ADA American Dental Association®

America's leading advocate for oral health

2013

Supplement to

Annual Reports and Resolutions

Volume 2

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Legislative, Health, Governance and Related Matters

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Membership and Related Matters

New Business

Legislative, Health, Governance and Related Matters

Resolution No. 95-2012 N/A

Report: Board Report 3 (2012) Date Submitted: July 2012

Submitted By: Board of Trustees

Reference Committee: Legislative, Health, Governance and Related Matters

Total Net Financial Implication: None Net Dues Impact:

Amount One-time Amount On-going Savings $126,056 FTE 0

ADA Strategic Plan Goal: Members (Required)

AMENDMENT OF THE ADA CONSTITUTION AND BYLAWS REGARDING THE OFFICES OF FIRST AND SECOND VICE PRESIDENT

Background: In response to Resolution 38H-2011, the Board of Trustees directed its Governance Committee to oversee a comprehensive study of the Association's governance. After careful deliberation, the Committee selected Westman and Associates (the Consultant) to provide suggested revisions to the governance of the ADA. Based on months of data collection and collaboration with the Committee, the Consultant provided a report to the Board of Trustees setting forth 80 suggestions for change in ADA governance. Among the suggestions received from the Consultants was the following:

Westman Suggestion #44. Eliminate the two Vice President positions.

Unlike the position in many state societies, the position of ADA vice president does not automatically succeed to the office of President-elect and then President. Moreover, the stated purpose of these positions, to represent the House, is in fact served by the President and President-elect, as well as the entire Board. The Board has been well served by many very able and dedicated Vice Presidents and thanks each of them for their service. Nevertheless, the Board concludes that the positions add complexity to our governance (by increasing the size of the Board and adding additional elections). The Board is recommending that this change take place at the close of the 2013 House (both to allow a smooth transition and because of the need for an amendment to the ADA Constitution).

Accordingly, the Board proposes the following resolutions, with the suggestion that the *Bylaws* amendments be referred back to the Board to be offered again in 2013, after the Constitutional changes are addressed by the 2013 House.

Resolution

95-2012. Resolved, that ARTICLE V. OFFICERS, *Section 10*. ELECTIVE OFFICERS of the ADA *Constitution* be amended to delete references to the First and Second Vice Presidents, as shown below (deletions are ~~stricken~~):

ARTICLE V. OFFICERS

Section 10. ELECTIVE OFFICERS: The elective officers of this Association shall be a President, a President-elect, ~~a First Vice President, a Second Vice President,~~ a Treasurer and a Speaker of the House of Delegates, each of whom shall be elected by the House of Delegates.

and be it further

Resolved, that CHAPTER VI. CONFLICT OF INTEREST of the ADA *Bylaws* be amended as follows (deletions ~~stricken~~):

CHAPTER VI. CONFLICT OF INTEREST

It is the policy of this Association that individuals who serve in elective, appointive or employed offices or positions do so in a representative or fiduciary capacity that requires loyalty to the Association. At all times while serving in such offices or positions, these individuals shall further the interests of the Association as a whole. In addition, they shall avoid:

a. placing themselves in a position where personal or professional interests may conflict with their duty to this Association.

b. using information learned through such office or position for personal gain or advantage.

c. obtaining by a third party an improper gain or advantage.

As a condition for selection, each nominee, candidate and applicant shall complete a conflict of interest statement as prescribed by the Board of Trustees, disclosing any situation which might be construed as placing the individual in a position of having an interest that may conflict with his or her duty to the Association. Candidates for offices of President-elect, ~~Second Vice President,~~ Treasurer, Speaker of the House, nominees for office of trustee, and nominees to councils and commissions shall file such statements with the Secretary of the House of Delegates to be made available to the delegates prior to election. As a condition of appointment, consultants, advisers and staff of Councils, Commissions and Special Committees, and each person nominated or seeking such positions, shall file conflict of interest statements with the executive director of this Association.

While serving in any elective, appointive or employed office or position, the individual shall comply with the conflict of interest policy applicable to his or her office or position, shall complete and file a conflict of interest statement for each year of service, and shall promptly report any situation in which a potential conflict of interest may arise.

The Board of Trustees shall approve any additional compliance activities that will implement the requirements of this chapter. The Board of Trustees shall render a final judgment on what constitutes a conflict of interest.

and be it further

Resolved, that CHAPTER VII. BOARD OF TRUSTEES, *Section 10*. COMPOSITION of the ADA *Bylaws* be amended as shown below (additions <u>underscored</u>, deletions ~~stricken~~):

Section 10. COMPOSITION: The Board of Trustees shall consist of one (1) trustee from each of the seventeen (17) trustee districts. Such seventeen (17) trustees~~,~~ <u>and</u> the President-elect ~~and the two Vice Presidents~~ shall constitute the voting membership of the Board of Trustees. In addition, the President, the Treasurer and the Executive Director of the Association, except as otherwise provided in the *Bylaws* shall be *ex officio* members of the Board without the right to vote.

and be it further

Resolved, that CHAPTER VII. BOARD OF TRUSTEES, *Section 130*. OFFICERS, Subsection A. CHAIR AND SECRETARY of the ADA *Bylaws* be amended as follows (deletions ~~stricken~~):

Section 130. OFFICERS:

A. CHAIR AND SECRETARY. The officers of the Board of Trustees shall be the President of the Association who shall be the Chair, and the Executive Director of the Association who shall be the Secretary.

In the absence of the President, the office of Chair shall be filled by the President-elect and, in his or her absence, by ~~the First or Second Vice President in that order and, in their absence,~~ a voting member of the Board shall be elected Chair *pro tem*.

In the absence of the Secretary, the Chair shall appoint a Secretary *pro tem.*

and be it further

Resolved, that CHAPTER VIII. ELECTIVE OFFICERS, *Section 10*. TITLE of the ADA *Bylaws* be amended as follows (deletions ~~stricken~~):

Section 10. TITLE: The elective officers of this Association shall be President, President-elect, ~~First Vice President, Second Vice President,~~ Treasurer and Speaker of the House of Delegates, as provided in Article V of the *Constitution.*

and be it further

Resolved, that CHAPTER VIII. ELECTIVE OFFICERS, *Section 30*. NOMINATIONS, Subsection A. of the ADA *Bylaws*, be amended as follows (deletions ~~stricken~~):

Section 30. NOMINATIONS:

A. Nominations for the offices of President-elect ~~and Second Vice President~~ shall be made in accordance with the order of business. Candidates ~~for these elective offices~~ 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 (4) minutes by the candidate from the podium, according to the protocol established by the Speaker of the House of Delegates. Seconding a nomination is not permitted.

and be it further

Resolved, that CHAPTER VIII. ELECTIVE OFFICERS, *Section 50*. TERM OF OFFICE of the ADA *Bylaws* be amended as follows (deletions ~~stricken~~):

Section 50. TERM OF OFFICE: The President, President-elect~~, First Vice President, Second Vice President~~ and Speaker of the House of Delegates shall serve for a term of one (1) year, except as otherwise provided in this chapter of the *Bylaws*, or until their successors are elected and installed. The term of office of the Treasurer shall be three (3) years, or until a successor is elected and installed. The Treasurer shall be limited to two (2) consecutive terms of three (3) years each, excepting the case of a former Treasurer who has been elected Treasurer *pro tem* as provided in Chapter VIII, Section 30 of these *Bylaws*, who may serve one (1) additional year.

and be it further

Resolved, that CHAPTER VIII. ELECTIVE OFFICERS, *Section 60.* INSTALLATION of the ADA *Bylaws* be amended as follows (deletions ~~stricken~~):

Section 60. INSTALLATION: The elective officers shall be installed at the last meeting of the annual session of the House of Delegates. The President-elect shall be installed as President at the next annual session of the House following election. ~~The Second Vice President shall be installed as First Vice President at the next annual session of the House following election.~~

and be it further

Resolved, that CHAPTER VIII. ELECTIVE OFFICERS, *Section 80*. VACANCIES, Subsection A. VACANCY OF ELECTIVE OFFICE of the ADA *Bylaws* be amended as follows (deletions ~~stricken~~):

Section 80. VACANCIES:

A. VACANCY OF ELECTIVE OFFICE: In the event the office of President becomes vacant, the President-elect shall become President for the unexpired portion of the term. In the event the office of President becomes vacant for the second time in the same term or at a time when the office of President-elect is also vacant, the ~~First Vice President~~ Board shall select by majority vote a sitting trustee to become President for the unexpired portion of the term. ~~In the event the office of First Vice President becomes vacant, the Second Vice President shall become the First Vice President for the unexpired portion of the term. A vacancy in the office of the Second Vice President shall be filled by a majority vote of the Board of Trustees.~~ In the event of a vacancy in the office of Speaker of the House of Delegates, the President, with approval of the Board of Trustees, shall appoint a Speaker *pro tem*. In the event the office of President-elect becomes vacant by reason other than the President-elect succeeding to the office of the President earlier than the next annual session, the office of President for the ensuing year shall be filled at the next annual session of the House of Delegates in the same manner as that provided for the nomination and election of elective officers, except that the ballot shall read "President for the Ensuing Year." A vacancy in the office of Treasurer shall be filled by a majority vote of the Board of Trustees until the process of inviting applications, screening and nominating candidates and electing a new Treasurer has been completed by the Board of Trustees and the House of Delegates. The Treasurer *pro tem* shall be eligible for election to a new consecutive three (3) year term. The newly elected Treasurer shall be limited to two (2) consecutive terms of three (3) years each, excepting the case of a former Treasurer who has been elected Treasurer *pro tem* as provided in Chapter VIII, Section 30 of these *Bylaws*, who may serve one (1) additional year.

and be it further

Resolved, that CHAPTER VIII. ELECTIVE OFFICERS, *Section 90*. DUTIES, Subsection C. FIRST VICE PRESIDENT of the ADA *Bylaws* be deleted in its entirety as follows (deletions ~~stricken~~):

~~C. FIRST VICE PRESIDENT. It shall be the duty of the First Vice President to:~~

~~a. Assist the President as requested.~~

~~b. Serve as an *ex officio* member of the House of Delegates without the right to vote.~~

~~c. Serve as an *ex officio* member of the Board of Trustees.~~

~~d. Succeed to the office of President, as provided in this chapter of the *Bylaws*.~~

and be it further

Resolved, that CHAPTER VIII. ELECTIVE OFFICERS, *Section 90*. DUTIES, Subsection D. SECOND VICE PRESIDENT of the ADA *Bylaws* be deleted in its entirety as follows (deletions ~~stricken~~):

~~D. SECOND VICE PRESIDENT. It shall be the duty of the Second Vice President to:~~

~~a. Assist the President as requested.~~

~~b. Serve as an *ex officio* member of the House of Delegates without the right to vote.~~

~~c. Serve as an *ex officio* member of the Board of Trustees.~~

~~d. Succeed to the office of First Vice President at the next annual session of the House of Delegates following election as Second Vice President.~~

~~e. Succeed immediately to the office of First Vice President in the event of vacancy not only for the unexpired term but also for the succeeding term.~~

and be it further

Resolved, that the remaining Subsections of *Section 90*. of CHAPTER VIII. of the ADA *Bylaws* be re-lettered accordingly.

2012 BOARD RECOMMENDATION: Vote Yes.

Board Vote: Resolution 95-2012

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	No
FEINBERG	Yes	LOW	Yes	STEFFEL	Yes	YONEMOTO	Yes

2013 BOARD RECOMMENDATION: Vote Yes.

Board Vote: Resolution 95-2012

BUCKENHEIMER	No	FEINBERG	Yes	NORMAN	No	VERSMAN	No
CROWLEY	Yes	GOUNARDES	No	ROBERTS	Yes	WEBER	Yes
DOW	Yes	HAGENBRUCH	No	SCOTT	No	YONEMOTO	Abstain
ENGEL	Yes	ISRAELSON	Yes	SEAGO	Yes	ZENK	Yes
FAIR	No	KIESLING	Yes	SUMMERHAYS	Yes	ZUST	Yes

Resolution No. 95-2012S-1 Substitute

Report: N/A Date Submitted: September 2013

Submitted By: Fourth Trustee District

Reference Committee: Legislative, Health, Governance and Related Matters

Total Net Financial Implication: _____ Net Dues Impact: _____

Amount One-time _____ Amount On-going _____ FTE _____

ADA Strategic Plan Goal: Members (Required)

SUBSTITUTE FOR RESOLUTION 95-2012: AMENDMENT OF THE ADA CONSTITUTION AND BYLAWS REGARDING THE OFFICES OF FIRST AND SECOND VICE PRESIDENT

The following substitute to Resolution 95-2012 (Worksheet:5000) was submitted by the Fourth Trustee District and transmitted on September 13, 2013, by Ms. Phyllis Cortazzo.

Background: Resolution 95-2012, if adopted in its present form, will eliminate the office of First and Second Vice President effective immediately with the adjournment *sine die* of the 2013 House of Delegates. As a result, the current Second Vice President would not serve as First Vice President, and the winner of this year's (2013) election for Second Vice President would never serve as Vice President ever. The Fourth District thinks it is not fair that a member exerts the effort and spends the necessary time to run a campaign for an ADA office and not have the chance to serve the two year term for Second and First Vice President.

The following resolution is being proposed as a substitute in lieu of Resolution 95-2012. This substitute resolution would phase out the office of Vice President in the next two administrative years by allowing the current Second Vice President and winner of this year's election for Second Vice President to serve the two years as Vice President as currently provided in the *Bylaws*. The Second Vice President elected in 2013 serves as Second vice president until adjournment *sine die* of the 2014 House of Delegates, and then serves as Vice President until the adjournment *sine die* of the 2015 House of Delegates. After the 2013 House of Delegates, elections for Second Vice President cease. The current office of First Vice President will be filled at the close of this year's House by advancing the current Second Vice President, Dr. Brian Scott (CA) to First Vice President where he will serve until adjournment *sine die* of the 2014 House of Delegates.

In addition, currently the two Vice Presidents are in line to become President for the unexpired portion of the President's term should the office of the President and President-Elect become vacant in the same administrative year. If the offices of the Vice Presidents were abolished, this substitute resolution provides for presidential succession.

Resolution

95-2012S-1. Resolved, that at the adjournment *sine die* of the 2014 House of Delegates, ARTICLE V. OFFICERS, *Section 10*. ELECTIVE OFFICERS, of the ADA *Constitution* shall be amended as follows (deletions ~~stricken~~):

ARTICLE V. OFFICERS

Section 10. ELECTIVE OFFICERS: The elective officers of this Association shall be a

President, a President-elect, a ~~First~~ Vice President, ~~a Second Vice President,~~ a Treasurer and a Speaker of the House of Delegates, each of whom shall be elected by the House of Delegates.

and be it further

Resolved, that at the adjournment *sine die* of the 2015 House of Delegates, ARTICLE V. OFFICERS, *Section 10*. ELECTIVE OFFICERS, of the ADA *Constitution* shall be amended as follows (deletions ~~stricken~~):

ARTICLE V. OFFICERS

Section 10. ELECTIVE OFFICERS: The elective officers of this Association shall be a President, a President-elect, ~~a Vice President,~~ a Treasurer and a Speaker of the House of Delegates, each of whom shall be elected by the House of Delegates.

and be it further

Resolved, that at the adjournment *sine die* of the 2014 House of Delegates, CHAPTER VI. CONFLICT OF INTEREST, of the ADA *Bylaws* shall be amended as follows (deletions ~~stricken~~):

CHAPTER VI. CONFLICT OF INTEREST

It is the policy of this Association that individuals who serve in elective, appointive or employed offices or positions do so in a representative or fiduciary capacity that requires loyalty to the Association. At all times while serving in such offices or positions, these individuals shall further the interests of the Association as a whole. In addition, they shall avoid:

a. placing themselves in a position where personal or professional interests may conflict with their duty to this Association.

b. using information learned through such office or position for personal gain or advantage.

c. obtaining by a third party an improper gain or advantage.

As a condition for selection, each nominee, candidate and applicant shall complete a conflict of interest statement as prescribed by the Board of Trustees, disclosing any situation which might be construed as placing the individual in a position of having an interest that may conflict with his or her duty to the Association. Candidates for offices of President-elect, ~~Second Vice President,~~ Treasurer, Speaker of the House, nominees for office of trustee, and nominees to councils and commissions shall file such statements with the Secretary of the House of Delegates to be made available to the delegates prior to election. As a condition of appointment, consultants, advisers and staff of Councils, Commissions and Special Committees, and each person nominated or seeking such positions, shall file conflict of interest statements with the executive director of this Association.

While serving in any elective, appointive or employed office or position, the individual shall comply with the conflict of interest policy applicable to his or her office or position, shall complete and file a conflict of interest statement for each year of service, and shall promptly report any situation in which a potential conflict of interest may arise.

The Board of Trustees shall approve any additional compliance activities that will implement the requirements of this chapter. The Board of Trustees shall render a final judgment on what constitutes a conflict of interest.

and be it further

Resolved, that at the adjournment *sine die* of the 2014 House of Delegates, CHAPTER VII. BOARD OF TRUSTEES, *Section 10*. COMPOSITION, of the ADA *Bylaws* shall be amended as follows (deletions ~~stricken~~):

> *Section 10.* COMPOSITION: The Board of Trustees shall consist of one (1) trustee from each of the seventeen (17) trustee districts. Such seventeen (17) trustees, the President-elect and the ~~two~~ Vice President~~s~~ shall constitute the voting membership of the Board of Trustees. In addition, the President, the Treasurer and the Executive Director of the Association, except as otherwise provided in the *Bylaws* shall be *ex officio* members of the Board without the right to vote.

and be it further

Resolved, that at the adjournment *sine die* of the 2015 House of Delegates, CHAPTER VII. BOARD OF TRUSTEES, *Section 10*. COMPOSITION, of the ADA *Bylaws* shall be amended as follows (deletions ~~stricken~~):

> *Section 10.* COMPOSITION: The Board of Trustees shall consist of one (1) trustee from each of the seventeen (17) trustee districts. Such seventeen (17) trustees and the President-elect ~~and the Vice President~~ shall constitute the voting membership of the Board of Trustees. In addition, the President, the Treasurer and the Executive Director of the Association, except as otherwise provided in the *Bylaws* shall be *ex officio* members of the Board without the right to vote.

and be it further

Resolved, that at the adjournment *sine die* of the 2014 House of Delegates, CHAPTER VII. BOARD OF TRUSTEES, *Section 130*. OFFICERS, Subsection A. CHAIR AND SECRETARY, of the ADA *Bylaws* shall be amended as follows (deletions ~~stricken~~):

> *Section* 130. OFFICERS:
>
> A. CHAIR AND SECRETARY. The officers of the Board of Trustees shall be the President of the Association who shall be the Chair, and the Executive Director of the Association who shall be the Secretary.
>
> In the absence of the President, the office of Chair shall be filled by the President-elect and, in his or her absence, by the ~~First or Second~~ Vice President in that order and, in their absence, a voting member of the Board shall be elected Chair *pro tem*.
>
> In the absence of the Secretary, the Chair shall appoint a Secretary *pro tem.*

and be it further

Resolved, that at the adjournment *sine die* of the 2015 House of Delegates, CHAPTER VII. BOARD OF TRUSTEES, *Section 130*. OFFICERS, Subsection A. CHAIR AND SECRETARY, of the ADA *Bylaws* shall be amended as follows (deletions ~~stricken~~):

> *Section 130.* OFFICERS:

A. CHAIR AND SECRETARY. The officers of the Board of Trustees shall be the President of the Association who shall be the Chair, and the Executive Director of the Association who shall be the Secretary.

In the absence of the President, the office of Chair shall be filled by the President-elect and, in his or her absence, by ~~the Vice President in that order and, in their absence,~~ a voting member of the Board shall be elected Chair *pro tem*.

In the absence of the Secretary, the Chair shall appoint a Secretary *pro tem.*

and be it further

Resolved, that at the adjournment *sine die* of the 2014 House of Delegates, CHAPTER VIII. ELECTIVE OFFICERS, *Section 10*. TITLE, of the ADA *Bylaws* shall be amended as follows (deletions ~~stricken~~):

Section 10. TITLE: The elective officers of this Association shall be President, President-elect, ~~First~~ Vice President, ~~Second Vice President,~~ Treasurer and Speaker of the House of Delegates, as provided in Article V of the *Constitution.*

and be it further

Resolved, that at the adjournment *sine die* of the 2015 House of Delegates, CHAPTER VIII. ELECTIVE OFFICERS, *Section 10*. TITLE, of the ADA *Bylaws* shall be amended as follows (deletions ~~stricken~~):

Section 10. TITLE: The elective officers of this Association shall be President, President-elect, ~~Vice President,~~ Treasurer and Speaker of the House of Delegates, as provided in Article V of the *Constitution.*

and be it further

Resolved, that at the adjournment *sine die* of the 2014 House of Delegates, CHAPTER VIII. ELECTIVE OFFICERS, *Section 30*. NOMINATIONS, Subsection A, of the ADA *Bylaws* shall be amended as follows (deletions ~~stricken~~):

Section 30. NOMINATIONS:

A. Nominations for the office~~s~~ of President-elect~~and Second Vice President~~ shall be made in accordance with the order of business. Candidates ~~for these elective offices~~ 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 (4) minutes by the candidate from the podium, according to the protocol established by the Speaker of the House of Delegates. Seconding a nomination is not permitted.

and be it further

Resolved, that at the adjournment *sine die* of the 2014 House of Delegates, CHAPTER VIII. ELECTIVE OFFICERS, *Section 50*. TERM OF OFFICE, of the ADA *Bylaws* shall be amended as follows (deletions ~~stricken~~):

> *Section 50.* TERM OF OFFICE: The President, President-elect~~, First Vice President~~ and ~~Second~~ Vice President shall serve for a term of one (1) year, except as otherwise provided in this chapter of the *Bylaws*, or until their successors are elected and installed. The Speaker of the House of Delegates shall be limited to two (2) terms of three (3) years each in total, consecutive or otherwise. The term of office of the Treasurer shall be three (3) years, or until a successor is elected and installed. The Treasurer shall be limited to two (2) consecutive terms of three (3) years each, excepting the case of a former Treasurer who has been elected Treasurer *pro tem* as provided in Chapter VIII, Section 30 of these *Bylaws*, who may serve one (1) additional year.

and be it further

Resolved, that at the adjournment *sine die* of the 2015 House of Delegates, CHAPTER VIII. ELECTIVE OFFICERS, *Section 50.* TERM OF OFFICE, of the ADA *Bylaws* shall be amended as follows (additions underscored, deletions ~~stricken~~):

> *Section 50.* TERM OF OFFICE: The President, and President-elect ~~and Vice President~~ shall serve for a term of one (1) year, except as otherwise provided in this chapter of the *Bylaws*, or until their successors are elected and installed. The Speaker of the House of Delegates shall be limited to two (2) terms of three (3) years each in total, consecutive or otherwise. The term of office of the Treasurer shall be three (3) years, or until a successor is elected and installed. The Treasurer shall be limited to two (2) consecutive terms of three (3) years each, excepting the case of a former Treasurer who has been elected Treasurer *pro tem* as provided in Chapter VIII, Section 30 of these *Bylaws*, who may serve one (1) additional year.

and be it further

Resolved, that at the adjournment *sine die* of the 2013 House of Delegates, CHAPTER VIII. ELECTIVE OFFICERS, *Section 60.* INSTALLATION, of the ADA *Bylaws* shall be amended as follows (deletions ~~stricken)~~:

