental Pain (*Trans.2005:327*)**

**Resolved**, that the following ADA Statement on the Use of Opioids in the Treatment of Dental Pain be adopted.

**Statement on the Use of Opioids in the Treatment of Dental Pain**

1. The ADA encourages continuing education about the appropriate use of opioid pain medications in order to promote both responsible prescribing practices and limit instances of abuse and diversion.
2. Dentists who prescribe opioids for treatment of dental pain are encouraged to be mindful of and have respect for their inherent abuse potential.
3. Dentists who prescribe opioids for treatment of dental pain are also encouraged to periodically review their compliance with Drug Enforcement Administration recommendations and regulations.
4. Dentists are encouraged to recognize their responsibility for ensuring that prescription pain medications are available to the patients who need them, for preventing these drugs from becoming a source of harm or abuse and for understanding the special issues in pain management for patients already opiate dependent.
5. Dentists who are practicing in good faith and who use professional judgment regarding the prescription of opioids for the treatment of pain should not be held responsible for the willful and deceptive behavior of patients who successfully obtain opioids for non-dental purposes.
6. Appropriate education in addictive disease and pain management should be provided as part of the core curriculum at all dental schools.

**Statement on Substance Abuse Among Dentists (*Trans.2005:328*)**

**Resolved**, that the following ADA Statement on Substance Abuse among Dentists be adopted.

**Statement on Substance Abuse Among Dentists**

1. Dentists who use alcohol are urged to do so responsibly. Dentists are also urged to use prescription medications only as prescribed by an appropriate, licensed healthcare professional and to avoid the use of illegal substances.
2. Colleagues, dental team members, and the dentists’ family members, are urged to seek assistance and intervention when they believe a dentists is impaired.

3. Early intervention is strongly encouraged.
4. Dentists with addictive illness are urged to seek adequate treatment and participate in long-term monitoring protocols to maximize their likelihood of sustained recovery.
5. Impaired dentists who continue to practice, despite reasonable offers of assistance, may be reported to appropriate bodies as required by law and/or ethical obligations.
6. Dentists in full remission from addictive illness should not be discriminated against in the areas of professional licensure, clinical privileges, or inclusion in dental benefit network and provider panels solely due to the diagnosis and recovery from that illness.
7. The ADA encourages additional research in the area of dentist impairment and the factors of successful recovery.

**Statement on Provision of Dental Treatment for Patients With Substance Use Disorders**  
**(Trans.2005:329)**

**Resolved**, that the following ADA Statement on Provision of Dental Treatment of Patients with Substance Use Disorders be adopted.

**Statement on Provision of Dental Treatment for Patients With Substance Use Disorders**

1. Dentists are urged to be aware of each patient's substance use history, and to take this into consideration when planning treatment and prescribing medications.
2. Dentists are encouraged to be knowledgeable about substance use disorders – both active and in remission – in order to safely prescribe controlled substances and other medications to patients with these disorders.
3. Dentists should draw upon their professional judgment in advising patients who are heavy drinkers to cut back, or the users of illegal drugs to stop.
4. Dentists may want to be familiar with their community's treatment resources for patients with substance use disorders and be able to make referrals when indicated.
5. Dentists are encouraged to seek consultation with the patient's physician, when the patient has a history of alcoholism or other substance use disorder.
6. Dentists are urged to be current in their knowledge of pharmacology, including content related to drugs of abuse; recognition of contraindications to the delivery of epinephrine-containing local anesthetics; safe prescribing practices for patients with substance use disorders – both active and in remission – and management of patient emergencies that may result from unforeseen drug interactions.
7. Dentists are obliged to protect patient confidentiality of substances abuse treatment information, in accordance with applicable state and federal law.

**Statement on Alcohol and Other Substance Use by Pregnant and Postpartum Patients**  
**(Trans.2005:329)**

**Resolved**, that the following ADA Statement on Alcohol and Other Substance Use by Pregnant and Postpartum Patients be adopted.

**State on Alcohol and Other Substance Use by Pregnant and Postpartum Patients**

1. Dentists are encouraged to inquire about pregnant or postpartum patients' history of alcohol and other drug use, including nicotine.
2. As healthcare professionals, dentists are encouraged to advise these patients to avoid the use of these substances and to urge them to disclose any such use to their primary care providers.

3. Dentists who become aware of postpartum patients' resumption of tobacco or illegal drug use, or excessive alcohol intake, are encouraged to recommend that the patient stop these behaviors. The dentist is encouraged to be prepared to inform the woman of treatment resources, if indicated.

**Statement on Dentist Health and Wellness (*Trans.2005:321*)**

**Resolved**, that the following ADA Statement on Dentist Health and Wellness be adopted.

**Statement on Dentist Health and Wellness**

To preserve the quality of their performance and advance the welfare of patients, dentists are encouraged to maintain their health and wellness, construed broadly as preventing or treating acute or chronic diseases, including mental illness, addictive disorders, disabilities and occupational stress. When health or wellness is compromised, so may be the safety and effectiveness of the dental care provided. When failing physical or mental health reaches the point of interfering with a dentist's ability to engage safely in professional activities, the dentist is said to be impaired.

In addition to maintaining healthy lifestyle habits, every dentist is encouraged to have a personal physician whose objectivity is not compromised. Impaired dentists whose health or wellness is compromised are urged to take measures to mitigate the problem, seek appropriate help as necessary and engage in an honest self-assessment of their ability to continue practicing.

Dentists are encouraged to participate in the ADA's Health Screening Program when they attend annual session, both to assist them in monitoring key indicators of personal health and to contribute to the body of knowledge about dentist health and well-being.

Dentists are strongly encouraged to have adequate disability and overhead protection insurance coverage which they review on a regular basis.

The ADA and/or its constituent and component societies, as appropriate, are encouraged to assist their members in being able to provide safe and effective care by:

- promoting health and wellness among dentists
- supporting peers in identifying dentists in need of help
- intervening promptly when the health or wellness of a colleague appears to have become compromised, including the offer of encouragement, coverage or referral to a dentist well-being program
- encouraging the development of mutual aid agreements among dentists, for practice coverage in the event of serious illness
- establishing or cooperating with dentist (or multidisciplinary) well-being programs that provide a supportive environment to maintain and restore health and wellness
- establishing mechanisms to assure that impaired dentists promptly cease practice
- reporting impaired dentists who continue to practice, despite reasonable offers of assistance, to appropriate bodies as required by law and/or ethical obligations
- supporting recovered colleagues when they resume patient care

**Statement on Substance Abuse Among Dental Students (*Trans.2005:328*)**

**Resolved**, that the following ADA Statement on Substance Use among Dental Students be adopted.

**Statement on Substance Use Among Dental Students**

1. The ADA supports educational programs for dental students that address professional impairment associated with substance abuse.
2. Dental students who use alcohol should strive to do so responsibly. Dental students are also urged to use prescription medications only when prescribed by an appropriate, licensed healthcare professional and to avoid the use of illegal substances.
3. Dental school administration and faculty are encouraged to promptly intervene once aware of inappropriate substance use by student.
4. Dental schools are strongly encouraged to support a student's referral to an addiction treatment program, if appropriate, and indicated by a thorough evaluation, prior to making disciplinary decisions.
5. Dental schools are encouraged to support only the responsible use of alcohol on their premises or at their functions or by faculty when with students in social settings.

Resolution No. 34 NewReport: N/A Date Submitted: July 2012Submitted By: Council on Dental PracticeReference Committee: Dental Benefits, Practice and HealthTotal Net Financial Implication: None Net Dues Impact: \_\_\_\_\_Amount One-time \_\_\_\_\_ Amount On-going \_\_\_\_\_ FTE 0ADA Strategic Plan Goal: Members (Required)**AMENDMENT OF THE POLICY, DEFINITION OF FEE-FOR-SERVICE PRIVATE PRACTICE****Background:** (*Reports:139*)**Recommendations—Policies to be Amended:** The Council believes that the policy “Definition of Fee-For-Service Private Practice” should be amended to reflect the changes in third-party reimbursement.**Resolution****34. Resolved**, that the ADA policy “Definition of Fee-for-Service Private Practice” (*Trans.1979:620*) be amended as follows (additions are underscored; deletions are ~~stricken~~):**Resolved**, that the following definition of the traditional fee-for-service private practice of dentistry be approved:

The ~~traditional~~ fee-for-service private practice of dentistry, historically the basic ~~and most~~ prevalent method for delivery of oral health care, is a one model in which the dentist, as a solo practitioner or in a group, is ultimately responsible for all professional and business aspects of the practice. In this model the fee to the patient is dictated by the service rendered, the patient maintains the freedom of choice of the dentist and the dentist has the freedom of choice of patients.

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

Resolution No. 35 NewReport: N/A Date Submitted: July 2012Submitted By: Council on Dental PracticeReference Committee: Dental Benefits, Practice and HealthTotal Net Financial Implication: None Net Dues Impact: Amount One-time  Amount On-going  FTE 0ADA Strategic Plan Goal: Members (Required)**AMENDMENT OF THE POLICY, ACTIVE AND INACTIVE DENTAL PATIENTS OF RECORD****Background:** (*Reports:139*)**Recommendations—Policies to be Amended:** The Council believes that the policy “Active and Inactive Dental Patients of Record” should be amended to improve the accuracy of the definition of active patients.**Resolution****35. Resolved,** that the ADA policy “Active and Inactive Dental Patients of Record” (*Trans.* 1991:621) be amended as follows (additions are underscored):**Resolved,** that only for the purposes of evaluating or appraising the assets of a dental practice do the following definitions of the terms “active” and “inactive” dental patients of record apply:

Active Dental Patient of Record: An active dental patient of record is any individual in either of the following two categories: Category I – patients of record who have had dental service(s) provided by the dentist in the past twelve (12) months; Category II – patients of record who have had dental services(s) provided by the dentist in the past twenty-four (24) months, but not within the past twelve (12) months. Patients who have requested their records be transferred to another dentist or who have indicated they will be discontinuing their treatment, as substantiated in the patient’s record, should be excluded from the “active” patient category. Each of these categories of active patients of record can be further divided into: (1) new or regular patients who have had a complete examination done by the dentist and, (2) emergency patients who have only had a limited examination done by the dentist.

Inactive Dental Patient of Record: An inactive dental patient of record is any individual who has become a patient of record and has not received any dental services(s) by the dentist in the past twenty-four (24) months.

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

Resolution No. 36 NewReport: N/A Date Submitted: July 2012Submitted By: Council on Dental PracticeReference Committee: Dental Benefits, Practice and HealthTotal Net Financial Implication: None Net Dues Impact: \_\_\_\_\_Amount One-time \_\_\_\_\_ Amount On-going \_\_\_\_\_ FTE 0ADA Strategic Plan Goal: Members (Required)

1 **AMENDMENT OF THE POLICY, PRIMARY DENTAL CARE**

2 **Background:** (*Reports:140*)

3 **Recommendations—Policies to be Amended:** The Council believes that the policy “Primary Dental Care”  
4 should be amended to be consistent with the descriptor of evaluations found in the *Code of Dental*  
5 *Procedures and Nomenclature* and current ADA policy.

6 **Resolution**

7 **36. Resolved**, that the ADA policy “Primary Dental Care” (*Trans.*1994:668; 2010:562) be amended by the  
8 addition of the words “treatment planning” after the word “prevention” so that the amended policy reads  
9 as follows (additions are underscored; deletions are ~~stricken~~):

10 *Primary Dental Care.* The dental care provided by a licensed dentist to patients beginning no later  
11 than age one and throughout their lifetime. Primary dental care is directed to evaluation, diagnosis,  
12 patient education, prevention, treatment planning and treatment of oral disease and injury, the  
13 maintenance of oral health, and the coordination of referral to specialists for care when indicated.  
14 Primary dental care includes services provided by allied personnel under the dentist’s supervision.

15 **BOARD RECOMMENDATION: Vote Yes.**

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

18 Resolution 36

Resolution No. 37 NewReport: N/A Date Submitted: July 2012Submitted By: Council on Dental PracticeReference Committee: Dental Benefits, Practice and HealthTotal Net Financial Implication: None Net Dues Impact: \_\_\_\_\_Amount One-time \_\_\_\_\_ Amount On-going \_\_\_\_\_ FTE 0ADA Strategic Plan Goal: Members (Required)**AMENDMENT OF THE POLICY, UNIFORM PROCEDURE FOR PERMANENT MARKING OF DENTAL PROSTHESES****Background:** (*Reports:140*)**Recommendations—Policies to be Amended:** The Council believes that the policy on “Uniform Procedure for Permanent Marking of Dental Protheses” should be amended to incorporate key elements of the 1978 policy on Identification through Prosthetic Devices as follows:**Resolution**

**37. Resolved**, that the ADA policy on “Uniform Procedure for Permanent Marking of Dental Protheses” (*Trans.1979:637*) be amended by deletion of the first resolving clause; deletion of the words “urge constituent societies to actively” in the second resolving clause; and the addition of a new second resolving clause, so that the amended policy reads as follows (additions are underscored; deletions are ~~stricken~~):

~~**Resolved**, that the procedure recommended by the Council on Federal Dental Services in its 1978 Supplemental Report 1 to the House of Delegates (Supplement 1, 1978:181) be strongly promoted for use by the dental profession, and be it further~~

~~**Resolved**, that the American Dental Association urge constituent societies to actively supports the use of uniform methods of marking dental prostheses for identification purposes, and be it further~~

~~**Resolved**, that a system of dental prosthetic identification should meet the following criteria:~~

1. Standardized identification, including the patient’s first and last names, typed on onionskin, linen, nylon, foil or similar materials, should be inserted into the dental prosthesis before final closure.
2. The identification should be legible and permanent.
3. The procedure for applying the identification markings should be clinically safe, economically practical and cosmetically acceptable.

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

Resolution No. 37S-1 SubstituteReport: N/A Date Submitted: October 2012Submitted By: Fifth Trustee DistrictReference Committee: Dental Benefits, Practice and HealthTotal Net Financial Implication: None Net Dues Impact: \_\_\_\_\_Amount One-time \_\_\_\_\_ Amount On-going \_\_\_\_\_ FTE 0ADA Strategic Plan Goal: Members (Required)**SUBSTITUTE FOR RESOLUTION 37: AMENDMENT OF THE POLICY, UNIFORM PROCEDURE FOR PERMANENT MARKING OF DENTAL PROSTHESES**

The following substitute for Resolution 37 (Worksheet:4055) was adopted by the Fifth Trustee District and transmitted on October 4, 2012, by Ms. Connie Lane, executive director, Mississippi Dental Association.

**Background:** In amending the ADA policy on "Uniform Procedure for Permanent Marking of Dental Prostheses," language changes should allow for future technological advances in any methods of performing standardized identification such as the use of laser technology in addition to other methods.

**Resolution**

**37S-1. Resolved,** that the ADA policy on "Uniform Procedure for Permanent Marking of Dental Prostheses" (*Trans.* 1979:637) be amended as follows (additions are underscoring; deletions are ~~stricken~~):

~~**Resolved,** that the procedure recommended by the Council on Federal Dental Services in its 1978 Supplemental Report 1 to the House of Delegates (Supplement 1, 1978:181) be strongly promoted for use by the dental profession, and be it further~~

**Resolved,** that the American Dental Association ~~urge constituent societies to actively~~ supports the use of uniform methods of marking dental prostheses for identification purposes, and be it further

**Resolved,** that a system of dental prosthetic identification should meet the following criteria:

1. Standardized identification, including the patient's first and last names, typed on onionskin, linen, nylon, foil or similar materials, should be inserted incorporated into the dental prosthesis. before final closure.

2. The identification should be legible and permanent.

3. The procedure for applying the identification markings should be clinically safe, economically practical and cosmetically acceptable.

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

Resolution No. 38 NewReport: N/A Date Submitted: July 2012Submitted By: Council on Dental PracticeReference Committee: Dental Benefits, Practice and HealthTotal Net Financial Implication: None Net Dues Impact: \_\_\_\_\_Amount One-time \_\_\_\_\_ Amount On-going \_\_\_\_\_ FTE 0ADA Strategic Plan Goal: Members (Required)**AMENDMENT OF THE POLICY, DENTAL IDENTIFICATION TEAMS****Background:** (*Reports:140*)

**Recommendations—Policies to be Amended:** The Council believes that the policy “Dental Identification Teams” should be amended to clarify the ADA’s support for constituent society dental identification teams and its support for the American Board of Forensic Odontologists’ recommendations for those constituents who have developed programs.

**Resolution**

**38. Resolved,** that the ADA policy on “Dental Identification Teams” (*Trans.1994:654*) be amended as follows (additions are underscored; deletions are ~~stricken~~):

**Resolved,** that the American Dental Association ~~urge all constituents~~ supports the American Board of Forensic Odontologists’ recommendation to develop dental identification teams that can be mobilized at times of need for local or regional mass fatality incidents (MFI), and be it further

**Resolved,** that state and regional ID teams receive initial and ongoing training by forensic odontologists experienced in MFI response.

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

Resolution No. 39 NewReport: N/A Date Submitted: July 2012Submitted By: Council on Dental PracticeReference Committee: Dental Benefits, Practice and HealthTotal Net Financial Implication: None Net Dues Impact: Amount One-time  Amount On-going  FTE 0ADA Strategic Plan Goal: Members (Required)**AMENDMENT OF THE POLICY, DENTAL RADIOGRAPHS FOR VICTIM IDENTIFICATION****Background:** (*Reports:141*)

**Recommendations—Policies to be Amended:** The Council believes that the policy “Dental Radiographs for Victim Identification” should be amended because this policy, well known in the dental community, no longer requires active promotion.

**Resolution**

**39. Resolved,** that the ADA policy on “Dental Radiographs for Victim Identification” (*Trans.2003:363*) be amended by deletion of the word “actively” after the word “ADA” in the first resolving clause to read as follows (additions are underscored; deletions are ~~stricken~~):

**Resolved,** that the ADA ~~actively~~ promote to practicing dentists the importance of providing, as permitted by state law, original radiographs and original records on patients of record that are requested by a legally authorized entity for victim identification and which will be returned to the dentist when no longer needed, and be it further

**Resolved,** that copies of these records should be retained by dentists as required by law.

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

Resolution No. 40 NewReport: N/A Date Submitted: July 2012Submitted By: Council on Dental PracticeReference Committee: Dental Benefits, Practice and HealthTotal Net Financial Implication: None Net Dues Impact: \_\_\_\_\_Amount One-time \_\_\_\_\_ Amount On-going \_\_\_\_\_ FTE 0ADA Strategic Plan Goal: Members (Required)**AMENDMENT OF THE POLICY, INSURANCE COVERAGE FOR CHEMICAL DEPENDENCY TREATMENT****Background:** (*Reports:141*)**Recommendations—Policies to be Amended:** The Council believes that the policy “Insurance Coverage for Chemical Dependency Treatment” should be amended because this coverage is now typically provided in health and disability plans.**Resolution****40. Resolved**, that the ADA policy “Insurance Coverage for Chemical Dependency Treatment” (*Trans.1986:519*) be amended as follows (additions are underscored; deletions are ~~stricken~~):

**Resolved**, that ~~the ADA believes that any constituent and component societies of the Association be urged to review current tripartite~~ ADA or constituent\* sponsored or endorsed medical and disability insurance coverage should include coverage for the treatment of chemical dependency (including alcoholism). ~~treatment and to seek to ensure the existence and adequacy of such coverage for their members, and be it further~~

**Resolved**, that ~~the societies examine state and local statutes and regulations relative to medical and disability insurance coverage for chemical dependency (including alcoholism) treatment and take appropriate action to ensure nondiscriminatory regulations and/or legislation.~~

\*Editorially corrected.

**BOARD RECOMMENDATION: Vote Yes.****BOARD VOTE: UNANIMOUS.**

Resolution No. 41 NewReport: N/A Date Submitted: July 2012Submitted By: Council on Dental PracticeReference Committee: Dental Benefits, Practice and HealthTotal Net Financial Implication: None Net Dues Impact: Amount One-time  Amount On-going  FTE 0ADA Strategic Plan Goal: Members (Required)**AMENDMENT OF THE POLICY, GUIDING PRINCIPLES FOR DENTIST WELL-BEING ACTIVITIES AT THE STATE LEVEL****Background:** (*Reports:141*)**Recommendations—Policies to be Amended:** The Council believes that the policy “Guiding Principles for Dentist Well-Being Activities at the State Level” should be amended to take a more proactive approach in the treatment of substance use disorders to prevent alcohol- or drug-related incidents.**Resolution****41. Resolved**, that the ADA policy on “Guiding Principles for Dentist Well-Being Activities at the State Level” (*Trans.2005:330*) be amended as follows (additions are underscored; deletions are ~~stricken~~):**Resolved**, that the ADA supports efforts by constituent and component dental societies in the development, maintenance, and collaboration with effective programs to identify and assist those dentists and dental students affected by conditions which potentially impair their ability to practice dentistry, and be it further**Resolved**, that constituent and/or component dental societies be urged to adopt the following Guiding Principles for Dentist Well-Being Activities at the State Level.

## Guiding Principles for Dentist Well-Being Activities at the State Level

1. Constituent dental societies, on behalf of their well-being programs, are encouraged to negotiate contracts or agreements with state dental boards, licensing agencies and other regulatory agencies to encourage dentists with substance use disorders to get into treatment before they have an alcohol- or drug-related incident, have some level of involvement in services for dentists affected by conditions which potentially or actually impair their ability to practice dentistry.
2. State-level programs to prevent and intervene in dentist and dental team member impairment should be strengthened, supported and well publicized as the most humane and effective method of protecting the interest of the public and of dental professionals.
3. Dental societies should be advocates for dentists to have the same rights of privacy and confidentiality of personal medical information as other persons.

4. Those dental societies that administer dentist well-being programs are urged to maintain a strong working relationship with their state boards of dentistry and with the appropriate ADA agencies.
5. The dental society should ensure that those who serve as dentist peer assistance volunteers are provided immunity from civil liability, except for willful or wanton acts.
6. The dental society should also ensure that those who serve as dentist peer assistance volunteers are appropriately trained and supervised in these activities.
7. Dental societies in states where services are provided to dentists by multidisciplinary or physician health programs are urged to develop strong relationships with those programs, in order to:
  - a. educate service providers about the particular needs of dentists and the dynamics of dental practice
  - b. assist providers in outreach to dentists in need of assistance
  - c. support dentists and families if treatment is necessary
  - d. assist program providers in developing monitoring contracts appropriate to individual dentist's practice situations
  - e. assist program providers in advocating for program participants with the dental board or licensing agency
8. Constituent and component dental societies are strongly encouraged to offer continuing education programs on the prevention, recognition and treatment of professional impairment.
9. Dental societies are encouraged to support well-being volunteer liaison activities to their dental schools.

and be it further

**Resolved**, that Resolution 18H-1996 (*Trans. 1996-693*), Guiding Principles for Dentist Well-Being Programs, be rescinded.

**BOARD RECOMMENDATION: Vote Yes.**

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

Resolution No. 42 NewReport: N/A Date Submitted: July 2012Submitted By: Council on Dental PracticeReference Committee: Dental Benefits, Practice and HealthTotal Net Financial Implication: None Net Dues Impact: Amount One-time  Amount On-going  FTE 0ADA Strategic Plan Goal: Members (Required)**1 RESCISSION OF THE POLICY, PROMOTION OF CAREERS IN GENERAL PRACTICE OF DENTISTRY****2 Background:** (*Reports:142*)

**3 Recommendations—Policies to be Rescinded:** The Council reviewed the policy “Promotion of Careers in  
**4 General Practice of Dentistry” and recommends rescission due to the success of the promotion of general  
5 practice in dentistry; approximately 80% of all dentists are currently in general practice.**

**6 Resolution**

**7 42. Resolved,** that Resolution 86-1973-H, “Promotion of Careers in General Practice of Dentistry”  
**8 (*Trans.1973:725*), be rescinded.**

**9 BOARD RECOMMENDATION: Vote Yes.**

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

**12** Resolution 42

1 WORKSHEET ADDENDUM  
2 COUNCIL ON DENTAL PRACTICE  
3 POLICY TO BE RESCINDED

4 **Promotion of Careers in General Practice of Dentistry (*Trans.1973:725*)**

5 **Resolved,** that the American Dental Association make a concentrated effort to promote the status of the  
6 general practice of dentistry and encourage graduating dental students to seek a career in the general  
7 practice of dentistry.

Resolution No. 43 NewReport: N/A Date Submitted: July 2012Submitted By: Council on Dental PracticeReference Committee: Dental Benefits, Practice and HealthTotal Net Financial Implication: None Net Dues Impact: Amount One-time  Amount On-going  FTE 0ADA Strategic Plan Goal: Members (Required)**1 RESCISSION OF THE POLICY, PRIMARY CARE PROVIDERS****2 Background:** (*Reports:142*)

**3 Recommendations—Policies to be Rescinded:** The Council reviewed the policy “Primary Care Providers”  
**4** and recommends rescission because this policy is redundant to the 1994 policy “Primary Dental Care  
**5** Provider” (*Trans.1994:668; 2010:548*).

**6 Resolution****7 43. Resolved,** that Resolution 140H-1995, “Primary Care Providers” (*Trans.1995:610*), be rescinded.**8 BOARD RECOMMENDATION: Vote Yes.**

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

**11** Resolution 43

1 WORKSHEET ADDENDUM  
2 COUNCIL ON DENTAL PRACTICE  
3 POLICY TO BE RESCINDED

4 **Primary Care Providers (*Trans.1995:610*)**

5 **Resolved**, that the American Dental Association recognizes that dentists in general practice are primary  
6 care providers regardless of the age of the patient.

Resolution No. 44 NewReport: N/A Date Submitted: July 2012Submitted By: Council on Dental PracticeReference Committee: Dental Benefits, Practice and HealthTotal Net Financial Implication: None Net Dues Impact: \_\_\_\_\_Amount One-time \_\_\_\_\_ Amount On-going \_\_\_\_\_ FTE 0ADA Strategic Plan Goal: Members (Required)**1 RESCISSION OF THE POLICY, DENTAL SOCIETY ACTIVITIES AGAINST ILLEGAL DENTISTRY****2 Background:** (*Reports:142*)

**3 Recommendations—Policies to be Rescinded:** The Council reviewed the policy “Dental Society Activities  
**4 Against Illegal Dentistry”** and recommends rescission because this policy is no longer needed as the ADA  
**5 State Public Affairs (SPA) program provides needed financial support.**

**6 Resolution**

**7 44. Resolved,** that Resolution 141H-1977 and Resolution 14H-2001, “Dental Society Activities Against  
**8 Illegal Dentistry”** (*Trans.1977:934; 2001:435*), be rescinded.

**9 BOARD RECOMMENDATION: Vote Yes.****10 Board Vote: Resolution 44**

BLANTON	Yes	GOUNARDES	Yes	NORMAN	Yes	SUMMERHAYS	Yes
DOW	Yes	HAGENBRUCH	No	RICH	Yes	VIGNA	Yes
ENGEL	Yes	ISRAELSON	Yes	ROBERTS	Yes	WEBER	Yes
FAIELLA	Yes	KIESLING	Yes	SEAGO	Yes	VERSMAN	No
FEINBERG	No	LOW	Yes	STEFFEL	Yes	YONEMOTO	No

WORKSHEET ADDENDUM

COUNCIL ON DENTAL PRACTICE

POLICY TO BE RESCINDED

**Dental Society Activities Against Illegal Dentistry (*Trans.*1977:934; 2001:435)**

**Resolved**, that the American Dental Association urge constituent and component dental societies to inform the Council on Dental Practice of society activities which relate to combating illegal dentistry, and be it further

**Resolved**, that the Council on Dental Practice provide this information to all constituent and component societies on a timely and periodic basis, and be it further

**Resolved**, that the American Dental Association Board of Trustees be authorized to provide financial aid to any constituent dental society that is faced with the imminent prospect of a substantial effort to legalize or promote denturism or any illegal practice of dentistry in its state through legislative action or use of the initiative process.

Resolution No. 45 NewReport: N/A Date Submitted: July 2012Submitted By: Council on Dental PracticeReference Committee: Dental Benefits, Practice and HealthTotal Net Financial Implication: None Net Dues Impact: Amount One-time  Amount On-going  FTE 0ADA Strategic Plan Goal: Members (Required)**RESCISSION OF THE POLICY, ACTIVITY TO STOP UNLICENSED DENTAL OR DENTAL HYGIENE PRACTICE****Background:** (*Reports:143*)**Recommendations—Policies to be Rescinded:** The Council reviewed the policy “Activity to Stop Unlicensed Dental or Dental Hygiene Practice” and recommends rescission because this policy is no longer needed as legislative authority for this activity belongs to the states.**Resolution****45. Resolved,** that Resolution 74H-1999, “Activity to Stop Unlicensed Dental or Dental Hygiene Practice” (*Trans.1999:947*), be rescinded.**BOARD RECOMMENDATION: Vote Yes.****BOARD VOTE: UNANIMOUS.**

1 WORKSHEET ADDENDUM

2 COUNCIL ON DENTAL PRACTICE

3 POLICY TO BE RESCINDED

4 **Activity to Stop Unlicensed Dental or Dental Hygiene Practice (*Trans.1999:947*)**

5 **Resolved,** that each constituent dental society be urged to support enactment of legislation which gives  
6 each Board of Dental Examiners the means to stop the illegal practice of dentistry or dental hygiene by an  
7 unlicensed person.

Resolution No. 46 NewReport: N/A Date Submitted: July 2012Submitted By: Council on Dental PracticeReference Committee: Dental Benefits, Practice and HealthTotal Net Financial Implication: None Net Dues Impact: Amount One-time  Amount On-going  FTE 0ADA Strategic Plan Goal: Members (Required)**1 RESCISSION OF THE POLICY, SALE OF DENTAL EQUIPMENT TO ILLEGAL PRACTITIONERS****2 Background: (Reports:143)**

**3 Recommendations—Policies to be Rescinded:** The Council reviewed the policy “Sale of Dental  
**4 Equipment to Illegal Practitioners”** and recommends rescission because there is little to no benefit gained  
**5 from this policy and the Council believes it carries a degree of legal risk.**

**6 Resolution**

**7 46. Resolved,** that Resolution 33H-2001, “Sale of Dental Equipment to Illegal Practitioners”  
**8 (Trans.2001:436), be rescinded.**

**9 BOARD RECOMMENDATION: Vote Yes.**

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

**12**

Resolution 46

## 1 WORKSHEET ADDENDUM

## 2 COUNCIL ON DENTAL PRACTICE

## 3 POLICY TO BE RESCINDED

4 **Sale of Dental Equipment to Illegal Practitioners (*Trans.2001:436*)**

5 **Resolved**, that the ADA strongly urges dental equipment manufacturers and suppliers to develop and  
6 implement guidelines which preclude the sale, transfer or conveyance of new and used dental equipment  
7 and supplies (except "over the counter" consumer care products) to illegal practitioners of dentistry, and  
8 be it further

9 **Resolved**, that the guidelines include the requirement that before manufacturers or suppliers sell, transfer  
10 or convey dental equipment and supplies to persons they believe plan to use the products in the practice  
11 of dentistry, the manufacturers and suppliers first verify that the purchaser is licensed to practice dentistry  
12 in the state where the products will be delivered, and be it further

13 **Resolved**, that the guidelines also include a requirement that contracts, purchase orders, and invoices  
14 used to sell, transfer or convey dental equipment and supplies require purchasers intending to use the  
15 equipment or supplies to provide dental care to include their dental license number, and be it further

16 **Resolved**, that in the case of as yet unlicensed dental students or recent graduates, the guidelines allow  
17 for the sale, transfer or conveyance of dental equipment and supplies, provided that the student or recent  
18 graduate supplies verification of current attendance in or graduation from an accredited dental school.

Resolution No. 47 New

Report: N/A Date Submitted: July 2012

Submitted By: Council on Dental Practice

Reference Committee: Dental Benefits, Practice and Health

Total Net Financial Implication: None Net Dues Impact:

Amount One-time \_\_\_\_\_ Amount On-going \_\_\_\_\_ FTE 0

ADA Strategic Plan Goal:      Members      (Required)

## RESCISSION OF THE POLICY, PROFESSIONAL QUALITY DENTURE TREATMENT FOR THE FINANCIALLY DISADVANTAGED

**Background:** (*Reports:143*)

**Recommendations—Policies to be Rescinded:** The Council reviewed the policy “Professional Quality Denture Treatment for the Financially Disadvantaged” and recommends rescission because this policy is outdated and no longer necessary.

## Resolution

**47. Resolved**, that Resolution 144H-1977, "Professional Quality Denture Treatment for the Financially Disadvantaged" (*Trans.*1977:929), be rescinded.

**BOARD RECOMMENDATION: Vote Yes.**

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

1 WORKSHEET ADDENDUM  
2 COUNCIL ON DENTAL PRACTICE  
3 POLICY TO BE RESCINDED

4 **Professional Quality Denture Treatment for the Financially Disadvantaged (*Trans.*1977:929)**

5 **Resolved**, that it be the policy of the American Dental Association that the phrase "Professional Quality  
6 Denture Treatment for Financially Disadvantaged" be used when referring to low cost, comprehensive  
7 denture care, and be it further  
8 **Resolved**, that all members be urged to continue to deliver high quality care in all phases of dentistry,  
9 and be it further  
10 **Resolved**, that all members be urged to continue to provide fee relief where indicated for purposes of  
11 allowing patients of all economic levels the opportunity to receive high quality treatment in all phases of  
12 dentistry including professional denture service.

Resolution No. 103-106 NewReport: CAPIR Supplemental Report 1 Date Submitted: September 2012Submitted 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  FTE 0ADA Strategic Plan Goal: Collaboration (Required)**COUNCIL ON ACCESS, PREVENTION AND INTERPROFESSIONAL RELATIONS SUPPLEMENTAL  
REPORT 1 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 2012 Annual Report of the Council on Access, Prevention and Interprofessional Relations (CAPIR). The Council met on June 28-30, 2012, at the ADA Headquarters Building in Chicago.

**Access to Oral Health Care and Building Oral Health Infrastructure:** The U.S. National Oral Health Alliance (<http://www.usalliancefororalhealth.org/>) will sponsor three additional colloquia over the next 12 months seeking common ground and unifying messages, while addressing metrics for improving oral health, financing models and strengthening the dental care delivery system. These prioritized areas that impact access were identified at the 2009 ADA-convened Access to Dental Care Summit. Previous colloquia have addressed medical and dental collaboration, prevention and public health infrastructure and oral health literacy.

Many current ADA activities align with Alliance priorities, such as: encouraging medical/dental collaboration through the National Interprofessional Initiative on Oral Health (<http://www.niioh.org/>) and stressing the importance of oral health during pregnancy, strengthening the public health infrastructure with an emphasis on prevention, and implementing the recommendations of the National Coalition Consensus Conference: Oral Health of Vulnerable Older Adults and Persons with Disabilities. The ADA may utilize this natural alignment as a platform for further collaboration between organized dentistry and the diverse oral health stakeholders represented within the Alliance.

Collaboration with the National Association of Community Health Centers (NACHC) resulted in a joint letter from ADA and NACHC leadership advocating for greater contracting between Federally Qualified Health Centers and private practice dentists to increase health center capacity to provide oral health care for underserved populations. In conjunction with NACHC, CAPIR is disseminating this letter in many ways, including through the executive directors of state and local dental societies and through information shared via the Leadership Update, *ADA News*, the *New Dentist* and National Network for Oral Health Access (NNOHA) newsletters. The DentaQuest Foundation has agreed to share the letter with the 20 state awardees of the Oral Health 2014 grants, as well as the five Primary Care Associations awarded the Strengthening the Oral Health Safety Net grants. State dental societies are closely involved with oral health coalitions, which are required within both grant programs. Currently 70% of health center dentists are members of the ADA.

**Supplemental Information in Response to Resolution 18H-2011 on Leading Community Efforts to Improve Oral Health:** A toolkit will be developed by January 2013, in conjunction with other appropriate ADA agencies, for use by individual dentists seeking to be leaders in grassroots community efforts that impact the oral health of the public. Current toolkit items under consideration address many of the opportunities and challenges that local dentists encounter when moving beyond their dental practices into their communities. These items include the ADA fluoridation toolkit and a proposed long-term care toolkit being developed by the

National Eldercare Advisory Committee within CAPIR, including use of the Incurred Medical Expense reimbursement mechanism. Interaction with community medical colleagues can be enhanced through use of the Smiles for Life curriculum with additional information available through the National Interprofessional Initiative on Oral Health. The ADA's new consumer website, [MouthHealthy.org](http://MouthHealthy.org), offers dental health information for the whole family, which will be especially helpful as the public's awareness of the importance of oral health rises in response to the recent Ad Council Campaign, to brush two minutes, twice a day. Dentists will be provided information to assist in advocating for school-based sealant programs as a principal primary prevention strategy along with community water fluoridation. *Fit, Healthy, and Ready to Learn: A School Health Policy Guide* developed by the National School Board Association could assist those dentists serving on school health advisory committees.

Items supporting growth of the local oral health safety net include the "Avenues to Access" ([http://www.ada.org/2574.aspx?currentTab=2#Avenues to Access](http://www.ada.org/2574.aspx?currentTab=2#Avenues%20to%20Access)) framework developed by the ADA's 2011-12 Hillenbrand Fellow, Dr. Elizabeth "Betsy" Shapiro; the joint letter of the ADA and National Association of Community Health Centers leadership encouraging greater contracting between health centers and private dentists; and the *Safety Net Dental Clinic Manual*, which can assist dentists serving on health center advisory committees to better understand the nuances of health center clinic development and ongoing operations.

Leadership within communities necessarily leads to consideration of where one fits within the larger public health infrastructure. Organizations, such as the Association of State and Territorial Dental Directors and the U.S. National Oral Health Alliance, offer resources for promoting collaboration and finding common ground among diverse stakeholders. Current surveillance data is critical for measuring outcomes. Oral health summaries for each state and territory can be found within the state synopses housed at the Centers for Disease Control and Prevention. Some state oral health departments offer similar data down to the county level.

**Fluoridation:** On July 16, 2012, the *ADA News* carried a cover story on the state of fluoridation across the nation. In the period from January 2011- May 2012, 43 of the 50 states had some type of fluoridation activity that required action by members and/or dental societies. The story detailed recent challenges that occurred in Florida, Montana, Texas and Wisconsin and provided strategies to assist members in dealing with this issue. As a result of these challenges, CAPIR, with consultation from its National Fluoridation Advisory Committee, joined with the Division of Communications in developing a tool kit titled "Fluoridation: Tap In To Your Health," which is available to dental societies via ADA Connect. The tool kit includes: 1) materials for building a fluoridation campaign; 2) materials for public distribution; 3) advocacy materials and 4) press statements and policies from the ADA. Launched at the ADA Management Conference on July 19, 2012, the tool kit was a first edition with additional items to be added in the months ahead. CAPIR is collaborating with other ADA agencies to ensure that members will be prepared for the additional challenges that will occur when the Department of Health and Human Services releases its final recommendation on the fluoride level to be used in community water fluoridation (projected for) later this year.

**Principles for Developing Children's Oral Health Programs:** The policy, American Dental Association Dental Health Program for Children (*Trans.*1966:179, 306; 1967:336), was developed 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 2010 House of Delegates adopted Resolution 4H-2010 (*Trans.*2010:552), which reads as follows:

**4H-2010. Resolved,** that the policy "American Dental Association Dental Health Program for Children" (*Trans.*1966:179, 306; 1967:336), Principle 16, be amended as follows (additions are shown by underscoring; deletions are shown by strikethroughs):

16. Priority consideration should be given to reimbursement for professional services on the "full ~~usual and customary~~ fee" basis.

and be it further

1       **Resolved**, that the policy, "American Dental Association Health Program for Children" (*Trans.*1966:179,  
2       306; 1967:336), be referred to the appropriate ADA agency for study and report to the 2011 House of  
3       Delegates.

4       The policy was reviewed by CAPIR. Following review, CAPIR agreed that the policy did serve its purpose as  
5       it led to the establishment of the federal Early Periodic Screening, Diagnosis and Treatment (EPSDT)  
6       program in 1967 which was designed to ensure that children enrolled in Medicaid receive comprehensive  
7       services. In light of that development as well as the current health care reform and the Essential Oral Health  
8       Care Act, CAPIR recommended to the 2011 House of Delegates that the policy be rescinded. Resolution 35-  
9       2011 (*Trans.*2011:454) reads as follows:

10       **35-2011. Resolved**, that the policy, "American Dental Association Health Program for Children,"  
11       (*Trans.*1966:179, 306; 1967:336; 2010:552) be rescinded.

12       The 2011 House of Delegates heard testimony in favor of and in opposition to rescission of the policy. The  
13       House directed that the appropriate ADA agency review the policy and report to the 2012 House of  
14       Delegates. CAPIR reviewed all current ADA policies specific to children's oral health and adopted the  
15       following resolution at its January 2012 meeting.

16       **Resolved**, that a CAPIR workgroup be established, consisting of Council members including but not  
17       limited to pediatric dentists, to develop a comprehensive document that includes a framework for  
18       guiding policy development at the federal, state and local level for improving children's oral health and  
19       that the draft document be presented to CAPIR for approval at its June meeting.

20       Following the January 2012 CAPIR meeting, the workgroup was formed and met numerous times via  
21       conference calls to review all current ADA policies specific to children's oral health, including the existing  
22       core principles, and recommended to the Council whether or not to delete, keep, or edit them as well as add  
23       any new principles. The draft proposed principles were presented and approved by the Council at its June  
24       2012 meeting for transmittal to the 2012 House of Delegates. (See Resolution 103, Worksheet:4078)

25       **ADA Policy on Person with Special Needs:** At its June 2012 meeting, the Council discussed a resolution  
26       adopted by the American Medical Association (AMA) House of Delegates encouraging the federal  
27       government to designate people with intellectual disabilities as a medically underserved population  
28       (MUP). The American Academy of Developmental Medicine and Dentistry (AADMD) approached the ADA to  
29       see if the Association would consider also adopting such a resolution as it is their opinion that it would be  
30       powerful to have the ADA and the AMA putting their support behind the concept. This request was referred to  
31       CAPIR for its consideration. The Council discussed the AMA resolution. Rather than support the resolution  
32       as stated, the Council felt it would be more appropriate to broaden existing ADA policy and therefore  
33       recommends that the ADA Policy on Persons with Special Needs (*Trans.*2002:390) be amended. (See  
34       Resolution 104, Worksheet:4088)

35       **Engaging Primary Care Providers in the Prevention and Management of Oral Disease through**  
36       **Education, Risk Assessment and Delivery of Preventive Dental Services:** At its June meeting the  
37       Council discussed the fact that primary care providers are integral to the prevention of oral disease across the  
38       lifespan and how the American Dental Association has the opportunity to position itself as a leader in  
39       promoting interprofessional delivery of services and interprofessional education through development of  
40       policy and by strategically collaborating with medical colleagues. Oral diseases, along with chronic and  
41       systemic diseases, share common risk factors, which necessitate close collaboration between oral health  
42       professionals and other primary care providers. Today's society is increasingly older and more diverse. Key  
43       determinants of health, such as biology, behavior, the environment, and health systems require a greater  
44       integration between the disciplines of dentistry, medicine and public health.

45       In preparation for the Council discussion on how best to engage primary care providers in the prevention and  
46       management of oral disease through education, risk assessment and the delivery of preventive services  
47       Suzanne Boulter, MD, FAAP, Adjunct Professor of Pediatrics, Dartmouth Medical School, Department of

Pediatrics and Paul Mulhausen, MD, Professor of Internal Medicine, University of Iowa Hospital & Clinic addressed the Council.

The Council discussed how pediatricians and dentists can make an impact on children's oral health by working together. Members spoke of the importance of pediatricians and other non-dental primary care providers performing oral health risk assessments, providing anticipatory guidance to families, providing appropriate preventive services such as fluoride varnish, and referring children to a dental home. The Council also discussed the opportunities of interprofessional health team members to improve oral health across the later lifespan and how nursing homes and other long-term care institutions have limited capacity to deliver oral health services and that residents living in these facilities, along with other vulnerable elders are more likely to be seen by primary care providers than by dentists.

The Council believes there are opportunities to leverage the existing health care workforce by engaging non-dental primary care providers in the delivery of oral health preventive services. In 2010, the ADA House of Delegates updated its policies on the dental home. Although the ADA strongly supports and advocates for establishing the dental home by age one, many general dentists have not fully embraced the concept of evaluating and treating very young children. By working with pediatricians and other healthcare providers, there are opportunities for care coordination with referrals to dentists and pediatric dentists. In addition, primary care providers become natural allies in advocacy efforts. Currently pediatricians are reimbursed in 44 states for the application of fluoride varnish. Pediatricians and family practitioners are generally the first person to see the newborn child and, furthermore, during the first year of life, see the baby on average six times for well-baby check-ups.

Two Institute of Medicine Reports were published in 2011 that address the challenges of the oral health system in the United States, particularly with vulnerable and underserved populations. *Advancing Oral Health in America* (<http://www.iom.edu/Reports/2011/Advancing-Oral-Health-in-America.aspx>) calls for a paradigm shift in how oral health is perceived and puts forth a charge to "change our nation's way of thinking—to help leaders, health care professionals, and individuals to better understand that oral health and oral diseases are a *health care* problem and not just a dental problem." One of the organizing principles for a new oral health initiative includes enhancing the role of nondental health care professionals. The second report, *Improving Access to Oral Health Care for Vulnerable and Underserved Populations*, (<http://www.iom.edu/Reports/2011/Improving-Access-to-Oral-Health-Care-for-Vulnerable-and-Underserved-Populations.aspx>) speaks to a vision for oral health care in the U.S. where "everyone has access to quality oral health care throughout the life cycle". Key findings and conclusions indicate multiple solutions will be necessary using an array of providers in a variety of settings.

The Council has worked towards initiating and promoting collaborations that focus on interprofessional relations. Some key initiatives include, but are not limited to:

- working with the National Interprofessional Initiative on Oral Health (NIIOH) to learn about the *Smiles for Life* curriculum ([www.smilesforlifeoralhealth.org](http://www.smilesforlifeoralhealth.org)) developed by Society of Teachers of Family Medicine
- recommending endorsement of the *Smiles for Life* curriculum and work in conjunction with other appropriate ADA agencies to actively promote its use across disciplines to promote oral health and the delivery of preventive dental services by appropriately trained primary care providers
- joining the U.S. National Oral Health Alliance (the Alliance) with one of six priority areas for forging common ground being medical and dental collaboration; the Alliance was a demonstrable outcome of the 2009 ADA-convened Access to Dental Care Summit

- appointing a liaison to the Executive Committee of the Section for Oral Health of the American Academy of Pediatrics with a focus specifically on children's oral health in 2010
- participating in a collaborative effort with the Health Resources Service Administration (HRSA) and the American College of Obstetrics and Gynecologists (ACOG), along with other dental and non-dental stakeholders, to develop a consensus statement on national perinatal guidelines for oral health
- joining the Strategic Directions Group of the National Diabetes Education Program (NDEP) in December, 2011; through collaborative efforts with NDEP, the ADA works with at least 50 stakeholder organizations with a common goal to reduce the disease burden of diabetes through increased awareness and knowledge

The ADA has two policies regarding physicians, nurses and other healthcare providers promoting oral health and delivering preventive dental services. These policies, as well as others, provide the basis to support dentists, physicians and trained designees to provide preventive dental services, support the promotion of oral health across the lifespan, support referrals to dentists by non-dental healthcare professionals, and maintain the role of the dentist as the leader of the team and encourage collaboration with appropriate organizations. It is clear there are many efforts reflective of interprofessional relations, collaboration, education, core competencies and engagement across disciplines.

Therefore, in that non-dentist primary care providers are key partners to promote oral health and prevent oral disease, the Council recommends amending two policies, Non-Dental Providers Completing Educational Program on Oral Health (*Trans*.2004:301), and Non Dental Providers Notification of Preventive Dental Treatment for Infants and Young Children (*Trans*.2004:303), to strengthen the intent of the policies to engage primary care providers in the delivery of oral health preventive services across the lifespan. (See Resolution 105, Worksheet:4089 and Resolution 106, Worksheet:4090)

**Policy Review:** In accordance with Resolution 111H-2010, Regular Comprehensive Policy Review, the Council on Access, Prevention and Interprofessional Relations began its assessment of assigned ADA policies. Suggestions to maintain, rescind or amend policies assigned to the Council will occur in future reports to the House.

### Resolutions

(Resolution 103; Worksheet:4078)  
(Resolution 104; Worksheet:4088)  
(Resolution 105; Worksheet:4089)  
(Resolution 106; Worksheet:4091)

Resolution No. 103 NewReport: CAPIR Supplemental Report 1 Date Submitted: September 2012Submitted 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  FTE 0ADA Strategic Plan Goal: Collaboration (Required)**PRINCIPLES FOR DEVELOPING CHILDREN'S ORAL HEALTH PROGRAMS****Background:** (See Council Access, Prevention and Interprofessional Relations Supplemental Report 1, Worksheet:4073)**Resolution****103. Resolved,** that the following Principles for Developing Children's Oral Health Programs be adopted as the Association's framework for guiding policy development at the federal, state and local level for improving children's oral health:**Principles for Developing Children's Oral Health Programs**

1. The following principles should be considered when developing children's oral health programs at the federal, state or local level.
2. Increase public awareness of the relationship and importance of children's good oral health to overall health. Dental care is essential to overall wellness – children cannot be healthy without it.
3. All dental services necessary to prevent oral disease and restore oral structures to health and function should be of high quality and available to all children.
4. All children, from birth through the age of 21 years, should be included in any program developed to improve the oral health of children. Existing resources should be made available on a priority basis to the most vulnerable and expanded on a planned and systematic basis to include everyone as rapidly as resources permit. Adequate funding should be prioritized so those children with the greatest need and those who will most benefit from care are first in line.
5. All individuals who have an interest in the oral health of children including parents, healthcare providers, pregnant women and caregivers need to understand the importance of good oral health, oral hygiene fundamentals, diet and nutritional guidelines, the need for regular dental care and how to navigate the health care delivery system to get dental care for children.
6. Individuals should be encouraged to be responsible for their own oral health and parents and caregivers should be motivated to accept responsibility for the oral health of their children as well as well as being active in the doctor patient relationship.
7. Parents and caregivers should have an ongoing relationship with a dentist by the child's first birthday so that they can collaboratively determine preventive and restorative treatment appropriate to the child's needs and the parents and/or caregivers resources.
8. Continuing education should be made available for all primary healthcare providers (including daycare workers/headstart staff) and should be integral to any program that is developed to improve the oral health of children.
9. 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, evaluation and financing of children's oral health programs.

10. Adequate funding should be provided for research to develop, implement, improve and evaluate programs and procedures which focus on improving the oral health of children.
11. Priority consideration should be given for adequate reimbursement for professional services.
12. Programs such as Medicaid and the State's Children Health Insurance Program (SCHIP) must ensure that vulnerable children with inadequate resources have access to essential oral health care. Children in low-income families who are not eligible for Medicaid must have access to essential oral health care through SCHIP. Eligibility should reflect regional differences in the cost of living and purchasing power.
13. The scope of the children's oral health 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.
14. Population and clinical preventive measures which are evidenced based should be an integral component when developing children's oral health programs. For example, fully funding community water fluoridation initiatives and school based oral health programs.
15. The services, existing resources and facilities of all private and public healthcare providers should be utilized in programs that are developed to improve the oral health of children.

and be it further

**Resolved**, that the policy, American Dental Association Dental Health Program for Children (*Trans.* 1966:97, 306; 1967:336; 2010:552), be rescinded.

**BOARD RECOMMENDATION: Vote Yes.**

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

\*Dr. Faiella was absent.

## 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)**

**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 "usual and customary 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.

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

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

Complete examination and diagnosis including radiographs.

Elimination of pain and infection.

Treatment of injuries.

Elimination of diseases of bone and soft tissues.

Treatment of anomalies.

1 Restoration of carious or fractured teeth.

2 Maintenance or recovery of space when this service will have an effect on occlusion.

3 Replacement of missing permanent teeth.

4 Treatment of malocclusions with priority provided for interceptive service and disfiguring or handicapping  
5 malocclusions.

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

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

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

#### 14 **Administration**

15 The administration of a Dental Health Program for Children should be based on full cooperation among the  
16 dental profession, the public and private agencies. Governmental health agencies have traditionally relied on  
17 advisory committees composed of nongovernmental experts and the lay public to assist in establishing  
18 policies and guidelines relating to the planning and operation of a publicly funded program. The use of  
19 advisory committees at national, state and local levels to assist governmental agencies in managing program  
20 responsibilities for a Dental Health Program for Children is essential. The use of private agencies to share in  
21 the administration and operation of governmental health care programs has also had a history of success. In  
22 the administration of grants for dental treatment programs, provision should be made for the use of an  
23 intermediary, such as the dental service corporation or the commercial insurance company. Voluntary  
24 prepayment organizations are now acting as fiscal intermediaries for such longstanding programs as the  
25 Dependents' Medical Care and the Federal Employees' Health Benefits Programs. Congress has also  
26 recognized the desirability of continuing this system of sharing administration in the new Title XVIII of the  
27 Social Security Act. Guidelines for Title XIX of the same Act give assurance that this principle will be applied  
28 to the newly expanded program for public assistance recipients. The use of private, voluntary prepayment  
29 organizations in the administration and operation of the American Dental Association Dental Health Program  
30 for Children should be specified in the enabling legislation and in guidelines for the program.

31 **National Level:** At the national level, where ultimate responsibility and authority for the approval of publicly  
32 funded plans lie, the program should be administered by the Secretary of the Department of Health,  
33 Education and Welfare, through the Division of Dental Health of the Public Health Service. The Secretary and  
34 the Division of Dental Health should have advice and assistance from an interagency committee, including  
35 representation from the Office of Education, all Department of Health, Education and Welfare agencies with  
36 dental programs, and from other agencies, such as the Department of Defense and the Office of Economic  
37 Opportunity, which have significant dental interests. A national advisory committee should be established to  
38 assist the Secretary in the administration of publicly funded elements of the program. The committee should  
39 be composed of dentists and members of the lay public.

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

1 advisory committee, composed of representatives of the dental profession and the lay public, to assist state  
2 health department officials.

3 **Local Level:** At the local level, the public funded elements of the program should be administered by an  
4 agency recognized by the state health department. There should be a local advisory dental committee,  
5 composed of representatives of the dental profession and the lay public, to assist the agency recognized by  
6 the state health department.

7 **Financing the Program Present Funding:** In the development of a Dental Health Program for Children,  
8 cost will be one of the significant factors. It has been increasingly apparent that the contribution of the private  
9 sector must be augmented by governmental assistance. The traditional method for sharing costs between  
10 federal and state governments is the grant-in-aid mechanism which has been in successful operation for  
11 many years. Limited funds are available at the present time to initiate the dental program, although it must be  
12 recognized that new legislation will be essential both to provide the additional funds needed for a total  
13 program and to provide one channel for funds which are now disbursed by many agencies of the federal  
14 government. The Department of Health, Education and Welfare now channels funds for dental programs of  
15 some type through the following seven agencies: Children's Bureau, Welfare Administration; Bureau of Family  
16 Services, Welfare Administration; Division of Community Health Services, Bureau of State Services, Public  
17 Health Service; Division of Indian Health, Bureau of Medical Services, Public Health Service; Division of  
18 Dental Health, Bureau of State Services, Public Health Service; Division of Hospital and Medical Facilities,  
19 Bureau of Medical Services, Public Health Service and Division of Plans and Supplementary Centers, Office  
20 of Education. In addition, the independent Office of Economic Opportunity provides funds for dental programs  
21 through its Community Action Program which includes Project Head Start. It should be clear that no federal  
22 funds are available for dental programs for the children of nonindigent or nonmedically indigent families,  
23 except for certain dependents of federal employees. Funding of a dental health program for nonindigent  
24 children must be derived from the private sector of the economy—on a voluntary basis.