> *Section 60.* INSTALLATION: The elective officers shall be installed at the last meeting of the annual session of the House of Delegates. The President-elect shall be installed as President at the next annual session of the House following election. The Second Vice President shall be installed as ~~First~~ Vice President at the next annual session of the House following election.

and be it further

Resolved, that at the adjournment *sine die* of the 2014 House of Delegates, CHAPTER VIII. ELECTIVE OFFICERS, *Section 60*. INSTALLATION, of the ADA *Bylaws* shall be amended as follows (deletions ~~stricken~~):

> *Section 60.* INSTALLATION: The elective officers shall be installed at the last meeting of the annual session of the House of Delegates. The President-elect shall be installed as President at the next annual session of the House following election. ~~The Second Vice President shall be installed as Vice President at the next annual session of the House following election~~.

and be it further

Resolved, that at the adjournment *sine die* of the 2014 House of Delegates, CHAPTER VIII. ELECTIVE OFFICERS, *Section 80*. VACANCIES, Subsection A. VACANCY OF ELECTIVE

OFFICE, of the ADA *Bylaws* shall be amended as follows (deletions ~~stricken~~):

> *Section 80.* VACANCIES:
>
> A. VACANCY OF ELECTIVE OFFICE: In the event the office of President becomes vacant, the President-elect shall become President for the unexpired portion of the term. In the event the office of President becomes vacant for the second time in the same term or at a time when the office of President-elect is also vacant, the ~~First~~ Vice President shall become President for the unexpired portion of the term. ~~In the event the office of First Vice President becomes vacant, the Second Vice President shall become the First Vice President for the unexpired portion of the term.~~ A vacancy in the office of the ~~Second~~ Vice President shall be filled by a majority vote of the Board of Trustees. In the event of a vacancy in the office of Speaker of the House of Delegates, the President, with approval of the Board of Trustees, shall appoint a Speaker *pro tem*. In the event the office of President-elect becomes vacant by reason other than the President-elect succeeding to the office of the President earlier than the next annual session, the office of President for the ensuing year shall be filled at the next annual session of the House of Delegates in the same manner as that provided for the nomination and election of elective officers, except that the ballot shall read "President for the Ensuing Year." A vacancy in the office of Treasurer shall be filled by a majority vote of the Board of Trustees until the process of inviting applications, screening and nominating candidates and electing a new Treasurer has been completed by the Board of Trustees and the House of Delegates. The Treasurer *pro tem* shall be eligible for election to a new consecutive three (3) year term. The newly elected Treasurer shall be limited to two (2) consecutive terms of three (3) years each, excepting the case of a former Treasurer who has been elected Treasurer *pro tem* as provided in Chapter VIII, Section 30 of these *Bylaws*, who may serve one (1) additional year.

and be it further

Resolved, that at the adjournment *sine die* of the 2015 House of Delegates, CHAPTER VIII. ELECTIVE OFFICERS, *Section 80*. VACANCIES, Subsection A. VACANCY OF ELECTIVE OFFICE of the ADA *Bylaws* shall be amended as follows (<u>additions underscored</u>, deletions ~~stricken~~):

> *Section 80.* VACANCIES:
>
> A. VACANCY OF ELECTIVE OFFICE: In the event the office of President becomes vacant, the President-elect shall become President for the unexpired portion of the term. In the event the office of President becomes vacant for the second time in the same term or at a time when the office of President-elect is also vacant, ~~the Vice President shall become President for the unexpired portion of the term~~ <u>the Board of Trustees shall select a President from among the voting members of the Board of Trustees or any of the past presidents for the unexpired portion of the term. Such a selection can take place at either a regular or special session of the Board of Trustees which in either case shall be convened by the Secretary of the Board of Trustees, who shall preside until either a temporary chair from among the voting members of the Board of Trustees or a President is selected</u>. ~~A vacancy in the office of the Vice President shall be filled by a majority vote of the Board of Trustees.~~ In the event of a vacancy in the office of Speaker of the House of Delegates, the President, with approval of the Board of Trustees, shall appoint a Speaker *pro tem*. In the event the office of President-elect becomes vacant by reason other than the President-elect succeeding to the office of the President earlier than the next annual session, the office of President for the ensuing year shall be filled at the next

annual session of the House of Delegates in the same manner as that provided for the nomination and election of elective officers, except that the ballot shall read "President for the Ensuing Year." A vacancy in the office of Treasurer shall be filled by a majority vote of the Board of Trustees until the process of inviting applications, screening and nominating candidates and electing a new Treasurer has been completed by the Board of Trustees and the House of Delegates. The Treasurer *pro tem* shall be eligible for election to a new consecutive three (3) year term. The newly elected Treasurer shall be limited to two (2) consecutive terms of three (3) years each, excepting the case of a former Treasurer who has been elected Treasurer *pro tem* as provided in Chapter VIII, Section 30 of these *Bylaws*, who may serve one (1) additional year.

and be it further

Resolved, that at the adjournment *sine die* of the 2014 House of Delegates, CHAPTER VIII. ELECTIVE OFFICERS, *Section 90*. DUTIES, Subsection C. FIRST VICE PRESIDENT, of the ADA *Bylaws* shall be amended as follows (deletions ~~stricken~~):

Section 90. DUTIES:

C. ~~FIRST~~ VICE PRESIDENT. It shall be the duty of the ~~First~~ Vice President to:
a. Assist the President as requested.
b. Serve as an *ex officio* member of the House of Delegates without the right to vote.
c. Serve as an *ex officio* member of the Board of Trustees.
d. Succeed to the office of President, as provided in this chapter of the *Bylaws*.

and be it further

Resolved, that at the adjournment *sine die* of the 2015 House of Delegates, CHAPTER VIII. ELECTIVE OFFICERS, *Section 90*. DUTIES, Subsection C. FIRST VICE PRESIDENT, of the ADA *Bylaws* shall be deleted in its entirety as follows (deletions ~~stricken~~):

~~*Section 90.* DUTIES:~~

~~C. VICE PRESIDENT. It shall be the duty of the Vice President to:~~
~~a. Assist the President as requested.~~
~~b. Serve as an *ex officio* member of the House of Delegates without the right to vote.~~
~~c. Serve as an *ex officio* member of the Board of Trustees.~~
~~d. Succeed to the office of President, as provided in this chapter of the *Bylaws*.~~

and be it further

Resolved, that at the adjournment *sine die* of the 2014 House of Delegates, CHAPTER VIII. ELECTIVE OFFICERS, *Section 90*. DUTIES, Subsection D. SECOND VICE PRESIDENT, of the ADA *Bylaws* shall be deleted in its entirety as follows (deletions ~~stricken through~~):

~~D. SECOND VICE PRESIDENT. It shall be the duty of the Second Vice President to:~~
~~a. Assist the President as requested.~~
~~b. Serve as an *ex officio* member of the House of Delegates without the right to vote.~~
~~c. Serve as an *ex officio* member of the Board of Trustees.~~
~~d. Succeed to the office of First Vice President at the next annual session of the House of Delegates following election as Second Vice President.~~
~~e. Succeed immediately to the office of First Vice President in the event of vacancy not~~

~~only for the unexpired term but also for the succeeding term.~~

and be it further

Resolved, that at the adjournment *sine die* of the 2014 House of Delegates, CHAPTER VIII. ELECTIVE OFFICERS, Section 90. DUTIES, Subsections E and F, of the ADA *Bylaws* be relettered as Subsections D and E,

and be it further

Resolved, that at the adjournment *sine die* of the 2015 House of Delegates, CHAPTER VIII. ELECTIVE OFFICERS, Section 90. DUTIES, Subsections D and E of the ADA *Bylaws* be relettered as subsections C and D.

BOARD RECOMMENDATION: Vote Yes.

Vote: Resolution 95-2012S-1

BUCKENHEIMER	No	FEINBERG	Yes	NORMAN	No	VERSMAN	No
CROWLEY	Yes	GOUNARDES	No	ROBERTS	Yes	WEBER	Yes
DOW	Yes	HAGENBRUCH	No	SCOTT	No	YONEMOTO	Yes
ENGEL	Yes	ISRAELSON	Yes	SEAGO	No	ZENK	Yes
FAIR	No	KIESLING	Yes	SUMMERHAYS	Yes	ZUST	Yes

NOTES

Resolution No. 99-2012 N/A

Report: Board Report 3 (2012) Date Submitted: July 2012

Submitted By: Board of Trustees

Reference Committee: Legislative, Health, Governance and Related Matters

Total Net Financial Implication: None Net Dues Impact:

Amount One-time Amount On-going FTE 0

ADA Strategic Plan Goal: Members (Required)

AMENDMENT OF THE ADA BYLAWS REGARDING NOTICE FOR DUES, SPECIAL ASSESSMENTS AND PROCEDURE FOR CHANGING THE DUES OF ACTIVE MEMBERS

Background: In response to Resolution 38H-2011, the Board of Trustees directed its Governance Committee to oversee a comprehensive study of the Association's governance. After careful deliberation, the Committee selected Westman and Associates (the Consultant) to provide suggested revisions to the governance of the ADA. Based on months of data collection and collaboration with the Committee, the Consultant provided a report to the Board of Trustees setting forth 80 suggestions for change in ADA governance. Among the suggestions received from the Consultants was the following:

> Westman Suggestion #65. Change the ADA B*ylaws* to enable a 30-day notice to members of a dues increase.

The Board agrees with this suggestion and believes it will bring better order to the current budgeting process. Currently, the Board is at times forced to propose a specific dues increase in the absence of a final proposed budget. A 30 day period would eliminate that issue. Moreover, the Board notes that the existing 90 day requirement appears to be premised on the use of certified mail, a practice which no longer seems to be necessary. Accordingly, in addition to a change in the time period, the Board is proposing a change in the required manner of communication. The Board also proposes to carry over the modifications in the time period to the requirement of notice to the general membership. Finally, to be consistent, the Board is recommending a parallel change to the *Bylaws* provisions governing notice in the procedure for changing the dues of active members and in proposing special assessments. Accordingly, the Board proposes the following resolution:

Resolution

99-2012. Resolved, that CHAPTER VII. BOARD OF TRUSTEES, *Section 100.* DUTIES, Subsection F. of the ADA *Bylaws* be amended as follows (additions underscored, deletions ~~stricken through~~):

> F. Prepare a budget for carrying on the activities of the Association for each ensuing fiscal year, and present for action by each House of Delegates a resolution setting forth the proposed dues of active members for the following year. Notice of such a resolution shall be sent electronically ~~by a certifiable method of delivery~~ to each constituent society and posted on ADA Connect or its equivalent for the House of Delegates not less than ~~ninety (90)~~ thirty (30) days before such session to permit prompt, adequate notice by each constituent society to its delegates and alternate delegates to the House of Delegates of this Association, and shall be announced to the general membership in an official publication of the Association at least ~~sixty (60)~~ fifteen (15) days in advance of the annual session.

and be it further

Resolved, that CHAPTER XVIII. FINANCES, *Section 40*. SPECIAL ASSESSMENTS of the ADA *Bylaws* be amended as follows:

Section 40. SPECIAL ASSESSMENTS: In addition to the payment of dues required in Chapter I, Section 20 of these *Bylaws*, a special assessment may be levied by the House of Delegates upon active, active life, retired and associate members of this Association as provided in Chapter I, Section 20 of these *Bylaws*, for the purpose of funding a specific project of limited duration. Such an assessment may be levied at any annual or special session of the House of Delegates by a two-thirds (2/3) affirmative vote of the delegates present and voting, provided notice of the proposed assessment has been presented ~~in writing~~ at least ~~ninety (90)~~ thirty (30) days prior to the first day of the session of the House of Delegates at which it is to be considered. Notice of such a resolution shall be sent ~~by a certifiable method of delivery~~ electronically to each constituent society and posted on ADA Connect or its equivalent for the House of Delegates not less than ~~ninety (90)~~ thirty (30) days before such session to permit prompt, adequate notice by each constituent society to its delegates and alternate delegates to the House of Delegates of this Association, and shall be announced to the general membership in an official publication of this Association at least ~~sixty (60)~~ fifteen (15) days in advance of the session. The specific project to be funded by the proposed assessment, the time frame of the project, and the amount and duration of the proposed assessment shall be clearly presented in giving notice to the members of this Association. Revenue from a special assessment and any earnings thereon shall be deposited in a separate fund as provided in Chapter XVII, Section 30 of these *Bylaws*. The House of Delegates may amend the main motion to levy a special assessment only if the amendment is germane and adopted by a two-thirds (2/3) affirmative vote of the delegates present and voting. The House of Delegates may consider only one (1) specific project to be funded by a proposed assessment at a time. However, if properly adopted by the House of Delegates, two (2) or more special assessments may be in force at the same time. Any resolution to levy a special assessment that does not meet the notice requirements set forth in the previous paragraph also may be adopted by a unanimous vote of the House of Delegates, provided the resolution has been presented in writing at a previous meeting of the same session

and be it further

Resolved, that CHAPTER XXII. AMENDMENTS, *Section 20.* AMENDMENT AFFECTING THE PROCEDURE FOR CHANGING THE DUES OF ACTIVE MEMBERS be amended as follows (additions underscored, deletions ~~stricken through~~):

Section 20. AMENDMENT AFFECTING THE PROCEDURE FOR CHANGING THE DUES OF ACTIVE MEMBERS: An amendment of these *Bylaws* affecting the procedure for changing the dues of active members may be adopted only if the proposed amendment has been presented in writing at least ~~ninety (90)~~ thirty (30) days prior to the first day of the session of the House of Delegates at which it is to be considered. Notice of such a resolution shall be sent electronically ~~by a certifiable method of delivery~~ to each constituent society not less than ~~ninety (90)~~ thirty (30) days before such session to permit prompt, adequate notice by each constituent society to its delegates and alternate delegates to the House of Delegates of this Association, and shall be announced to the general membership in an official publication of the Association at least ~~sixty (60)~~ fifteen (15) days in advance of the annual session.

Amendments affecting the procedure for changing the dues of active members may also be adopted by a unanimous vote provided that the proposed amendment has been presented in writing at a previous meeting of the same session.

1 **2012 BOARD RECOMMENDATION: Vote Yes.**

2 **Board Vote: Resolution 99**

BLANTON	Absent	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	Yes	STEFFEL	Yes	YONEMOTO	Yes

3 **2013 BOARD RECOMMENDATION: Vote Yes.**

4 **2013 BOARD VOTE: UNANIMOUS.**

Resolution No. 1 New

Report: Task Force to Study Councils: Council, Commission and Committee Self-Assessments Date Submitted: June 2013

Submitted By: Task Force to Study Councils

Reference Committee: Legislative, Health, Governance and Related Matters

Total Net Financial Implication: None Net Dues Impact:

Amount One-time Amount On-going FTE 1.0

ADA Strategic Plan Goal: Members (Required)

REPORT OF THE TASK FORCE TO STUDY COUNCILS: COUNCIL, COMMISSION AND COMMITTEE SELF-ASSESSMENTS

Background: Resolution 94H-2012 urged the President to appoint a task force to address certain issues affecting councils. Dr. Faiella appointed the following trustees and delegates to serve on that task force:

Trustees: Carol Summerhays (chair, District 13), Gary Yonemoto (District 14), and Mark Zust (District 6)

Delegates: Carolyn Malon (District 1), Michael Halasz (District 7), Barbara Rich (District 4), and Matthew Roberts (District 15)

Resolution 94H-2012 provides:

Resolved, that the President is urged to create an ad hoc task force of no more than seven members of the Board and House to investigate issues effecting councils raised in Report 3 of the Board of Trustees on the Governance Study of 2012 and to report back to the Board in time to allow the Board to report to the 2013 House, and be it further

Resolved, that the task force be charged with investigating issues raised in the Governance Report affecting councils and, in particular, the following:

a. Whether (and how) to assign accountability for council performance management to the Board of Trustees (Westman Suggestion #21).

b. Whether the current size of councils is best for the Association and, if not, what size would be appropriate and how would that be accomplished (Westman Suggestion #24).

c. To review existing policies on periodic review of council structure and operations and recommend changes to them as needed to better assure a thorough and objective review of existing council structure (Westman Suggestion #27).

In addition, Resolution 177-2012 was referred to the task force:

Resolved, that suggestions 29 (Sunset the Council on Communications) and 31 (Sunset the Council on Membership) contained in the Governance Study submitted by Westman and Associates be reexamined by the Board of Trustees, and be it further

Resolved, that the Board of Trustees report on the results of that reexamination to the 2013 House of Delegates, including a detailed explanation of the rationale for maintaining the Council on Membership and/or the Council on Communications if that is the conclusion reached by the Board of Trustees or a specific implementation plan if the conclusion is to sunset one or both of these councils.

The task force met over several months, conducted research and analyzed each of the issues it was asked to address. This report will summarize the conclusions of the task force on each of these issues and offer recommendations for the House to consider. Its recommendations on the issue of self-assessments are directed to both councils and commissions. In addition, the task force's proposed resolution on self-assessments urges the Board to apply these same recommendations to the Board's New Dentist Committee and the Committee on International Programs and Development.

Issue 1. Whether (and how) to assign accountability for council performance management to the Board of Trustees: The task force believes this issue could be misunderstood as phrased because it appears to assume that councils are not accountable to the Board. Councils are, of course, ultimately accountable to the House, as committees of the House, but they are also accountable in certain ways to the Board. ADA *Bylaws* already spell out precisely how councils are accountable to the Board:

> *Bylaws* CHAPTER VII. BOARD OF TRUSTEES, *Section 90*. POWERS: The Board of Trustees shall be the managing body of the Association, vested with full power to:
>
> * * *
>
> H. *Remove a council member for cause* in accordance with procedures established by the Board of Trustees in its Rules.
>
> L. *Supervise, monitor and guide, on an interim basis, the activities of all councils* and special committees in order to ensure the fulfillment of initiatives and directives assigned to each council or special committee by the House of Delegates or Board of Trustees subject to the requirement that all interim actions of the Board must be approved by the House of Delegates.
>
> *Bylaws* CHAPTER VII. BOARD OF TRUSTEES, *Section 100*. DUTIES: It shall be the duty of the Board of Trustees to:
>
> F. Prepare a budget for carrying on the activities of the Association for each ensuing fiscal year.
>
> I. *Appoint annually the chair of each council*, except as otherwise provided in these *Bylaws*, and to *act upon council, commission and bureau nominations for consultants and advisers* except as otherwise provided in these *Bylaws*.
>
> J. *Provide interim guidance and supervision to all councils* and special committees in order to ensure the fulfillment of initiatives and directives assigned to each council or special committee by the House of Delegates or Board of Trustees.
>
> K. *Review the reports of councils and special committees of the Association and to make recommendations concerning such reports* to the House of Delegates.

In addition to the above powers and duties of the Board, pursuant to the *Organization and Rules of the Board of Trustees* there is a trustee who acts as a Board liaison to each council for the purpose of reviewing the programs and activities of the council to which the Trustee is assigned (*Organization and Rules of the Board of Trustees*, July 2012, page 17).

In light of this review of the noted governance documents, the task force concluded that the Board already possesses appropriate oversight of councils. More oversight is not needed to assure that councils carry out the directives of the House. In this instance, the task force believes the current provisions of the ADA *Bylaws* and the *Organization and Rules of the Board of Trustees* on this issue are adequately drafted. The task force notes that its conclusions in this regard are fully consistent with

results of the council survey discussed below and the summary results of which are attached hereto as Appendix 1. Accordingly, the task force proposes no action with respect to this issue.

Issue 2. Whether the current size of councils is best for the Association and, if not, what size would be appropriate and how would that be accomplished: The task force quickly concluded that this issue could not be addressed without input from council members about their respective councils. Accordingly, the task force drafted a survey directed to members of each council, as well as some past members, the trustee liaison and council staff. The survey was constructed in such a way as to allow the results to be broken down by council. The task force felt this was the appropriate way to view the data because the needs of councils may vary.

The summary survey results are attached to this report as Appendix 1. In presenting the data, the task force noted that the staff responses did not materially affect the results, but nevertheless decided that the published survey results would be limited to volunteer data.

More than 73% of volunteers responded to the survey (current and former council members and the trustee liaison). Given the fact that many first-year council members had very limited experience with the councils, such a high response rate demonstrates a serious interest by council members in the structure and effectiveness of these volunteer bodies. Some key findings from the survey are:

- Nearly 80% of volunteers who responded feel that the current size of his or her council was appropriate. Approximately 70% of volunteer respondents felt that the current size of his or her council enhanced council deliberations. Only 6% felt that the current size of councils hindered deliberations.
- Over 90% of volunteers believe that current council size either enhances or has no effect on the ability of councils to take action.
- Approximately 75% of volunteer respondents believe that geographic representation on councils is either important or very important. This includes the Council on Dental Education and Licensure (CDEL) and the Council on Scientific Affairs (CSA) which do not use geographic representation, and generally did not support geographic representation.

Based on these strong survey results from those with the most intimate knowledge of council and commission operations, the task force is not recommending any across-the-board reduction in council size at this time. The task force is very much aware that the survey results are subjective and could be deemed to be self-serving. For that reason, the task force is proposing that the self-assessments proposed in the following section of this report be reviewed by both the Board and the House so that either of these bodies may make recommendations for reform based on more complete information. The task force believes the information from the self-assessments is essential for any decision about council size, structure or other reform.

Some councils indicated a greater willingness to consider changes in structure and size, but this willingness (or unwillingness) varies from council to council. Accordingly, as is discussed below, the task force strongly believes that each council needs to undertake a critical self-evaluation to address whether the size or structure of the council should be changed.

Issue 3. To review existing policies on periodic review of council structure and operations and recommend changes to them as needed to better assure a thorough and objective review of existing council structure: In addressing this issue, the task force began by reviewing existing House resolutions on the topic. The task force is aware of two such resolutions:

> **118H-2002. Resolved,** that the Board of Trustees develop a sunset review process for each council and commission to occur on a regular rotational basis with a report describing the process to the 2003 House of Delegates, and be it further

Resolved, that this review process should include consultation with each council and commission and address each council and commission's relevancy, productivity, efficiency, mission and duties.

119H-2002. Resolved, that each ADA council and commission conduct a self-study to determine its relevance; address its efficiency, productivity; and examine its mission and duties, and be it further

Resolved, that the result of these studies be reported to the 2003 House of Delegates.

Following the 2002 House, the Board did develop a series of questions to be used by councils and commissions in conducting self-assessments. (The task force reviewed these questions in developing its own proposed resolution.) The Board reported back to the 2003 House on the results, including its plan for councils to conduct a self-assessment every five years. It appears, since then, that some councils did repeat their self-assessments, but compliance was not uniform. Accordingly, the task force believes that new policy is required which will require councils and commissions to conduct a self-assessment and to report the results in their annual reports to the House. After consultation with the Speaker, the task force is recommending that for purposes of clarity, Resolution 118H-2002 be rescinded and be replaced by the resolution proposed below. Resolution 119H-2002 was a directive, not a policy, and has been accomplished. Accordingly, that resolution need not be rescinded.

By proposing a resolution calling on councils and commissions to report on their self-assessments to the House, both the Board and the House will be able to undertake a substantive review of those self-assessments. The task force believes that the councils and commissions will understand the serious nature of this work and will propose substantive reforms to their size and structure as each council or commission believes is appropriate. If they do not, both the Board and the House will be positioned to fill the void and propose their own reforms. Thus, it is entirely up to the councils and commissions themselves to provide the needed information and to take the necessary action to assure that the Association's governance is as effective and efficient as possible. If they do not, the Board and the House must.