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

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

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

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

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

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

## 8 **New Legislative Authority**

9 New federal legislation will eventually be needed if there is to be an orderly development of a Dental Health  
10 Program for Children. Even though existing law provides a large measure of authority to finance dental care  
11 costs of several million indigent and dentally indigent children, the system for allocating these federal funds  
12 does not adequately assure that resulting programs will have professional guidance or standards to achieve  
13 the quality of care available from private dental practitioners today. Equally objectionable is the system's  
14 inflexibility. Title XIX of the Social Security Act, for example, is designed to provide comprehensive care to all  
15 needy and near needy persons. But there is no way under Title XIX for a state to concentrate its dental  
16 resources upon children; nor is there provision for designing an orderly plan that will permit the states to  
17 enlarge programs by age groups, an approach that is essential under existing limitations of both manpower  
18 and funds. Legislation should be sought first to provide federal project grants for pilot programs in at least 40  
19 communities throughout the country. After a sufficient time has elapsed to evaluate the pilot programs, a  
20 permanent legislative design should be fashioned to provide the states the opportunity to bring all children  
21 within the Dental Health Program for Children, with provision for appropriate cost sharing by federal, state and  
22 local governments and private and voluntary agencies.

## 23 **Conclusion**

24 The American Dental Association, on the basis of its unique competence in the field of dentistry and under its  
25 obligation to foster the improvement of personal and national health, recommends a national dental health  
26 program for the children of the United States. Such a program has been the objective of the Association and  
27 of the dental profession for many years. Strong national attitudes predict that such a program can now be  
28 initiated with new potential for adequate funding. Legislation is already in existence to provide much of the  
29 administration and support which will be needed to initiate the program. The program should be started by the  
30 selection of a number of communities which will establish pilot or exploratory programs to provide the  
31 professional, administrative, statistical and other data which are needed to guide the national program in its  
32 future development. Funding will be largely on the traditional grant-in-aid basis and responsibility for the  
33 planning and operation of the program will rest heavily at state and local levels. The advice of the dental  
34 profession will be made continuously available through the establishment of advisory councils at all levels.  
35 The community should have the responsibility for the essential design of its program in order to meet local  
36 needs and conditions. All dental services should be provided under the program which are necessary to  
37 prevent disease and to restore and maintain oral health. The program must ensure the provision of the  
38 highest quality of dental care and special emphasis must be placed on preventive services. All preschool and  
39 school children through the age of 18 should eventually be included in a national program. There should be a  
40 continuing, organized program of dental health and patient education. Existing facilities and resources,  
41 especially those of private practice, should be fully utilized and plans should be developed to provide an  
42 adequate supply of well qualified dental personnel for the program. State and local health departments  
43 should have a major role in the administration of the program. Administration at the national level should be  
44 coordinated through an interagency committee with representation from all federal agencies having a role in  
45 the dental program. The translation of this program into reality in the predictable future will require a new  
46 awareness on the part of many agencies and individuals of the value of dental health services to the  
47 individual child, the community, state and nation. Dentists and dental societies must apply their professional  
48 knowledge and leadership effectively by cooperation with the administering agencies at all levels. Only a full  
49 partnership of the profession and those administering the program can convert the Dental Health Program for

- 1 Children to a national asset that will bring returns for many years to come in terms of a healthier and stronger
- 2 nation.

Resolution No. 104 NewReport: CAPIR Supplemental Report 1 Date Submitted: September 2012Submitted 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  FTE 0ADA Strategic Plan Goal: Collaboration (Required)

1 **AMENDMENT OF THE POLICY, PERSONS WITH SPECIAL NEEDS**

2 **Background:** (See CAPIR Supplemental Report 1, Worksheet:4073)

3 **Resolution**

4 **104. Resolved**, that the ADA policy on Persons with Special Needs (*Trans.*2002:390) be amended as  
5 follows (additions are underscored, deletions are ~~stricken~~):

6 **ADA Policy on the Aged, Blind and Disabled ~~Persons with Special Needs~~**

7  
8 **Resolved**, that the Association supports appropriate initiatives and legislation to improve and  
9 foster the oral health of aged, blind and disabled persons ~~with special needs~~, and be it further

10 **Resolved**, that “people with intellectual disabilities” be utilized when referring to persons  
11 previously acknowledged as “mentally retarded”, and be it further

12 **Resolved**, that constituent and component dental societies be encouraged to support state  
13 and local initiatives and legislation to improve the oral health of aged, blind and disabled  
14 persons ~~with special needs~~, and be it further

15 **Resolved**, that dental and allied dental programs be encouraged to educate students about  
16 the oral health needs and issues of aged, blind and disabled persons ~~with special needs~~.

17 **BOARD RECOMMENDATION: Vote Yes.**

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

20 \*Dr. Faiella was absent.

21 Resolution 104

Resolution No. 105 NewReport: CAPIR Supplemental Report 1 Date Submitted: September 2012Submitted 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 \_\_\_\_\_ FTE 0ADA Strategic Plan Goal: Collaboration (Required)**AMENDMENT OF THE POLICY, NON-DENTAL PROVIDERS COMPLETING EDUCATIONAL PROGRAMS ON ORAL HEALTH****Background:** (See CAPIR Supplemental Report 1, Worksheet:4073)**Resolution****105. Resolved**, that the ADA policy, Non-Dental Providers Completing Educational Programs on Oral Health (*Trans.*2004:301) be amended as follows (additions are underscored, deletions are ~~stricken~~):**Non-Dental Primary Care Providers Completing Educational Program on Oral Health****Resolved**, that ~~only~~ dentists, physicians, non-dentist primary care providers, and their properly supervised and trained designees, be ~~allowed~~ encouraged to provide preventive dental services to infants, ~~and~~ young children, and patients of all ages, and be it further**Resolved**, that ~~anyone that provides~~ primary care providers who deliver preventive dental services ~~to infants and young children~~ should have completed an appropriate educational program on oral health, common oral pathology, dental disease risk assessment, dental caries and dental preventive techniques appropriate for this the age groups under their care, and be it further**Resolved**, that oral health risk assessment, anticipatory guidance, oral hygiene instruction, fluoride varnish, are appropriate preventive services that should be promoted across disciplines, and be it further**Resolved**, that the definition of non-dentist primary care provider include physicians, nurses, physician assistants and pharmacists, and be it further**Resolved**, that the ADA supports the development of interprofessional education and core competencies specific to the delivery of preventive dental services by non-dentist primary care providers, and be it further**Resolved**, that the ADA urge constituent societies to support this policy.**BOARD COMMENT:** The Board appreciates the work of the Council on Access, Prevention and Interprofessional Relations and recognizes the dedication of the Council under its *Bylaws* authority to providing leadership, vision and coordination of the ADA's activities to advance oral health care within the

1 health delivery system, promote prevention as the cornerstone of oral health and improve access to oral  
 2 health services for underserved populations. The Board, however, engaged in extensive discussion and  
 3 voiced several concerns with Resolution 105. These include definition of a non-dentist primary care provider  
 4 and scope of dental services that would be encouraged to be provided (i.e., what is the definition of  
 5 preventive dentistry). Therefore, the Board recommends that Resolution 105 not be adopted.

6 **BOARD RECOMMENDATION: Vote No.**

7 **Board Vote: Resolution 105**

BLANTON	No	GOUNARDES	No	NORMAN	No	SUMMERHAYS	Absent
DOW	No	HAGENBRUCH	No	RICH	No	VIGNA	No
ENGEL	No	ISRAELSON	No	ROBERTS	No	WEBER	No
FAIELLA	Absent	KIESLING	No	SEAGO	No	VERSMAN	No
FEINBERG	No	LOW	No	STEFFEL	No	YONEMOTO	No

Resolution No. 106 NewReport: N/A Date Submitted: September 2012Submitted 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 \_\_\_\_\_ FTE 0ADA Strategic Plan Goal: Collaboration (Required)**AMENDMENT OF THE POLICY, NON-DENTAL PROVIDERS NOTIFICATION OF PREVENTIVE DENTAL TREATMENT FOR INFANTS AND YOUNG CHILDREN****Background:** (See Council on Access, Prevention and Interprofessional Relations Supplemental Report 1, Worksheet:4073)**Resolution****106. Resolved**, that the ADA policy, Non-Dental Primary Care Providers Notification of Preventive Dental Treatment for Infants and Young Children (*Trans.*2004:303), be amended as follows (additions are underscored, deletions are ~~stricken~~):**Non-Dental Primary Care Providers Notification of Preventive Dental Treatment for Infants and Young Children****Resolved**, that prior to any preventive dental treatment of an infant or young child a dental disease risk assessment should be performed by a dentist or appropriately trained physician primary care provider, and be it further**Resolved**, that risk assessments, screenings or oral evaluations of infants and young children by non-dentists primary care providers are not to be considered comprehensive dental exams, and be it further**Resolved**, that it is essential that non-dentists primary care providers who provide preventive dental services to an infant or young child ~~notify a dentist of the custodial parent/legal guardians choosing as to what services were rendered and~~ refer the patient to a dentist for a comprehensive examination and to establish a dental home.**BOARD COMMENT:** The Board appreciates the work of the Council on Access, Prevention and Interprofessional Relations and recognizes the dedication of the Council under its *Bylaws* authority to providing leadership, vision and coordination of the ADA's activities to advance oral health care within the health delivery system, promote prevention as the cornerstone of oral health and improve access to oral health services for underserved populations. The Board, however, believes Resolutions 105 and 106 need to be considered together in any policy change. The Board, therefore, recommends that Resolution 106 not be adopted.

1 **BOARD RECOMMENDATION: Vote No.**

2 **Board Vote: Resolution 106**

BLANTON	No	GOUNARDES	No	NORMAN	No	SUMMERHAYS	Absent
DOW	No	HAGENBRUCH	No	RICH	Yes	VIGNA	No
ENGEL	No	ISRAELSON	No	ROBERTS	No	WEBER	No
FAIELLA	Absent	KIESLING	No	SEAGO	No	VERSMAN	No
FEINBERG	No	LOW	No	STEFFEL	No	YONEMOTO	No

Resolution No. 107 NewReport: CDP Supplemental Report 1 Date Submitted: September 2012Submitted By: Council on Dental PracticeReference Committee: Dental Benefits, Practice and HealthTotal Net Financial Implication: None Net Dues Impact: Amount One-time  Amount On-going  FTE 0ADA Strategic Plan Goal: Members (Required)**COUNCIL ON DENTAL PRACTICE SUPPLEMENTAL REPORT 1 TO THE HOUSE OF DELEGATES: THE EMERGING ISSUE OF TELEDENTISTRY**

**Background:** In 2011, the House of Delegates tasked the Council on Dental Practice with investigating and reporting on the development of teledentistry as it relates to dental practice. Resolution 61H-2011 (*Trans.*2011:459) reads:

**61H-2011. Resolved**, that the Council on Dental Practice, in collaboration with other appropriate ADA agencies, investigate the emerging issue of teledentistry as it relates to dental practice and report to the 2012 House of Delegates, and be it further

**Resolved**, that a representative of the ADA Division of Dental Practice attend the 2012 American Telemedicine Association Meeting with a report to the 2012 House of Delegates.

The Council formed a subcommittee to address this resolution. Articles and resources were collected, reviewed and discussed throughout the year. This report of is a summary of findings, culminating with policy recommendations.

**Telemedicine and Teledentistry:** Telephone consultations between patients and clinicians have been in use for many years. Radios have linked emergency responders to nurses or physicians at central hospitals or medical centers for years as well. With the development of computer technologies and telecommunications, telemedicine has markedly advanced in the past 30 years and particularly in the past 10 years as telecommunication costs decreased.

Telemedicine is a broad term used to describe electronic medical information exchange over a distance. In 1997, the federal government defined telemedicine as "the use of electronic communication and information technologies to provide or support clinical care at a distance."<sup>1</sup> The American Telemedicine Association has defined it as "the use of medical information exchanged from one site to another via electronic communications to improve patients' health status."<sup>2</sup> The state of California defines telehealth as the practice of healthcare, delivery, diagnosis, consultation, treatment and education using interactive audio, video or data communication.<sup>3</sup>

Teledentistry is the branch of telemedicine that is concerned with dentistry. The term "teledentistry" has been used since 1997<sup>4</sup> and while there is no set definition of the term, it has generally been understood to include the use of telecommunications equipment to aid in the delivery of dentistry between dentists, specialists and the patients that they treat. The Georgia Board of Dentistry defines teledentistry as "the practice of dentistry at a distance through the use of electronic information, imaging and communication technologies." These technologies include "interactive audio, video, and data communications as well as store-and-forward technologies, to provide and support dental care delivery, diagnosis, consultation, treatment, transfer of medical data and education."<sup>5</sup>

1 In this report, teledentistry will include the use of information technology to send data, graphics, audio, images  
2 and video for the purpose of clinical care and/or education between participants who are physically separated.  
3 Teledentistry is a combination of telecommunications (including the use of computers and the Internet) and  
4 dentistry, involving the exchange of clinical information and images over remote distances.

5 **Technological Requirements:** Computer knowledge is necessary in order for dental care practitioners to  
6 participate in teledentistry. While most people are now comfortable using equipment such as computers,  
7 intraoral cameras, email and chat, there may be the occasional technical difficulty that requires technical skills  
8 to correct. This could include network connections, bandwidth, etc. Digital radiography is easiest to use with  
9 teledentistry, but incorporating scanning capabilities can enable traditional radiographs to be transmitted as  
10 well.

11 Hardware, software and network connections are needed. Minimally, a computer with an adequate hard drive  
12 and fast processor is necessary. Digital cameras, intraoral cameras, a digital x-ray unit, webcam, and  
13 imaging software are often needed. Dial up internet connections are not adequate for teledentistry; internet  
14 connections via broadband, a digitally subscribed line (DSL) connection, cable and satellite modems,  
15 integrated service digital networks (ISDN) and/or high capacity T1 lines are recommended.<sup>6</sup>

16 Lack of interoperability between practice management systems is another barrier to adoption of teledentistry.  
17 Because personal preferences often determine what type of technology is used, such as one practice  
18 management system over another, or one computer operating system over another, compatibility may be an  
19 issue. This could result in barriers that prevent the transmittal of information such as charts, imaging or data  
20 between practitioners. Establishing a support system that is compatible within teleconference locations will  
21 reduce the risks of technical difficulties when transferring data.

22 The ADA endorses the use of DICOM (Digital Imaging and Communications in Medicine) as the standard  
23 means to exchange patient images. In 2011, ADA's Standards Committee on Dental Informatics (SCDI)  
24 published a new technical report to extend DICOM's specifications using email exchanges, Attachment of  
25 DICOM Datasets Using E-Mail in Dentistry (Technical Report No. 1048).<sup>7</sup> Another technical report, Secure  
26 Exchange and Utilization of Digital Images in Dentistry (Technical Report No. 1060) outlines methods for  
27 secure electronic exchange of diagnostic quality digital radiographs, photographic images and other imaging  
28 used in dentistry.<sup>8</sup>

29 **Implementation of Teledentistry in the United States:** Use of teledentistry was first described by the U.S.  
30 Army in 1994.<sup>9</sup> The Total Dental Access Project (TDA) focused on three core areas; patient care, continuing  
31 dental education and dentist-laboratory communications. This was seen as the frontier of teledentistry, where  
32 information technology was used to provide clinical care support.<sup>10</sup> Deemed successful, the project proved to  
33 reduce overall costs, improve lines of communication and reach more remote areas.

34 Several states or dental schools have initiated projects in teledentistry. The University of Nebraska began a  
35 teledentistry project to operate in conjunction with Nebraska's statewide telehealth network in 2003. Major  
36 functions of the network were to provide education for patients and providers, improve quality of care and to  
37 serve as a communication source in the event of an emergency. Two federally qualified health centers were  
38 linked to the network, and teledentistry consisted of consultations for oral pathology and endodontics. Real  
39 time continuing education was also accessed through the network.<sup>11</sup>

40 The Division of Dentistry at Children's Hospital Los Angeles obtained funding in 2003 to establish school  
41 based clinics for high risk children through a high speed computer network that provided for  
42 videoconferencing and real time remote input from the hospital's oral health care, craniofacial, medical and  
43 other subspecialty professionals.<sup>12</sup>

44 In 2005, a teledentistry and distance learning project were initiated by the University of Florida to improve  
45 access to oral health and improve the educational experiences of dental students and other practitioners at  
46 community based clinics.<sup>13</sup> Also in 2005, the University of Minnesota created a telecommunications network

1 that linked university specialists with dentists and dental students in rural remote sites.<sup>14</sup>

2 Arizona's Department of Health Services received a grant from the federal government to develop a  
3 teledentistry project. By 2009, five sites were involved in the project, including a remote site (Hopi Health  
4 Care Center Dental Program) and the Scottsdale neighborhood outreach program. The project highlighted  
5 demonstration practice models using enhanced dental teams and developed regional and local  
6 infrastructure.<sup>15</sup>

7 **Research in Teledentistry:** Few studies documenting the accuracy of teledental interactions have been  
8 published.

9 In 1995, a Haiti pilot study was used to connect dental specialists in Washington, D.C., to general dentists  
10 using a satellite system for teleconsultation.<sup>16</sup> Video quality in this study was poor and proved insufficient for  
11 accurate diagnosis. Results of the study showed that the low quality of teleconsultation equipment  
12 transmitted images that were inadequate as diagnostic tools. At the time, a low bit rate satellite system was  
13 used for the teledentistry program. Telecommunication devices have become much more advanced since  
14 this pilot program was conducted.

15 Orthodontic referrals were studied in a British controlled trial in 2005. Orthodontic consultants reviewed  
16 patient information remotely via a 'store and forward' system to determine appropriateness for orthodontic  
17 referral; and the same decision was made in a dental clinic. It was found that teledentistry was a valid system  
18 for identifying patients for orthodontic referral.<sup>17</sup> 'Store and forward' is a term used to describe the transfer of  
19 patient data from one site to another through the use of an intermediate station and then to a final destination.  
20 For example, the intermediate station could be a hard drive, flash drive, DVD or similar technology.<sup>17</sup>

21 Screening children for oral disease using both teledentistry and direct visual exams was studied in 2007.  
22 While a greater proportion of children were observed to have caries using transmitted images than through  
23 direct observation (42%:28%), the difference was not found to be statistically significant.<sup>18</sup>

24 A preliminary teledentistry study conducted in Peru and published in 2008 suggested that distance diagnosis  
25 using two practitioners resulted in a more successful identification of oral lesions.<sup>19</sup> Eighty-eight percent of  
26 oral lesions were diagnosed accurately through the use of digital photographs when reviewed by two  
27 practitioners. A similar study showed that when three photographs were taken of a patient and remotely  
28 analyzed by four separate dentists, the remote diagnosis had accuracy up to 100%.<sup>20</sup> Results of the studies  
29 suggest that co-diagnosis through teledentistry would extend quality patient care and accuracy in treatment  
30 planning.

31 A 2008 study found no difference between groups of patients when general dentists provided interceptive  
32 orthodontic treatment to socially disadvantaged children regardless of the method of oversight. One group of  
33 dentists provided treatment under the direct supervision of an orthodontist, and the second group provided  
34 care using teledental communication with an orthodontist.<sup>21</sup>

35 In Serbia, a 2009 study assessing the diagnostic agreement of remote dentists and real time dentists  
36 concerning impacted wisdom teeth found almost complete agreement.<sup>22</sup>

37 A study regarding the marking of root canal locations prior to endodontic therapy by a non-specialist  
38 practitioner was conducted and published in 2011.<sup>23</sup> The maximum proportion of accurate detections was  
39 related to years of professional experience. Use of teledentistry could allow experienced dentists to guide  
40 less experienced practitioners and improve the overall success of the procedure.

41 Use of teledentistry in Alaska's Dental Health Aide Therapist (DHAT) program was reported in a recent  
42 publication of the *Journal of Public Health Dentistry*. DHATs are supervised by dentists in remote locations  
43 through the Indian Health Service investment in telemedicine.<sup>1</sup>

Virtual dental examinations were studied in the Pacific Center for Special Care at the University of the Pacific School of Dentistry. Their report, published in 2012, concluded that a virtual exam is a strong substitute for an in person examination.<sup>24</sup>

**Potential Impact on the Dental Profession:** The technological tools to implement teledentistry are available today. However, there are several practical concerns that must be overcome before teledentistry could be widely implemented.

*Interoperability.* All commercially available digital dental radiographic systems are not compliant with the voluntary DICOM standard. Some DICOM capable systems continue to use proprietary formats. The development of interoperable electronic health records is still emerging. Integration of these electronic elements is important to the acceptance of teledentistry.

*Licensure.* States have been recognized as the appropriate jurisdictions to determine licensure of dentists. State licensure is a critical element in preserving that standard of practice and for the protection of citizens of the state.

When dentists provide clinical consultations with other dentists or directly with patients across state lines, licensure issues must be addressed. The traditional application of state dental practice acts requires a 'teledentist' be licensed in both the state where the patient resides and the state in which the service is provided.<sup>25</sup> Obtaining licensure in every state that a teledentist would wish to practice would be time consuming and costly. While the majority of dentists have a state license, some in the military or Indian Health Service have a federal license that allows them to practice in any state.<sup>26</sup> Some groups have proposed adopting a limited national licensure to allow for the expansion of teledental services. The ADA's Position Statement on Federal Intervention in Licensure (*Trans.*1975:187, 718) states that "the American Dental Association strongly opposes federal licensure and federal intervention in the state licensing system."

The American Telemedicine Association advocates for state licensure reciprocity or other solutions to simplify the delivery of telemedicine services. Some states have begun to address this issue.

Teledentistry is expressly addressed in Alabama, California, Kentucky, Missouri, Maine and New Mexico's state laws.<sup>27</sup>

- Alabama provided for a new type of special purpose license to out of state licensed dentists, limited to practice across state lines only. These licenses would be issued only to applicants that grant similar licenses to Alabama dentists.
- California applied dentistry to the Telemedicine Development Act, and provided an out of state practitioner may in conjunction with an in-state licensed practitioner, deliver services using interactive audio, video or data communications with the informed consent of the patient.
- Kentucky required informed patient consent and confidentiality of the patient's medical information be maintained.
- Missouri prohibited the practice of teledentistry without a Missouri license.
- Maine allowed teledental consultations provided that recommendations are made to a dentist licensed in Maine.
- New Mexico allowed for in state telehealth care to help in underserved areas.

Georgia's Board of Dentistry published a proposed rule regarding teledentistry in 2010.<sup>5</sup> Although not yet adopted, the proposal would generally allow a dentist licensed in any state to deliver a teledental service in Georgia, provided that the in-state dentist is licensed in Georgia and is responsible for the diagnosis and treatment of the patient.

*Referral.* Teledentistry has the potential to greatly increase access to dental specialists. The U.S. Department of Health and Human Services (HHS) reported that by the end of 2011 there was a shortage of

1 4,670 dental health professionals within the U.S. While discussions on the accuracy of this number are  
2 ongoing, it is generally agreed that there is a maldistribution of dentists in the United States. Nationally, 65%  
3 of these HHS shortages occurred in non-metropolitan areas.<sup>28</sup> Dentists who practice in rural areas may have  
4 limited options for patient referral to specialists.

5 Multiple disciplines within the dental field can use telecommunication technology as a way to discuss  
6 appropriate diagnosis and treatment for patients. Dental specialists in disciplines such as oral and  
7 maxillofacial radiology and oral pathology are especially well suited for teledentistry, because their diagnostic  
8 and consultative skills can sometimes be performed from a site that is distant to the patient and treating  
9 dentist. Some preliminary studies have found orthodontists can assist general dentists in the delivery of  
10 interceptive orthodontic treatment<sup>21</sup>; identification of root canal locations can assist practitioners<sup>23</sup>; and the  
11 need for oral surgery can be determined via teledental consultation.<sup>22</sup>

12 *Malpractice/Informed Consent.* Malpractice is defined as “an act of negligence committed by a member of a  
13 profession in the performance of professional services in which there has been a departure from the standard  
14 of care to which the profession is held.”<sup>29</sup> Malpractice risks are inherent in any doctor-patient interaction.  
15 Questions that may arise include which state law would apply (the patient’s or the teledentist’s) and which  
16 standard of care would apply. Requirements for informed consent using teledentistry may differ from  
17 traditional requirements. For example, the patient may need to be informed of any risks associated with  
18 distance diagnosis.

19 *HIPAA/HITECH.* Many dental offices are covered health care providers under HIPAA because they transmit  
20 covered transactions electronically (e.g., claims, eligibility, authorization, etc.), or because they use another  
21 entity (such as a clearinghouse) to conduct covered transactions in electronic form on their behalf. HIPAA  
22 covered entities must comply with the provisions of the HIPAA Privacy Rule, the HIPAA Security Rule, and  
23 the HITECH Breach Notification Rule. It is reasonable to assume that many dentists or dental practices  
24 involved in teledentistry are covered entities under these provisions.

25 When implementing teledentistry procedures, it may be necessary to work with qualified counsel to ensure  
26 that HIPAA compliance requirements, such as policies and procedures, documentation, and training, are  
27 complete and up to date. The practice’s HIPAA Notice of Privacy Practices and informed consent forms  
28 should be reviewed to determine whether they need to be updated to include information about teledentistry  
29 practices.

30 A security risk analysis should be performed as it would be for any new workflow, and the findings should be  
31 documented. The findings of the risk analysis should then inform development of reasonable, prudent  
32 policies with appropriate procedures for workforce members to follow in likely teledentistry scenarios.

33 To minimize the risk of a Breach Notification situation, all electronically stored and transmitted patient  
34 information should be appropriately encrypted where and whenever it is possible to do so. Covered dentists  
35 should also implement other administrative, physical, and technical access controls so that electronic  
36 protected health information remains accessible only to authorized users.

37 Special consideration should be paid to business associate agreements. New agreements may be needed  
38 with teledentistry tech support companies, individuals such as videographers, health information exchanges,  
39 or prescription gateways. Business associate agreements must comply with HIPAA Privacy and Security  
40 Rule requirements. Additional provisions regarding issues such as subcontracting or assignment of duties,  
41 indemnification, and the provision of liability insurance may also be appropriate. If your potential new  
42 business associate is located overseas, there may be additional legal concerns. The dental practice may  
43 itself become the business associate of another covered entity if the dental practice performs an activity  
44 involving protected health information on behalf of the covered entity. There may be additional legal concerns  
45 related to state law (such as state data security laws), and industry standards for protecting sensitive  
46 personally identifiable information.

1 *Payment for Services.* The Centers for Medicare and Medicaid Services (CMS) defines telehealth services to  
2 include those that require a face-to-face meeting with the patient. A medical model for procedure  
3 reimbursement is found in CMS's Medicare's coverage of telemedicine or telehealth services. There are  
4 three major areas for reimbursement: remote patient, face-to-face services via live video conferencing; non  
5 face-to-face services via video conferencing or store and forward technology; and home telehealth services.  
6 Eligible services include consultations, office visits, individual psychotherapy and pharmacologic  
7 management. A special modifier is used to indicate the service was provided through a telecommunications  
8 system. Reimbursement levels are the same as for traditionally delivered services.<sup>30</sup>

9 Payment for services rendered is the traditional method used to generate revenues in dental  
10 practice. Currently, there are no dental procedure codes specific to teledentistry in the *Code on Dental*  
11 *Procedures and Nomenclature (CDT Code)*. The consultation code requires the consultant to perform an oral  
12 evaluation, which implies an in-person encounter.<sup>31</sup> Office visits are not routinely billed as  
13 procedures. Although the *CDT Code's* unspecified codes are available for reporting teledental consultations,  
14 the lack of accurately descriptive coding may make reimbursement difficult for dentists who deliver these  
15 services.

16 Transmission of data and imaging for insurance and third-party benefit administration would be facilitated by  
17 teledentistry capabilities.

18 *Supervision of Auxiliary Staff.* The ADA's Comprehensive Policy Statement on Allied Dental Personnel  
19 (*Trans.*1996:699; 1997:691; 1998:713; 2001:467; 2002:400; 2006:307; 2010:505) recognizes several types of  
20 supervision of auxiliary staff. Personal, direct and indirect supervision require an on-site role for dentists.  
21 Two types of supervision do not require on-site presence of a dentist:

22 *General Supervision.* A type of supervision in which a dentist is not required to be in the  
23 dental office or treatment facility when procedures are provided, but has personally  
24 diagnosed and treatment planned the condition to be treated, has personally authorized the  
25 procedures, and will evaluate the performance of the allied dental personnel.