The task force also considered the schedule according to which councils and commissions should conduct their self-assessments. The task force believes that for some councils this work is overdue and therefore proposes that each council and commission do so and report to the 2014 House in their annual reports. The task force proposes in its resolution that the councils submit their reports on self-assessment in time for consideration by the Board at its June 2014 meeting, in order to assure sufficient time to fully consider the reports and to propose its own resolutions if need be.

Thereafter, the task force is proposing ongoing self-assessments on a rotating basis. The task force is aware that some councils are already undertaking self-assessments and does not wish to burden those councils with repetitive work. Those councils should be congratulated for their initiative. Therefore, the task force is recommending that any such council should be excused from repeating a self-assessment next year. In addition, the task force is aware that two committees of the Board, the New Dentist Committee and the Committee on International Programs and Development, operate similarly to councils and, therefore, the task force's resolution urges the Board to include these committees in the self-evaluation process.

Finally, the task force considered the manner of self-assessment to be conducted. The task force considered creating a set form which every council and commission would complete. The task force ultimately rejected this option because it eliminates flexibility and assumes that every council and commission is similarly situated and would be helped by an identical process. Accordingly, the task force is proposing that each council and commission conduct its self-assessment in the manner each decides is best, but that each council and commission must address specific issues and report their results to the House. In this way, flexibility is preserved while also guaranteeing that each self-assessment addresses certain core issues.

While the task force is recommending that the Board determine the precise issues to be addressed in the self-assessments, the task force offers the following set of issues (phrased as questions to the councils and commissions) for the Board's consideration:

1. Threshold Issues
    a. State the primary value of your council or commission to a member.
    b. Should your council or commission continue to exist? If not, why?
    c. Is your council or commission effective in carrying out its bylaws authority? If not why?
    d. What are the top three goals to be accomplished by your council or commission annually? How are these related to member value? How successful has your council or committee been with respect to these goals?
    e. How do you define/measure success for the council or commission annually?

2. Structure
    a. Should your council or commission be skills based, or elected at large?
    b. Do you have an agenda that enables strategic discussion to the extent you would like?
    c. Do you have the optimal number of members to conduct business well and efficiently?
    d. Is the manner of member selection ideal (*e.g.* geographic vs. skills based)?
    e. Do you have the right number of committees and members on committees? Should you use standing committees or ad hoc task forces?
    f. Would a task force structure as opposed to a council structure be better? Worse?

3. Efficiencies
    a. Is the decision making process efficient? If not why?
    b. How can you reduce the time spent by volunteers on your work, while still doing what needs to be done?
    c. Do you meet in person enough? Too much? Too little?
    d. What work done by volunteers could be handled by staff?
    e. Are issues brought to your council in an efficient or appropriate manner?
    f. Are you provided with sufficient information to address and decide issues?
    g. Is the discussion of issues efficient and effective?
    h. Are there matters left to the council or commission that should be handled by a smaller group?
    i. Do you effectively use conference calls and web-based meeting time? Can you do so more or better?
    j. Are you aware of the staff time devoted to your activities? Can that staff time be directed to other activities?
    k. Is your staff support sufficient?

4. Areas of Responsibility
    a. Based on a review of the bylaws, should some responsibilities be placed elsewhere or discontinued?
    b. Are you addressing each area of responsibility? If not, should you, or should you change the bylaws?
    c. Can your responsibilities be consolidated with those of another entity or be done better by another entity?

5. Agenda Review: As you consider a self-assessment, use your agenda as a tool in the assessment:
    a. Is each item an efficient use of your time?
    b. Which items can be handled in other ways—conference calls, consent, etc.?
    c. What are you doing which is "down in the weeds", operational as opposed to directional?
    d. What can you ask staff to take over?

6. Are you spending time on big issues and strategic direction?

In drafting its proposed resolution and its list of topics a self-assessment may address, the task force considered the 2002-2003 self-assessment process created by the Board, the suggestions found in the Westman study from last year's governance study (2012 Board Report 3), and its own collective judgment. In addition, a draft of the task force's list of topics was shared with the chairs and vice-chairs of the councils and commissions. Based on this work, the task force believes its list of topics, or something similar to be developed by the Board, will result in an enlightened self-assessment; and proposals from the councils and commissions themselves for changes to their structure, responsibilities and operations, as needed.

The task force recognizes that this approach to potential council and commission reform places the responsibility on councils and commissions to undertake serious self-assessments and to fully consider whether the current structure is the best structure possible for the Association. This approach also places a burden on the Board and the House to carefully review and evaluate the self-assessments by each council and commission and any resulting recommendations for reform. It is up to the Board and the House to judge the thoroughness of the councils' and commissions' self-assessments and, if necessary, propose changes for any given council or commission believed necessary. The task force is comfortable with this approach because it is certain that the councils and commissions will act appropriately and also confident in the ability of the Board and the House to judge the reports of councils.

Resolution 177-2012: The task force considered Resolution 177-2012 but concluded that it was not well positioned to revisit work of the Board from the preceding year. Accordingly, the task force asked the President to assign this resolution to the Board's Governance Committee for development of a report.

For all the reasons outlined above, the task force proposes the following resolution:

Resolution

1. Resolved, that each council and commission undertake a thorough self-assessment based on a topical outline to be developed by the Board of Trustees and submit a report to the 2014 House of Delegates (in time for the Board to consider the report at its June 2014 meeting) on the process and its results, including any proposed resolutions to implement those results, and be it further

Resolved, that following 2014, each council and commission undertake a thorough self-assessment on a rotating basis over every five years based on a schedule and outline to be developed by the Board of Trustees, and within the Annual Report include information on the process followed and results to the next session of the House, including any proposed resolutions to implement those results, and be it further

Resolved, that the Board be urged to require the New Dentist Committee and the Committee on International Programs and Development to undertake a self-assessment, with reports to the Board, and to be included in the schedule applicable to councils and commissions, and be it further

Resolved, any council which has undertaken a thorough self-assessment in 2013 as determined by the Board and reported on that self-assessment to the 2013 House of Delegates is exempted from the requirement to conduct a self-assessment in 2014, and be it further

Resolved, that 118H-2002 (*Trans. 2002:374*) be rescinded.

BOARD RECOMMENDATION: Vote Yes.

BOARD VOTE: UNANIMOUS.

Appendix 1
2013 *ADA Council Survey*
Final Results (Council Members only)

Sample: The sample for this Web-based survey consisted of 217 current and 86 recent members of all 12 ADA councils, as well as 63 selected ADA staff who support those councils.

Methodology: A link to the survey was e-mailed to 366 addresses on February 19, 2013. Reminder e-mails were sent to non-respondents on February 27 and March 7, 2013.

Response: Data collection ended on March 18, 2013; a total of 269 individuals responded to the survey. The final overall adjusted response rate was 73.5%.

Looking at response rate by respondent type, 79.3% of current council members, 61.6% of recent council members, and 69.8% of staff completed the survey. A breakdown of response rates by council affiliation is shown below.

Council	Number	Respondents	Overall Response Rate	Council Member Response Rate
CAS	41	33	80.5%	84.4%
CAPIR	39	26	66.7%	68.8%
CC	27	22	81.5%	82.6%
CDBP	35	27	77.1%	81.5%
CDEL	28	19	67.9%	61.9%
CDP	30	23	76.7%	78.3%
CEBJA	23	19	82.6%	88.9%
CGA	31	22	71.0%	73.1%
CM	31	24	77.4%	82.1%
CMIRP	31	22	71.0%	69.0%
CSA	23	16	69.6%	65.0%
NDC	27	16	59.3%	54.2%

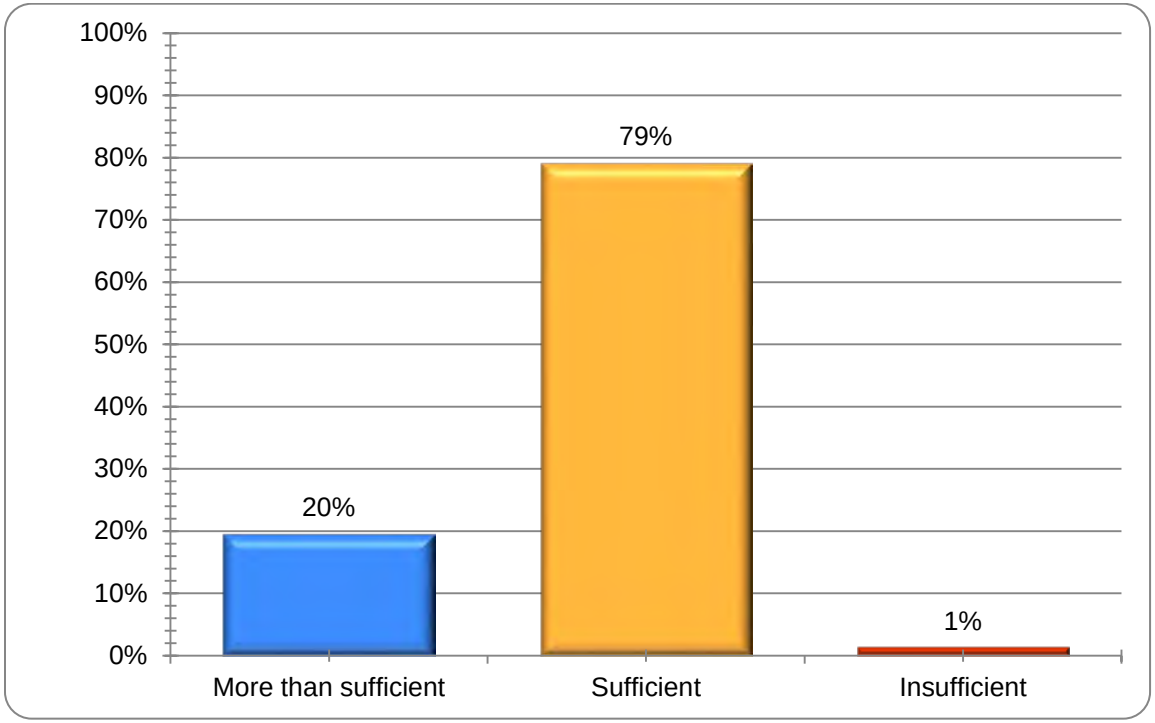
Purpose: The survey was conducted to gather data from each council in order to make recommendations to the Board and House of Delegates as required by resolution 94H-2012. Please note that this report presents the results for current and recent council members only; responses from ADA staff are excluded.

Overall Results

Overall Results

In your opinion, how sufficient is the current number of members on the [council]?
Response Rate: **100% (N=225)** Question Type: **Choose one** Tag: **Q1**

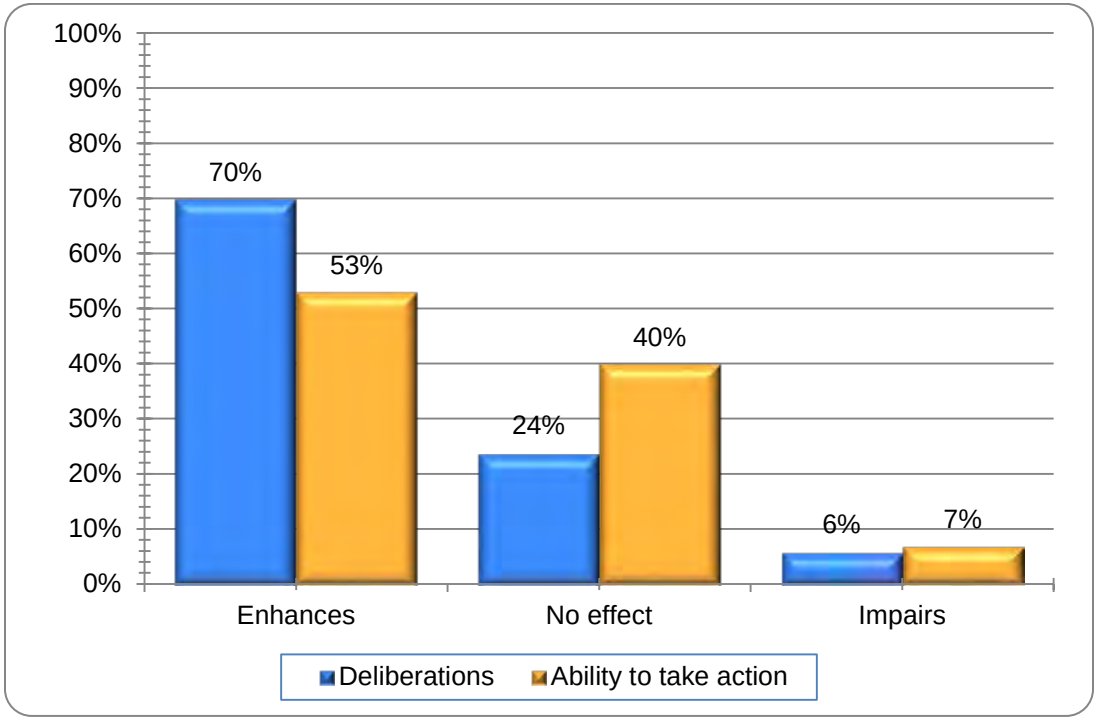
More than sufficient	**44**	**20%**
Sufficient	**178**	**79%**
Insufficient	**3**	**1%**
Total Responses	**225**	



Overall Results

How does your council's current size affect its deliberations/ability to take action?

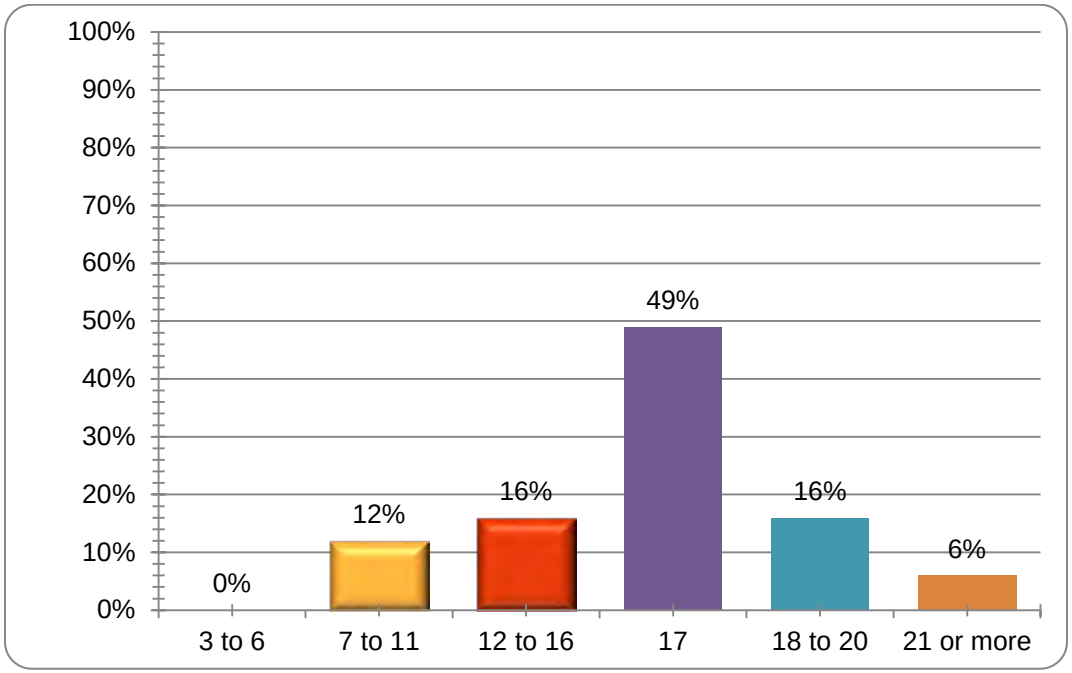
	Enhances	No effect	Impairs	**Total Responses**
Deliberations	157	55	13	**225**
	70%	24%	6%	
Ability to take action	115	87	16	**218**
	53%	40%	7%	
Total Responses	**272**	**142**	**29**	**443**



Overall Results

What do you think is the optimal number of members for the [council]?
Response Rate: **97% (N=218)** Question Type: **Choose one** Tag: **Q6**

3 to 6	**1**	**0%**
7 to 11	**27**	**12%**
12 to 16	**35**	**16%**
17	**106**	**49%**
18 to 20	**35**	**16%**
21 or more	**14**	**6%**
Total Responses	**218**	

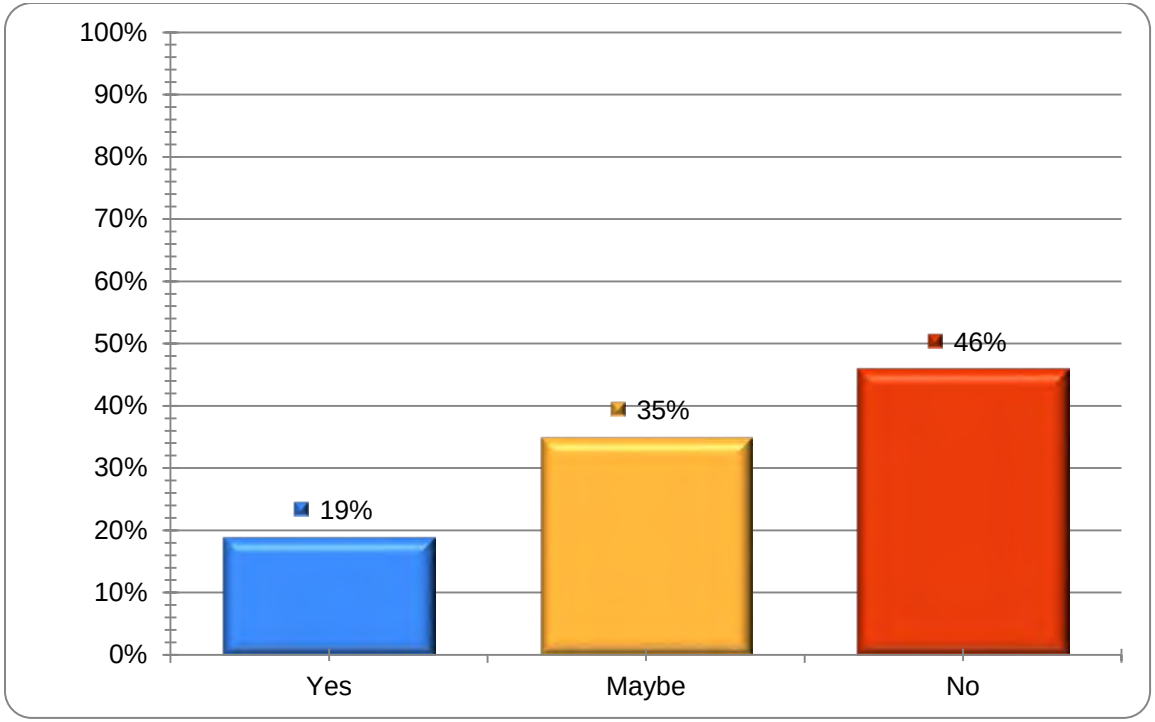


Overall Results

In the event that a smaller number of members were required for the [council], would rotating the open seats yearly among the 17 districts be an appropriate way of selecting members?

Response Rate: **100% (N=225)** Question Type: **Choose one** Tag: **Q7**

Yes	**43**	**19%**
Maybe	**78**	**35%**
No	**104**	**46%**
Total Responses	**225**	

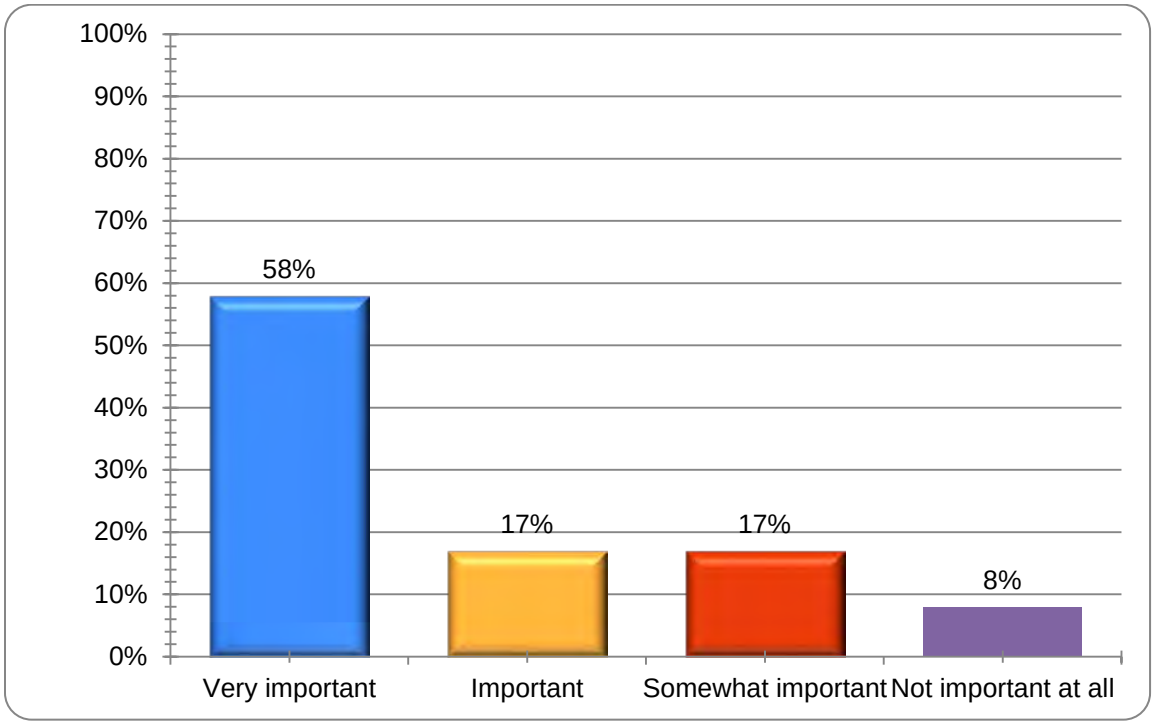


Overall Results

How important is geographic representation for the [council]?

Response Rate: **100% (N=224)** Question Type: **Choose one** Tag: **Q10**

Very important	**129**	**58%**
Important	**38**	**17%**
Somewhat important	**38**	**17%**
Not important at all	**19**	**8%**
Total Responses	**224**	

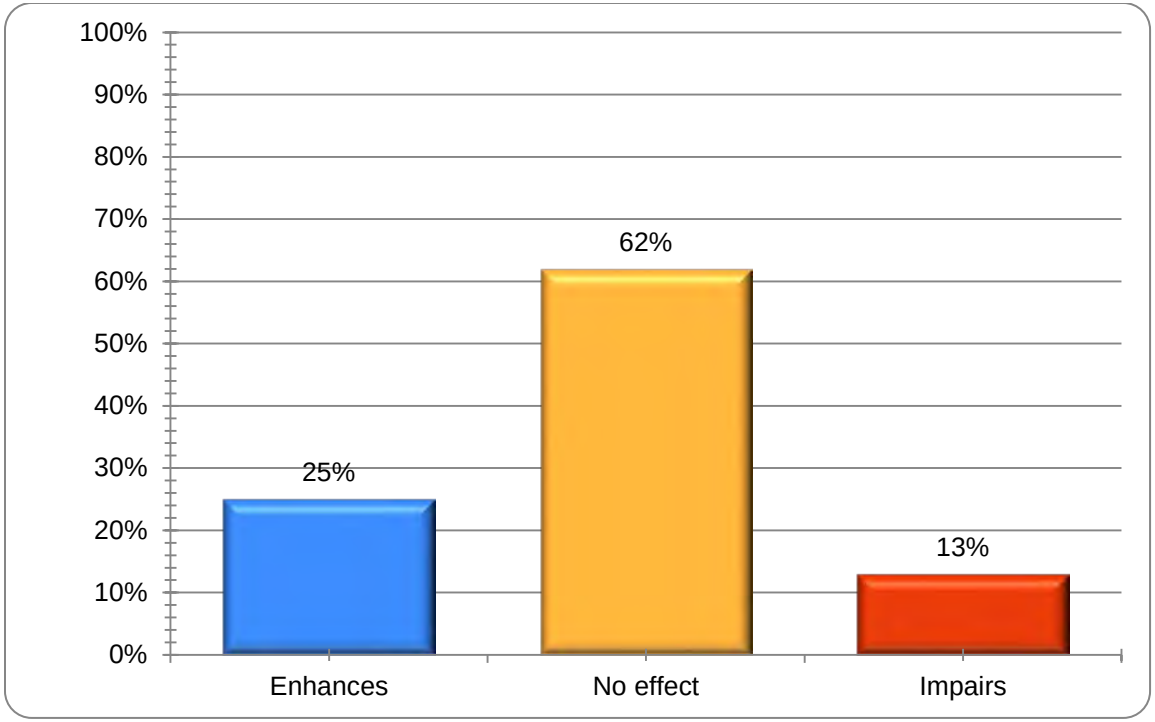


Overall Results

The [council] currently reports to the ADA House of Delegates. How does this reporting structure affect its ability to work with the ADA Board of Trustees?