26 *Public Health Supervision.* A type of supervision in which a licensed dental hygienist may  
27 provide dental hygiene services, as specified by state law or regulations, when such services  
28 are provided as part of an organized community program in various public health settings, as  
29 designated by state law, and with general oversight of such programs by a licensed dentist  
30 designated by the state.

31 Expansion of public health programs using teledentistry to supervise dental hygienists may positively  
32 impact underserved communities, such as nursing home residents, home bound patients or schools.  
33 Remote supervision via teledentistry is not included in current ADA policy.

34 *Long Distance, Lifelong Learning.* Telecommunications allows advanced opportunities for professionals to  
35 further their education and build skills. The U.S. Army has used teledentistry in postgraduate dental  
36 residency programs for several years.<sup>32</sup> Many dental care practitioners are already familiar with online  
37 continuing education opportunities. Teledentistry offers more advanced teaching methods because it allows  
38 virtual face-to-face communication with peers and immediate feedback. The ability to have real-time or even  
39 delayed interaction can allow for new opportunities in dental education because general practitioners will have  
40 easier access to consultation and postgraduate education.<sup>33</sup>

41 The use of telecommunications could also enhance distance education learning that typically takes place  
42 through self-directed continuing education web-based programs. While self-instruction courses allow students  
43 to learn at their own pace, researchers found that the lack of verbal communication between the student and  
44 course instructor was a primary cause for course dissatisfaction in 38.8% of the participants.<sup>16</sup> By allowing an  
45 instructor to interact personally with off-site dentists, instructors would be able to provide individualized  
46 learning priorities and address individual questions.

**Conclusion:** Some of the potential benefits of teledentistry include improved consultative, diagnostic and/or treatment services to patients; enhanced educational opportunities for dentists; and improved access to care through remote supervision of auxiliary staff. Legal, technological, and financial considerations need to be addressed to enable the adoption of teledentistry.

Teledentistry is an evolving field that offers the potential to improve patient outcomes through consultation, distance learning and increased access to care. Therefore, the Council recommends adoption of the following resolution.

### Resolution

**107. Resolved,** that the following definition of teledentistry be adopted:

Teledentistry, a component of telehealth, is the electronic exchange of dental patient information from one geographic location to another for interpretation and/or consultation among authorized healthcare professionals. Teledentistry utilizes both information and communication technologies and includes the electronic exchange of diagnostic image files, including radiographs, photographs, video, optical impressions and photomicrographs of patients.

and be it further

**Resolved,** that dentists should be encouraged to consider conformance with the Digital Imaging and Communications in Medicine (DICOM) standards when selecting and using imaging systems, and be it further

**Resolved,** that the appropriate ADA agencies develop standards and implementation guidelines to assist dentists with all aspects of teledentistry.

**BOARD COMMENT:** Teledentistry is a reality and is not going away. The ADA must ensure that its activities related to teledentistry, including the development of standards and guidelines, will comply with ADA's policy positions that dentists are solely responsible to provide diagnostic, treatment planning and irreversible procedures to patients. Through their own laws governing teledentistry, states must determine whether their citizens are best served by dentists living and licensed in the state or by dentists living and licensed outside of the state.

**BOARD RECOMMENDATION: Vote Yes.**

**Board Vote: Resolution 107**

BLANTON	Yes	GOUNARDES	Yes	NORMAN	Yes	SUMMERHAYS	Absent
DOW	Yes	HAGENBRUCH	Yes	RICH	Yes	VIGNA	Yes
ENGEL	Yes	ISRAELSON	Yes	ROBERTS	Yes	WEBER	Yes
FAIELLA	Absent	KIESLING	Yes	SEAGO	Yes	VERSMAN	Yes
FEINBERG	Yes	LOW	Yes	STEFFEL	Yes	YONEMOTO	Yes

Resolution No. 107S-1 SubstituteReport: N/A Date Submitted: October 2012Submitted By: Fifth Trustee DistrictReference Committee: Dental Benefits, Practice and HealthTotal Net Financial Implication: None Net Dues Impact: \_\_\_\_\_Amount One-time \_\_\_\_\_ Amount On-going \_\_\_\_\_ FTE 0ADA Strategic Plan Goal: Members (Required)**SUBSTITUTE FOR RESOLUTION 107: TELEDENTISTRY**

The following substitute for Resolution 107 (Worksheet:4099) was adopted by the Fifth Trustee District and transmitted on October 4, 2012, by Ms. Connie Lane, executive director, Mississippi Dental Association.

**Background:** Due to technological advances, teledentistry is a growing trend that will continue to become more important to dentists in the future as an effective and efficient means of patient information sharing and health care delivery. It is imperative that the profession of dentistry establish the parameters and acceptable professional licensure requirements for those professionals who engage in the practice of teledentistry.

**Resolution**

**107S-1. Resolved,** that the following definition of teledentistry be adopted (additions underscored; deletions ~~stricken~~):

Teledentistry, a component of telehealth, is the electronic exchange of dental patient information from one geographic location to another for interpretation and/or consultation among ~~authorized healthcare professionals~~ licensed physicians and dentists. Teledentistry utilizes both information and communication technologies and includes the electronic exchange of diagnostic image files, including radiographs, photographs, video, optical impressions and photomicrographs of patients.

and be it further

**Resolved,** that dentists should be encouraged to consider conformance with the Digital Imaging and Communications in Medicine (DICOM) standards when selecting and using imaging systems, and be it further

**Resolved,** that the appropriate ADA agencies develop standards and implementation guidelines to assist dentists with all aspects of teledentistry.

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

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Resolution No. 109 NewReport: CDP Supplemental Report 2 Date Submitted: September 2012Submitted By: Council on Dental PracticeReference Committee: Dental Benefits, Practice and HealthTotal Net Financial Implication: None Net Dues Impact: \_\_\_\_\_Amount One-time \_\_\_\_\_ Amount On-going \_\_\_\_\_ FTE 0ADA Strategic Plan Goal: Members (Required)**COUNCIL ON DENTAL PRACTICE SUPPLEMENTAL REPORT 2 TO THE HOUSE OF DELEGATES:  
DENTAL SOCIETY FUNDING FOR CONSTITUENT DENTIST WELL-BEING PROGRAMS**

**Background:** The ADA supports efforts by constituent and component dental societies in the development, maintenance, and collaboration with diversion programs to identify and assist dentists and dental students affected by addiction and impairment issues which impair their ability to practice dentistry. Dentist well-being programs do not financially support the treatment of their members but rather the peer-assistance activities at the constituent level. These programs have been found to have an 80-90% success rate in maintaining a dentist's recovery, thereby preserving the quality of performance, protection of the patient and well-being of the dentist.

As noted in the Council's 2011 Constituent Dental Society Well-Being Committee Survey, an average budget for a constituent dental society's dentist well-being program was \$3,500. Of the 35 constituent society dentist well-being programs that responded, 14 have enacted a dental society line item to pay for dentist well-being activities. Eight of the 43 constituent society dentist well-being programs are funded through member donations. For states with contracted diversion programs, additional funds are needed for marketing, educational programs and funding for legislative activities. However, the majority of constituent society dentist well-being programs are working with diminished resources while continuing to provide education and treatment programs for both dental students and established practitioners.

Resolution 110H-2010 (*Trans.*2010:543, 564), Advocating for Victims of Addictive Disease, directed the Council on Dental Practice, through its Dentist Well-Being Advisory Committee, to develop an action plan that includes the development of protocols to support state and constituent-sponsored intervention programs. Most state well-being programs lack adequate resources to provide services to support dentists' recovery.

Therefore, The Council recommends adoption of the following resolution.

**Resolution**

**109. Resolved**, that the American Dental Association urges each constituent dental society to implement an optional donation line item for well-being programs on its annual dues statement.

**BOARD RECOMMENDATION: Vote Yes.**

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

\*Dr. Faiella was absent.

Resolution No. 111 NewReport: N/A Date Submitted: September 2012Submitted By: Fifteenth Trustee DistrictReference Committee: Dental Benefits, Practice and HealthTotal Net Financial Implication: \$36,726.25 Net Dues Impact: \$0.35Amount One-time \$36,726.25 Amount On-going  FTE 0.25ADA Strategic Plan Goal: Members (Required)**ESTABLISHMENT OF AN ADA EDUCATIONAL PROGRAM TO ASSIST SENIOR DENTAL STUDENTS IN THE ANALYSIS AND EVALUATION OF EMPLOYMENT CONTRACTS**

The following resolution was submitted by the Fifteenth Trustee District and transmitted on August 29, 2012, by Ms. Donna Cortez, executive affairs manager, Texas Dental Association.

**Background:** Dental students may become ADA members in their senior year (D4) of dental school. Many are being offered positions as an employee-dentist in dental management service organizations (DMSO's). At one Texas dental school this past year, there were numerous occurrences of student recruitment for post-doctoral employment; it is believed that of the 95 D4 graduates, 49 accepted employment within non-dentist owned private equity firms. The amount of student debt, the certitude of an income, the amount of income, bonus structure, as well as the opportunity to refine one's skills in a financially-secure environment, and having experienced colleagues available for consult, all make these employment opportunities attractive.

Some evidence also points to contract employment being an exit strategy for retiring doctors.

However, all may not be as good as it appears. Allegations of production quotas have been made by some who have worked for these entities. In such situations, some have reported the doctor's ethics of treatment can be challenged working under such conditions, and dentists who find themselves in these situations suddenly realize that the consequences of terminating the contract may put them in financial jeopardy.

Anecdotal evidence suggests that some of the contracts being offered to the D4 students can be quite onerous. Contracts can include provisions to pay back signing bonuses plus penalties or other financial incentives if the contract is terminated early. Also, onerous restrictive covenants at the end of the contract period may prevent them from being employed by another practice, or opening their own practice, for a time period significant enough to cause serious financial distress, even bankruptcy.

Employment contracts can be difficult to understand, even by experienced doctors. The advantage to an ADA member of having an employment contract analysis service for these employment contracts would be highly valued. The ADA presently does not offer such a service.

These employment contracts are being offered by non-dentist owned private equity firms, dentist owners who are non-ADA members, and ADA members. Contract analysis between ADA members could have the appearance of conflicting interests of the Association with one of the members, therefore this service would not be offered if both the potential employee-dentist and the employer were ADA members, the exception being if the employer-dentist owned five or more dental offices with ten or more dentists. Furthermore, no more than 10 hours per student would be allocated from the ADA Legal Department; therefore, be it

**Resolution**

**111. Resolved**, that the appropriate ADA agency be instructed to establish an educational program to provide assistance and resources to senior dental students (D4's) who have joined the ADA and are contemplating and evaluating contracts of employment or associateship with dental practices owned by non-dentist private equity firms, or employment or associateship with large group dental practices consisting of five or more locations with 10 or more dentists, and be it further

**Resolved**, that such assistance and resources include, to the extent permitted legally and ethically, the preparation and distribution of informational and educational materials concerning the evaluation of contracts and particularly relevant contract terms, and the identification of issues to which the applicant should give particular attention when considering the contract, and be it further

**Resolved**, that the American Dental Association disseminate the availability of this service in all manners possible including social media and other electronic means of communication, as well as appropriate print media and events.

**BOARD RECOMMENDATION: Vote Yes.**

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

\*Dr. Faiella was absent.

Resolution No. 162 NewReport: N/A Date Submitted: September 2012Submitted By: First Trustee DistrictReference Committee: Dental Benefits, Practice and HealthTotal Net Financial Implication: None Net Dues Impact: Amount One-time  Amount On-going  FTE 0ADA Strategic Plan Goal: Public Health (Required)**BONE MARROW MATCHING PROGRAMS**

The following resolution was adopted by the First Trustee District and submitted on September 16, 2012, by Dr. Judith M. Fisch, caucus chair.

**Background:** Four out of every ten American patients in need of bone marrow transplants have the good luck to find matching donors. The system for testing volunteers is simple, requiring only an oral mucosal swab, at no costs to potential donors. Donors complete a confidential form provided by DKMS America, which is used only to contact the donor if they are a match. The process is completely confidential. Participating dentists will receive necessary supplies from DKMS America and sample swabs will be returned to DKMS America, free of charge. Additional information is available at [dkmsamericas.org](http://dkmsamericas.org). Once matched to a patient in need, stem cell collection requires only blood collection, the loss of which is inconsequential to the donor, who rapidly generates replacement by his/her own healthy bone marrow. The reason that 60% of patients seeking matching donors do not find them is that there are insufficient numbers of participants within the matching system.

Dental offices are ideally suited for the purpose of recruiting volunteers and gathering samples. The only requirement is that potential donors be between 18-55 years of age and healthy. The ADA could be a leader in encouraging participation in the registry.

**Resolution**

**162. Resolved,** that the ADA urges members to support participation in the bone marrow matching program by providing appropriate literature in their offices, gathering samples and forwarding them for registration.

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

\*Dr. Faiella was absent.

Resolution No. 163 NewReport: NA Date Submitted: September 2012Submitted By: Fourteenth Trustee DistrictReference Committee: Dental Benefits, Practice and HealthTotal Net Financial Implication: \$1,400 Net Dues Impact: \$0.01Amount One-time                      Amount On-going \$1,400 FTE 0.50ADA Strategic Plan Goal: Members (Required)1 **STRATEGIZING ON ADVOCACY OF THIRD PARTY ISSUES**2 The following resolution was adopted by the Fourteenth Trustee District and transmitted on September 14,  
3 2012, by Dr. Thomas Schripsema, chair, Resolutions Committee.4 **Background:** Arguably, the number one concern of our member dentists is third party interference in the  
5 doctor/patient relationship as well as third party efforts to influence and control procedures and materials. In  
6 addition, dentists are increasingly expressing frustration at the encumbrances created by third party  
7 bureaucracies.8 When member dentists ask, "What is the ADA doing for me?" they are most often referring to what the ADA is  
9 doing to help them navigate the day-to-day affairs of their practices. When the ADA has been proactive in  
10 meeting third party challenges, membership has spiked, as dentists see a tangible practice benefit and value  
11 to their membership. In order to meet our member needs and maintain our market share of the dental  
12 population we need to be visibly addressing third party issues head-on.13 Several divisions and councils of the ADA are substantially impacted by third parties issues. These councils  
14 include Dental Benefit Programs, Dental Practice, Governmental Affairs, and Access, Prevention and  
15 Interprofessional Relations. In addition, the Councils on Membership and Communications, provide integral  
16 support and communication to our members on third party issues. In order to be more effective in dealing  
17 with third party issues and develop comprehensive strategies, a committee composed of members of the  
18 above referenced councils should be engaged in reviewing third party issues and what each of the councils is  
19 doing in relation to third parties, and coordinating activities to avoid duplication of effort as well as making  
20 sure that the ADA is doing everything possible to resolve issues.21 This committee should submit a report to the Board of Trustees prior to each Board meeting for discussion  
22 and appropriate action and to the ADA House of Delegates for its annual session.23 **Resolution**24 **163. Resolved**, that in the context of this policy, the term "Third Party" shall refer to any benefit plan,  
25 managed care organization, regulatory agency, employer, or organization that tries to control or influence  
26 the provision of dental care by members of the dental team or their patients, and be it further27 **Resolved**, that the Board of Trustees be directed to create a committee on Third Party strategy to  
28 coordinate advocacy activities of ADA councils that are substantially impacted by third party issues, and  
29 be it further30 **Resolved**, that the committee be composed of two representatives from the Board of Trustees and two  
31 members from each of the following: Council on Dental Benefit Programs, Council on Dental Practice,

Council on Governmental Affairs, Council on Access, Prevention and Interprofessional Relations; and one member from the following: Council on Membership, and Council on Communications, and be it further

**Resolved**, that the committee meet at least quarterly by conference call and utilize an electronic community to regularly exchange relevant information related to third party activities and their agency's actions, and be it further

**Resolved**, that the committee will develop appropriate, comprehensive, and timely Association advocacy strategies related to Third Party activities for approval by the Board, and be it further

**Resolved**, that the committee report to the Board of Trustees prior to each Board meeting, and that they report to the ADA House of Delegates each year.

**BOARD COMMENT:** The Board appreciates the sentiment expressed by the Fourteenth Trustee District and fully understands the importance of third-party payer issues to the membership and the need to effectively communicate trends and initiatives to the Board. The Board is aware that CDBP and all councils regularly collaborate to gather input for their initiatives, particularly regarding third party issues, and to assist in their implementation. Additionally, the Board has requested that CDBP provide it with quarterly updates. The Board feels that it would not be an effective use of volunteer time and financial resources to duplicate the efforts of CDBP, or any other council. Therefore, the Board recommends that Resolution 163 not be adopted.

**BOARD RECOMMENDATION: Vote No.**

**Board Vote: Resolution 163**

BLANTON	No	GOUNARDES	No	NORMAN	No	SUMMERHAYS	Absent
DOW	No	HAGENBRUCH	No	RICH	No	VIGNA	No
ENGEL	No	ISRAELSON	No	ROBERTS	No	WEBER	No
FAIELLA	Absent	KIESLING	No	SEAGO	No	VERSMAN	Yes
FEINBERG	No	LOW	No	STEFFEL	No	YONEMOTO	Yes

Resolution No. N/A N/AReport: CAPIR Supplemental Report 2 Date Submitted: September 2012Submitted 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  FTE 0ADA Strategic Plan Goal: Public Health (Required)

**COUNCIL ON ACCESS, PREVENTION AND INTERPROFESSIONAL RELATIONS SUPPLEMENTAL  
REPORT 2 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 3 to the 2011 House of Delegates (HOD). A chronology of the development of the CDHC project may be found in Appendix 1.

**2012 Update:** In December 2011, the Board of Trustees received a report from CAPIR on the CDHC pilot program highlighting some of the following key issues: Cohort 2 CDHC trainees completed their training; project staff and the Evaluation Committee continued to work on designing and implementing a comprehensive evaluation of the CDHC; and a financial update was presented demonstrating that the project continued to maintain expenses under budget.

In April 2012, the Board of Trustees received an updated report addressing a post CDHC pilot program transition plan. The Board was informed that Rio Salado College (RSC), the current on-line curriculum provider, has expressed interest to continue offering the curriculum for the CDHC program upon completion of the pilot.

Previously, at the January 2012 meeting, the Council voted unanimously to adopt the following resolution:

**Resolved**, that ADA legal staff continue to work with Rio Salado College to develop a non-exclusive licensing agreement to the content of the CDHC Curriculum (the "CDHC Content") for its own use in developing training, testing and teaching programs for individuals who will provide community assistance in the oral health care field.

The most recent reports received by the Board focused on the following main topics: the execution of the curriculum licensing agreement with RSC; the training of the last cohort of students currently in their internship; the evaluation component of the program; and financial updates. Additionally, appended to the July 2012 report was a CONFIDENTIAL Case Study document which depicted evaluation results from a clinic impacted by a CDHC.

**Current Status:** 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 Education Subcommittee, Evaluation Subcommittee, Sustainability Subcommittee and Communication Subcommittee continue to support the Workgroup. A summary of major issues being address by these groups is provided below.

**Field Update:** Eight Cohort 2 trainees, three from Temple University, three from the University of Oklahoma and two from the University of California at Los Angeles (the former American Indian site), completed the program this past fall. On October 21-22, 2011, Association representatives conducted an in person site visit, met with Cohort 2 clinic directors and discussed the evaluation phase of the project. ADA representatives took part in similar activities at Temple University in Philadelphia on December 11-13, 2011. See: <http://www.ada.org/news/6776.aspx>

Sixteen of the 20 Cohort 3 trainees (four from Temple University, six from Arizona School of Dentistry and Oral Health and six from the University of Oklahoma), are currently enrolled in the internship phase of their CDHC training and are expected to complete the program this fall.

**Education:** The Education Committee has concluded one of its main charges. The CDHC curriculum was evaluated and revised, based on the experiences of Cohorts 1 and 2. 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 Committee 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 new courses were cross-referenced with the ADA's original CDHC competencies (formerly known as Modules 1-6), to ensure that all foundation knowledge and skills areas are included. Additional responsibilities for the Education Committee may include evaluation of content and student performance as Cohort 3 students complete the curriculum. The Education Committee may also consider and recommend integrated sequencing of the dental and community health worker courses for future implementation by educational institutions.

**Evaluation:** The Evaluation Committee continues to work on the evaluation of the CDHC pilot program. The evaluation of the CDHC project has 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 objective of the structure and process evaluation is to improve the CDHC program and provide a comprehensive curriculum for CDHC training. The goal of the evaluation of the CDHC training process is to examine the pilot program through a process approach by reviewing two broad dimensions of the program, structure and process. The intent is to provide a comprehensive and meaningful evaluation of the program. Structure evaluation involves an assessment of the infrastructure used to provide the training and education. It encompasses such issues as the comprehensiveness of the curriculum, assessment of instructors and a determination as to whether the equipment necessary for training is available. Of critical importance is the accessibility of the program to students who wish to participate. Process evaluation measures the success of the implemented training and analysis as to whether the expected competencies and skills were learned by the students. Process is most often driven or moderated by the structure which forms the foundation for the evaluation. An RFP (Request for Proposals) was developed and posted in June 2012. A consultant has not yet been identified. The goal of the CDHC patient access and outcome evaluation is to assess the impact of the CDHC on patient access to dental care and health outcomes. The design of the evaluation is clinic driven and uses patient access or outcomes goals that have been targeted by the clinic leadership for intervention by the CDHC.

One of the most important inputs into the decision to introduce a new dental provider into the workforce is an objective evaluation of the role of the dental team member with defined metrics and data analysis. For the CDHC pilot program, the evaluation gathers information regarding the role of the CDHC in increasing access to dental care in a community, providing quality clinical services, impacting patient health outcomes and assisting the clinic in reaching its oral healthcare goals for patients. Determining if the CDHC's work had any impact in the dental clinic meeting its goals is a process of identifying the goals of the clinic, determining a set of indicators that can be used to measure clinic goals and performing the measurements involved. An evaluation of the success that CDHCs have in improving patient access, quality, and outcomes in terms of the goals set by dental clinics, will provide valuable input into the decisions of others to use CDHCs.

The data collection requirements for the project call for patient encounter data to be collected from each clinic to analyze the results for each patient access goal chosen by the clinic for the case study. The data will be collected from the clinic patient management system or collected from dental records manually including forms developed specific to the pilot program. Data captured for the evaluation project are stored in a secure relational database being developed by the Department of Information Technology and CDHC project staff at the ADA. Stored data are fully encrypted and sent via secure connections to the ADA.

ADA has completed nine case studies for four Cohort 1 clinics, seven of which are included in this report. The case studies involve a variety of initiatives including school-based programs, senior center outreach programs, a mobile dental clinic and a targeted diabetic population program. The cumulative data indicates a positive impact by the CDHC on improving access to care in their respective communities, increasing the dental capacity of the clinics and increasing revenues through billable services. Please note that some CDHCs in the program had no prior dental background, others were dental assistants, EFDAs or registered dental hygienists. See Appendices 2 to 8 for the detailed case studies and Appendix 9 for the summary analyses.

**Sustainability:** The Sustainability Committee continues to review options regarding the future viability of programs utilizing the Community Dental Health Coordinator (CDHC). The Department of State Government Affairs 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, who will work under the general supervision of a licensed dentist in settings outside of traditional dental offices and dental clinics. CAPIR volunteers continue to emphasize the importance of patient navigation as a principal duty of the CDHC necessitating a code for case management. Such a 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.

CAPIR continues to develop a model to predict the economic sustainability of the CDHC in the workplace. The pro forma calculator flow diagram (Appendix 10) depicts how data will be captured to assess various scenarios in which the CDHC will be employed. As there are several practice models under evaluation in geographically diverse areas, the pro forma model is limited in addressing all confounding variables such as payer mix, access to care barriers, wage rates and disease burden. Key to understanding the pro forma is the inherent value of CDHCs as a community health worker with dental knowledge. This individual contributes to programmatic success (efficiency, effectiveness and productivity); however, these services are generally not directly billable. This value-added component will be captured via proxy metrics as it is considered a strong determinant in demonstrating the successful viability of oral health programs utilizing CDHCs.

In developing the pro forma, the Sustainability Committee is aware of concerns about the efficient use of existing highly trained dental team members being trained as CDHCs, such as expanded function dental assistants and dental hygienists. Though cross-training is encouraged, the question is whether it is cost-effective and efficient to have these procedure-based team members providing prevention information and patient navigation resources in the community. Is the model more appropriately designed to primarily train high school graduates or dental assistants as CDHCs? For the cost analysis, data will include, but is not limited to, the cost of the CDHC training (tuition, equipment and travel expenses), the opportunity cost (i.e., lost earnings during training if applicable, the operational costs for facilities [i.e., overhead] and the practice model [number of dentists and allied professionals]). To project revenue, assumptions will be made as to the number of hours the CDHC is in the office versus in the field on a weekly basis. The types of procedures the CDHC performs (workflow) and frequency of services will also be projected. Cohort 1 data, analyzed as part of the overall CDHC evaluation, will provide data regarding the use of the CDHC in a dental practice.

**Financial Update:** Based on a projected cost of \$8.5 million, the House of Delegates authorized a total of \$7 million for the CDHC Pilot Program. As of June 30, 2012, the project has incurred expenses totaling \$5,404,988.04. The remaining funds include \$50,000 in funding obtained through a grant from the American

Dental Association Foundation for 2012. To date, the Board of Trustees has appropriated \$6,165,092.00 in funding for the project, including \$800,000 for projected 2012 expenses.

Expenses to date for 2012 include Cohort 3 payments (Temple, Oklahoma and Arizona); payments to Rio Salado College; and costs incurred for the evaluation. Approximately \$865,000 of expenses has been off-set by a donation from Henry Schein to pay for equipment for some of the students.

Appendix 11 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 2012 projections have been adjusted to reflect actual incurred expenses through 2011 and expected expenses for 2012-13. Cohort 3 training will be completed in October 2012. The remaining program expenses are projected for the evaluation and transition of the pilot program.

**Transition Plan Update:** 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 are currently being 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. Rio Salado College, the current on-line curriculum provider, has expressed interest to continue offering the curriculum for the CDHC program upon completion of the pilot. A licensing agreement was drafted and has recently been executed. Pending approval from the Department of Education, Rio Salado College is positioned to begin training future CDHCs outside of the pilot program before the end of this current year. CAPIR is currently developing a plan to successfully transition the program post pilot.

**Communication:** CAPIR continues to track the program and identify communications opportunities. These include identifying CDHC program graduates suitable to interact with the media and preproduction planning for a new video. The video is one marketing product that can and should be produced to bring the reality of the CDHC program and the contributions already being made by graduates working in public health settings to multiple audiences. It is also now possible to begin pitching individual CDHCs to interested media. The recent agreement with Rio Salado College undoubtedly will lead to marketing opportunities, but they have yet to be specifically identified. While Rio Salado College is establishing the program and evaluative data continues to come in from working CDHCs, communications functions will consist mainly of identifying media targets of opportunities, production of the video and positioning CDHCs in the broader scope of on-going efforts to communicate solutions to access barriers. There has been increased national media attention placed on access and workforce issues which offers opportunities to promote the CDHC. The ADA State Public Affairs program has allocated funds for public affairs support for national issues and the national public affairs agency, Chlopak, Leonard and Schlecter, has been retained to support ADA media relations through the remainder of 2012. The CHDC is a solution that will feature in those media relations efforts. The agency, which has worked for the ADA for several years and is familiar with the Association's issues and policies, officially comes on line on July 23, 2012. Pending budget approval it is expected that the video will be finalized for distribution prior to year end.

**State Activity:** Building on the enactment of a practice act revision in 2011, New Mexico became the first state to formally adopted regulations governing the practice of Community Dental Health Coordinators. While several other states are considering moving forward with legislation to codify CDHC in 2013 and beyond, New Mexico is far ahead of any other jurisdiction. Currently, the New Mexico Dental Association (NMDA) and the ADA are working to facilitate the educational component for CDHC within the state. Additionally, Oregon specifically authorized a CDHC pilot project in legislation passed in 2011 but no parameters have yet been approved by the Oregon Health Authority.

Each constituent dental society faces unique political circumstances. Support from the constituent society is 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. Further, some states have expressed an interest in CDHC in its entirety while others are considering a more modular approach. The Council is working with its educational partners to explore those opportunities.