Response Rate: **98% (N=221)** Question Type: **Choose one** Tag: **Q11**

Enhances	**55**	**25%**
No effect	**138**	**62%**
Impairs	**28**	**13%**
Total Responses	**221**	

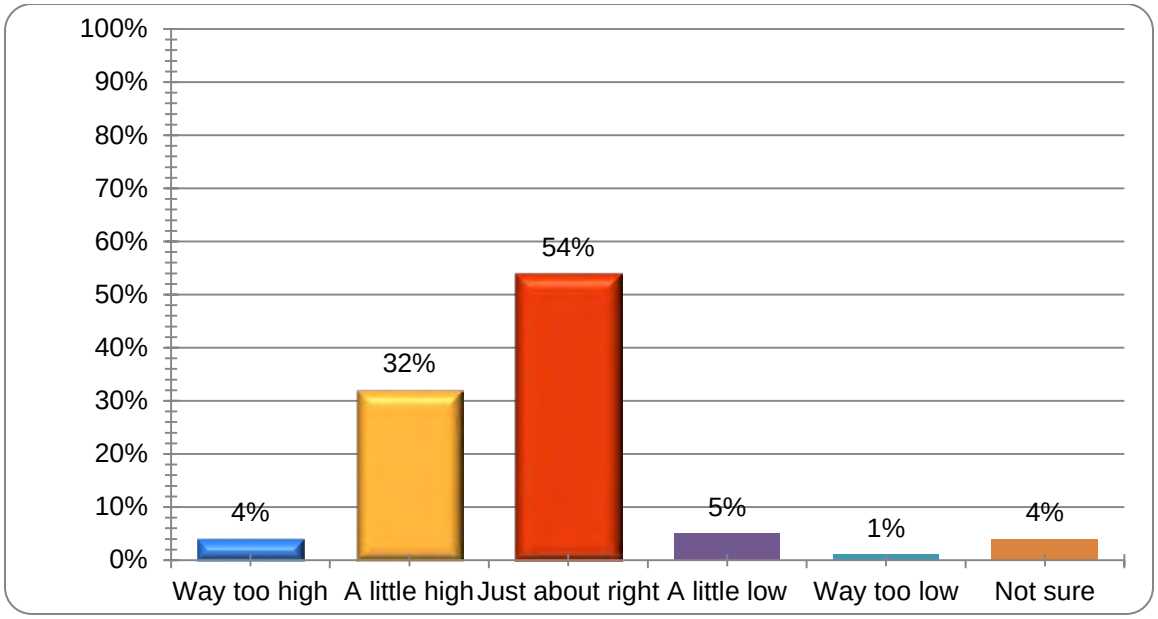


Overall Results

Please select the statement below that best describes the workload of the [council] (currently, or while you served on the council if you are no longer a member).

Response Rate: **100% (N=225)** Question Type: **Choose one** Tag: **Q12**

Way too high	**8**	**4%**
A little high	**71**	**32%**
Just about right	**121**	**54%**
A little low	**12**	**5%**
Way too low	**3**	**1%**
Not sure	**10**	**4%**
Total Responses	**225**	

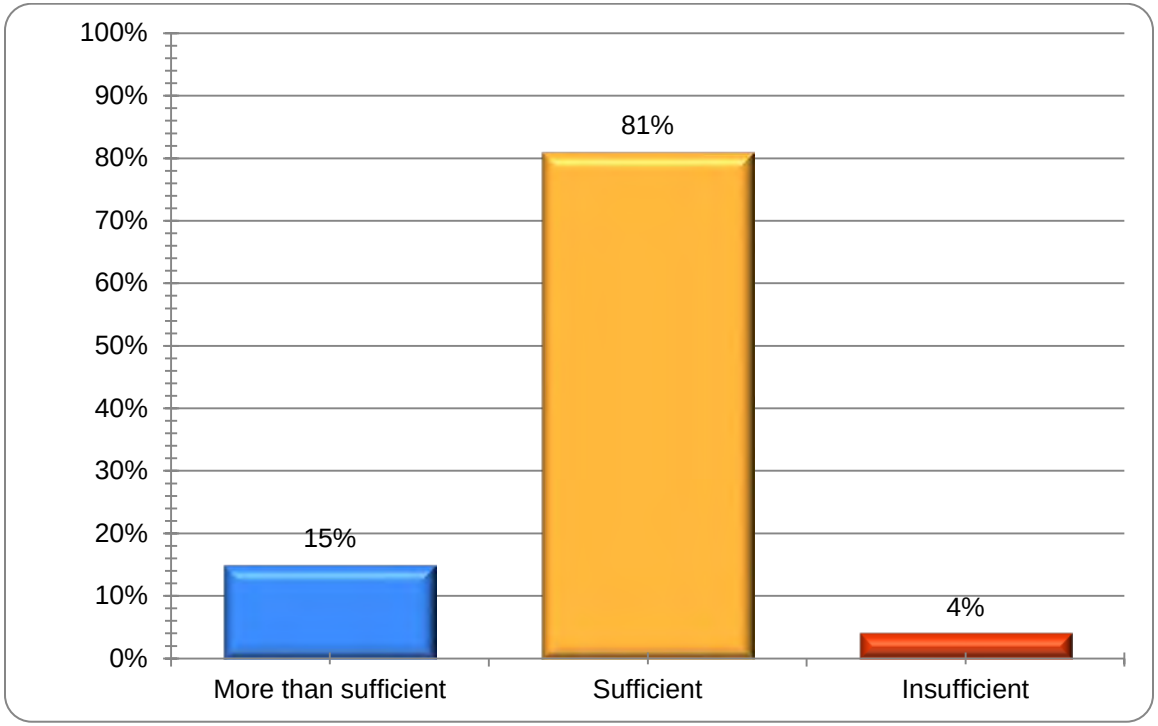


Council on ADA Sessions Results

Council on ADA Sessions Results

In your opinion, how sufficient is the current number of members on the [council]?
Response Rate: **100% (N=27)** Question Type: **Choose one** Tag: **Q1**

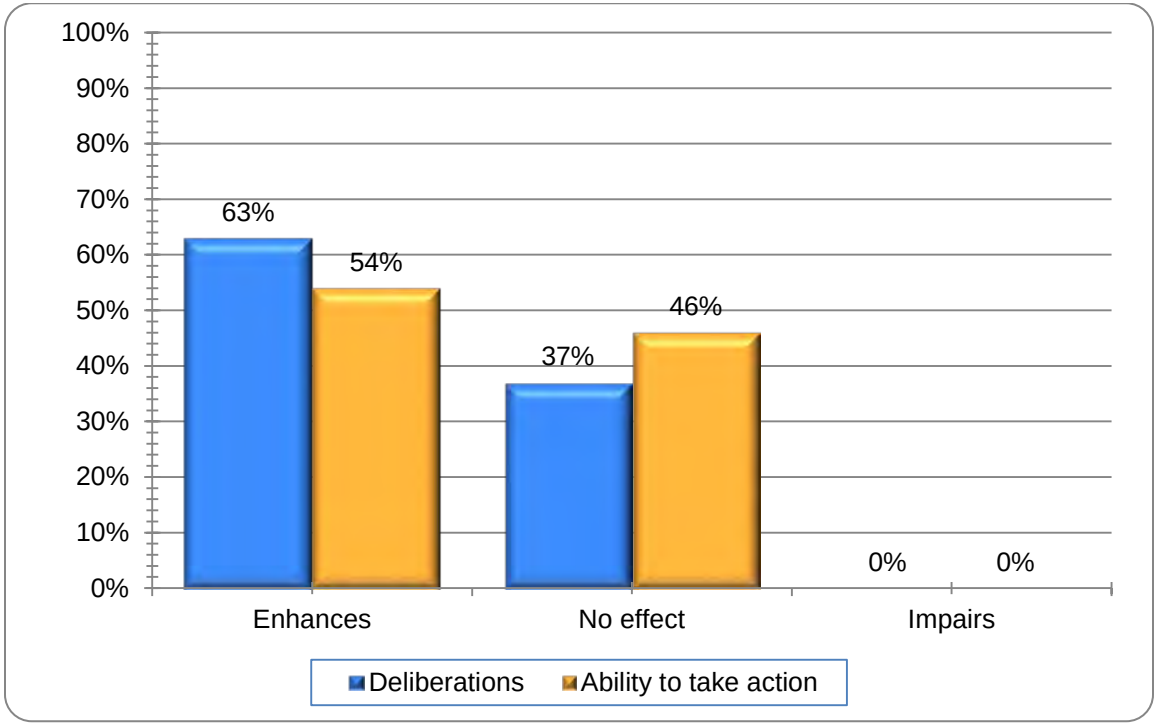
More than sufficient	**4**	**15%**
Sufficient	**22**	**81%**
Insufficient	**1**	**4%**
Total Responses	**27**	



Council on ADA Sessions Results

How does your council's current size affect its deliberations/ability to take action?

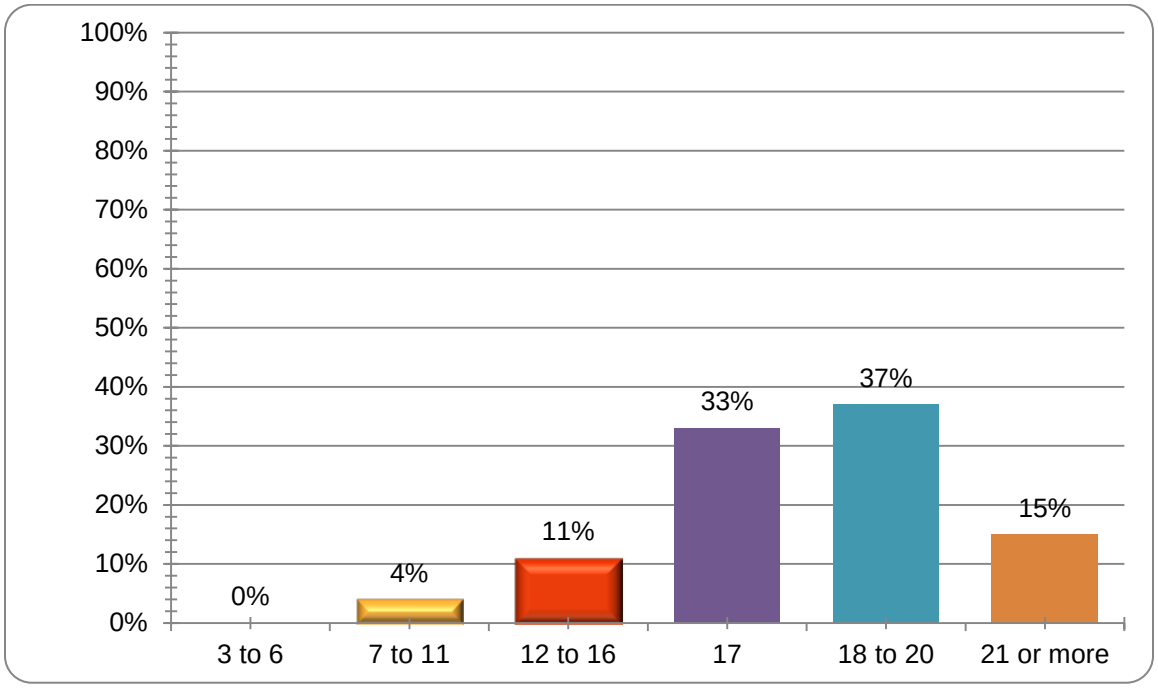
	Enhances	No effect	Impairs	**Total Responses**
Deliberations	17	10	0	**27**
	63%	37%	0%	
Ability to take action	14	12	0	**26**
	54%	46%	0%	
Total Responses	**31**	**22**	**0**	**53**



Council on ADA Sessions Results

What do you think is the optimal number of members for the [council]?
Response Rate: **100% (N=27)** Question Type: **Choose one** Tag: **Q6**

3 to 6	**0**	**0%**
7 to 11	**1**	**4%**
12 to 16	**3**	**11%**
17	**9**	**33%**
18 to 20	**10**	**37%**
21 or more	**4**	**15%**
Total Responses	**27**	

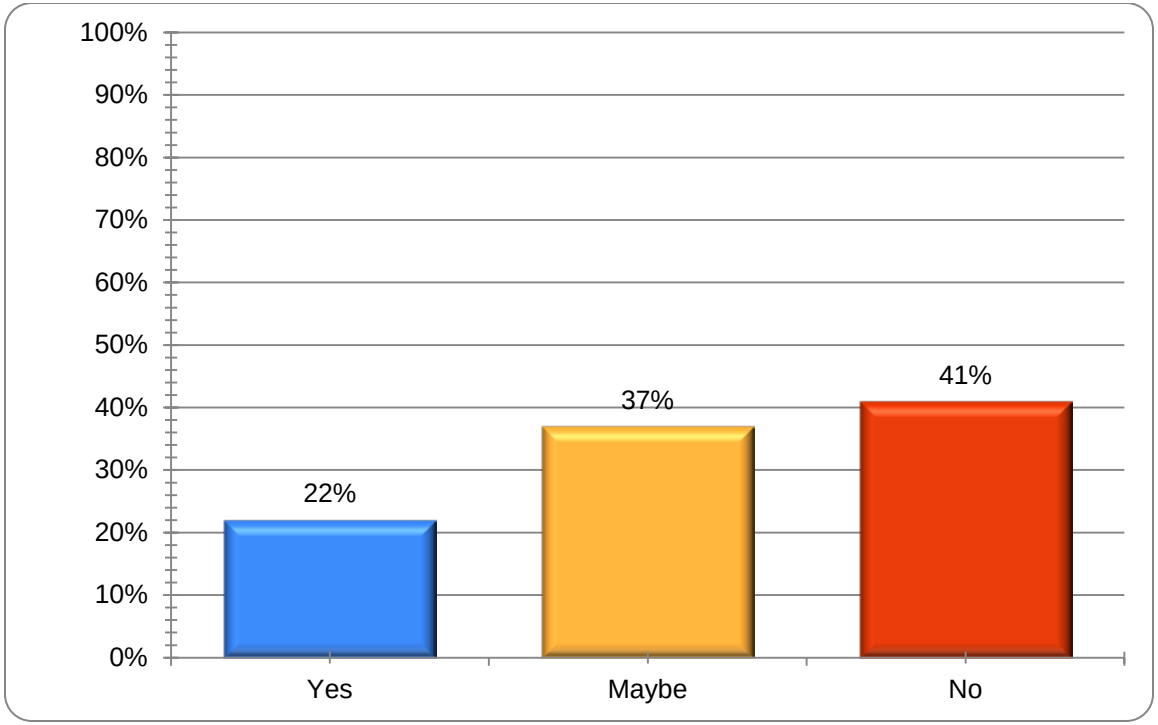


Council on ADA Sessions Results

In the event that a smaller number of members were required for the [council], would rotating the open seats yearly among the 17 districts be an appropriate way of selecting members?

Response Rate: **100% (N=27)** Question Type: **Choose one** Tag: **Q7**

Yes	**6**	**22%**
Maybe	**10**	**37%**
No	**11**	**41%**
Total Responses	**27**	

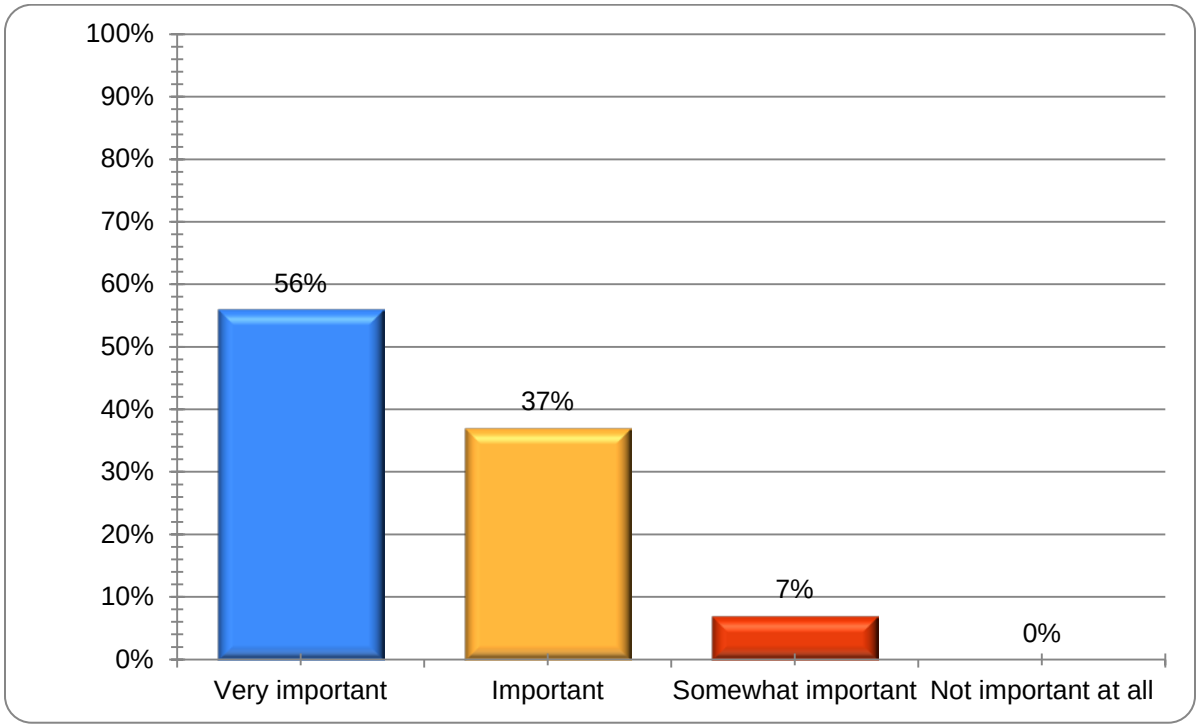


Council on ADA Sessions Results

How important is geographic representation for the [council]?

Response Rate: **100% (N=27)** Question Type: **Choose one** Tag: **Q10**

Very important	**15**	**56%**
Important	**10**	**37%**
Somewhat important	**2**	**7%**
Not important at all	**0**	**0%**
Total Responses	**27**	

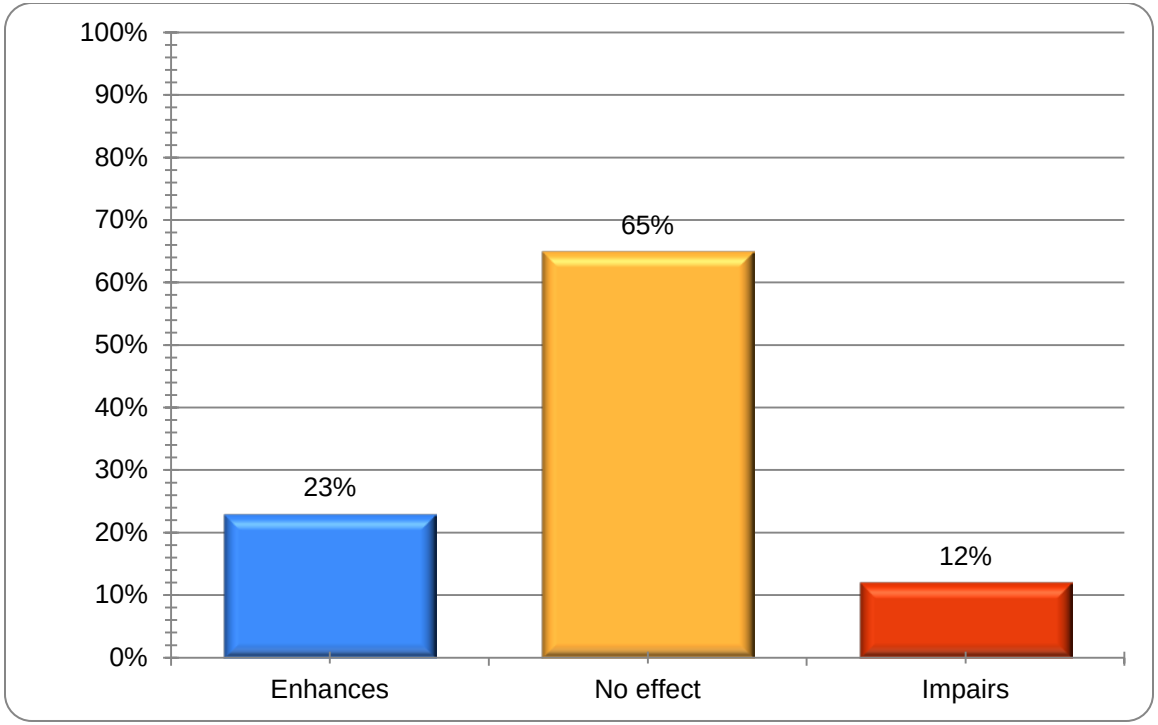


Council on ADA Sessions Results

The [council] currently reports to the ADA House of Delegates. How does this reporting structure affect its ability to work with the ADA Board of Trustees?

Response Rate: **96% (N=26)** Question Type: **Choose one** Tag: **Q11**

Enhances	**6**	**23%**
No effect	**17**	**65%**
Impairs	**3**	**12%**
Total Responses	**26**	

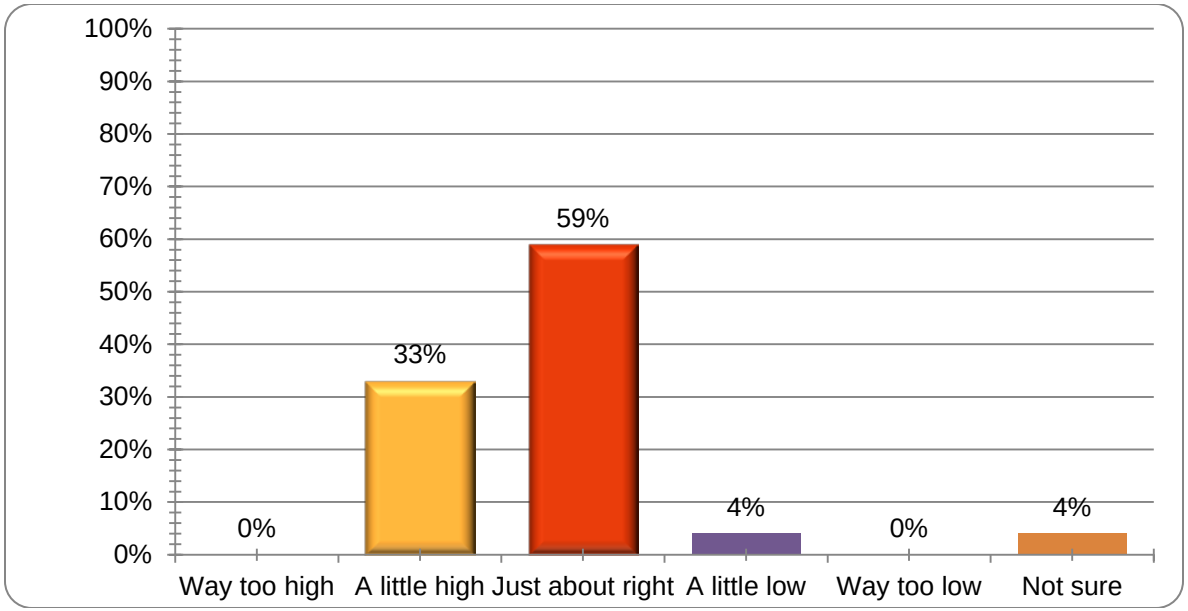


Council on ADA Sessions Results

Please select the statement below that best describes the workload of the [council] (currently, or while you served on the council if you are no longer a member).

Response Rate: **100% (N=27)** Question Type: **Choose one** Tag: **Q12**

Way too high	**0**	**0%**
A little high	**9**	**33%**
Just about right	**16**	**59%**
A little low	**1**	**4%**
Way too low	**0**	**0%**
Not sure	**1**	**4%**
Total Responses	**27**	



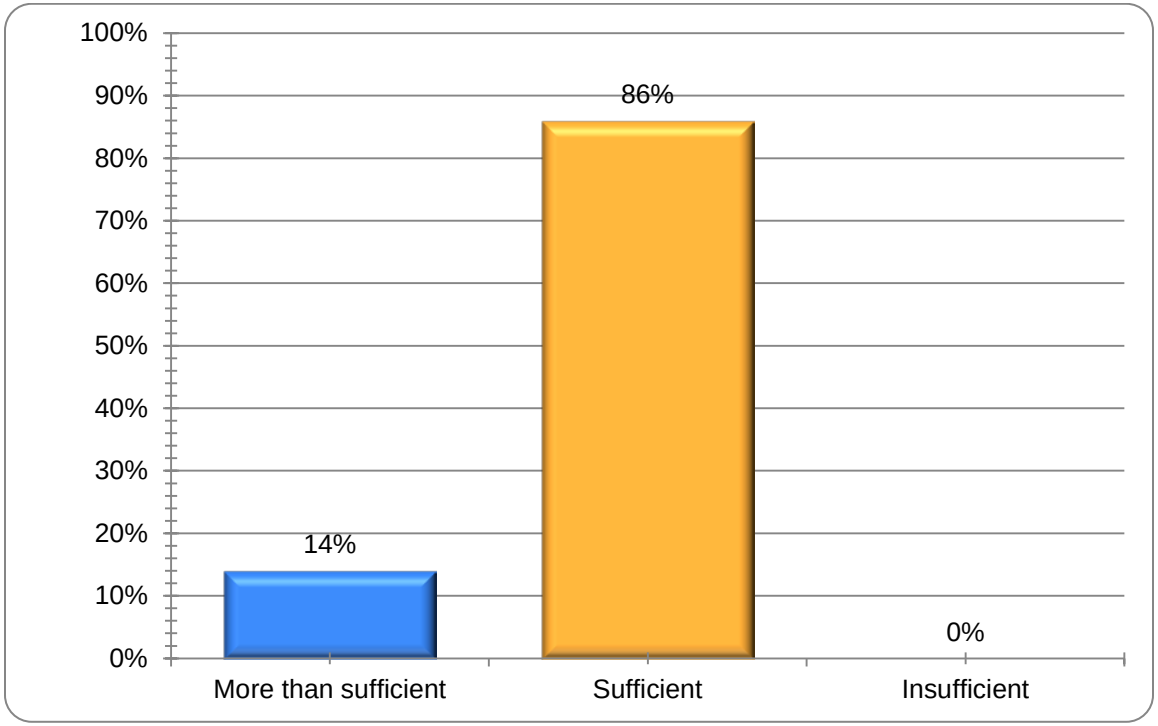
Council on Access, Prevention, and Interprofessional Relations Results

Council on Access, Prevention, and Interprofessional Relations Results

In your opinion, how sufficient is the current number of members on the [council]?

Response Rate: **100% (N=22)** Question Type: **Choose one** Tag: **Q1**

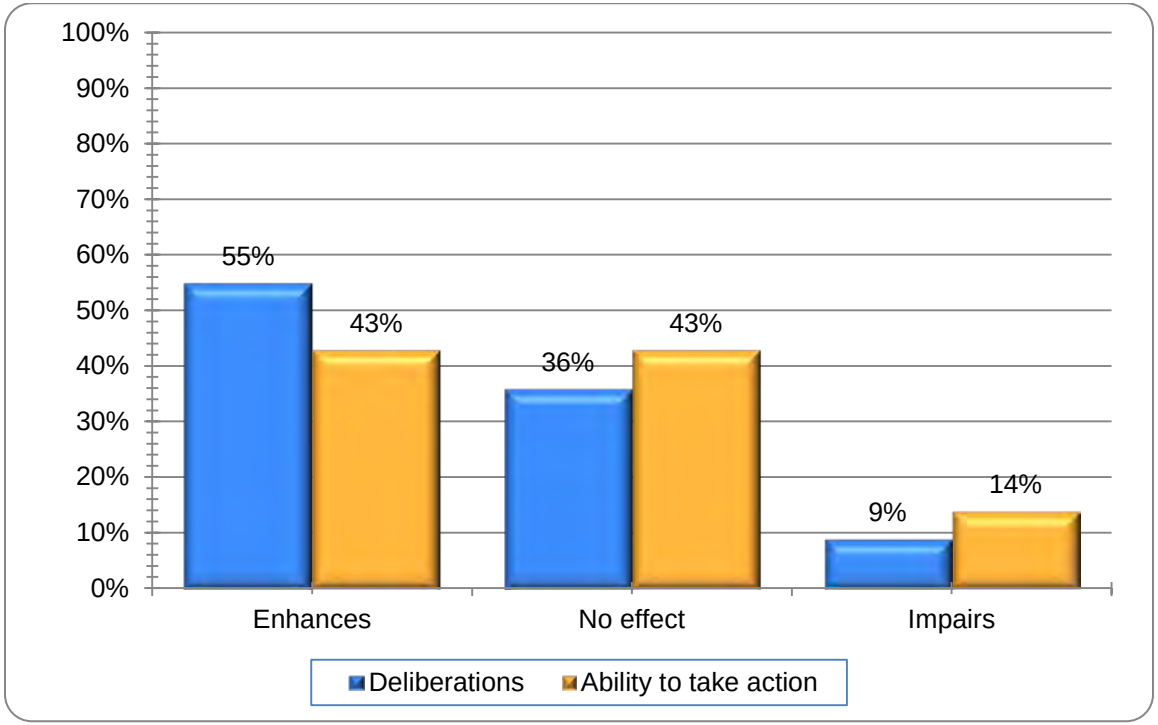
More than sufficient	**3**	**14%**
Sufficient	**19**	**86%**
Insufficient	**0**	**0%**
Total Responses	**22**	



Council on Access, Prevention, and Interprofessional Relations Results

How does your council's current size affect its deliberations/ability to take action?

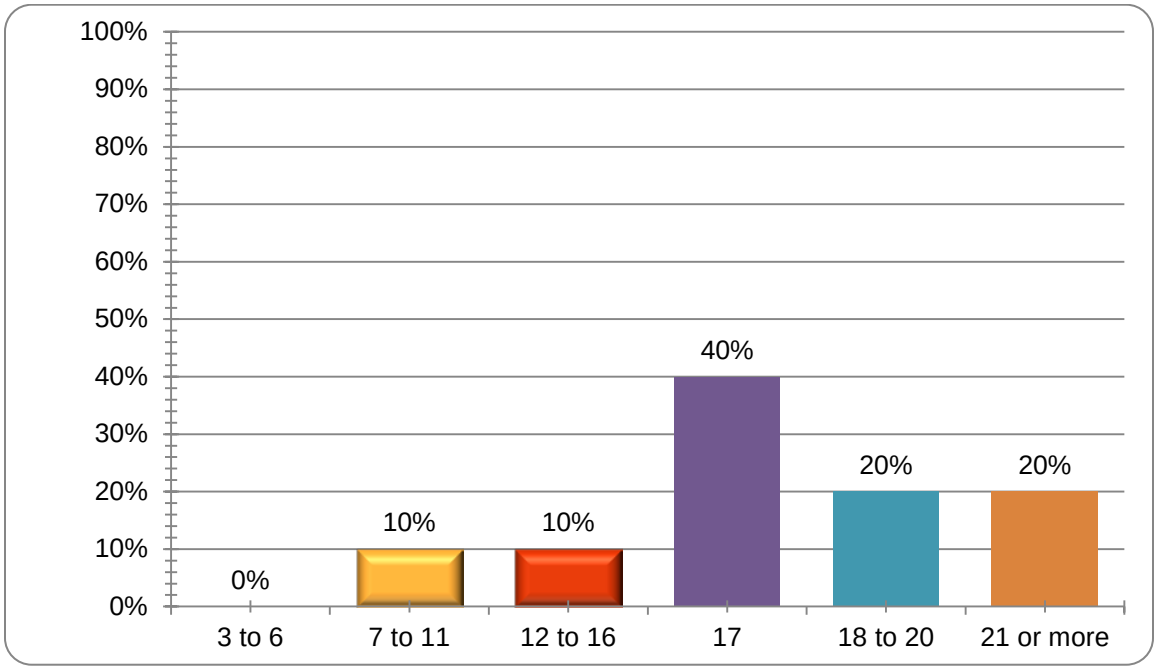
	Enhances	No effect	Impairs	**Total Responses**
Deliberations	12	8	2	**22**
	55%	36%	9%	
Ability to take action	9	9	3	**21**
	43%	43%	14%	
Total Responses	**21**	**17**	**5**	**43**



Council on Access, Prevention, and Interprofessional Relations Results

What do you think is the optimal number of members for the [council]?
Response Rate: **91% (N=20)** Question Type: **Choose one** Tag: **Q6**

3 to 6	**0**	**0%**
7 to 11	**2**	**10%**
12 to 16	**2**	**10%**
17	**8**	**40%**
18 to 20	**4**	**20%**
21 or more	**4**	**20%**
Total Responses	**20**	

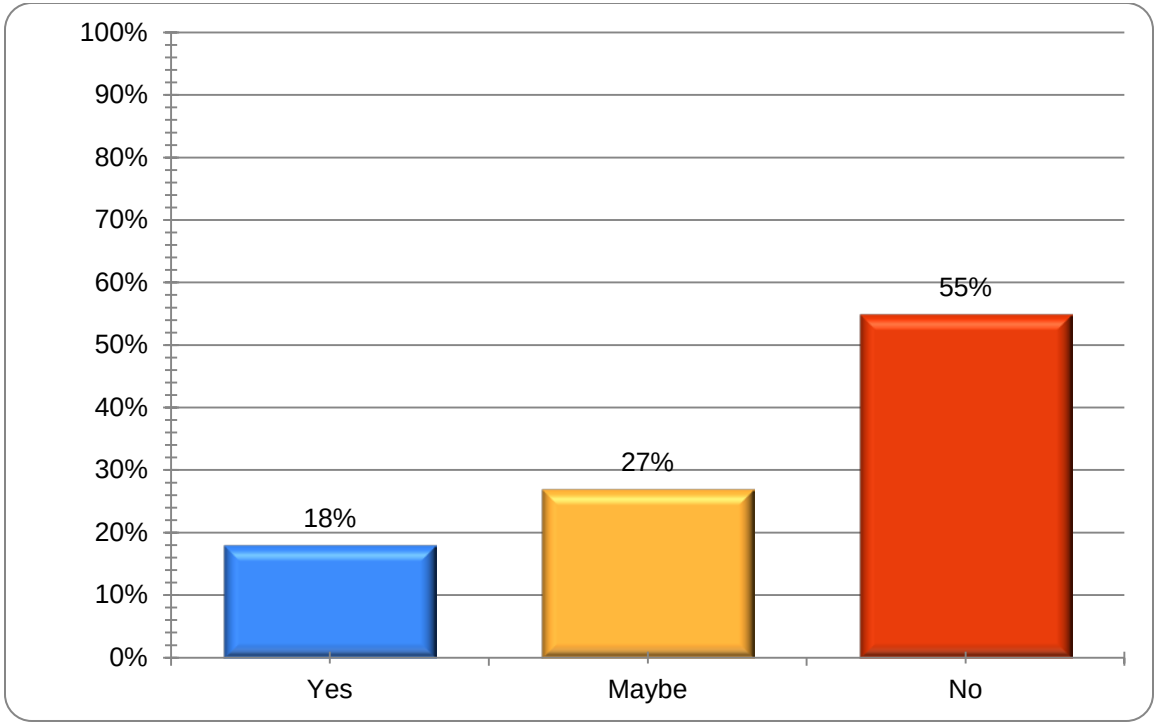


Council on Access, Prevention, and Interprofessional Relations Results

In the event that a smaller number of members were required for the [council], would rotating the open seats yearly among the 17 districts be an appropriate way of selecting members?

Response Rate: **100% (N=22)** Question Type: **Choose one** Tag: **Q7**

Yes	**4**	**18%**
Maybe	**6**	**27%**
No	**12**	**55%**
Total Responses	**22**	

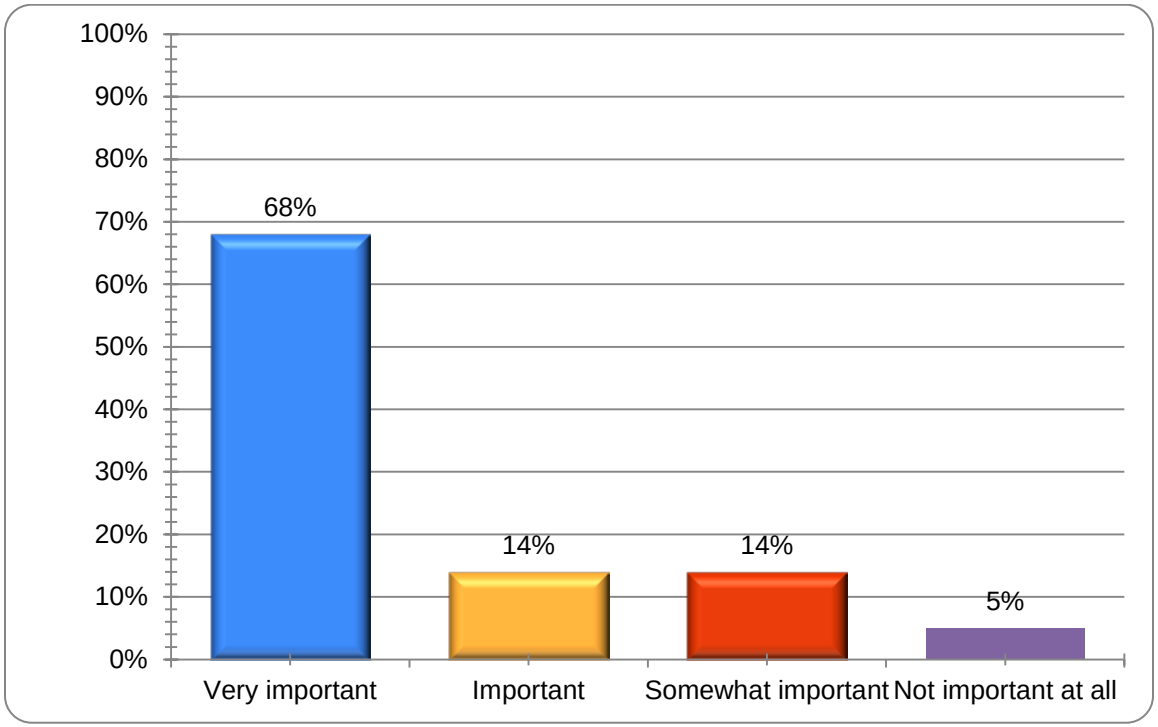


Council on Access, Prevention, and Interprofessional Relations Results

How important is geographic representation for the [council]?

Response Rate: **100% (N=22)** Question Type: **Choose one** Tag: **Q10**

Very important	**15**	**68%**
Important	**3**	**14%**
Somewhat important	**3**	**14%**
Not important at all	**1**	**5%**
Total Responses	**22**	

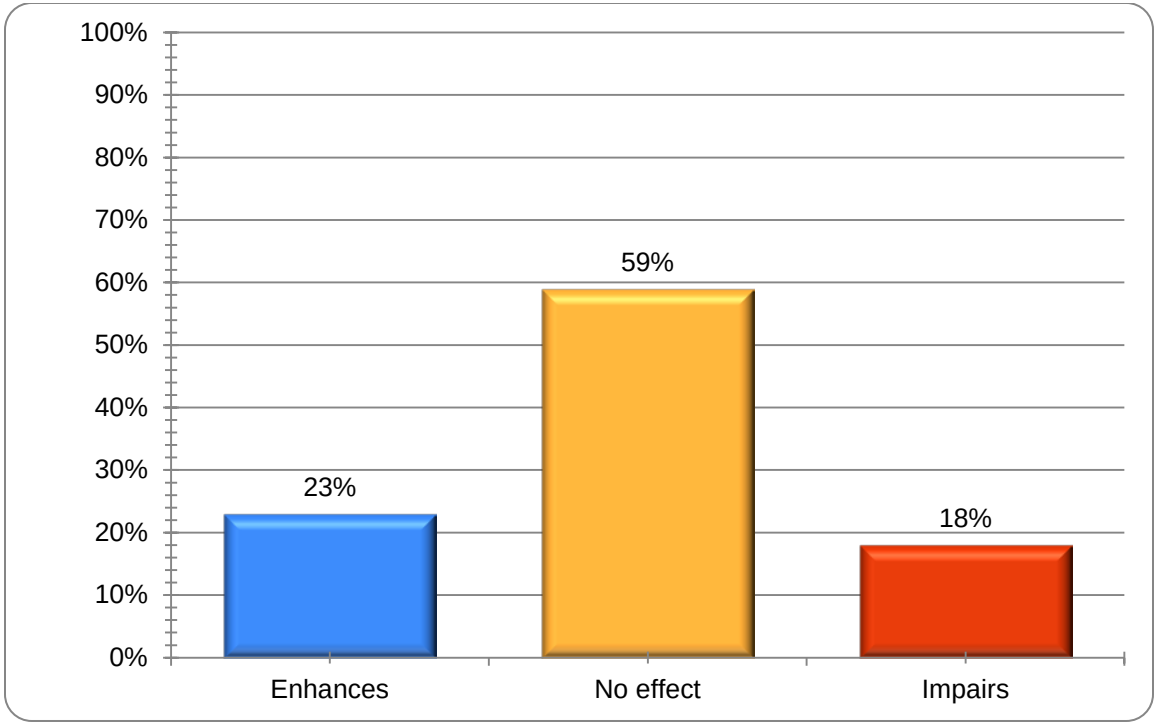


Council on Access, Prevention, and Interprofessional Relations Results

The [council] currently reports to the ADA House of Delegates. How does this reporting structure affect its ability to work with the ADA Board of Trustees?

Response Rate: **100% (N=22)** Question Type: **Choose one** Tag: **Q11**

Enhances	**5**	**23%**
No effect	**13**	**59%**
Impairs	**4**	**18%**
Total Responses	**22**	

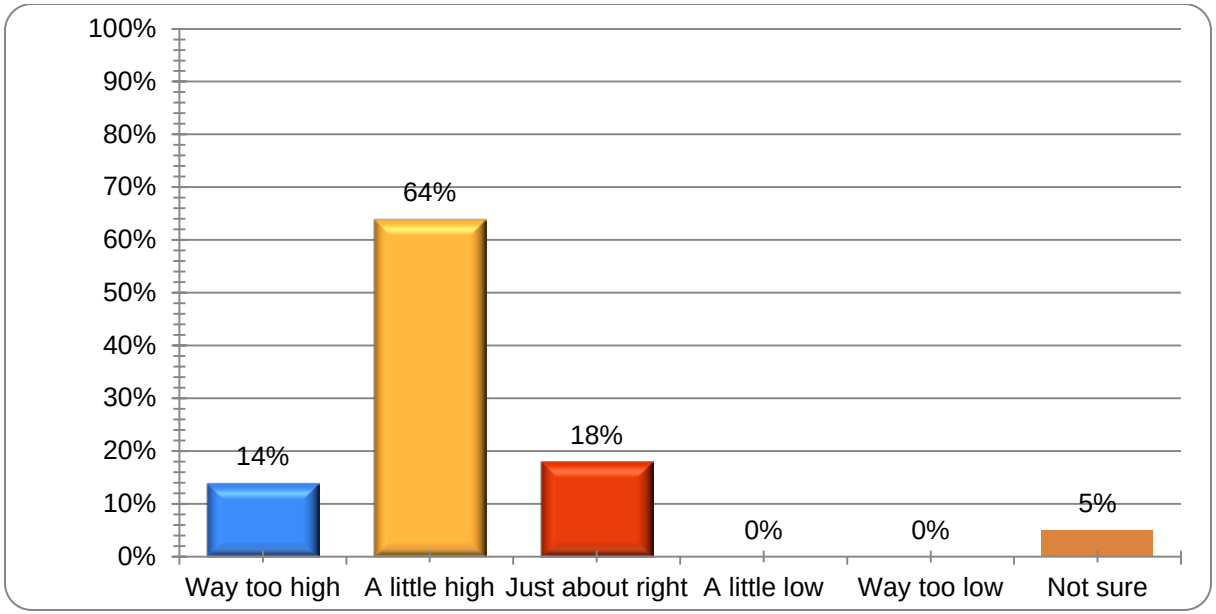


Council on Access, Prevention, and Interprofessional Relations Results

Please select the statement below that best describes the workload of the [council] (currently, or while you served on the council if you are no longer a member).