**Summary:** Sixteen of the 20 Cohort 3 students are currently enrolled in the program and are due to complete their training at the end of their internship in the fall of 2012. The community health worker portion of the curriculum has been revamped. Project staff conducted field site visits and began collecting patient data from several Cohort 1 and Cohort 2 clinics. Results thus far indicate that the CDHCs have a significant positive impact in their clinics and communities. Rio Salado College is positioned to begin training future CDHCs before the end of this current year.

### Resolutions

This report is information and no resolutions are presented.

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\*Appendices 1-11 can be found in the House of Delegates community of ADA Connect in the 2012 Resolutions and Reports library at <http://connect/ada.org> and in the House of Delegates area on ADA.org at <https://www.ada.org/members/2012hodreports.aspx>.

## Appendix 1

### Chronology of the Development of the CDHC Project

- **2004:** In June 2004, the ADA Board of Trustees approved funding for a task force to develop strategies for the ADA to address proposals for new workforce models and to build on the Association's efforts on access and workforce (*Trans.*2004:216). The Workforce Models Task Force was charged to analyze available data and information regarding the adequacy of the current workforce to meet the access needs of the underserved in both rural and urban settings and develop a position paper with recommendations and solutions to address the concerns. The Board's action was reported to the 2004 ADA House of Delegates in Board Report 18 (*Supplement 1* 2004:4088).
- **2005:** Report 15 of the Board of Trustees to the House of Delegates: Dental Workforce Models (*Supplement 2* 2005:6002) was considered by the House. In the report, the Workforce Models Task Force proposed five classifications of dental assistants and two classifications of dental hygienists. Included was the "community dental health aide," a proposed allied dental team member with preventive skills and who could provide basic restorative procedures under a dentist's supervision in community-based settings. The Task Force's report was discussed and debated at both the Reference Committee on Dental Workforce and the House of Delegates. The House adopted Resolution 85H-2005 (*Trans.*2005:300), calling for a new 19-member task force to collect and review existing data, develop additional information and report to the 2006 House of Delegates.

In a separate but related resolution, the House also adopted Resolution 96H-2005 (*Trans.*2005:343), which called for the President to appoint a committee to define, develop and evaluate a training and certification process for community-based oral health aides who would function under the supervision of a dentist.

- **2006:** In April 2006, the Chair of the Resolution 96H-2005 Committee, Dr. Perry Tuneberg, reported to the Board the Committee's progress developing core competencies for the new position. He noted that the Committee had determined that the term "Community Dental Health Coordinator" would better describe this new auxiliary role.
- In June 2006, the Board considered a report of the ADA Dental Workforce Task Force 2006 (*Supplement 2* 2006:5000), which was subsequently forwarded to the 2006 House of Delegates. The report recommended four categories of allied dental workforce personnel: dental assistants, oral preventive assistants, dental hygienists and community dental health coordinators. The House of Delegates adopted Resolution 3H-2006 (*Trans.*2006:306) supporting the models as presented in the report, with the exception that references to "formal education" and "Certification Required" throughout the report be changed to "additional education and a certificate of completion as determined by each state board of dentistry." The resolution also called for the appointment of a task force to develop and test the Oral Preventive Assistant model and to report progress to the 2007 House of Delegates.

In a separate report, the Resolution 96H-2005 Committee outlined its progress and recommended the establishment of the National Coordinating and Development Committee (NCDC) to create the Community Dental Health Coordinator model training program, including a complete curriculum with implementation and evaluation guidelines. The House was supportive and adopted Resolution 25H-2006 (*Trans.*2006:308), directing the appointment of the NCDC to oversee the project, including implementation of at least three pilot programs, with a progress report to the 2007 House of Delegates. The estimated cost for development of the model training program was \$334,000. The ADA Foundation Board of Directors committed the funding to support the development of the model.

- The Board of Trustees considered a Progress Report on Workforce Initiatives at its December 2006 meeting. The report included information on members appointed by ADA President, Dr. Kathleen Roth, to the NCDC (Dr. Robert Brandjord, chair, Dr. Amid Ismail, Dr. Vincent Filanova, Dr. Kathleen O'Loughlin and Dr. John McFarland) and the Curriculum Committee (Dr. Amid Ismail, chair, Dr. Carol Turner, Dr. Paul Glassman, Ms. Joanne Nyquist, Dr. Robert Weyant and Dr. Judith Skelton).
- **2007:** ADA President, Dr. Mark Feldman, appointed members to two CDHC-related committees in late 2007 to support the work of the NCDC. The CDHC Implementation and Evaluation Committee, chaired by Dr. Carol Turner, was charged with oversight of the Pilot Project. The CDHC Philanthropic Committee, chaired by Dr. Vince Filanova, was charged to explore and identify potential funding sources to support the pilots. Drs. Mark Feldman, John Findley and Robert Brandjord served as *ex officio* members of both committees.
- The House received Report 14 of the Board of Trustees: Update on the Allied Dental Personnel Workforce Models (*Supplement 2 2007:5053*). At that time, the House adopted Resolution 54H-2007 (*Trans.2007:383*), encouraging the NCDC to complete the development of the curriculum and pilot and evaluate the model in at least three sites, allocating up to \$2,000,000 from reserves to fund the pilots and encouraging the Committee to seek additional funding to complement the ADA funding where feasible, and directing that the Board of Trustees provide a progress report to the 2008 House of Delegates.
- **2008:** The Board considered a progress report, Update on Workforce Models: Community Dental Health Coordinator and Oral Preventive Assistant Projects, in April 2008. The report described the selected pilot sites for the CDHC program (University of Oklahoma for rural, University of California at Los Angeles (UCLA) for Native American and University of Michigan for urban) and the progress related to the creation of the OPA curriculum. A draft communications plan for the CDHC Program was also included.
- In June 2008, members of the CDHC Implementation and Evaluation Committee (Dr. Carol Turner, chair, Dr. Amid Ismail, Dr. Dunn Cumby, Dr. John McFarland and Dr. Robert Brandjord, *ex officio*), reviewed two independent research agencies' proposal to conduct the evaluation component of the CDHC pilot project.

The 2008 ADA House of Delegates received Report 10 of the Board of Trustees: Update on the Community Dental Health Coordinator Pilot Program (*Supplement 2 2008:4037*). The report outlined the current funding status as well as anticipated additional financial implications for ongoing operations and evaluation. The report described the activities and conclusions of the CDHC Implementation and Evaluation Committee. It also included a recommendation that the ADA commit to long-term financial support of the program. Dr. Robert Brandjord also made a presentation to all interested delegates. The House adopted Resolution 39H-2008 (*Trans.2008:424*) which reads as follows.

**39H-2008. Resolved**, that the ADA commit up to \$5 million to support the continuation of the CDHC pilot programs in order to evaluate the effectiveness of the CDHC model, and be it further

**Resolved**, that the ADA identify outside funding for the three pilot sites, project support, equipment and supplies, and be it further

**Resolved**, that as soon as possible the CDHC curriculum modules be made available for possible integration into expanded function dental assistant programs, and be it further

**Resolved**, that the ADA assist states as they develop workforce models, and be it further

**Resolved**, that the CDHC Philanthropic Committee and the CDHC Implementation and Evaluation Committee report with a financial update annually and outcomes assessment when available to the House of Delegates for the duration of the pilot program.

- The Board received another update report at its December 2008 meeting. The report noted the potential transfer of the urban pilot training site from Detroit to Philadelphia, under the leadership of Dr. Amid Ismail and included a letter of support regarding this transfer from the Michigan Dental Association. The ADA Foundation's additional support of \$250,000 over five years was also described.
- **2009:** The joint CDEL/CAPIR report to the Board of Trustees presented a summary of activities related to the CDHC pilot program. It described what had occurred to facilitate the transition of the CDHC Pilot to the Council on Access, Prevention and Interprofessional Relations in response to Resolution B-14-2009 (*Trans.*2009:249) which reads as follows:

**B-14.2009. Resolved**, that the CDHC be placed under the primary purview of the Council on Access, Prevention and Interprofessional Relations (CAPIR), and that CAPIR shall work with the Council on Dental Education and Licensure and the Council on Dental Practice.

The report discussed the project kick-off meeting on March 9 at the University Of Oklahoma School of Dentistry and the initiation of training for 12 trainees from the University Of Oklahoma School of Dentistry and the University of California at Los Angeles. The report indicated that Temple University would be submitting a request to offer the urban CDHC pilot training program in Philadelphia.

Pursuant to the directive of the House of Delegates in Resolution 39H-2008 that the CDHC curriculum modules be made available as soon as possible, the development of a template CDHC preliminary curriculum license was also completed in early 2009. Work continued with National Opinion Research Center (NORC) on the design of the pilot program's evaluation component. Efforts to identify companies and foundations that potentially could provide support for the CDHC project were also described. The Board of Trustees was advised that a management plan had been developed with input from the CAPIR Chair and Vice Chair and position description questionnaires were developed to add additional staff to support the program. The Chair designated Dr. David Holwager, CAPIR member from the Seventh Trustee District, to assume a lead role in working with Council staff on the project.

- In August 2009, the Board considered a progress report update on the Community Dental Health Coordinator Pilot Program, which primarily focused on the deliberations of CAPIR during its June 2009 meeting. Under the direction of Dr. Lindsey Robinson, chair, CAPIR, the Council initiated a SWOT analysis (Strengths, Weaknesses, Opportunities and Threats) specific to the CDHC Pilot Program. The Council concluded that there were critical issues that required immediate attention and approved the following resolutions.

**Resolved**, that a workgroup be appointed by the Chair comprised of three CAPIR members and one representative from the Board of Trustees to establish a management structure for the CDHC program.

**Resolved**, that CAPIR request the Board of Trustees direct that \$2.5 million be immediately transferred from the ADA reserves into the CDHC cost center.

Dr. David Holwager (IN) was appointed by Dr. Robinson to chair the Workgroup. Drs. Eleanor Gil (MS) and Gary Davis (PA) were the two other Council members selected to serve on the Workgroup. Dr. Ken Rich had been appointed by President John Findley to serve as the Board of Trustees liaison to CAPIR specific to the CDHC project and also serve on the Workgroup. In addition, the report also presented a challenge raised by the Oklahoma Dental Hygienists Association (ODHA) about the legality of the CDHC pilot project in Oklahoma.

Shortly after the Council meeting, Dr. Kathleen O'Loughlin informed CAPIR that ADA human resources would be aligned and directed, as needed, to support the project. With her assistance, the approval of the Workgroup and the CAPIR Chair, a structure that is volunteer driven was developed to manage the project. Staff from various ADA agencies has been tasked to support the CDHC program. A monthly log of hours spent monitors the Association's human resource investment in the project. From January-June 2010, ADA staff has worked over 6,500 hours on the CDHC program with contributions from Dental Education, Dental Practice, Communications, Marketing, Corporate Relations, Executive Offices, Finance, Legal, Membership, Government and Public Affairs and the ADA Foundation.

CAPIR remains the division that has oversight for the project under the direction of the Council's workgroup. To streamline the management of the project across divisions and committees and to enable greater communication with the pilot program directors, a process management template was developed (Appendix 1). The contracts for each Pilot Program were reviewed and processes were implemented to ensure accountability and transparency throughout the pilot program.

- In September 2009, CAPIR Supplemental Report 4 was presented to the HOD which provided an update on the Community Dental Health Coordinator (CDHC) Pilot Program, including a chronology of the development of the CDHC, progress made before and after the transfer of the project to CAPIR, a description of the process and approach CAPIR had taken in managing the program, a description of field activities and operations of the pilot training sites, efforts to identify outside funding to support the project, an update of the evaluation and a financial report. The report also described negotiations that occurred between Temple University Maurice H. Kornberg School of Dentistry to resubmit a proposal to serve as the urban site for the CDHC Pilot Program.
- In December 2009, the Board considered a progress report, Update on the Community Dental Health Coordinator Pilot Programs. The Board was provided with an update on Workgroup telephone conference calls that had occurred throughout the fall and on a face to face meeting of the Workgroup on Sunday, October 1, 2009, in Honolulu. The report described the progress made by the UCLA and University of Oklahoma's first cohort students enrolled in the CDHC program. Temple University students had been selected and begun their EFDA training at Harcum College prior to starting the CDHC program in March 2010 as part of the second cohort. Curriculum issues related to the community health worker training were still being discussed and a thorough assessment of the overall status of the program was scheduled to take place at a face to face meeting with the workgroup and subsequently with CAPIR at its January 2010 meeting.
- **2010:** The Council devoted a significant portion of time at its January and June 2010 meetings discussing the Community Dental Health Coordinator (CDHC) Pilot Program. In January the Council had the opportunity to meet and get updates from the CDHC Pilot Program site directors at the University of California at Los Angeles, Salish Kootenai College (SKC), University of Oklahoma and Temple University Kornberg School of Dentistry.

During the January meeting, the chief dental officer of the Health Resources and Services Administration (HRSA) addressed the Council. He described a comprehensive national study of the community health worker (CHW) workforce and of the factors that affected utilization and development of these health care workers. He concluded by saying that CHWs were able to gain access to hard-to-reach populations and were willing to work in neighborhoods or rural areas where other professionals were reluctant to practice. Ms. Susan Bauer, executive director, Community Health Partnership of Illinois, spoke to the Council about *promotores de salud* ("health promoters") working within migrant health programs. She articulated how, in her opinion, CDHCs would be valuable members of the dental team within her centers and looked forward to the opportunity to hire CDHCs in the future.

The CDHC Workgroup provided an overview of the CDHC program and the progress made by the workgroup since the last Council meeting. Council members were in full agreement with the

Workgroup that the tide of untreated disease among underserved populations cannot be stemmed by drilling, filling or extracting. The Council discussed the fact that the ADA alone could not support the CDHC project until it reaches a point of self-sufficiency. For this pilot program to survive, the Council articulated that the assistance of industry, philanthropy and government would be needed.

A great deal of time was spent by the Council discussing the need for clearly articulating to a variety of audiences exactly what the CDHC program is, and of equal importance, what it is not. The following actions specific to Community Dental Health Coordinator Pilot Program were adopted:

**Resolved**, that the Council on Access, Prevention and Interprofessional Relations request the Division of Legal Affairs to assess whether licensure agreements can be structured to allow more freedom to share all or parts of the Community Dental Health Coordinator curriculum.

**Resolved**, that Council on Access, Prevention and Interprofessional Relations and its Community Dental Health Coordinator workgroup explore the possibility of abandoning the trademark for "Community Dental Health Coordinator," and the workgroup will report back its findings at the June 2010 Council meeting.

**Resolved**, that the revisions to the Community Dental Health Coordinator pilot curriculum, as outlined in Appendix 4, be considered for implementation with the 2nd cohort of students who will begin their training in March 2010 (financial implication: \$22,500).

**Resolved**, that a Communication Committee be developed to explain and promote the Community Dental Health Coordinator model, and be it further

**Resolved**, that this committee be chaired by a current freshman CAPIR member and include at least one member from the Council on Communications.

**Resolved**, that the Council on Access, Prevention and Interprofessional Relations recommend that the ADA recognize the newly graduated Community Dental Health Coordinators at the opening session of the 2010 House of Delegates and an ADA officer attend the students' graduations.

**Resolved**, that the Council on Access, Prevention and Interprofessional Relations encourage Community Dental Health Coordinator pilot site directors and other stakeholders to actively recruit community health workers to enroll as trainees in the CDHC pilot program.

**Resolved**, that the Council on Access, Prevention and Interprofessional Relations encourage dental safety net programs to actively integrate community health workers with the activities of Community Dental Health Coordinators.

**Resolved**, that ADA officers and staff actively pursue financial and in-kind support from corporate entities to support the Community Dental Health Coordinator pilot.

At its June meeting an update was provided to the Council on field activities and program implementation. A significant portion of the meeting was devoted to issues surrounding communication activities and work done by the Communications Committee and the launching of the 'ambassador' program in which CAPIR and other ADA volunteer leaders agreed to speak about the project and the CDHC's scope of duties at constituent society and ADA district meetings. Ambassadors attended a half-day public speaking course conducted by Communications staff during a portion of the June meeting. CAPIR took the following actions:

**Resolved**, that the CDHC workgroup appointed by the chair presently comprised of three CAPIR members and one representative from the Board of Trustees, be expanded to include

up to five CAPIR members and one representative from the Board of Trustees to establish a management structure for the CDHC program.

**Resolved**, that up to \$40,000 be allocated to support the activities of the Communication Subcommittee and that the source for these funds come from the ADA Foundation's annual contribution to support the implementation of the CDHC Pilot Program.

In advance of its July 28, 2010, meeting, a report on the CDHC program was included on the ADA Foundation Board of Directors agenda. The report was in response to the Foundation Board of Directors' request for annual assessment regarding the on-going development of the CDHC program. ADA Foundation Board review of an annual status report is done prior to the release of the Foundations annual contribution of \$50,000 in support of the program.

Unfortunately, the Foundation Board's July 28, 2010, meeting agenda included a substantial number of pressing issues which required the Board's immediate attention. As a result, consideration of the ADA Foundation 2010 support for the CDHC pilot was postponed to the December 8, 2010, meeting of the ADAF Board of Directors.

It is uncertain if future funds will be available from the ADA Foundation. Therefore support of the activities of the Communication Subcommittee will be funded through the available funds for the pilot program allocated by the House of Delegates.

The Board of Trustees received another update report on the CDHC Program at its July meeting.

In October 2010, CAPIR Supplemental Report 4 was presented to the House of Delegates which provided an update on the first and second cohort of students; plans to significantly enhance and revamp the CHW portion of the curriculum in anticipation of the kickoff of Cohort 3; the establishments of a Communication Subcommittee; information regarding Henry Schein's provision of in-kind support for the CDHC program; and the opportunity to leverage dollars that were not available when the CDHC program was being developed resulting in significant savings for the ADA; and a description of the process and structure evaluation that was developed in order to position CDHC training programs to garner significant resources from government and philanthropy to assess CDHCs' impact on improving community oral health status.

- **2011:** 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.

## Appendix 2

### **CDHC CASE STUDY 1 REPORT: INCREASE IN DENTAL SERVICE**

#### Introduction

The focus for this case study is to evaluate the impact of the CDHC as a new member of the dental team in a community health center which serves the surrounding rural community. Dental services are provided in the dental clinic at the health center by one dentist who was joined by a CDHC in 2011. Within the scope of the dental practice act of the State, the CDHC provides diagnostic and preventive services to patients at the clinic working under the supervision of dentist. By utilizing the CDHC to promote oral health and deliver preventive care, the dentist can schedule more comprehensive care and thereby increase the capacity of the practice.

The case study measured the clinic utilization pre- and post-CDHC implementation; i.e. during the time period when the dentist practiced solo and when the CDHC joined the team. The numbers of patients seen and dental procedures provided were analyzed during the same six month periods in 2010 and 2011.

The goal of the clinic was to increase access to care in the community through utilization of the CDHC to promote oral health and provide preventive services. The CDHC worked on-site at the clinic. The CDHC is trained to provide a limited set of procedures to patients to support the diagnosis of dental disease by a dentist and to provide preventive services directly to patients under the supervision of a dentist.

To measure the success of this goal, the current case study was conducted, aiming to answer the following questions:

1. Does using the CDHC increase the number of patients that can be seen by the clinic?
2. Does using the CDHC permit the dentist to deliver more comprehensive care to patients?
3. Does using the CDHC increase revenue for the clinic?

#### Data Collection

In order to answer the above questions, data was extracted from the clinic's Eagle Soft patient management system for the pre and post CDHC periods. The current analysis focuses on the time periods of January 1 to June 30, 2010, and January 1 to June 30, 2011.

#### Analysis

Descriptive statistics were computed to capture the volume of procedures during the pre and post CDHC time periods. These statistics include frequencies for types of services provided, and the revenues associated with the types of services provided.

#### Results

The addition of the CDHC to the dental team did increase the number of procedures performed and revenue billed by the clinic. In 2010, 1,066 billable procedures were performed as compared to 2,307 procedures in 2011. Net revenue increased by \$140,152 from 2010 to 2011.

As would be expected based on the core competencies of the CDHC, services within the scope of CDHC practice impacted utilization and revenue by increasing the number of diagnostic and preventative procedures occurring in the clinic. Increases for revenue gains in restorative, endodontic and oral surgery procedures also occurred.

Differences observed in the volume of procedures during the two time periods were statistically significant ( $p < .01$ ).<sup>i</sup>

Table 1 shows the pre and post CDHC changes in clinic production. Table 2 provides a comparison of the changes in clinic production specific to the procedures within the scope of CDHC training and practice. (The procedures listed include those performed by the CDHC and those performed by the dentist in the clinic.)

Table 1: Utilization by CDT Category  
January to June 2010 Compared to January to June 2011

CDT Code	CDT Categories	Number of Procedures 2010	Number of Procedures 2011	Value of Service Provided 2010	Value of Service Provided 2011
D0120-D0999	Diagnostics	414	1,077	\$13,189.69	\$37,690.75
D1000-D1999	Preventative procedures	132	352	\$5,186.24	\$16,207.20
D2000-D2999	Restoratives	186	337	\$24,917.97	\$66,111.27
D3000-D3999	Endodontics	13	24	\$5,480.00	\$10,934.96
D4000-D4999	Periodontics	54	68	\$6,495.00	\$9,660.01
D5900-D5999	Maxillofacial prosthetics	36	48	\$14,475.00	\$23,798.00
D7000-D7999	Oral and maxillofacial surgery	172	206	\$19,495.00	\$60,354.55
D9000-D9999	Adjunctive general services	59	195	\$2,160.00	\$6,793.82
	Total	1,066	2,307	\$91,398.90	\$231,550.56

Table 2: Utilization: Diagnostic and Preventive Services  
January to June 2010 Compared to January to June 2011

CDT Code	CDT Categories	Number of CDHC Services 2010	Number of CDHC Services 2011	Value of Service Provided 2010	Value of Service Provided 2011
D0270-D0277	Bite wing films	97	213	\$2,879.76	\$6,951.48
D0210-D0240	Intraoral films	67	134	\$879.73	\$2,072.63
D1110-D1120	Prophylaxis	80	247	\$3,780.20	\$12,459.80
D1351	Sealants	16	15	\$480.00	\$1,545.00
D2940	Temporization	2	6	\$70.00	\$217.02
D1203-D1206	Topical fluoride/fluoride varnish	19	89	\$380.00	\$1,957.40
	Total	281	704	\$8,469.69	\$25,203.33

## Summary

Findings demonstrate that the addition of the CDHC and deployment of the CDHC exclusively in the clinic positively increased the procedure volume of the clinic and associated revenue. The number of procedures provided at the clinic after adding the CDHC was double compared to the time period before

the CHDC, and clinic revenue increased by nearly 2 ½ times. Two key factors contributed to these increases: 1) the CDHC was able to provide preventive procedures; and 2) the dentist was able to provide an increased number of comprehensive procedures to patients. The addition of the CDHC to the dental team has clearly improved access to dental services for members of this community.

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<sup>i</sup> Despite an increase in fees from the time period before the CDHC to the time period after the CDHC, the observed differences in procedures were great enough such that they cannot be explained solely by the change in fees.

## Appendix 3

### ***CDHC CASE STUDY 8 REPORT: DIABETES CLINIC***

#### Introduction

The focus for this case study is a community health center which serves the surrounding tribal community. Dental services are provided by five fulltime dentists, eleven fulltime assistants, six fulltime dental hygienists and now, one CDHC. This community health center houses a diabetes clinic as well as a dental clinic in a single location, allowing patients and dental staff to easily move between clinics for diabetic and dental care.

Maintaining oral health through regular dental care can aid in improving the overall health of patients with chronic diabetes. In order to increase access to dental care for diabetic patients seen in the diabetes clinic at the community health center, the CDHC implemented delivery of dental services within the diabetes clinic starting in December of 2010. At that time, the CDHC began providing scheduled dental screenings and preventive care in a designated space within the diabetes clinic one day per week. In cases where dental exams were needed, the CDHC called a dentist from the dental clinic to come to the diabetes clinic and perform that service. For comprehensive dental care, patients were referred to the dental clinic within the community health center; any necessary follow-up dental appointments were scheduled for patients by the CDHC. Ultimately, the goal of the CDHC was to improve access to dental care for diabetes patients in order to help them maintain their overall health.

In order to determine whether or not this goal has been achieved through implementation of the CDHC's diabetes clinic program described above, the current case study was conducted, aiming to answer the following questions:

1. How many patients were brought into the dental clinic in the community health center through contact with the CDHC at the diabetes clinic in the community health center?
2. What types of dental services were provided for diabetic patients?
3. What was the value of the dental care provided to diabetic patients?
4. What was the missed appointment rate for patients who received dental care in the diabetes clinic compared to the missed appointment rate for all patients who received dental care in the dental clinic?

#### Data Collection

In order to answer the above questions, data was extracted from the Dentrix Enterprise patient management system. The current analysis focused on the time period starting December 14, 2010 and ending September 27, 2011 – the time during which the diabetes clinic hosted the CDHC. All patient data was captured real time in Dentrix via a secured internet connection and all clinic data was captured using the facility's local area network.

#### Analysis

Descriptive statistics were computed separately for patients served in the diabetes clinic and those served in the dental clinic in order to compare patient populations for each setting at the community health center. These statistics include frequencies and a Chi-square test for types of services provided, the average number of services provided, and proportions of missed and cancelled appointments.

Any given patient may have received dental care in the diabetes clinic on multiple occasions and during each visit may have received multiple services. Therefore, additional analyses were conducted at the patient level and at the visit level. At the patient level, averages were computed for total value of care,

value of care per visit, and total number of services provided. At the visit level, averages were computed for total value of care and number of services provided during a visit.

## Results

### **Summary**

Findings demonstrate that the addition of the CDHC has aided in improving access to dental care among diabetic patients in the tribal community through patient navigation. The CDHC scheduled diabetes patients to come into the diabetes clinic specifically dental services. Over a nine-month period, the CDHC provided dental services *only one day per week* to these patients; ultimately, the CDHC served 114 patients in the diabetic clinic at this community health center. Among these patients, there were no missed appointments with the CDHC and only one cancellation. The total care value of services provided to patients seen in the diabetes clinic and brought into the dental clinic by the CDHC was \$45,800. Billable services provided by the CDHC alone generated \$13,922 of that \$45,800 during that nine-month period, with the CDHC seeing patients in the diabetes clinic only one day per week.

### **Diabetes Clinic vs. Dental Clinic**

Overall, there were differences in the types of services provided to patients who were seen in the diabetes clinic compared to patients seen only in the dental clinic ( $\chi^2 = 65.9$ ,  $p < .0001$ ). Patients who received dental care in the diabetes clinic primarily received screening or preventive services, but they did receive some comprehensive care services over in the dental clinic.

Both patients who received dental care in the diabetes clinic and the dental clinic had scheduled appointments for care at the community health center; however, the CDHC specifically arranged appointments made with patients at the diabetes clinic. Among patients seen at the diabetes clinic, there were no records missed appointments and only one cancellation, while among patients seen at the dental clinic, there was a missed appointment rate of 17.6% and a cancellation rate of 9.1%.

### **Diabetes Clinic**

*Patients.* One hundred fourteen patients received dental care (billable and non-billable) in the diabetes clinic, and some went on to receive comprehensive care in the dental clinic. On average, a dental patient who received care in the diabetes clinic visited the health center 1.7 times, underwent 6 dental procedures (dental services) total, and received \$402 of total care, or \$238 of care per visit.

	<i>Mean</i>	<i>Median<sup>1</sup></i>	<i>S.D.</i>	<i>Minimum</i>	<i>Maximum</i>	<i>N (patients)</i>
Number of visits	1.7	--	--	--	--	114
Care value per visit	\$238	\$231	\$72	\$137	\$663	114
Number of services	6.1	5.5	3.1	2	15	114
Total care value	\$402	\$346	\$225	\$137	\$1,110	114

Eighty-five of the 114 patients who visited the diabetes clinic received billable dental care from the CDHC. On average, these patients visited the health center 1.5 times, underwent 2 dental procedures (dental services) total, and received \$164 of total care or \$111 of care per visit.

	<i>Mean</i>	<i>Median<sup>1</sup></i>	<i>S.D.</i>	<i>Minimum</i>	<i>Maximum</i>	<i>N (patients)</i>
Number of visits	1.5	--	--	--	--	85
Care value per visit	\$112	\$98	\$44	\$39	\$260	85
Number of services	2.1	2.0	1.2	1	7	85
Total care value	\$164	\$111	\$95	\$39	\$429	85

*Procedures.* Overall, 690 dental procedures (dental services) were performed on the 114 patients who visited the diabetes clinic. Among patients who were seen at the diabetes clinic, services were primarily screening or preventive (85.2%) – for comprehensive care, these patients were scheduled to see a dentist in the dental clinic.

Patients seen at Diabetes Clinic		
	<i>Frequency</i>	<i>Percent</i>
Preventive procedures	465	67.4%
Screening	123	17.8
Periodontic procedures	94	13.6
Restorative procedures	5	0.7
Adjunctive general services	2	0.3
Maxillofacial prosthetics	1	0.1
Endodontic procedures	0	0.0
Implant services	0	0.0
Oral and maxillofacial surgery	0	0.0
Prosthodontic procedures	0	0.0
Orthodontic	0	0.0

Of the total number of dental procedures provided in the diabetes clinic, 175 CDHC-level procedures (dental services) were billable and provided to the 85 patients. Over half (57%) of the services provided by the CDHC were prophylaxis and the remaining 43% were intraoral and bitewing x-rays. (A dentist was called over to the diabetes clinic to provide any necessary diagnostics). The diabetes patient population is primarily adult, thus the CDHC provided no fluoride treatments or sealants which would be seen more in younger patient populations.

Diabetes Clinic

	<i>Frequency</i>	<i>Percent</i>
Prophlaxis	99	56.6%
Intraoral film	35	20.0
Bite-wing film	41	23.4
Topical fluoride	0	0.0
Prophylaxis with fluoride	0	0.0
Sealants	0	0.0
Digital photographs	0	0.0
Temporalization	0	0.0

## Appendix 4

### **CDHC CASE STUDY 9 REPORT: ELEMENTARY SCHOOL OUTREACH**

#### Introduction

The focus of this case study is a community health center which serves the surrounding American Indian rural community. Dental services are provided in the dental clinic at the health center by five fulltime dentists, eleven fulltime assistants, six fulltime dental hygienists, and one CDHC. Prior to entering the CDHC pilot training program, the CDHC practiced as a licensed dental hygienist in the clinic and participated in limited outreach programs. Post-training, the CDHC has worked in both the field and the clinic on various outreach initiatives.

For this initiative, the goal of the CDHC was to provide preventive services, promote oral health and, through patient navigation and care coordination, increase access to dental care for elementary school students in order to help them maintain their overall health. The CDHC arranged for screenings and delivery of dental services to occur at the local elementary school during the fall of 2010, spring of 2011, and fall 2011, not visiting the elementary school during summer months. The CDHC also scheduled appointments at the dental clinic for patients to receive comprehensive care and followed up with screened patients in regards to their scheduled appointments at the dental clinic.

To measure the success of this goal, the current case study was conducted to answer the following questions:

1. Did the elementary school outreach program result in screened students visiting the dental clinic?
2. How many students came to the dental clinic through the CDHC's elementary school outreach program?
3. What types of dental services were provided to students at the elementary school?
4. What types of dental services were provided to students at the dental clinic?
5. What was the value of the dental care provided to students at the elementary school?
6. What was the value of the dental care provided to students at the dental clinic?
7. What was the missed appointment rate for students who had appointments for comprehensive care at the dental clinic?

#### Data Collection

Data was extracted from the Dentrix Enterprise patient management system. The current analysis focuses on appointments that took place during the time period in which students were screened and received comprehensive care – December 2010 through September 2011 (excluding summer months). All patient data was captured real time in Dentrix via a secured internet connection and all clinic data was captured using the facility's local area network.

#### Analysis

Descriptive statistics were computed to reflect dental services provided in the elementary school versus dental services provided in the dental clinic. These statistics include frequencies for dates of service, types of services provided, days between screening and comprehensive care, and proportions of missed and cancelled appointments.

Any given patient may have received dental care on multiple occasions and during each visit may have received multiple services. Therefore, other analyses were conducted at the patient level and at the visit level. At the patient level, averages were computed for total value of care, value of care per visit, number of visits, and total number of services provided. At the visit level, averages were computed for total value of care and number of services provided during a visit.

Additional analyses were conducted to describe those patients who received comprehensive care in the dental clinic only after they had been seen at the elementary school.

## Results

### **Summary**

Findings demonstrate that the addition of the CDHC has aided in improving access to dental care among elementary students in the community. Over a seven-month period, the CDHC served 201 children in the elementary school for a total of 436 school visits over 32 days. Seventy-four of those 201 children went on to receive comprehensive dental care in the dental clinic; sixty-one of those had not been seen at the dental clinic prior to being seen at school. Typically, these patients came to the clinic 56<sup>i</sup> days after screening. The total care value of services provided to the children seen in the elementary school and brought into the dental clinic through elementary school outreach was \$130,499. CDHC services alone amounted to \$41,613 of care, while \$88,886 of care was provided at the dental clinic during that seven-month period.

### **Elementary School Outreach Events**

<b>Patients:</b>	<b>201</b>
<b>Visits:</b>	<b>436</b>
<b>Procedures:</b>	<b>1,818</b>

Overall, there were differences in the types of services provided to these children at the school compared to services they received at the dental clinic. At school, preventive care and screenings were provided. Comprehensive care was provided at the dental clinic.

On average, patients had 2 visits, 4 dental procedures (dental services) per visit, and received \$442 of total care, or \$204 of care per visit.

	<i>Mean</i>	<i>Median<sup>ii</sup></i>	<i>S.D.</i>	<i>Minimum</i>	<i>Maximum</i>	<i>N (patients)</i>
Number of visits	2.2	2.0	0.9	1.0	5.0	201
Care value per visit	\$204	\$192	\$144	\$44	\$886	201
Number of services per visit	4.2	4.0	2.8	1.0	17.0	201
Total care value	\$442	\$392	\$232	\$131	\$1,319	201

*Services provided.* 1,818 dental procedures were performed in school. One-third (34.6%) of procedures were sealants (per tooth) and another quarter (23.0%) were fluoride varnish.

### Procedures at Elementary School

		<i>Frequency<sup>iii</sup></i>	<i>Percent</i>
D0120- D0180	Clinical oral evaluation	168	9.2
D0210- D0350	Radiographs/diagnostic imaging	183	10.1
D1110- D1120	Dental prophylaxis	210	11.6
D1206	Fluoride varnish	419	23.0
D1330	Oral health instructions	209	11.5
D1351	Sealant	629	34.6
	<b>TOTAL</b>	<b>1,818</b>	<b>100.0</b>

### Dental Care in the Dental Clinic

<b>Patients: 74</b> <b>Visits: 137</b> <b>Procedures: 546</b> <b>New Patients: 61</b>
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On average, patients had 2 visits, 4 dental procedures (dental services) per visit, and received \$562 of total care, or \$304 of care per visit.

	<i>Mean</i>	<i>Median<sup>2</sup></i>	<i>S.D.</i>	<i>Minimum</i>	<i>Maximum</i>	<i>N (patients)</i>
Number of visits	1.9	1.0	1.5	1.0	9.0	74
Care value per visit	\$304	\$237	\$385	0.0	\$3,825	74
Number of services per visit	3.9	4.0	3.2	1.0	32.0	74
Total care value	\$562	\$380	\$615	\$44	\$4,427	74

*Services provided.* 546 dental procedures were performed in the dental clinic. Restorations (15.2%) were the most common type of services provided. Another 14.8% of procedures were sealants (per tooth) and 10.3% were fluoride varnish.

**Procedures at Dental Clinic**

		<i>Frequency<sup>3</sup></i>	<i>Percent</i>	<i>Fee (per procedure)</i>
D0120- D0180	Clinical oral evaluation	58	10.6%	\$ 44 - 88
D0210- D0350	Radiographs/diagnostic imaging	63	11.5	39 - 158
D1110- D1120	Dental prophylaxis	27	5.0	67 - 98
D1206	Fluoride varnish	56	10.3	36
D1330	Oral health instructions	19	3.5	39
D1351	Sealant	81	14.8	50
D1201- D1999	Other preventive procedures	2	0.4	0 - 91
D2000- D2999	Restoratives	104	19.1	88 - 393
D3000- D3999	Endodontics	7	1.3	88 - 240
D5000- D5999	Maxillofacial prosthetics	3	0.6	67 - 119
D7000- D7999	Oral and maxillofacial surgery	13	2.4	171 -348
D8000- D8999	Orthodontics	19	3.5	0
D9000- D9999	Adjunctive general services	94	17.2	38 - 436
TOTAL		546	100.0	--

For elementary school patients who made an appointment at the dental clinic, the rate of missed appointments was 38% (of appointments made); the rate of cancelled appointments was 4.9%.

*New Patients*<sup>iv</sup>. Sixty-one of the elementary students screened at school had not been seen in the clinic prior to their dental visit at school and went on to receive comprehensive care at the dental clinic. These patients came to the dental clinic approximately 75 days after screening at the school (mean=74.9,). Over half (50.9%) of these patients visited the clinic within two months of their screening at school (median=56.0).

<i>Time between screening and clinic visit</i>	<i>Frequency</i> <sup>3</sup>	<i>Percent</i>
Less than one month	14	23.0
One to two months	17	27.9
Two to three months	9	14.8
Three to four months	10	16.4
Over four months	11	18.0

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<sup>i</sup> Median is reported due to the skewed distribution of number of days between school visit and dental clinic visit. The mean was about 75 days.

<sup>ii</sup> The median value is the most representative statistic throughout this report given the influence of extreme outliers.

<sup>iii</sup> NOTE: Interpret any frequencies of less than 30 with caution as they may not be statistically reliable.

<sup>iv</sup> For the purposes of this report, a "new patient" is defined as a patient who did not have record of a dental appointment in the dental clinic prior to receiving dental services at the elementary school; this definition is based on the time period from December 2010 to September 2011 for which appointment data was collected.

## Appendix 5

### ***CDHC CASE STUDY 23 REPORT: SENIOR CITIZEN OUTREACH***

#### Introduction

The focus of this case study is a community health center which serves the surrounding American Indian rural community. Dental services are provided in the dental clinic at the health center by five fulltime dentists, eleven fulltime assistants, six fulltime dental hygienists, and one CDHC. Prior to entering the CDHC pilot training program, the CDHC practiced as a licensed dental hygienist in the clinic and participated in limited outreach programs. Post-training, the CDHC has worked in both the field and the clinic on various outreach initiatives.

For this initiative, the goal of the CDHC was to provide preventive services, promote oral health and, through patient navigation and care coordination, increase access to dental care for senior citizens in order to help them maintain their overall health. The CDHC arranged for screenings and delivery of dental services to occur at the local elder care center one day per week starting in December of 2010. The CDHC also scheduled appointments at the dental clinic for patients to receive comprehensive care and followed up with screened patients in regards to their scheduled appointments at the dental clinic.

To measure the success of this goal, the current case study was conducted, aiming to answer the following questions:

1. How many patients were brought into the dental clinic in the community health center through contact with the CDHC at the elder care center?
2. Did the outreach activities at the elder care center result in the screened senior citizens visiting the clinic?
3. What types of dental services were provided for senior citizen patients?
4. What was the value of the dental care provided to senior citizen patients?
5. What was the missed appointment rate for patients who received dental care in the elder care center compared to the missed appointment rate for all patients who received dental care in the dental clinic?

#### Data Collection

In order to answer the above questions, data was extracted from the Dentrix Enterprise patient management system. The current analysis focused on the time period starting December 15, 2010 and ending September 28, 2011 – the time during which the elder care center hosted the CDHC. All patient data was captured real time in Dentrix via a secured internet connection and all clinic data was captured using the facility's local area network.

#### Analysis

Descriptive statistics were computed to reflect care occurring in the schools versus in the dental clinic. These statistics include frequencies for dates of service, types of services provided, the average number of days between screening and comprehensive care, and proportions of missed and cancelled appointments.

Any given patient may have received dental care on multiple occasions and during each visit may have received multiple services. Therefore, additional analyses were conducted at the patient level and at the visit level. At the patient level, averages were computed for total value of care, value of care per visit, number of visits, and total number of services provided. At the visit level, averages were computed for total value of care and number of services provided during a visit.

Additional analyses were conducted to describe those patients who, after screening at the elder care center, received comprehensive care in the dental clinic.

## Results

### Summary

Findings demonstrate that the addition of the CDHC has aided in improving access to dental care among senior citizens in the local community. Over a nine-month period, providing dental services one day per week (for a total of 35 days), the CDHC served 119 seniors in the elder care center; 102 went on to receive comprehensive care at the dental clinic; 89 of those had not been seen at the dental clinic prior to screening. Typically, these patients came to the clinic 56<sup>i</sup> days after screening. The total care value of services provided to the seniors seen in the elder care center and brought into the dental clinic through elder care center outreach was \$147,376. CDHC services alone amounted to \$42,482 of care, while \$104,894 of care was provided at the dental clinic during that nine-month period.

### Elder Care Center Screenings

<b>Patients:</b>	<b>119</b>
<b>Visits:</b>	<b>178</b>
<b>Procedures:</b>	<b>611</b>

Overall, there were differences in the types of services provided to these seniors at the elder care center compared to services they received at the dental clinic. At the elder care center, preventive care, periodontal care, and screenings were provided. Comprehensive care was provided at the dental clinic.

On average, patients had 2 visits at the elder care center, 3 dental procedures (dental services) per visit, and received \$357 of total care, or \$232 of care per visit.

	<i>Mean</i>	<i>Median<sup>ii</sup></i>	<i>S.D.</i>	<i>Minimum</i>	<i>Maximum</i>	<i>N (patients)</i>
Number of visits	1.5	1.0	0.6	1.0	3.0	119
Care value per visit	\$239	\$231	\$98	\$75	\$859	119
Number of services per visit	3.4	3.0	1.2	2.0	11.0	119
Total care value	\$357	\$303	\$199	\$75	\$1,335	119

*Services provided.* 611 dental procedures were performed in the elder care center. Almost one-third (29.1%) of procedures were oral hygiene instruction, almost one-third (28.2%) were fluoride varnish, and another 16.4% were periodontal maintenance.

		Procedures at Elder Care Center	
		<i>Frequency<sup>iii</sup></i>	<i>Percent</i>
D0120-D0180	Clinical oral evaluation	4	0.7%
D0210-D0350	Radiographs/diagnostic imaging	69	11.3
D1110-D1120	Dental prophylaxis	73	12.0
D1206	Fluoride varnish	172	28.2
D1330	Oral health instructions	178	29.1
D2000-D2999	Restoratives	2	0.3
D4000-D4999	Periodontics	112	18.3
D9000-D9999	Adjunctive general services	1	0.2
TOTAL		611	100.0

#### Dental Care in the Dental Clinic

**Patients: 102**

**Visits: 293**

**Procedures: 869**

**New Patients: 89**

On average, patients had 3 visits, 3 dental procedures (dental services) per visit, and received \$1,020 of total care, or \$360 of care per visit.

	<i>Mean</i>	<i>Median<sup>2</sup></i>	<i>S.D.</i>	<i>Minimum</i>	<i>Maximum</i>	<i>N (patients)</i>
Number of visits	2.9	2.0	2.0	1.0	11.0	102
Care value per visit	\$ 358	\$231	\$ 555	\$ 0	\$5,200	102
Number of services per visit	3.0	3.0	1.6	1.0	9.0	102
Total care value	\$1,028	\$596	\$1,107	\$83	\$6,784	102

*Services provided.* 869 dental procedures were performed at the dental clinic. In addition to screening/preventive procedures (62.1%), restorative (11.3%), periodontic (8.3%), maxillofacial prosthetic (4.0%), and other comprehensive care procedures took place.

**Procedures at Dental Clinic**

		<i>Frequency<sup>3</sup></i>	<i>Percent</i>	<i>Fee (per procedure)</i>
D0120-D0180	Clinical oral evaluation	130	15.0%	\$ 44 - 88
D0210-D0350	Radiographs/diagnostic imaging	133	15.3	32 - 162
D0415-D0999	Other diagnostics	22	2.5	118
D1110-D1120	Dental prophylaxis	50	5.8	67 - 98
D1206	Fluoride varnish	107	12.3	36
D1330	Oral health instructions	93	0.1	39
D1351	Sealant	4	10.7	50
D1201-D1999	Other preventive procedures	1	0.5	50
D2000-D2999	Restoratives	98	11.3	0 - 1,027
D3000-D3999	Endodontics	4	0.5	88 - 216
D4000-D4999	Periodontics	72	8.3	156 - 238
D5000-D5999	Maxillofacial prosthodontics	35	4.0	67 - 1,948
D6000-D6199	Implant services	2	0.2	1,838
D6200-D6999	Prosthodontics	7	0.8	68 - 1,027
D7000-D7999	Oral and maxillofacial surgery	12	1.4	171 - 258
D8000-D8999	Orthodontics	7	0.8	0 - 5,200
D9000-D9999	Adjunctive general services	92	10.6	0 - 207
	<b>TOTAL</b>	<b>869</b>	<b>100.0</b>	<b>--</b>

For senior citizen patients who made an appointment at the dental clinic, the rate of missed appointments and cancelled appointments was very similar; 8.6% versus 8.4% (of appointments made), respectively.

*New patients*<sup>iv</sup>. Eighty-nine senior citizens screened at the elder care center had not been seen in the clinic prior to their dental visit at the elder care center and went on to receive comprehensive care at the dental clinic. These patients came to the dental clinic approximately 65 days after screening at the elder care center (mean = 64.6). Over half (53.0%) visited the dental clinic within two months of their screening at the elder care center (median = 56.0).

<i>Time between screening and clinic visit</i>	<i>Frequency</i> <sup>3</sup>	<i>Percent</i>
Less than one month	27	30.3%
One to two months	20	22.5
Two to three months	10	11.2
Three to four months	23	25.8
Over four months	9	10.1

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<sup>i</sup> Median is reported here due to the skewed distribution of number of days between school visit and dental clinic visit. The mean was about 75 days.

<sup>ii</sup> The median value is the most representative statistic throughout this report given the influence of extreme outliers for variables reported.

<sup>iii</sup> NOTE: Interpret any frequencies of less than 30 with caution as they may not be statistically reliable.

<sup>iv</sup> For the purposes of this report, a "new patient" is defined as a patient who did not have record of a dental appointment in the dental clinic prior to receiving dental services at the elder care center; this definition is based on the time period from December 2010 to September 2011 for which appointment data was collected.

## Appendix 6

### ***CDHC CASE STUDY 22 REPORT: HIGH SCHOOL OUTREACH***

#### Introduction

The focus for this case study is a community health center which serves the surrounding American Indian rural community. Dental services are provided in the dental clinic at the health center by five fulltime dentists, eleven fulltime assistants, six fulltime dental hygienists and now, one CDHC. Prior to entering the CDHC pilot training program, the CDHC practiced as a licensed dental hygienist in the clinic and participated in limited outreach programs. Post-training, the CDHC has worked in both the field and the clinic on various outreach initiatives.

For this initiative, the goal of the CDHC was to provide preventive services, promote oral health and, through patient navigation and care coordination, increase access to dental care for high school students in order to help them maintain their overall health. The CDHC arranged for screenings and delivery of dental services to occur at the local high school during the fall of 2010, spring of 2011, and fall 2011. The high school was not open during summer months. The CDHC also scheduled appointments at the dental clinic for students to receive comprehensive care and followed up with screened students in regards to their scheduled appointments at the dental clinic.

To measure the success of this goal, the current case study was conducted, aiming to answer the following questions:

1. How many students came to the dental clinic through the CDHC's school outreach program?
2. Did the high school outreach activities result in the screened students visiting the clinic?
3. What types of dental services were provided to students at the dental clinic?
4. What was the value of the dental care provided to students at the dental clinic?
5. What was the missed appointment rate for students who had appointments for comprehensive care at the dental clinic?

#### Data Collection

In order to answer the above questions, data was extracted from the Dentrix Enterprise patient management system. The current analysis focuses on the time period during which students were screened and received comprehensive care—December 2010 through September 2011 (excluding summer months). All patient data was captured real time in Dentrix via a secured internet connection and all clinic data was captured using the facility's local area network.

#### Analysis

Descriptive statistics were computed to reflect care occurring in the schools versus in the dental clinic. These statistics include frequencies for dates of service, types of services provided, the average number of days between screening and comprehensive care, and proportions of missed and cancelled appointments.

Any given patient may have received dental care on multiple occasions and during each visit may have received multiple services. Therefore, additional analyses were conducted at the patient level and at the visit level. At the patient level, averages were computed for total value of care, value of care per visit, number of visits, and total number of services provided. At the visit level, averages were computed for total value of care and number of services provided during a visit.

Additional analyses were conducted to describe those patients who, after screening at the high school, received comprehensive care in the dental clinic.

## Results

### Summary

Findings demonstrate that the addition of the CDHC has aided in improving access to dental care among high school students in the community. Over a seven-month period, the CDHC served 30 students in the high school for a total of 50 school visits over 21 days. Sixteen of those 30 students went on to receive comprehensive dental care in the dental clinic after screening; five of those had not been seen at the dental clinic prior to screening at school. Two of the five came to the dental clinic within one month of their dental visit at school. The total care value of services provided to the students seen at high school and the dental clinic was \$18,813. Billable services provided by the CDHC alone generated \$7,204, while \$11,609 of care was provided to high school students at the dental clinic during that seven month period.

### High School Outreach Events

<b>Patients:</b> 30
<b>Visits:</b> 50
<b>Procedures:</b> 211

Overall, there were differences in the types of services provided to the students at the school compared to services they received at the dental clinic. At school, preventive care and screenings were provided. Comprehensive care was provided at the dental clinic.

On average, students had 2 visits, 4 dental procedures (dental services) per visit, and received \$387 of total care, or \$232 of care per visit.

	<i>Mean</i>	<i>Median<sup>i</sup></i>	<i>S.D.</i>	<i>Minimum</i>	<i>Maximum</i>	<i>N (patients)</i>
Number of visits	1.7	1.0	0.8	1.0	3.0	30
Care value per visit	\$232	\$245	\$141	\$80	\$875	30
Number of services per visit	4.2	4.0	2.9	1.0	18.0	30
Total care value	\$387	\$257	\$233	\$137	\$1,048	30

*Services provided.* 211 dental procedures were performed at the high school. 39.3% of procedures were sealants (per tooth) and another 19.0% were fluoride varnish.

		Procedures at High School	
		<i>Frequency<sup>j</sup></i>	<i>Percent</i>
D0120-D0180	Clinical oral evaluation	11	5.2
D0210-D0350	Radiographs/diagnostic imaging	20	9.5
D1110-D1120	Dental prophylaxis	28	13.3
D1206	Fluoride varnish	40	19.0
D1330	Oral health instructions	29	13.7
D1351	Sealant	83	39.3
TOTAL		211	100.0

### Dental Care in the Dental Clinic

**Patients: 16**  
**Visits: 30**  
**Procedures: 94**  
**New Patients: 5**

On average, patients had 2 visits, 3 dental procedures (dental services) per visit, and received \$450 of total care, or \$240 of care per visit.

	<i>Mean</i>	<i>Median<sup>1</sup></i>	<i>S.D.</i>	<i>Minimum</i>	<i>Maximum</i>	<i>N (patients)</i>
Number of visits	1.9	1.0	1.6	1.0	7.0	16
Care value per visit	\$240	\$198	\$221	\$ 0	\$824	16
Number of services per visit	3.1	2.5	2.3	1.0	10.0	16
Total care value	\$450	\$311	\$404	\$88	\$1,528	16

*Services provided.* 94 dental procedures were performed at the dental clinic; 19.2% of procedures were restorations, while 11.7% were fluoride varnish and 10.6% were bitewing films.

		Procedures at Dental Clinic		
		Frequency <sup>3</sup>	Percent	Fee (per procedure)
D0120-D0180	Clinical oral evaluation	14	14.9	\$ 44 - 88
D0210-D0350	Radiographs/diagnostic imaging	16	17.0	39 - 158
D0415-D0999	Other diagnostics	1	1.1	118
D1110-D1120	Dental prophylaxis	7	7.5	98
D1206	Fluoride varnish	11	11.7	36
D1330	Oral health instructions	7	7.4	39
D1351	Sealant	5	5.3	50
D2000-D2999	Restoratives	19	20.2	138 - 393
D7000-D7999	Oral and maxillofacial surgery	1	1.1	171
D8000-D8999	Orthodontics	6	6.4	0
D9000-D9999	Adjunctive general services	7	7.5	0
TOTAL		94	100.0	--

For high school patients who made an appointment at the dental clinic, the rate of missed appointments was 22.4% (of appointments made); the rate of cancelled appointments was 14.3%.

*New Patients<sup>iii</sup>*. Five of the high school students screened at school had not been seen in the clinic prior to their dental visit at school and went on to receive comprehensive care at the dental clinic. Two of five of these patients visited the clinic within one month of their screening at school, one within two to three months, and two over four months after screening.

<sup>i</sup> The median value is the most representative statistic throughout this report given the influence of extreme outliers for variables reported.

<sup>ii</sup> NOTE: Interpret any frequencies of less than 30 with caution as they may not be statistically reliable.

<sup>iii</sup> For the purposes of this report, a "new patient" is defined as a patient who did not have record of a dental appointment in the dental clinic prior to receiving dental services at the high school; this definition is based on the time period from December 2010 to September 2011 for which appointment data was collected.

## Appendix 7

### ***CDHC CASE STUDY 11 REPORT: PRE-SCHOOL OUTREACH***

#### Introduction

The focus of this case study is a community health center which serves the surrounding Native American rural community. Dental services are provided in the dental clinic at the health center by three fulltime dentists, six fulltime assistants, two fulltime dental hygienists, and one CDHC. The CDHC works in the clinic as a dental assistant to compensate for staffing shortages and also coordinates outreach initiatives.

For this initiative, the goal of the CDHC was to provide preventive services, promote oral health and, through patient navigation and care coordination, increase access to dental care for pre-school children in order to help them maintain their overall health. The primary role of the CDHC was to coordinate outreach at each pre-school location and the delivery of subsequent care rather than providing services at outreach events. The CDHC arranged for the clinic's dental hygienist to conduct screenings and deliver dental services at the local pre-schools during the school year. The CDHC scheduled appointments at the dental clinic for children in need of comprehensive care.

To measure the success of this goal, the current case study was conducted to answer the following questions:

1. Did the pre-school outreach program result in screened children visiting the dental clinic?
2. How many children came to the dental clinic through the CDHC's pre-school outreach program?
3. What types of dental services were provided to children at the pre-schools?
4. What types of dental services were provided to children at the dental clinic?
5. What was the value of the dental care provided to children at the pre-schools?
6. What was the value of the dental care provided to children at the dental clinic?
7. What was the missed appointment rate for children who had appointments for comprehensive care at the dental clinic?

#### Data Collection

Data was extracted from the Dentrix Enterprise patient management system. The current analysis focuses on appointments that took place during the time period in which children were screened and received comprehensive care – April 2010 through March 2012. All patient data was captured real time in Dentrix via a secured internet connection and all clinic data was captured using the facility's local area network.

#### Analysis

Descriptive statistics were computed to reflect dental services provided in the pre-schools versus dental services provided in the dental clinic. These statistics include frequencies for dates of service, types of services provided, days between screening and comprehensive care, and proportions of missed and cancelled appointments.

Any given patient may have received dental care on multiple occasions and during each visit may have received multiple services. Therefore, other analyses were conducted at the patient level and at the visit level. At the patient level, averages were computed for total value of care, value of care per visit, number of visits, and total number of services provided. At the visit level, averages were computed for total value of care and number of services provided during a visit.

Additional analyses were conducted to describe those children who received comprehensive care in the dental clinic only after they had been seen at pre-school.