Response Rate: **100% (N=22)** Question Type: **Choose one** Tag: **Q12**

Way too high	**3**	**14%**
A little high	**14**	**64%**
Just about right	**4**	**18%**
A little low	**0**	**0%**
Way too low	**0**	**0%**
Not sure	**1**	**5%**
Total Responses	**22**	

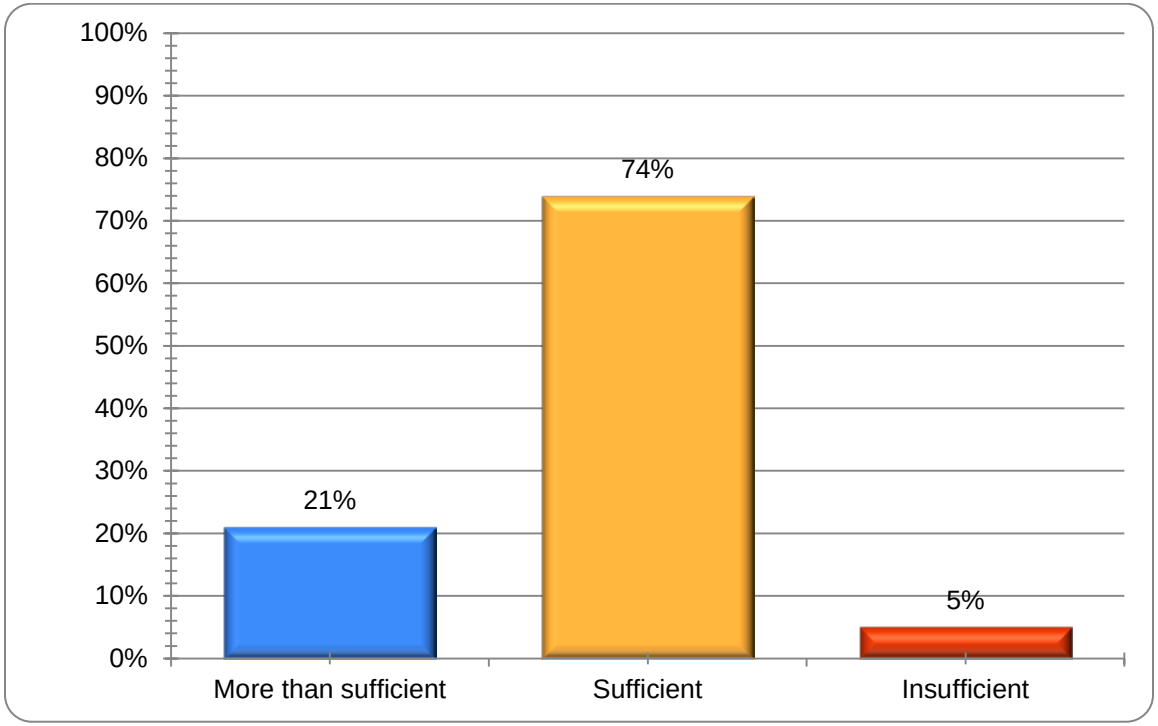


Council on Communications Results

Council on Communications Results

In your opinion, how sufficient is the current number of members on the [council]?
Response Rate: **100% (N=19)** Question Type: **Choose one** Tag: **Q1**

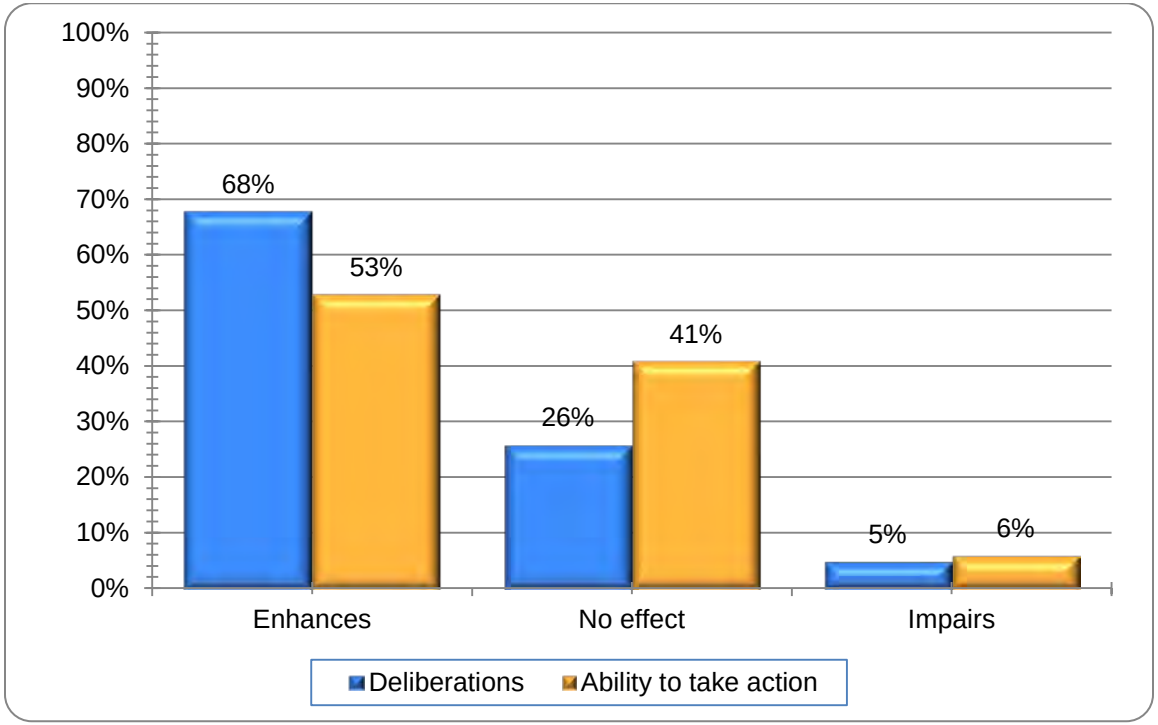
More than sufficient	**4**	**21%**
Sufficient	**14**	**74%**
Insufficient	**1**	**5%**
Total Responses	**19**	



Council on Communications Results

How does your council's current size affect its deliberations/ability to take action?

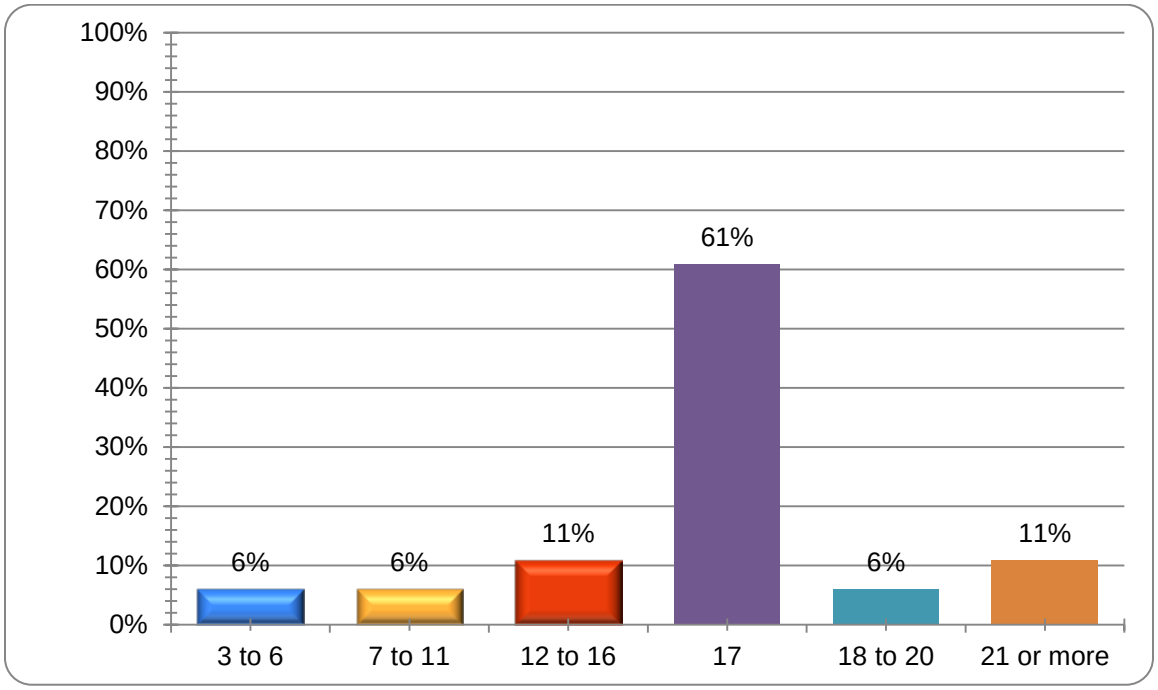
	Enhances	No effect	Impairs	**Total Responses**
Deliberations	13	5	1	**19**
	68%	26%	5%	
Ability to take action	9	7	1	**17**
	53%	41%	6%	
Total Responses	**22**	**12**	**2**	**36**



Council on Communications Results

What do you think is the optimal number of members for the [council]?
Response Rate: **95% (N=18)** Question Type: **Choose one** Tag: **Q6**

3 to 6	**1**	**6%**
7 to 11	**1**	**6%**
12 to 16	**2**	**11%**
17	**11**	**61%**
18 to 20	**1**	**6%**
21 or more	**2**	**11%**
Total Responses	**18**	

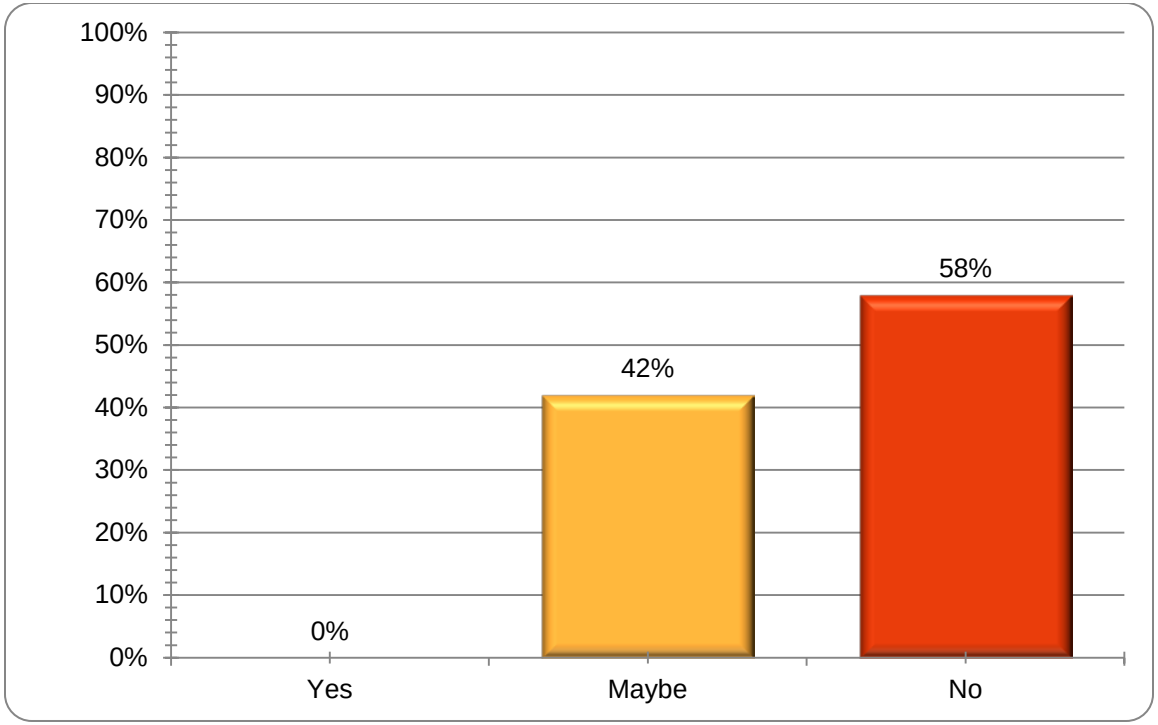


Council on Communications Results

In the event that a smaller number of members were required for the [council], would rotating the open seats yearly among the 17 districts be an appropriate way of selecting members?

Response Rate: **100% (N=19)** Question Type: **Choose one** Tag: **Q7**

Yes	**0**	**0%**
Maybe	**8**	**42%**
No	**11**	**58%**
Total Responses	**19**	

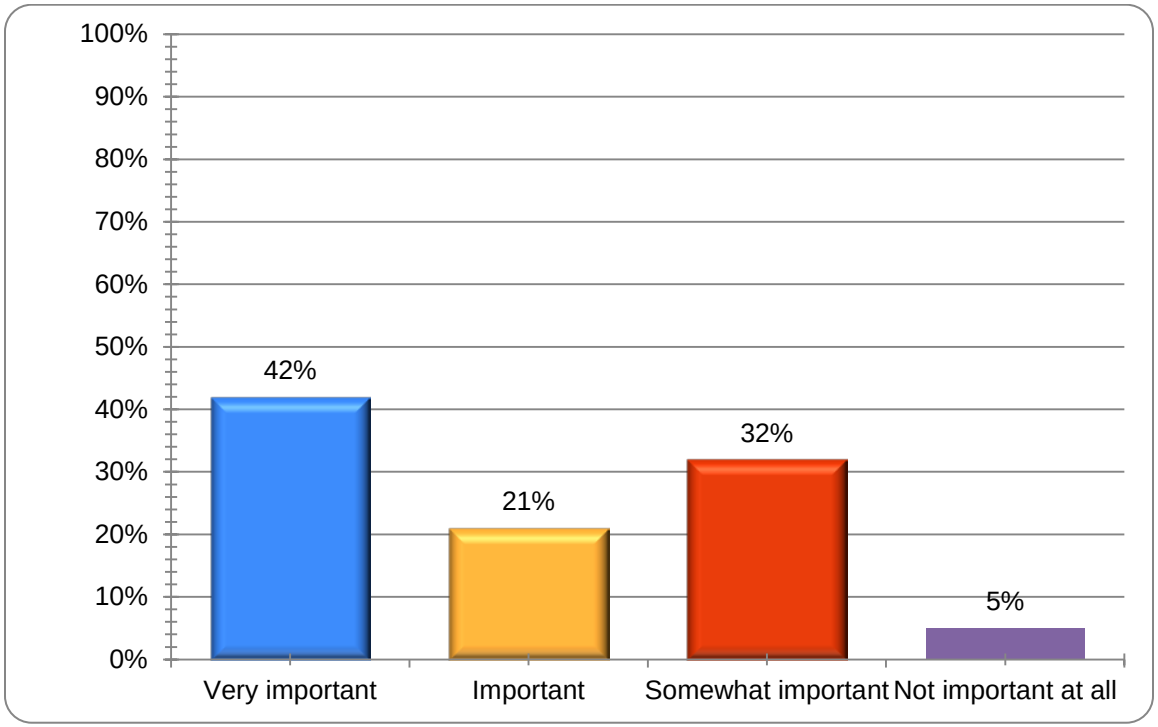


Council on Communications Results

How important is geographic representation for the [council]?

Response Rate: **100% (N=19)** Question Type: **Choose one** Tag: **Q10**

Very important	**8**	**42%**
Important	**4**	**21%**
Somewhat important	**6**	**32%**
Not important at all	**1**	**5%**
Total Responses	**19**	

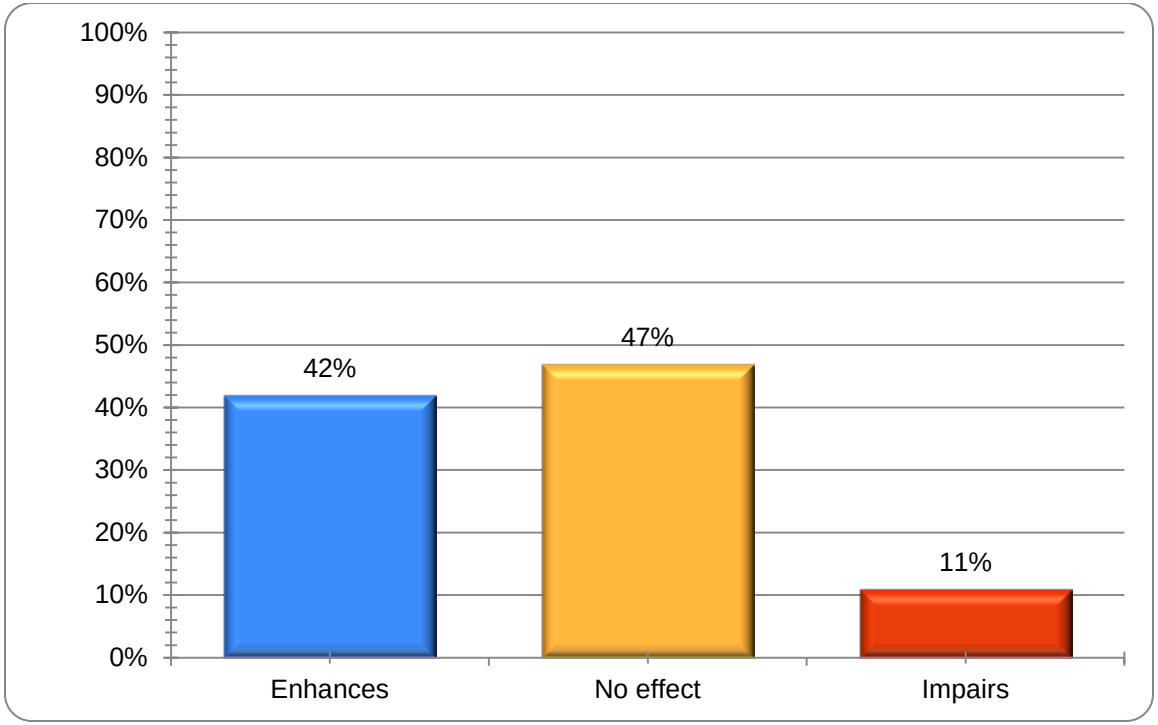


Council on Communications Results

The [council] currently reports to the ADA House of Delegates. How does this reporting structure affect its ability to work with the ADA Board of Trustees?

Response Rate: **100% (N=19)** Question Type: **Choose one** Tag: **Q11**

Enhances	**8**	**42%**
No effect	**9**	**47%**
Impairs	**2**	**11%**
Total Responses	**19**	

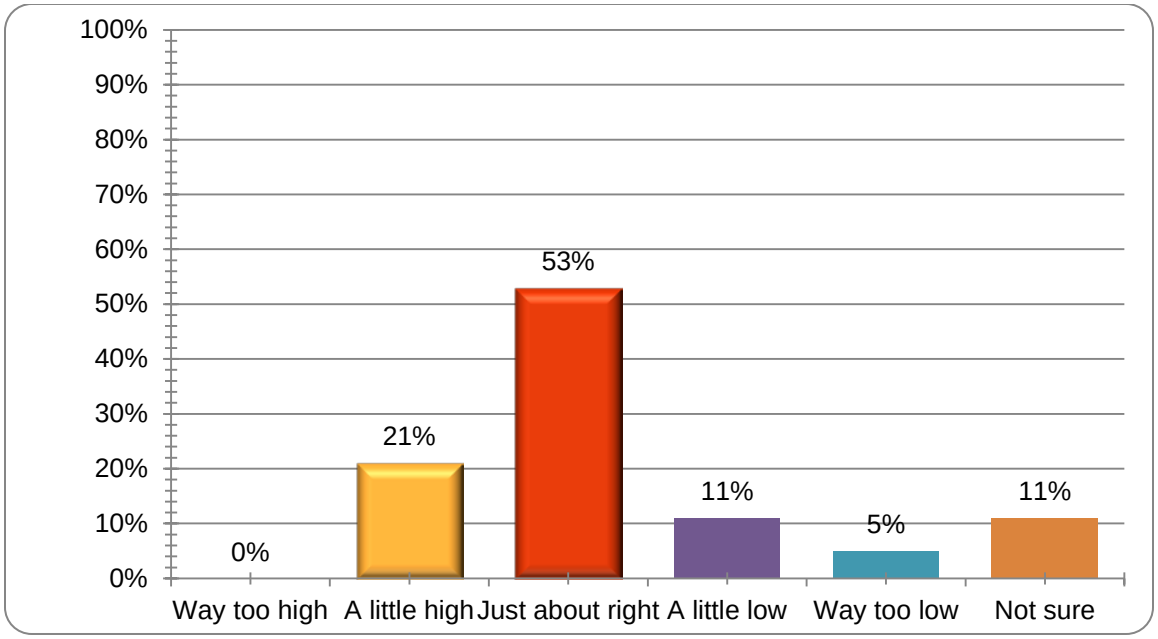


Council on Communications Results

Please select the statement below that best describes the workload of the [council] (currently, or while you served on the council if you are no longer a member).

Response Rate: **100% (N=19)** Question Type: **Choose one** Tag: **Q12**

Way too high	**0**	**0%**
A little high	**4**	**21%**
Just about right	**10**	**53%**
A little low	**2**	**11%**
Way too low	**1**	**5%**
Not sure	**2**	**11%**
Total Responses	**19**	

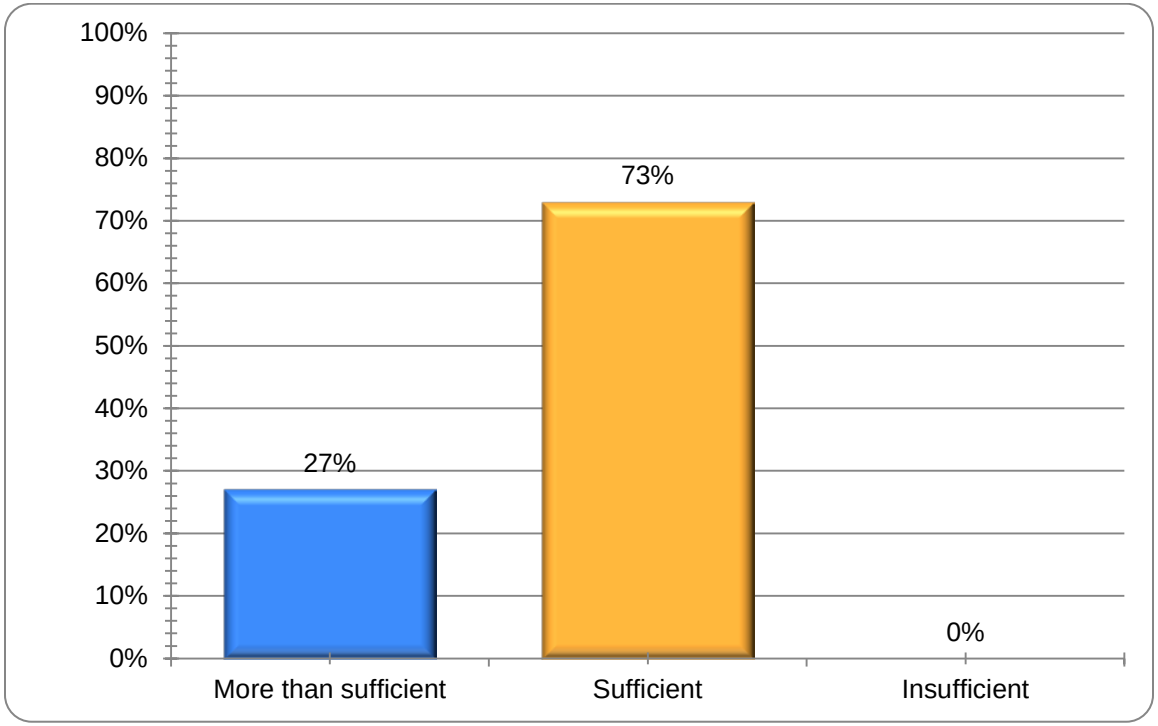


Council on Dental Benefit Programs Results

Council on Dental Benefit Programs Results

In your opinion, how sufficient is the current number of members on the [council]?
Response Rate: **100% (N=22)** Question Type: **Choose one** Tag: **Q1**

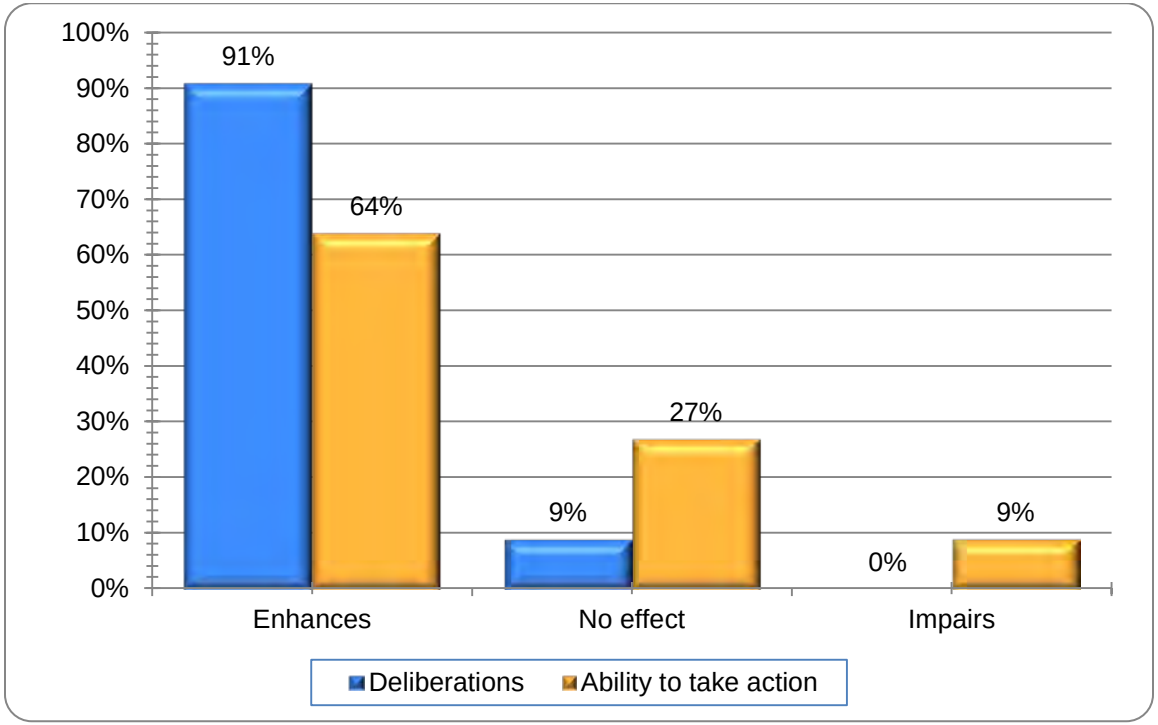
More than sufficient	**6**	**27%**
Sufficient	**16**	**73%**
Insufficient	**0**	**0%**
Total Responses	**22**	



Council on Dental Benefit Programs Results

How does your council's current size affect its deliberations/ability to take action?