## Results

### Summary

Findings demonstrate that the addition of the CDHC has aided in improving access to dental care among pre-school children in the community through patient navigation and coordination of care. Over a ten-month period, 240<sup>i</sup> children were served in the pre-schools for a total of 390 school visits over 33 days. One hundred eighteen of those 240 children went on to receive comprehensive dental care in the dental clinic; 61 of those had not been seen at the dental clinic prior to being seen at school. Typically, these children came to the clinic 81<sup>ii</sup> days after screening. The total care value of services provided to the children seen in the pre-schools and brought into the dental clinic through pre-school outreach was \$157,452. Outreach services alone amounted to \$105,501 of care, while \$51,951 of care was provided at the dental clinic during that ten-month period.

### Pre-school Outreach Events

<b>Patients:</b>	<b>240</b>
<b>Visits:</b>	<b>390</b>
<b>Procedures:</b>	<b>2,141</b>

Overall, there were differences in the types of services provided to children at pre-schools compared to services they received at the dental clinic. At pre-school, the majority of care provided was preventive.

On average, children had 2 visits, 4 dental procedures (dental services) per visit, and received \$440 of total care, or \$271 of care per visit.

	<i>Mean</i>	<i>Median<sup>iii</sup></i>	<i>S.D.</i>	<i>Minimum</i>	<i>Maximum</i>	<i>N (children)</i>
Number of visits	1.6	2.0	0.8	1.0	5.0	240
Care value per visit	\$271	\$145	\$290	\$40	\$1,745	240
Number of services per visit	5.5	4.0	4.3	1.0	20.0	240
Total care value	\$440	\$294	\$426	\$40	\$3,258	240

*Services provided.* 2,141 dental procedures were performed in pre-schools.

		Procedures at Pre-School	
		<i>Frequency<sup>v</sup></i>	<i>Percent</i>
D1110-D1120	Dental prophylaxis	280	13.1
D1206	Fluoride varnish	177	8.3
D1351	Sealant	674	31.5
D1201-D1999	Other preventive procedures	757	35.4
D2000-D2999	Restoratives	253	11.8
TOTAL		2,141	100.0

### Dental Care in the Dental Clinic

**Patients: 118**

**Visits: 229**

**Procedures: 806**

**New Patients: 61**

On average, children had 2 visits, 3 dental procedures (dental services) per visit, and received \$440 of total care, or \$227 of care per visit.

	<i>Mean</i>	<i>Median<sup>2</sup></i>	<i>S.D.</i>	<i>Minimum</i>	<i>Maximum</i>	<i>N (children)</i>
Number of visits	1.9	1.0	1.4	1.0	8.0	118
Care value per visit	\$227	\$208	\$179	\$0	\$1,545	118
Number of services per visit	3.5	3.0	2.2	1.0	15.0	118
Total care value	\$440	\$255	\$485	\$40	\$2,864	118

*Services provided.* 806 dental procedures were performed in the dental clinic.

**Procedures at Dental Clinic**

		<i>Frequency<sup>3</sup></i>	<i>Percent</i>	<i>Fee (per procedure)</i>
D0120-D0180	Clinical oral evaluation	144	17.9%	\$ 62 - 75
D0210-D0350	Radiographs/diagnostic imaging	98	12.2	0 - 109
D0414-D0999	Other diagnostics	4	0.5	0
D1110-D1120	Dental prophylaxis	90	11.2	62 - 84
D1206	Fluoride varnish	127	15.8	40
D1351	Sealant	74	9.2	47
D1201-D1999	Other preventive procedures	144	17.9	36 - 91
D2000-D2999	Restoratives	100	12.4	98 - 279
D3000-D3999	Endodontics	9	1.1	80 - 184
D4000-D4999	Periodontics	3	0.4	180 - 250
D7000-D7999	Oral and maxillofacial surgery	11	1.4	159 - 273
D9000-D9999	Adjunctive general services	2	0.2	0
	<b>TOTAL</b>	<b>806</b>	<b>100.0</b>	<b>--</b>

For children who made an appointment at the dental clinic, the rate of missed appointments was 15% (of appointments made); the rate for cancelled appointments was 6.0%.

*New Patients*<sup>v</sup>. Sixty-one of the children screened had not been seen in the clinic prior to their dental visit at pre-school and went on to receive comprehensive care at the dental clinic. These children came to the dental clinic approximately 81 days after screening at the school (mean=139.0.). Over one-quarter (26.2%) of these children visited the clinic within one month of their screening at pre-school (median=81.0).

<i>Time between screening and clinic visit</i>	<i>Frequency</i> <sup>3</sup>	<i>Percent</i>
Less than one month	16	26.2%
One to two months	8	13.1
Two to three months	10	16.4
Three to four months	3	4.9
Over four months	24	39.3

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<sup>i</sup> This is the number of children at outreach who received care designated by ADA CDT service codes. Children who refused care or were did not receive care for other reasons are not included in this analysis.

<sup>ii</sup> Median is reported due to the skewed distribution of number of days between school visit and dental clinic visit. The mean was about 139 days.

<sup>iii</sup> The median value is the most representative statistic throughout this report given the influence of extreme outliers.

<sup>iv</sup> NOTE: Interpret any frequencies of less than 30 with caution as they may not be statistically reliable.

<sup>v</sup> For the purposes of this report, a "new patient" is defined as a child who did not have record of a dental appointment in the dental clinic prior to receiving dental services at the pre-school; this definition is based on the time period from August 2010 to March 2012 for which appointment data was collected.

## Appendix 8

### ***CDHC CASE STUDY 12 REPORT: ELEMENTARY OUTREACH***

#### Introduction

The focus of this case study is a community health center which serves the surrounding Native American rural community. Dental services are provided in the dental clinic at the health center by three fulltime dentists, six fulltime assistants, two fulltime dental hygienists, and one CDHC. The CDHC works in the clinic as a dental assistant to compensate for staffing shortages and also coordinates outreach initiatives.

For this initiative, the goal of the CDHC was to provide preventive services, promote oral health and, through patient navigation and care coordination, increase access to dental care for elementary school children in order to help them maintain their overall health. The primary role of the CDHC was to coordinate outreach at each elementary school location and the delivery of subsequent care rather than providing services at outreach events. The CDHC arranged for the clinic's dental hygienist to conduct screenings and deliver dental services at the local elementary schools during the school year. The CDHC scheduled appointments at the dental clinic for children in need of comprehensive care.

To measure the success of this goal, the current case study was conducted to answer the following questions:

1. Did the elementary school outreach program result in screened children visiting the dental clinic?
2. How many children came to the dental clinic through the CDHC's elementary school outreach program?
3. What types of dental services were provided to children at the elementary schools?
4. What types of dental services were provided to children at the dental clinic?
5. What was the value of the dental care provided to children at the elementary schools?
6. What was the value of the dental care provided to children at the dental clinic?
7. What was the missed appointment rate for children who had appointments for comprehensive care at the dental clinic?

#### Data Collection

Data was extracted from the Dentrix Enterprise patient management system. The current analysis focuses on appointments that took place during the time period in which children were screened and received comprehensive care – April 2010 through March 2012. All patient data was captured real time in Dentrix via a secured internet connection and all clinic data was captured using the facility's local area network.

#### Analysis

Descriptive statistics were computed to reflect dental services provided in the elementary schools versus dental services provided in the dental clinic. These statistics include frequencies for dates of service, types of services provided, days between screening and comprehensive care, and proportions of missed and cancelled appointments.

Any given patient may have received dental care on multiple occasions and during each visit may have received multiple services. Therefore, other analyses were conducted at the patient level and at the visit level. At the patient level, averages were computed for total value of care, value of care per visit, number of visits, and total number of services provided. At the visit level, averages were computed for total value of care and number of services provided during a visit.

Additional analyses were conducted to describe those children who received comprehensive care in the dental clinic only after they had been seen at elementary school.

## Results

### Summary

Findings demonstrate that the addition of the CDHC has aided in improving access to dental care among preschool children in the community through patient navigation and coordination of care. Over a ten-month period, 583<sup>i</sup> children were served in the elementary schools for a total of 1,023 school visits over 69 days. Four hundred one of those 583 children went on to receive comprehensive dental care in the dental clinic; 234 of those had not been seen at the dental clinic prior to being seen at school. Typically, these children came to the clinic 90<sup>ii</sup> days after screening. The total care value of services provided to the children seen in the elementary schools and brought into the dental clinic through elementary school outreach was \$602,862. Outreach services alone amounted to \$373,880 of care, while \$228,982 of care was provided at the dental clinic during that ten-month period.

### Elementary School Outreach Events

<b>Patients:</b>	<b>583</b>
<b>Visits:</b>	<b>1,023</b>
<b>Procedures:</b>	<b>7,711</b>

Overall, there were differences in the types of services provided to these children at the school compared to services they received at the dental clinic. At school, the majority care provided was preventive.

On average, children had 2 visits, 7 dental procedures (dental services) per visit, and received \$641 of total care, or \$365 of care per visit.

	<i>Mean</i>	<i>Median<sup>iii</sup></i>	<i>S.D.</i>	<i>Minimum</i>	<i>Maximum</i>	<i>N (children)</i>
Number of visits	1.8	2.0	0.8	1.0	4.0	583
Care value per visit	\$365	\$333	\$287	\$36	\$1,325	583
Number of services per visit	7.5	7.0	5.4	1.0	23.0	583
Total care value	\$641	\$619	\$435	\$40	\$2,129	583

*Services provided.* 7,711 dental procedures were performed in school.

### Procedures at Elementary School

		<i>Frequency<sup>iv</sup></i>	<i>Percent</i>
D1110-D1120	Dental prophylaxis	716	9.3
D1206	Fluoride varnish	603	7.9
D1351	Sealant	3,966	51.4
D1201-D1999	Other preventive procedures	1,844	23.9
D2000-D2999	Restoratives	577	7.5
D4000-D4999	Periodontics	5	0.1
	<b>TOTAL</b>	<b>7,711</b>	<b>100.0</b>

### Dental Care in the Dental Clinic

<b>Patients:</b>	<b>397</b>
<b>Visits:</b>	<b>896</b>
<b>Procedures:</b>	<b>3,618</b>
<b>New Patients:</b>	<b>234</b>

On average, children had 2 visits, 3 dental procedures (dental services) per visit, and received \$577 of total care, or \$256 of care per visit.

	<i>Mean</i>	<i>Median<sup>2</sup></i>	<i>S.D.</i>	<i>Minimum</i>	<i>Maximum</i>	<i>N (children)</i>
Number of visits	2.3	2.0	1.5	1.0	10.0	397
Care value per visit	\$256	\$230	\$192	\$0	\$1,364	397
Number of services per visit	4.0	3.0	3.1	1.0	21.0	397
Total care value	\$577	\$423	\$537	\$0	\$4,682	397

*Services provided.* 3,618 dental procedures were performed in the dental clinic.

**Procedures at Dental Clinic**

		<i>Frequency<sup>3</sup></i>	<i>Percent</i>	<i>Fee (per procedure)</i>
D0120-D0180	Clinical oral evaluation	435	12.0%	\$ 56 - 88
D0210-D0350	Radiographs/diagnostic imaging	514	14.2	0 - 109
D0415-D0999	Other diagnostics	10	0.3	0
D1110-D1120	Dental prophylaxis	298	8.2	62 - 84
D1206	Fluoride varnish	465	12.9	40
D1351	Sealant	826	22.8	47
D1201-D1999	Other preventive procedures	544	15.0	0 - 57
D2000-D2999	Restoratives	367	10.1	0 - 279
D3000-D3999	Endodontics	33	0.9	81 - 706
D4000-D4999	Periodontics	4	0.1	140 - 250
D7000-D7999	Oral and maxillofacial surgery	108	3.0	0 - 273
D9000-D9999	Adjunctive general services	14	0.4	0 - 130
TOTAL		3,618	100.0	--

For elementary school children who made an appointment at the dental clinic, the rate of missed appointments was 16% (of appointments made); the rate of cancelled appointments was 3.5%.

*New Children<sup>v</sup>*. Two hundred thirty-one of the children screened at school had not been seen in the clinic prior to their dental visit at school and went on to receive comprehensive care at the dental clinic. These children came to the dental clinic approximately 90 days after screening at the school (mean=93.2.). Over one-third (38.4%) of these children visited the clinic within two months of their screening at school (median=90.0).

<i>Time between screening and clinic visit</i>	<i>Frequency<sup>3</sup></i>	<i>Percent</i>
Less than one month	42	17.9
One to two months	48	20.5
Two to three months	29	12.4
Three to four months	47	20.1
Over four months	68	29.1

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<sup>i</sup> This is the number of children at outreach who received care designated by ADA CDT service codes. Children who refused care or were did not receive care for other reasons are not included in this analysis.

<sup>ii</sup> Median is reported due to the skewed distribution of number of days between school visit and dental clinic visit. The mean was about 93 days.

<sup>iii</sup> The median value is the most representative statistic throughout this report given the influence of extreme outliers.

<sup>iv</sup> NOTE: Interpret any frequencies of less than 30 with caution as they may not be statistically reliable.

<sup>v</sup> For the purposes of this report, a “new patient” is defined as a child who did not have record of a dental appointment in the dental clinic prior to receiving dental services at the elementary school; this definition is based on the time period from August 2010 to March 2012 for which appointment data was collected.

## **CASE STUDY SUMMARIES: CDHC PILOT PROGRAM EVALUATION**

### **August 2012**

#### **Case Study 1: Addition of CDHC to Dental Team**

- With the addition of the CDHC in 2011, the clinic saw increases in billable procedures.
  - 2,307 procedures in 2011
  - 1,066 procedures in 2010
- The total care value of services provided increased.
  - \$231,551 in 2011
  - \$ 91,399 in 2010
- Services within the scope of CDHC practice increased.
  - 2011: 704 procedures; \$25,203
  - 2010: 281 procedures; \$ 8,470

#### **Case Study 8: Diabetes Clinic**

- Over a nine-month period, providing dental services *only one day per week*, the CDHC served 114 patients in the diabetic clinic within this community health center.
- The total care value of services provided to patients seen in the diabetes clinic and brought into the dental clinic by the CDHC was \$45,800.
  - Billable services provided by the CDHC alone generated \$13,922
  - Billable services provided by other dental providers equaled \$31,878
  - Average value of care provided to a patient equaled \$402.
- The CDHC specifically arranged appointments for patients at the diabetes clinic.
  - Rate of missed appointments for diabetes clinic patients was zero.
  - The overall rate of missed appointment among patients seen at the dental clinic is 18%.

#### **Case Study 11: Pre-School Outreach**

- Over a ten-month period, 240 children received care at daycare and Head Start.
- The total care value of services provided to children seen at daycare and Head Start and brought into the dental clinic by the CDHC was \$157,452.
  - Billable services provided at preschool outreach alone generated \$105,501
  - Billable services provided at the dental clinic equaled \$51,951
  - Average value of care provided to a child equaled \$440.
- The CDHC referred children to the dental clinic if further care was necessary.
  - Rate of missed appointments at the clinic for these children was 15%.

#### **Case Study 9: Elementary School Outreach**

- Over a seven-month period, 201 children received care in the elementary school.
- The total care value of services provided to children seen at school and brought into the dental clinic by the CDHC was \$130,499.
  - Billable services provided at elementary school outreach alone generated \$41,613
  - Billable services provided at the dental clinic equaled \$88,886
  - Average value of care provided to a child equaled \$442.
- The CDHC referred children to the dental clinic if further care was necessary.

#### **Case Study 12: Elementary School Outreach**

- Over a ten-month period, 583 children received care in the elementary schools.
- The total care value of services provided to children seen in the elementary schools and brought into the dental clinic by the CDHC was \$602,862.
  - Billable services provided at elementary school outreach alone generated \$373,880
  - Billable services provided at the dental clinic equaled \$228,982
  - Average value of care provided to a child equaled \$641.
- The CDHC referred children to the dental clinic if further care was necessary.
  - Rate of missed appointments at the clinic for these children was 16%.

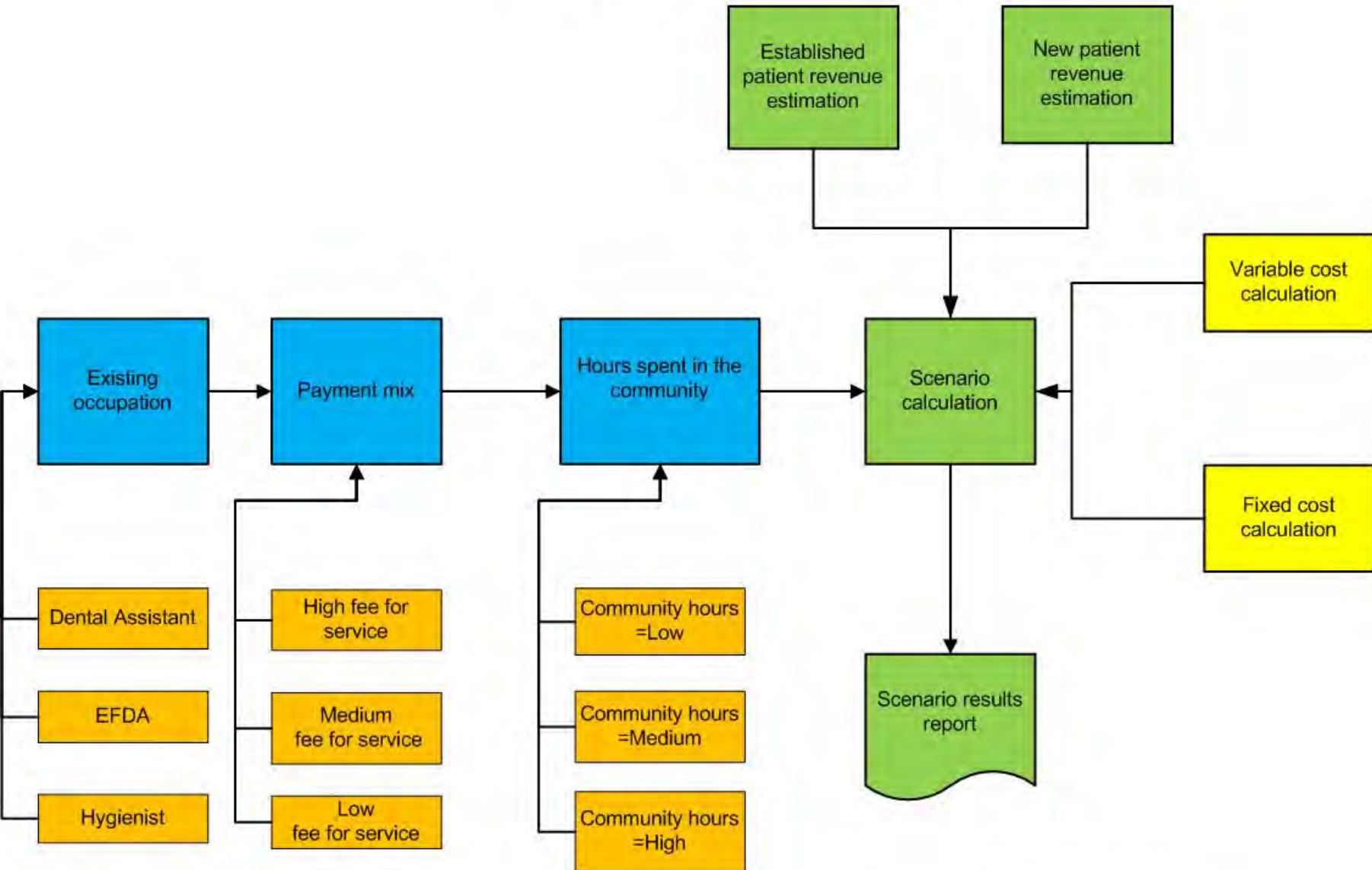
### **Case Study 22: High School Outreach**

- Over a seven-month period, 30 children received care in the high school.
- The total care value of services provided to children seen at high school and brought into the dental clinic by the CDHC was \$18,813.
  - Billable services provided at high school outreach alone generated \$7,204
  - Billable services provided at the dental clinic equaled \$11,609
  - Average value of care provided to a child equaled \$387.
- The CDHC referred children to the dental clinic if further care was necessary.

### **Case Study 23: Senior Outreach**

- Over a ten-month period, 119 senior citizens received care at the elder care center.
- The total care value of services provided to senior citizens seen at the elder care center and brought into the dental clinic by the CDHC was \$147,376.
  - Billable services provided at outreach alone generated \$42,482
  - Billable services provided at the dental clinic equaled \$104,894
  - Average value of care provided to a senior citizen equaled \$357.
- The CDHC referred senior citizens to the dental clinic if further care was necessary.
- Rate of missed appointments at the clinic for these senior citizens was 9%.

# CDHC Pro Forma Calculator Plan



Green = Scenario processing  
Gold = User input choices  
Blue = Scenario variable parameters  
Yellow = Scenario constant parameters

**BUDGET STATUS REPORT**  
**CDHC Pilot Program**  
**June 30, 2012**

<b>Revenues</b>	
Contribution Revenue (XADA)	0.00
<b>Total Revenues</b>	<b>0.00</b>
<b>Expenses</b>	
Salaries	62,723.05
Total Salaries and Temporary Help	62,723.05
Total Fringe Benefits	6,587.48
Volunteer/Nonstaff Airfare	0.00
Staff Airfare	2468.80
Vol/Nonstaff checked baggage f	0.00
Staff checked baggage fees	0.00
Open Item Expenses Air/Other	3038.60
Volunteer/Nonstaff GrndTrnsprt	0.00
Staff Ground Transportation	1204.67
Volunteer Per Diem	0.00
Volunteer/Nonstaff Lodging	0.00
Staff Lodging	2853.25
Volunteer/Nonstaff Meals	0.00
Staff Meals	1443.66
Miscellaneous Travel	39.00
Total Travel Expenses	11047.98
Artwork & Photographic	0.00
Outside Services	396494.77
Publications & Subscriptions	0.00
Telephone Usage	414.61
Postage, Mailings & Freight	87.54
Office Equip Repairs Mainten	0.00
Stationery & Supplies	0.00
Computer Software	0.00
Computer/Printers Supplies	20.30
Total Program/Activity	397017.22
<b>Total Expenses</b>	<b>477375.73</b>
<b>Net Revenue/(Expense)</b>	<b>-477375.73</b>
<b>YTD Net Operational Expenses 2012</b>	<b>477355.43</b>
<b>Summary of CDHC Spending to Date:</b>	
2008 Spending	242,386
2009 Operating Expenses	814,876
2009 Capital Equipment Purchases	418,138
2010 Operating Expenses	1,446,311
2010 Capital Equipment Purchases	19,500
2011 YTD Capital Purchases	143,079
2011 Net Operating Expenses	1,684,156
YTD 2012 Net Operating Expenses	477,355
	5,245,801
<b>Reserve Funding</b>	
2007 Commitment	2,000,000
2009 Commitment	2,365,092
2011 Commitment	1,000,000
2012 Commitment	800,000
Total ADA Funding	6,165,092
Total Spending through June 2012	5,245,801
<b>Total Remaining Reserve Money</b>	<b>919,291</b>

## EXPENSE SUMMARY

**2009 Expenses - Summary by Category**

Salaries and Temporary Help	\$ 43,468.09
Travel Expenses	\$ 26,142.78
Program Activity	\$ 745,263.70
Capital Equipment	\$ 418,138.00

Total \$ 1,233,014.57

**2010 Expenses - Summary by Category**

Salaries and Temporary Help	\$ 120,478.00
Travel Expenses	\$ 56,336.61
Program Activity	\$ 1,248,589.62
Capital Equipment	\$ 19,500.00

Total \$ 1,465,811.00 audit adjustment \$ 1,986,401.31

**2011 Expenses - Summary by Category**

Salaries and Temporary Help	\$ 117,108.00
Travel Expenses	\$ 42,058.31
Program Activity	\$ 1,884,156.00
Capital Equipment	\$ 143,079.00

audit adjustment \$ 1,986,401.31

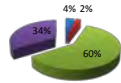
**2012 Expenses - Summary by Category**

Salaries and Temporary Help	\$ 69,270.53
Travel Expenses	\$ 11,047.98
Program Activity	\$ 397,017.22
Capital Equipment	\$ -

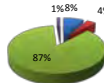
\$ 477,335.73

**2009 Expense Summary**

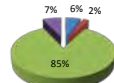
Salaries and Temporary Help Travel Expenses  
Program Activity Capital Equipment

**2010 Expense Summary**

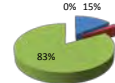
Salaries and Temporary Help Travel Expenses  
Program Activity Capital Equipment

**2011 Expense Summary**

Salaries and Temporary Help Travel Expenses  
Program Activity Capital Equipment

**2012 Expense Summary YTD**

Salaries and Temporary Help Travel Expenses  
Program Activity Capital Equipment

**2009 Expenses - Summary by Program Sites**

Rio Salado	\$ 133,761.57
UCLA	\$ 94,821.93
Oklahoma	\$ 337,539.94
Temple	\$ 34,140.00
Consulting/Evaluation	\$ 47,489.81

\$ 647,753.25

**2010 Expenses - Summary by Program Sites**

Rio Salado	\$ 139,907.48
UCLA	\$ 273,504.54
Oklahoma	\$ 510,332.95
Temple	\$ 335,285.00
Consulting/Evaluation	\$ -

\$ 1,259,029.97

**2011 Expenses - Summary by Program Sites**

Rio Salado	\$ 171,403.96
UCLA	\$ 414,899.00
Oklahoma	\$ 542,430.76
Temple	\$ 339,455.08
Arizona	\$ 147,617.00
Consulting/Education*	\$ 24,000.00
Consulting/Evaluation	\$ 7,176.77
	\$ 1,646,982.57

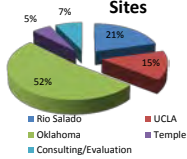
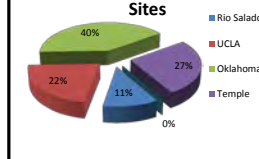
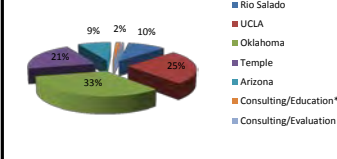
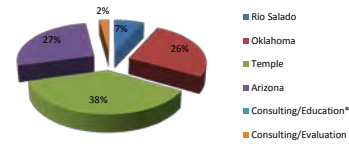
\*2011 curriculum revisions

**2012 Expenses YTD - Summary by Program Sites**

Rio Salado	\$ 38,127.00
Oklahoma	\$ 140,636.67
Temple	\$ 203,271.19
Arizona	\$ 145,400.00
Consulting/Education*	\$ 12,256.15
Consulting/Evaluation	\$ -

\$ 539,691.01

\*YTD expenses includes payments not yet accrued

**2009 Expenses by Program Sites****2010 Expenses by Program Sites****2011 Expenses by Program Sites****2012 Expenses by Program Sites**

## Summary Revenue vs. Expenses

### ADA Funding

<b>2007</b> Allocation	\$	2,000,000.00
<b>2008</b> Available funds	\$	2,000,000.00
Expenses	\$	242,386.00
Remaining funds	\$	<b>1,757,614.00</b>
<b>2009</b> Allocation	\$	2,365,092.00
Available funds (includes allocation)	\$	4,122,706.00
2009 Expenses	\$	1,233,014.00
Remaining funds	\$	<b>2,889,692.00</b>
<b>2010</b> Available funds	\$	2,889,692.00
2010 Expenses	\$	1,465,811.00
Remaining ADA funds	\$	<b>1,423,881.00</b>
<b>2011</b> Available funds (includes \$1 mil allocated)	\$	<b>2,423,881.00</b>
2011 Expenses	\$	<b>1,986,401.31</b>
Remaining funds	\$	437,479.69
<b>2012</b> Available funds (includes \$800K allocation)	\$	1,237,479.69
2012 Expenses YTD	\$	477,375.73
Remaining funds	\$	<b>760,103.96</b>

### ADAF Funding

<b>2009</b> allocated	\$	50,000.00
<b>2011</b> allocated	\$	100,000.00
<b>2012</b> allocated	\$	50,000.00