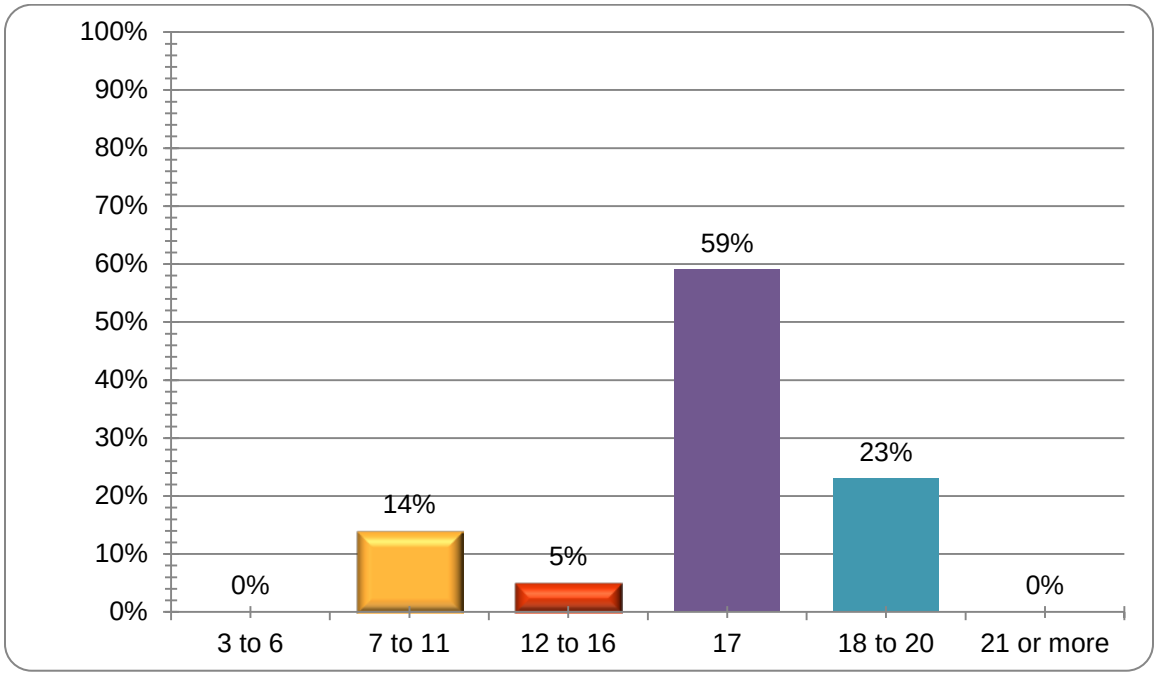
	Enhances	No effect	Impairs	**Total Responses**
Deliberations	20	2	0	**22**
	91%	9%	0%	
Ability to take action	14	6	2	**22**
	64%	27%	9%	
Total Responses	**34**	**8**	**2**	**44**



Council on Dental Benefit Programs Results

What do you think is the optimal number of members for the [council]?
Response Rate: **100% (N=22)** Question Type: **Choose one** Tag: **Q6**

3 to 6	**0**	**0%**
7 to 11	**3**	**14%**
12 to 16	**1**	**5%**
17	**13**	**59%**
18 to 20	**5**	**23%**
21 or more	**0**	**0%**
Total Responses	**22**	

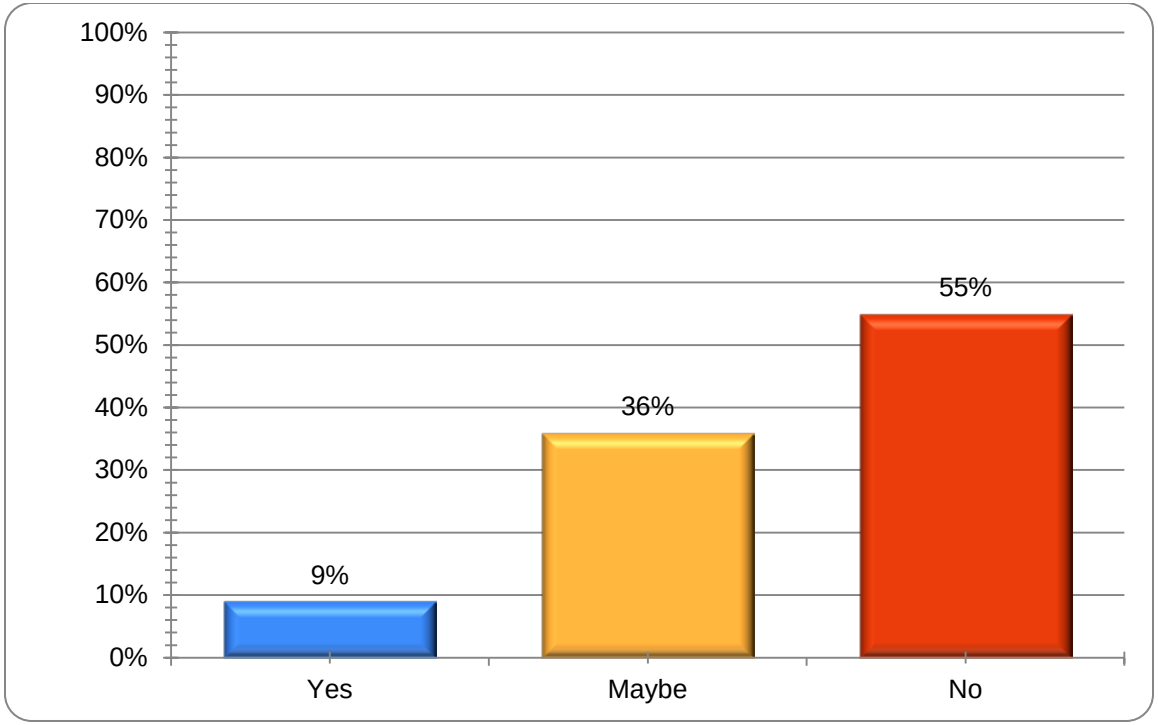


Council on Dental Benefit Programs Results

In the event that a smaller number of members were required for the [council], would rotating the open seats yearly among the 17 districts be an appropriate way of selecting members?

Response Rate: **100% (N=22)** Question Type: **Choose one** Tag: **Q7**

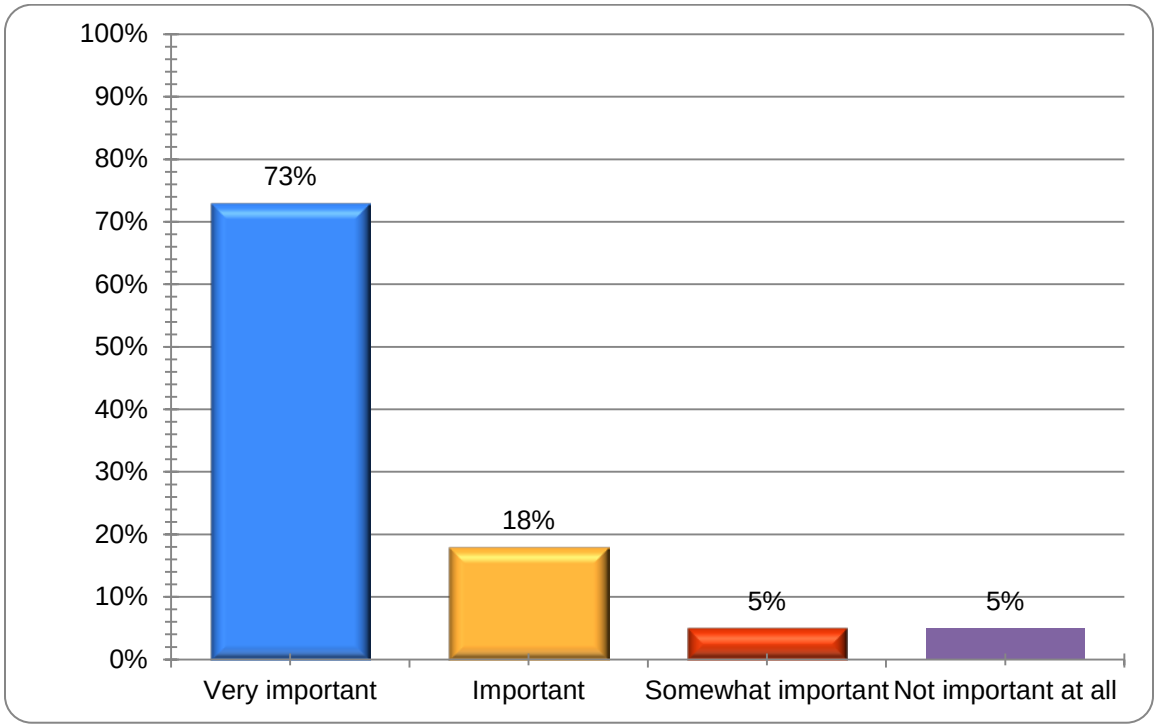
Yes	**2**	**9%**
Maybe	**8**	**36%**
No	**12**	**55%**
Total Responses	**22**	



Council on Dental Benefit Programs Results

How important is geographic representation for the [council]?
Response Rate: **100% (N=22)** Question Type: **Choose one** Tag: **Q10**

Very important	**16**	**73%**
Important	**4**	**18%**
Somewhat important	**1**	**5%**
Not important at all	**1**	**5%**
Total Responses	**22**	

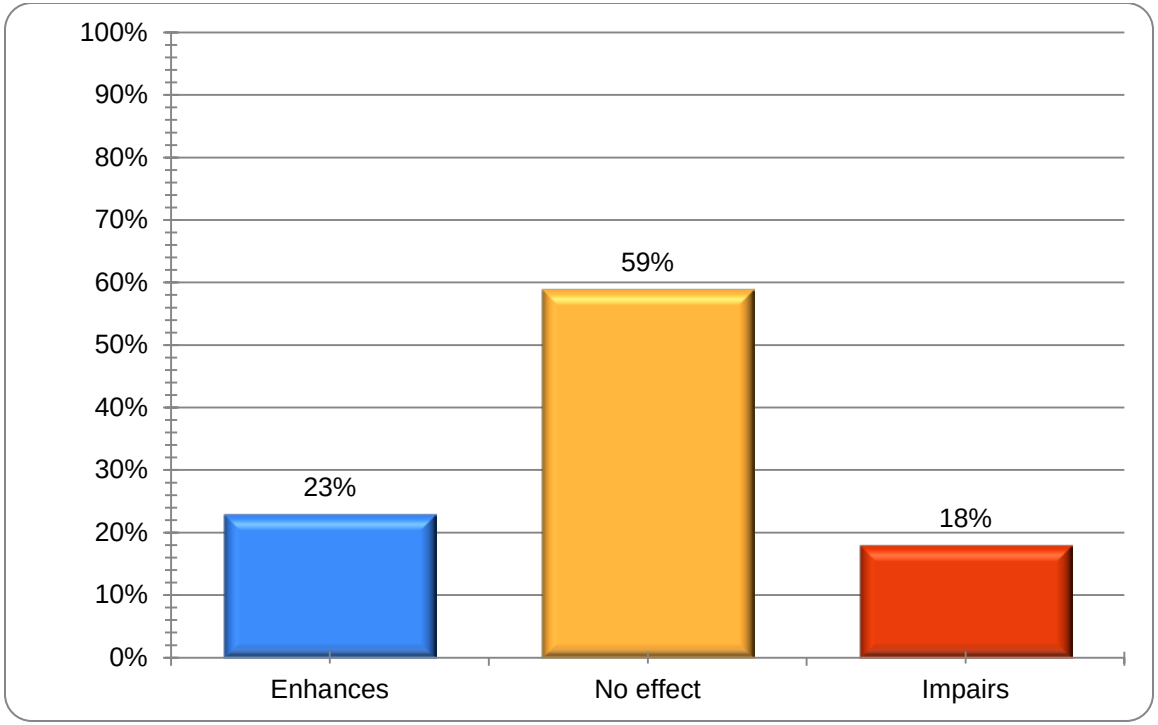


Council on Dental Benefit Programs Results

The [council] currently reports to the ADA House of Delegates. How does this reporting structure affect its ability to work with the ADA Board of Trustees?

Response Rate: **100% (N=22)** Question Type: **Choose one** Tag: **Q11**

Enhances	**5**	**23%**
No effect	**13**	**59%**
Impairs	**4**	**18%**
Total Responses	**22**	

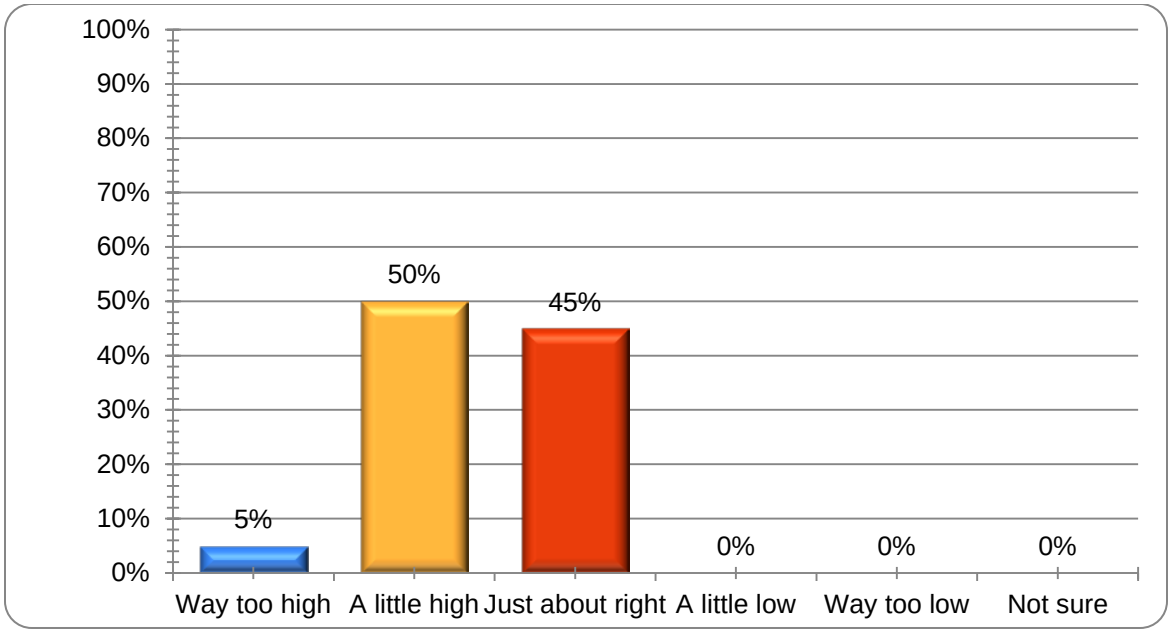


Council on Dental Benefit Programs Results

Please select the statement below that best describes the workload of the [council] (currently, or while you served on the council if you are no longer a member).

Response Rate: **100% (N=22)** Question Type: **Choose one** Tag: **Q12**

Way too high	**1**	**5%**
A little high	**11**	**50%**
Just about right	**10**	**45%**
A little low	**0**	**0%**
Way too low	**0**	**0%**
Not sure	**0**	**0%**
Total Responses	**22**	

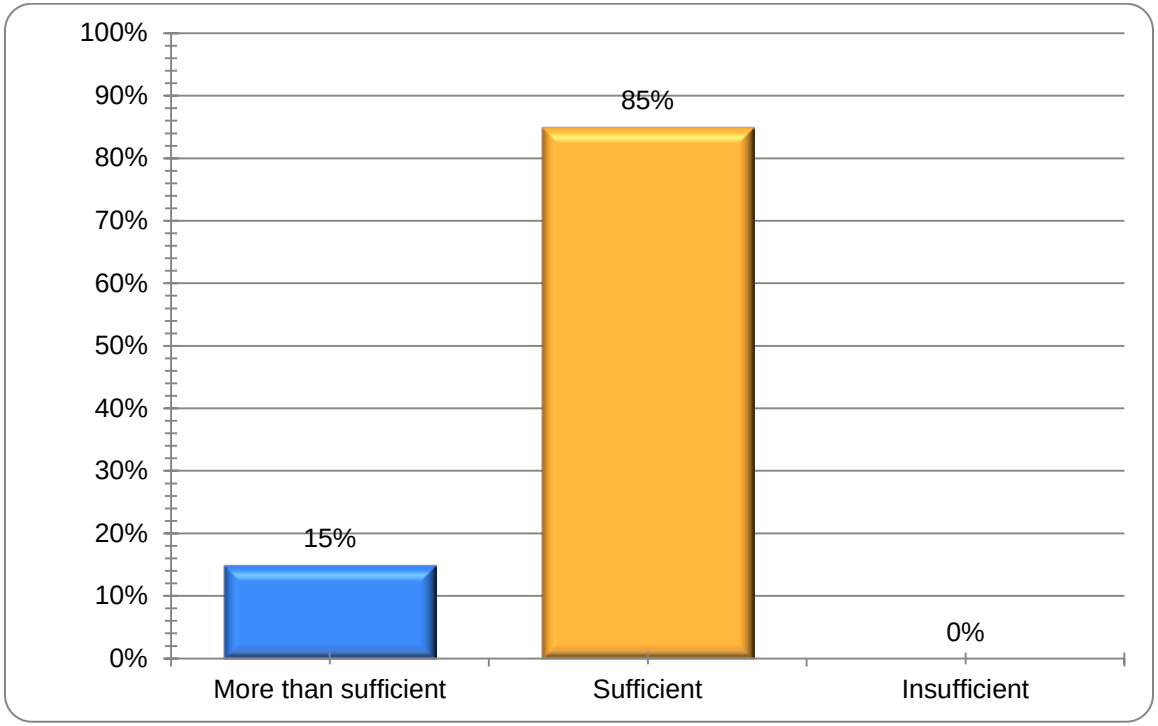


Council on Dental Education and Licensure Results

Council on Dental Education and Licensure Results

In your opinion, how sufficient is the current number of members on the [council]?
Response Rate: **100% (N=13)** Question Type: **Choose one** Tag: **Q1**

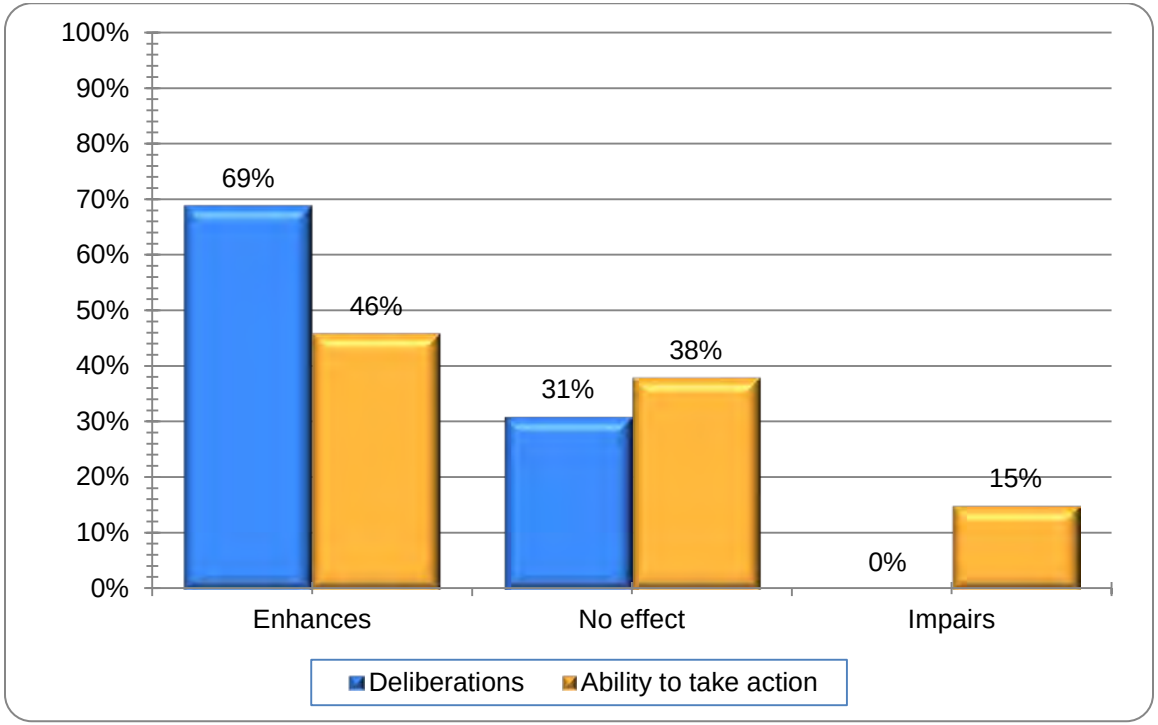
More than sufficient	2	15%
Sufficient	11	85%
Insufficient	0	0%
Total Responses	13	



Council on Dental Education and Licensure Results

How does your council's current size affect its deliberations/ability to take action?