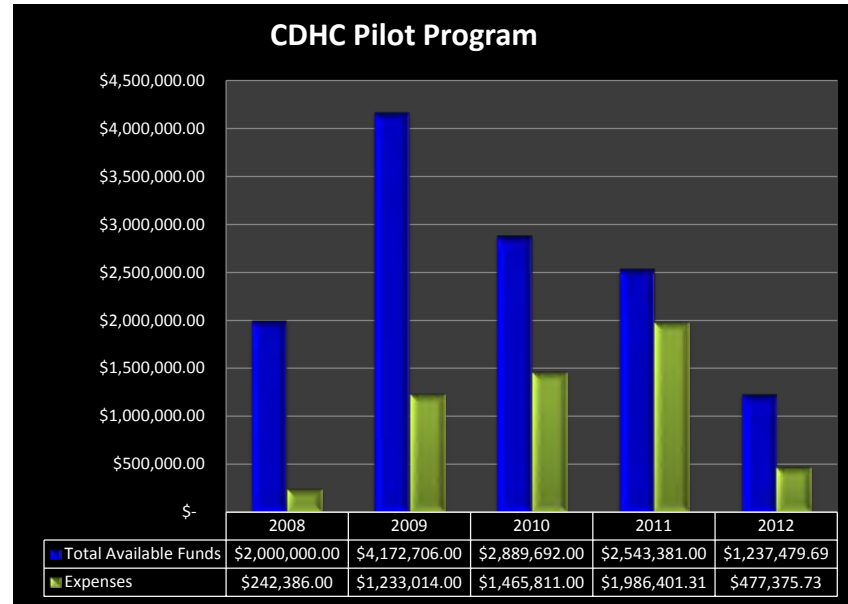
**Total remaining funds \$ 960,103.96**

	Total Available Funds	Expenses
<b>2008</b>	\$ 2,000,000.00	\$ 242,386.00
<b>2009</b>	\$ 4,172,706.00	\$ 1,233,014.00
<b>2010</b>	\$ 2,889,692.00	\$ 1,465,811.00
<b>2011</b>	\$ 2,543,381.00	\$ 1,986,401.31
<b>2012</b>	\$ 1,237,479.69	\$ 477,375.73
<b>Total</b>	<b>\$ 5,404,988.04</b>	

\*2009 available funds includes ADAF allocated funding

\*2011 available funds includes ADAF grant

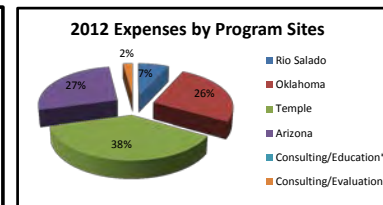
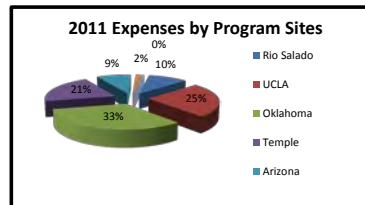
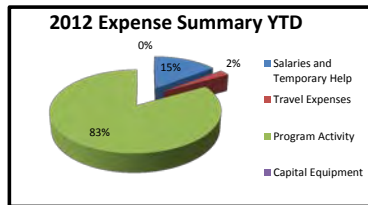
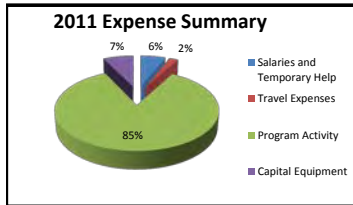
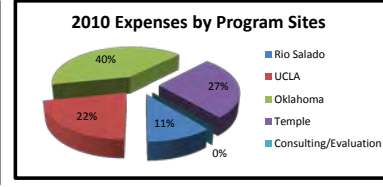
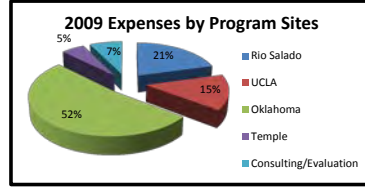
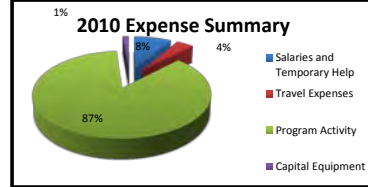
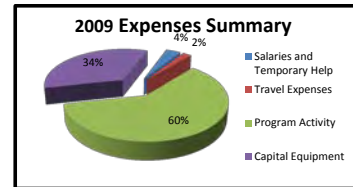
\*2012 available funds includes ADAF grant



## Dashboard

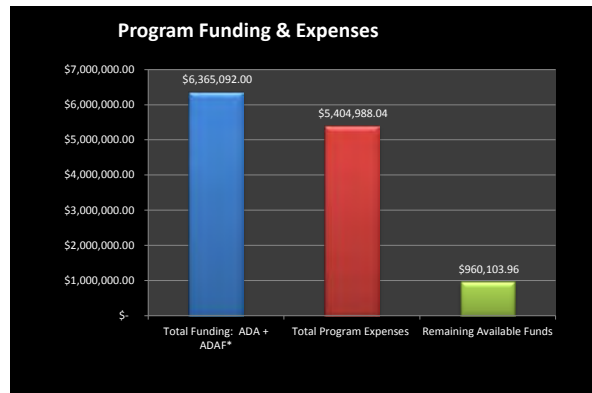
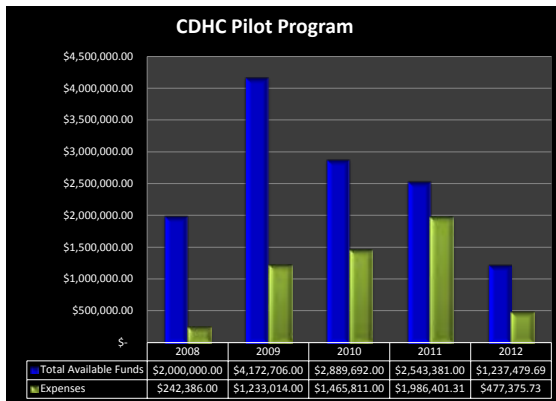
Expense Summary	2009	2010	2011	2012	Expenses by Program Site	2009	2010	2011	2012
Salaries and Temporary Help	\$ 43,468.09	\$ 120,478.00	\$ 117,108.00	\$ 69,270.53	Rio Salado	\$ 133,761.57	\$ 80,122.48	\$ 171,403.96	\$ 38,127.00
Travel Expenses	\$ 26,142.78	\$ 56,336.61	\$ 42,058.31	\$ 11,047.98	UCLA	\$ 94,821.93	\$ 175,485.51	\$ 414,899.00	\$ -
Program Activity	\$ 745,265.70	\$ 1,248,589.62	\$ 1,684,156.00	\$ 397,017.22	Oklahoma	\$ 337,539.94	\$ 468,419.00	\$ 542,430.76	\$ 140,636.67
Capital Equipment	\$ 418,138.00	\$ 19,500.00	\$ 143,079.00	\$ -	Temple	\$ -	\$ 369,425.00	\$ 339,455.08	\$ 203,271.19
					Arizona	\$ -	\$ -	\$ 147,617.00	\$ 145,400.00
					Consulting	\$ 47,489.81	\$ -	\$ 24,286.00	\$ 12,256.15
Total	\$ 1,233,014.57	\$ 1,444,904.23	\$ 1,986,401.31	\$ 477,335.73		\$ 613,613.25	\$ 1,093,451.99	\$ 1,642,102.80	\$ 539,691.01

\*does not include ADA expenses



Revenue vs. Expenses	Total Funds	Expenses
2008	\$ 2,000,000.00	\$ 242,386.00
2009	\$ 4,172,706.00	\$ 1,233,014.00
2010	\$ 2,889,692.00	\$ 1,465,811.00
2011	\$ 2,543,381.00	\$ 1,927,235.12
2012	\$ 1,237,479.69	\$ 477,335.73

Program Funding & Expenses	
Total Funding: ADA + ADAF*	\$ 6,365,092.00
Total Program Expenses	\$ 5,404,988.04
Remaining Available Funds	\$ 960,103.96



## Budget Projections

### 2012 Estimate: Adjusted

	Actual Spending 2008	Actual Spending 2009	Actual Spending 2010	Actual Spending 2011	Projected 2012	Projected 2013	Total
3 Pilot Sites: Temple, UCLA, OK, Arizona (2011)	-	432,362	1,425,404	1,444,402	572,878	126,000	4,001,046
Management of Online Curriculum: Rio Salado	-	133,762	139,907	171,404	50,000		495,073
Evaluation of Program	-	47,490	-	2,500	200,000	-	249,990
CHW curriculum revisions				24,000	5,000		29,000
Project Support: ADA staff and volunteer expenses	241,325	121,592	182,400	201,017	160,000		906,334
Equipment and Supplies	1,061	418,138	19,500	143,079	360,000		941,778
Total	242,386	1,153,343	1,767,211	1,986,402	1,347,878	126,000	6,623,220

### Assumptions for adjusted projections

UCLA paid in full for cohorts 1 and 2

Equipment & Supplies 2010: adjusted based upon Henry Schein donation for equipment: cohort 2 (2010) \$389,038.05

Equipment & Supplies 2011: adjusted based upon Henry Schein donation for equipment: cohort 3 (2011) \$475,930.95

Henry Schein donations for nine cohort 2 students and eleven cohort 3 students (43,266.45 per student)

ADA expenses for 2010 include equipment for five cohort 2 students plus ytd expenses of \$19, 500

ADA expenses for 2011 include equipment for seven cohort 3 students plus estimated computer expenses for all students

Line item for CHW curriculum expenses based upon review of CDHC workgroup and pilot program directors

Addition of Arizona School of Dentistry and Oral Health (ASDOH)

\*\*curriculum revisions noted for consulting only

Resolution No. N/A N/AReport: CAPIR Supplemental Report 3 Date Submitted: September 2012Submitted 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 \_\_\_\_\_ FTE 0ADA Strategic Plan Goal: Members (Required)

**COUNCIL ON ACCESS, PREVENTION AND INTERPROFESSIONAL RELATIONS SUPPLEMENTAL  
REPORT 3 TO THE HOUSE OF DELEGATES: FORMULATING A STRATEGIC APPROACH FOR  
ADDRESSING THE COMPLEX EMERGING ISSUES RELATED TO ORAL HEALTH AND NUTRITION IN  
THE UNITED STATES**

**Background:** At its January 2011 meeting, the Council on Access, Prevention and Interprofessional Relations (CAPIR), held an extended discussion on soda and sweetened beverages noting that these items may contribute to caries risk across the life-span. Additionally, the Council was informed that the Council on Communications had discussed soda consumption by young children at its meeting earlier in January. At the January 2011 meeting, CAPIR adopted an action requesting the ADA Board of Trustees form an interagency workgroup to discuss soda consumption and caries risk in young children and develop potential policy. In April 2011, the Board of Trustees asked CAPIR to review the issue and seek input from other agencies, as appropriate, on the development of policies for consideration by the House of Delegates.

At its June 2011 meeting, CAPIR adopted the following resolution:

**Resolved,** that CAPIR approves the formation of an oral health and nutrition ad hoc advisory committee to consist of representatives from, but not limited to, the Council on Communications, Council on Dental Practice, Council on Scientific Affairs, Council on Government Affairs and the Council on Access, Prevention and Interprofessional Relations, and other experts to formulate a strategic approach for addressing the complex emerging issues related to oral health and nutrition in the United States and to submit a report to the 2012 HOD.

The chairs of the Councils noted above were contacted and asked to appoint members to the ad-hoc committee. An ad-hoc committee was formed consisting of the following member representatives:

Dr. Rocky Napier, Council on Access, Prevention and Interprofessional Relations, chair  
Dr. Jonathan Shenkin, Council on Communications  
Dr. Jon Johnston, Council on Dental Practice  
Dr. Brian Novy, Council on Scientific Affairs  
Dr. Mary Jennings, Council on Government Affairs

In addition, Teresa Marshall, Ph.D., R.D., CAPIR consultant on nutrition issues, acted as expert consultant for the Oral Health and Nutrition Ad Hoc Advisory Committee. Council directors were contacted and an ADA staff member from each participating Council was assigned to the Committee to act as a liaison. This report reflects the majority opinion of the Advisory Committee.

In preparation for the Committee's discussions, members received the following background documents:

- 1 • the history and charge to the workgroup
- 2 • current ADA policies related to nutrition
- 3 • CAPIR reports on nutrition (June 2010-January 2012)
- 4 • links to nutrition-related content on ADA.org and nutrition-related products available through the *ADA*
- 5 *Catalog*
- 6 • guidance from the ADA Board of Trustees urging focus on fulfilling the ADA's Strategic Plan Goals 1
- 7 and 4

8 On February 22, 2012, members of the Committee convened by phone for the first of three conference calls.  
9 Subsequent calls were held on March 3, 2012, and March 21, 2012.

10 Four main points penetrated all of the Committee's discussions.

- 11 1. Oral health is dependent on proper nutrition (eating a well-balanced diet).
- 12 2. Oral health is dependent on good eating habits (limiting snacking and eating in between meals
- 13 [frequency of intake]).
- 14 3. It is not practical to classify some foods and beverages as being more or less harmful to oral health
- 15 than others.
- 16 4. The best way to get people to adopt healthier diets and establish better eating habits is through a
- 17 strong program of nutritional education that begins prenatally and continues throughout the life span.

18 Throughout the discussions, it became clear that the members' comments focused on four themes that could  
19 be used as a foundation in developing strategies to address issues related to oral health and nutrition.

- 20 • Best Available Science and Best Practices
- 21 • Role of Collaboration
- 22 • Communication/Education
- 23 • Development of Policy That Promotes Good Nutrition

24 **Best Available Science and Best Practices:** Additional evidence-based research is needed to ensure that  
25 the science base for nutritional education and recommendations are of the highest quality. However, while  
26 there will always be a desire for high-quality research, the fact is that it is extremely difficult to conduct  
27 randomized controlled nutritional studies on population groups. From an ethical perspective one cannot  
28 assign subjects to a cariogenic test group, thus nutritional studies rely heavily on the behavior of subjects. An  
29 individual's diet typically encompasses many food stuffs and intake patterns, each of which might have  
30 contradictory effects on caries and other health risks.

31 The Committee agreed that efforts are needed to determine how lower level evidence-based research, the  
32 best science that is currently available, can inform policy.

33 In this situation, identifying successful strategies, or best practices, that encourage individuals to adopt eating  
34 habits that maintain optimal oral health is key. In some cases, these best practices might best be determined  
35 at the state level by looking at state administered nutrition programs and populations. Consideration could be  
36 given to conducting pilot programs at this level through WIC or food stamp programs to see what actually  
37 works related to specific foods or eating patterns. The outcomes of these studies could inform further  
38 research and legislative strategies and policies.

39 **Role of Collaboration:** Dental providers need to be informed about their role in providing nutritional  
40 guidance to their patients and the role they can play in providing messaging about general health concerns  
41 such as obesity. Collaboration with primary health care providers and external agencies can also be an  
42 effective method to educate the public about the importance of good nutrition and the role good nutrition and  
43 good eating habits play in oral health. However, the dental community must first work to ensure that non-

dental providers understand the value of good oral health and the role dental professionals can play in improving not only the public's oral but general health through nutritional education.

Educating non-dental primary care providers about the importance of good oral health and developing a working relationship with these providers on a one-to-one and organizational basis is imperative. Opportunities exist for dental professionals to create interprofessional relationships with non-dental providers. Relationships with obstetricians/gynecologists and the American Congress of Obstetricians and Gynecologists (ACOG), pediatricians and the American Academy of Pediatrics (AAP) and registered dietitians and the Academy of Nutrition and Dietetics (AND) are key to ensuring good nutrition information is provided to those involved in prenatal and early childhood health care. It is crucial that nutritional education and good eating habits be established early as it is extremely difficult to change eating habits once they are established. Additionally, good nutrition and eating habits are important factors in preventing dental disease especially early childhood caries that can be devastating to the health of young children. Noting that the risk of caries continues across the lifespan and may increase in older adults, it will also be important to work with those who provide health care to adults and elders. In light of the growing need for care of the baby boomer population, it will not be possible to ignore the need for effective preventive measures for this population.

ADA is currently involved in a number of collaborative projects with non-dental providers that provide opportunities to strengthen nutritional initiatives. For example, the ADA continues to collaborate with the AAP Section on Oral Health. Following the success of the ADAF funded program to train Chapter Oral Health Advocates, the ADA continues to work closely with AAP to ensure the importance of oral health remains a priority. ADA also continues its liaison activities with the American Medical Association and is a member of the National Diabetes Education Program.

ADA has also established collaborations with organizations that promote good health practices for children and their caretakers. For example, Sesame Workshop, the nonprofit educational organization behind Sesame Street, in partnership with Sam's Club and MetLife Foundation, has developed [Healthy Teeth, Healthy Me](#), a bilingual (English/Spanish), multimedia outreach initiative. The initiative leverages the power of the beloved Sesame Street characters to motivate children two to five years of age, their parents, and their caregivers, to care for children's oral health. On ADA's consumer Web site, [MouthHealthy.org](#), the section devoted to preschoolers contains the Sesame Street videos, one of which focuses on making good food choices and drinking water.

**Communication/Education:** As mandated by Congress, the *Dietary Guidelines for Americans (DGA)* are developed and released jointly by the U.S. Department of Agriculture (USDA) and the U.S. Department of Health and Human Services (HHS) every five years to ensure the public receives the most current, scientifically sound nutrition advice available. The DGA are *evidence-based* Federal recommendations written for use by policymakers and health/nutrition professionals and are designed to prevent and reduce diet-related chronic diseases, while promoting good health and healthy weight. The DGA are part of the majority of dental schools nutrition curricula and provide a science base for dentists to provide nutritional information to patients.

In addition, the USDA and HHS also develop DGA-based consumer messages and tools for the general public. The DGA was last revised in 2010 and a new icon, "MyPlate," replaced the pyramid icon in 2011. This colorful plate provides consumers an easy visual example of how to dish up proper portions for breakfast, lunch and dinner. The icon also emphasizes ideal portion sizes for fruit, vegetable, grains, protein and dairy food groups. One of the messages accompanying MyPlate recommends drinking water instead of sugary drinks. Consumers and health care professionals can visit [www.ChooseMyPlate.gov](http://www.ChooseMyPlate.gov) to view the icon and dietary guidelines. There are also links to tools such as getting a personalized eating plan, healthy eating tips, weight loss information, menu planning, diet analysis and more.

Launched in June 2012, the ADA's consumer Web site, [MouthHealthy.org](#), provides information about nutrition for all ages from infants to elderly adults including links to "MyPlate."

The ADA, along with 35 other groups in the dental community, formed the Partnership for Healthy Mouths, Healthy Lives and is collaborating with the Ad Council to produce a campaign that encourages good oral health. To raise the awareness of the importance of preventing dental disease, the campaign is designed to increase knowledge of prevention, including brushing with fluoride toothpaste, flossing, good nutrition and seeing a dentist on a regular basis. By capturing the attention of caregivers through catchy public messages, they hope to motivate the public to take the first step toward implementing a lifetime of solid oral health habits, including developing healthy eating habits.

Education plays an important role in changing the behaviors of patients. As mentioned previously, dentists can play a significant role in educating patients about the importance of good eating habits and should be prepared to take on that role. These efforts can help improve and maintain dental health and encourage good overall health. It is important to begin counseling at an early age starting with before the mother gives birth and continue throughout the lifespan. To encourage behavior change, messages to the patient should be positive, emphasizing what *should* be done, rather than what *should not* be done. Dentists may wish to collaborate with registered dietitians when additional assistance is indicated.

**Development of Policy that Promotes Good Nutrition:** Reimbursement for “nutritional counseling” currently suffers much the same fate as reimbursement for tobacco cessation. Parameters of exactly what activities over what time comprise “nutritional counseling” are vague. Published outcomes from nutritional counseling are extremely limited and so companies are unlikely to provide benefits even though a CDT code exists to identify this service. Until issues related to reimbursement for this service can be resolved, it is most unlikely nutritional counseling will become common place.

While the Ad Hoc Committee was not charged with making a recommendation regarding current ADA nutrition-related policy, members were provided all existing ADA nutrition-related policies as background. As discussions continued, members noted that policy, Preventive Health Statement on Nutrition and Oral Health (*Trans.*1996:682), appears to provide substantial support for ADA nutritional activities. This policy can be viewed as Appendix 1.

At its June 2012 meeting, CAPIR was provided an update on the status of the Ad Council Campaign and noted its positive educational messaging. In discussing the “carrot or stick” approach to behavior change, the Council noted that in the past, there have been attempts to legislate taxes on soda in several states that were expected to decrease sales in much the same way increased taxes/price of cigarettes decreases sales. During the CAPIR meeting, the Department of State Government Affairs was able to supply information on recent state efforts to pass this type of legislation. That summary is available as Appendix 2.

**Suggested Strategies:** The Ad Hoc Committee on Nutrition formulated the following strategies for future consideration by the Council:

- Determine how lower level evidence based research, the best science that is currently available, can inform policy.
- Support pilot programs that produce outcomes that could inform further research, legislative strategies and policies.
- Focus on education to change behavior.
- Develop materials to facilitate nutritional education as it relates to oral health (i.e., talking points, brochures, specific oral health information in DGA).
- Start nutrition education early, preferably prenatally, and continue educational efforts throughout the lifespan.
- Collaborate with non-dental providers both on a one-to-one basis and organizationally to increase their knowledge on the importance of oral health and how efforts to provide nutritional education can improve both oral and general health.
- Collaborate with ADEA/dental schools to ensure dentists receive nutritional training that prepares them to discuss nutrition related issues with patients.

- ## 4 Resolutions

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## Appendix 1

**Preventive Health Statement on Nutrition and Oral Health (1996:682)**

**Resolved**, that with respect to nutrition and oral health, the Association encourage dentists to maintain current knowledge of nutrition recommendations such as the *Dietary Guidelines for Americans*, published by the U.S. Department of Agriculture and the U.S. Department of Health and Human Services, as they relate to general and oral health and disease, and be it further

**Resolved**, that the Association encourage dentists to effectively educate and counsel their patients about proper nutrition and oral health, including eating a well-balanced diet and limiting the number of between-meal snacks, and be it further

**Resolved**, that the Association encourage constituent and component dental societies to work with school officials to ensure that school food services, including vending services and school stores, provide nutritious food selections, and be it further

**Resolved**, that the Association oppose targeting children in the promotion and advertisement of foods low in nutritional value and high in cariogenic carbohydrates, and be it further

**Resolved**, that the Association encourage continued federal support for programs that provide nutrition services and education for infants, children, pregnant women and the elderly, and be it further

**Resolved**, that the Association encourage the appropriate government agencies to prevent the distribution of non-nutritious and highly cariogenic foodstuffs under federal nutrition service programs, and be it further

**Resolved**, that Resolution 27-1973-H (*Trans.*1973:659), Sale of Sugar-Rich Products in Schools; Resolution 28-1973-H (*Trans.*1973:660), Food Product Labeling; Resolution 56-1974-H (*Trans.*1974:687), Amendment to National School Lunch Act and Federal Food Stamp Program; Resolution 24H-1978 (*Trans.*1978:500), Statement on Advertising of Sugar-Rich Products to Children over Television; Resolution 129H-1978 (*Trans.*1978:510), Reference to Sugar Substances in School Textbooks; Resolution 98H-1979 (*Trans.*1979:625), Report to the House of Delegates of Task Force on the Prohibition of the Sale of Confections in Schools; and Resolution 8H-1983 (*Trans.*1983:544), American Dental Association Support of Child Nutrition Programs, be rescinded.

## Appendix 2

**Soda Tax Activity in States**

(2011 &amp; 2012 proposals and status)

State	Proposed	Status	✓ = Distribution of funds for dental purposes
<b>CA</b> <a href="#">AB 669</a> <a href="#">2011</a>	The legislature's stated intent was to diminish the human and economic costs of obesity and dental disease in California. Would have created a dedicated revenue source for health programs designed to prevent and treat childhood obesity and dental disease. The tax on bottled sweetened beverages and sweetened beverages distributed in this state shall be one cent (\$0.01) per fluid ounce. The fund created would be generally used for obesity issues and general health/activity promotion.	Did not pass in 2011; held over to 2012	20% to coordinate statewide childhood obesity prevention activities and to fund state-level childhood obesity prevention and <b>children's dental programs</b> . This funding shall support programs that use educational, environmental, policy, and other public health approaches that achieve the following goals: improve access to and consumption of healthy, safe, and affordable foods and beverages; reduce access to and consumption of calorie-dense, nutrient-poor foods; encourage physical activity; decrease sedentary behavior; and raise awareness about the importance of nutrition and physical activity to childhood obesity prevention. (Remaining percentages got to obesity prevention)
<b>HI</b> <a href="#">HB 1062</a> <a href="#">HB 1188</a> <a href="#">HB 1216</a> <a href="#">SB 1179</a> <a href="#">2011</a>	1062 & 1188 would have specified a tax of \$.10 to \$.25 for containers up to 12 ounces or over 12 ounces (respectively). 1216 & 1170 would have created a tax without specific amounts.	Did not pass in 2011; held over to 2012	Obesity prevention
<b>HI</b> SB 2408 2012	Tax on sugar-sweetened beverages and deposit portions of the revenue generated to the community health centers special fund, the trauma system special fund, and the John A. Burns school of medicine medical loan forgiveness program special fund established and funded by additional revenue sources pursuant to this Act.	Failed	Moneys in the special fund shall be used to support the John A. Burns school of medicine medical loan forgiveness program for medical students graduating after May 1, 2013.
<b>HI</b> SB 3019 2012	The purpose of this Act is to establish a tax on sugar-sweetened beverages and deposit portions of the revenue generated to the community health centers special fund and the trauma system special fund.		Distribution (1) community health centers special fund established under section 321-1.65; and (2) the trauma system special fund established under section 321-22.5.
<b>NE</b> LB 753 2012	Provide for sales taxation of soft drinks as prescribed	Indefinitely Postponed	Obesity prevention
<b>RI</b> <a href="#">HB 5432</a> <a href="#">SB 295</a>	A soft drink tax would be set at a rate of one cent (\$0.01) per ounce would be created. The tax would be paid by the distributor,	Pending	Used for public health efforts and programs focused on the goal of eradicating obesity

<a href="#">2011</a>	manufacturer or wholesaler. To be used for public health efforts and programs focused on the goal of eradicating obesity. "Soft drink" means any nonalcoholic beverage...containing sugar, corn syrup or any other high-calorie sweetener... "Soft drink" does not include "diet" or sugarless, low-calorie beverages.		
<b>RI</b> HB 7342 SB 2798  2012	Imposes a sugar-sweetened beverage tax upon every sugar-sweetened beverage, syrup, powder or other base product sold within the state of Rhode Island by a distributor, manufacturer, or wholesaler to a retailer or other purchaser, calculated as follows:  (1) The tax on sugar-sweetened beverages shall be one dollar and twenty-eight cents (\$1.28) per gallon of sugar-sweetened beverage.	Pending	Obesity reduction
<b>TN</b> <a href="#">SB 521</a> <a href="#">HB 537</a>  <a href="#">2011</a>	Would have created a one cent per fluid ounce tax on any person manufacturing, producing, or importing or causing to be imported into this state and selling within this state bottled soft drinks that contain added sugar or caloric sweeteners.	Did not pass in 2011; held over to 2012	Unspecified in bill
<b>VT</b> <a href="#">HB151</a>  <a href="#">2011</a>	Would have imposed an excise tax on every distributor of \$0.01 per ounce upon sugar-sweetened beverages sold in the state. Proceeds are to be used for health-related initiative listed in the bill (dental not specifically listed).	Did not pass in 2011; held over to 2012	1/3 to "Vermont healthy weight initiative fund." 1/3 shall be deposited in the Catamount fund (state health insurance assistance program). 1/3 shall be used to fund the credit in 32 V.S.A. § 9413 and the administration of this chapter.
<b>VT</b> SB 615  2012	Imposes a \$0.01 per ounce upon sugar-sweetened beverages sold in the state.  Imposes an excise tax of \$0.01 per ounce of syrup and powder sold in the state.		✓  Deposits 1/3 of collections into the Vermont oral health improvement fund (that would have been created under this bill) to: (1) support the Medicaid dental reimbursement rates; (2) support the VT dentists loan repayment program (3) support the Head Start and school-based Tooth Tutor program administered by the department of health; (4) support costs incurred by entities that own or control water systems in complying with the fluoridation requirements in this bill (5) support the Baby Bottle Tooth Decay education program administered by the department of health.