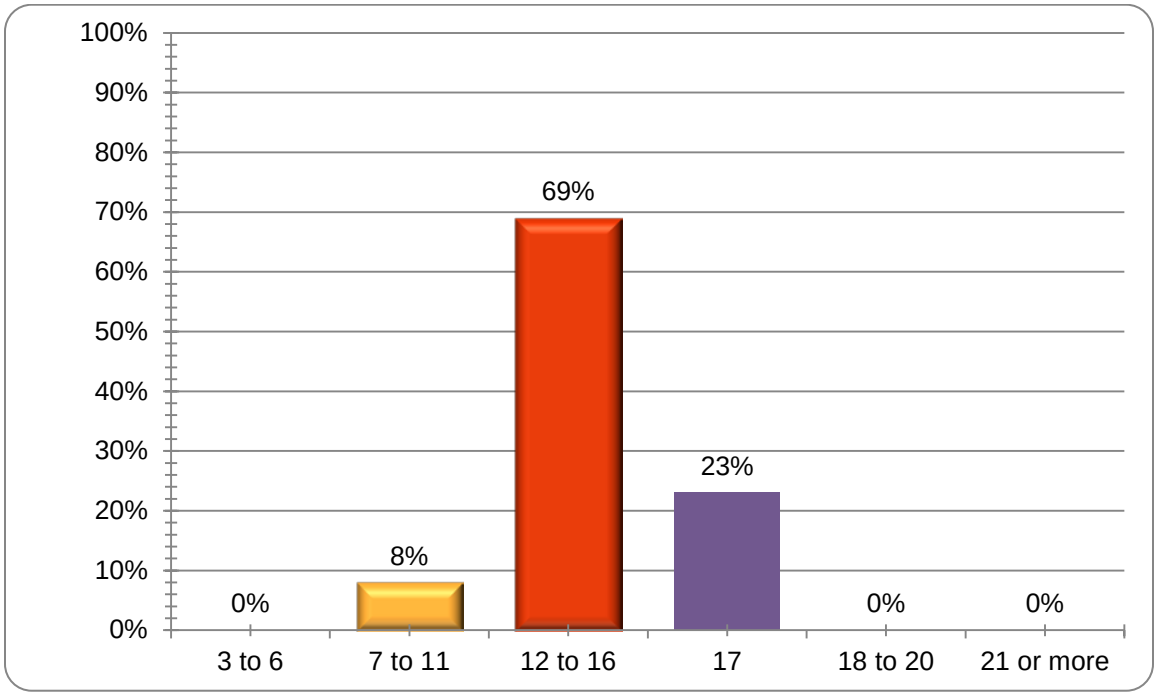
	Enhances	No effect	Impairs	Total Responses
Deliberations	9	4	0	13
	69%	31%	0%	
Ability to take action	6	5	2	13
	46%	38%	15%	
Total Responses	15	9	2	26



Council on Dental Education and Licensure Results

What do you think is the optimal number of members for the [council]?
Response Rate: **100% (N=13)** Question Type: **Choose one** Tag: **Q6**

3 to 6	0	0%
7 to 11	1	8%
12 to 16	9	69%
17	3	23%
18 to 20	0	0%
21 or more	0	0%
Total Responses	13	

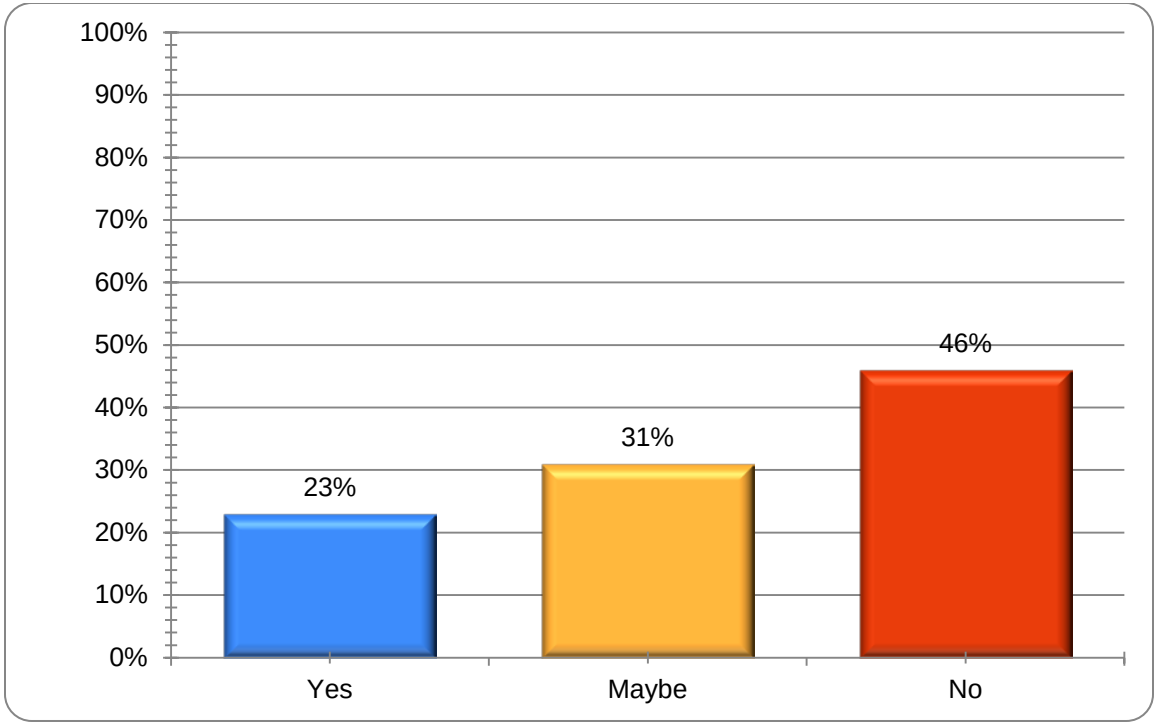


Council on Dental Education and Licensure Results

In the event that a smaller number of members were required for the [council], would rotating the open seats yearly among the 17 districts be an appropriate way of selecting members?

Response Rate: **100% (N=13)** Question Type: **Choose one** Tag: **Q7**

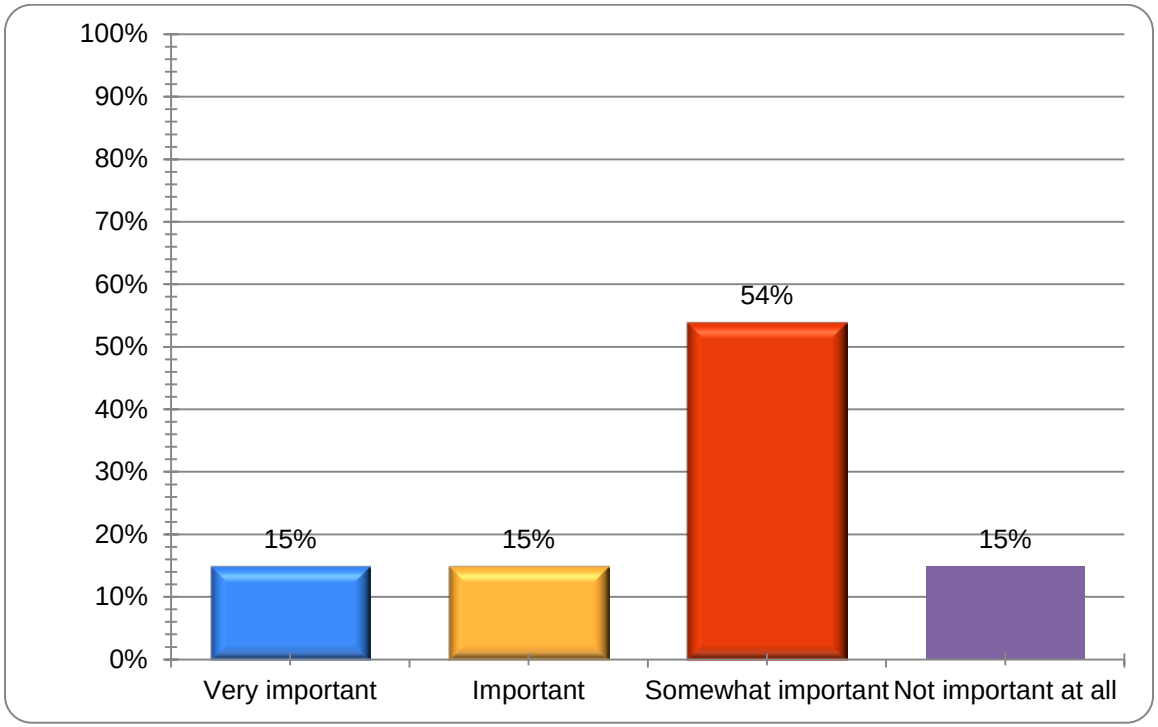
Yes	3	23%
Maybe	4	31%
No	6	46%
Total Responses	13	



Council on Dental Education and Licensure Results

How important is geographic representation for the [council]?
Response Rate: **100% (N=13)** Question Type: **Choose one** Tag: **Q10**

Very important	2	15%
Important	2	15%
Somewhat important	7	54%
Not important at all	2	15%
Total Responses	13	

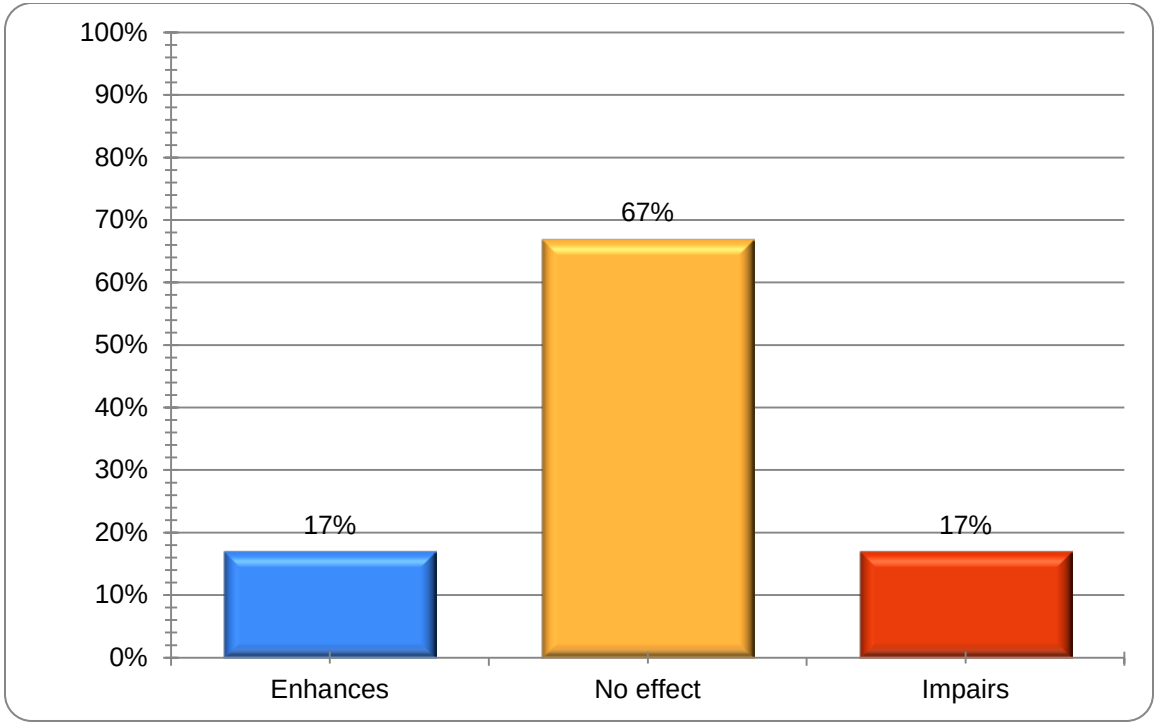


Council on Dental Education and Licensure Results

The [council] currently reports to the ADA House of Delegates. How does this reporting structure affect its ability to work with the ADA Board of Trustees?

Response Rate: **92% (N=12)** Question Type: **Choose one** Tag: **Q11**

Enhances	2	17%
No effect	8	67%
Impairs	2	17%
Total Responses	12	

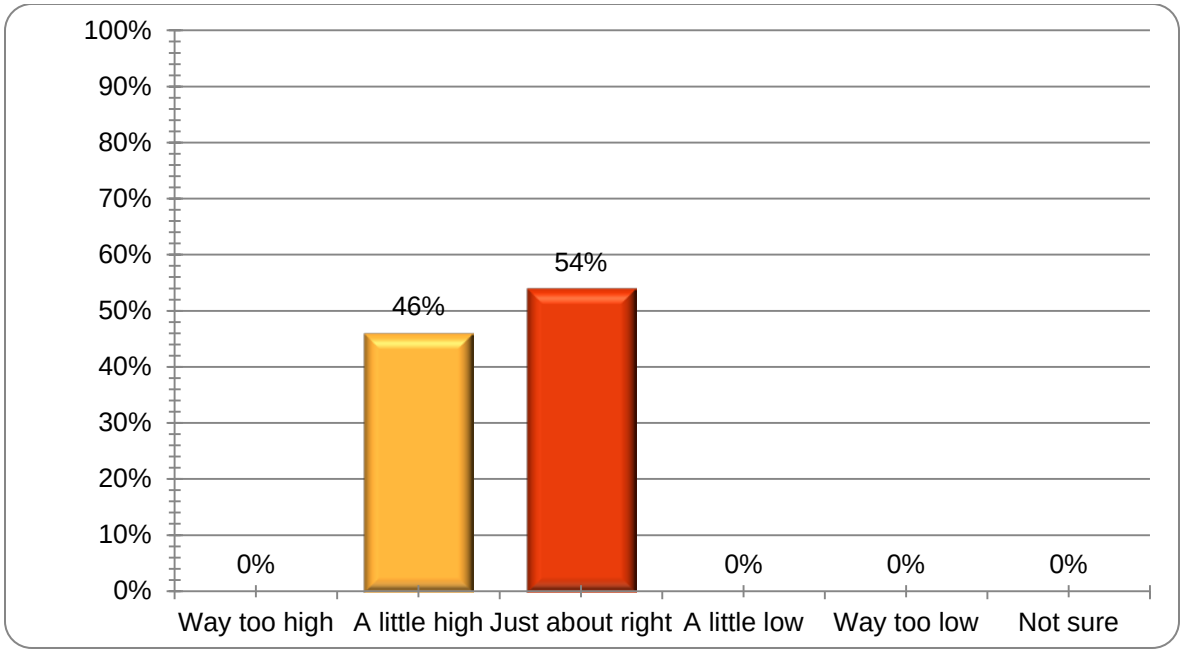


Council on Dental Education and Licensure Results

Please select the statement below that best describes the workload of the [council] (currently, or while you served on the council if you are no longer a member).

Response Rate: **100% (N=13)** Question Type: **Choose one** Tag: **Q12**

Way too high	0	0%
A little high	6	46%
Just about right	7	54%
A little low	0	0%
Way too low	0	0%
Not sure	0	0%
Total Responses	13	

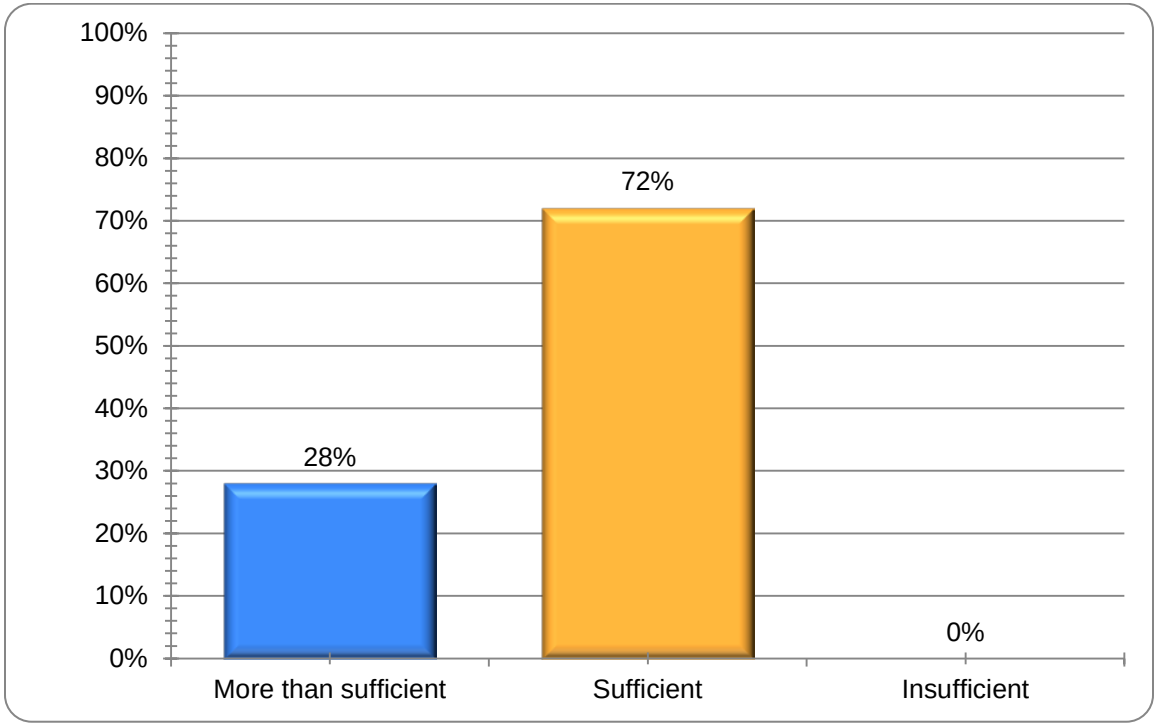


Council on Dental Practice Results

Council on Dental Practice Results

In your opinion, how sufficient is the current number of members on the [council]?
Response Rate: **100% (N=18)** Question Type: **Choose one** Tag: **Q1**

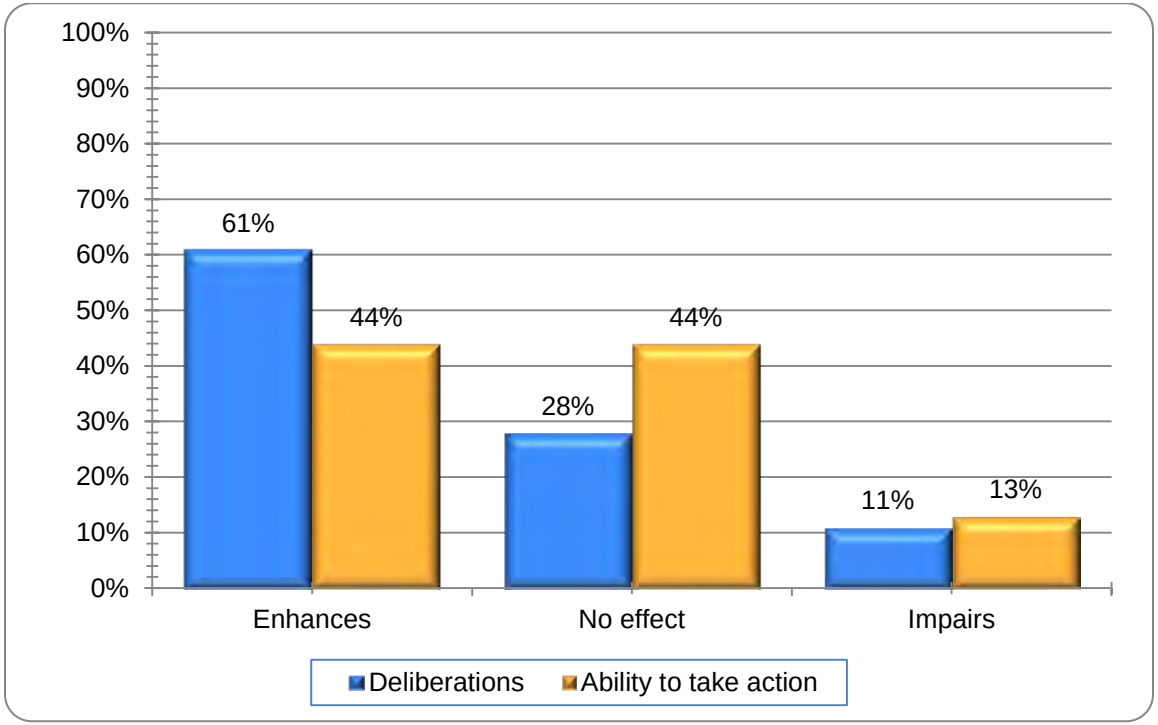
More than sufficient	**5**	**28%**
Sufficient	**13**	**72%**
Insufficient	**0**	**0%**
Total Responses	**18**	



Council on Dental Practice Results

How does your council's current size affect its deliberations/ability to take action?

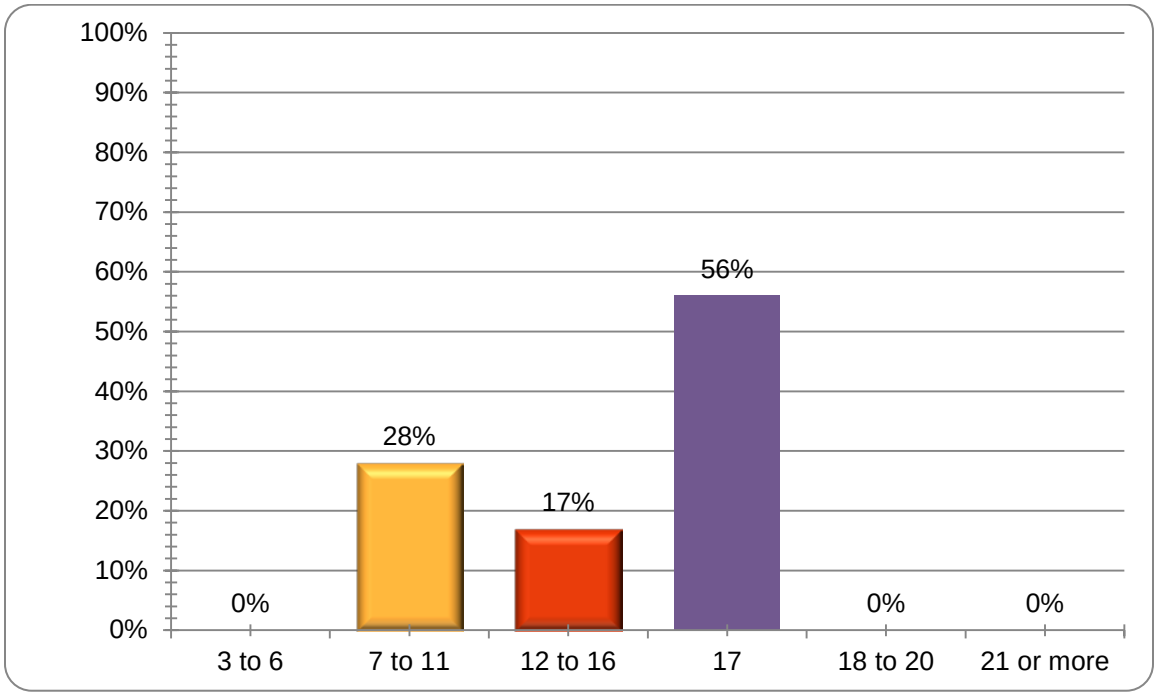
	Enhances	No effect	Impairs	**Total Responses**
Deliberations	11	5	2	**18**
	61%	28%	11%	
Ability to take action	7	7	2	**16**
	44%	44%	13%	
Total Responses	**18**	**12**	**4**	**34**



Council on Dental Practice Results

What do you think is the optimal number of members for the [council]?
Response Rate: **100% (N=18)** Question Type: **Choose one** Tag: **Q6**

3 to 6	**0**	**0%**
7 to 11	**5**	**28%**
12 to 16	**3**	**17%**
17	**10**	**56%**
18 to 20	**0**	**0%**
21 or more	**0**	**0%**
Total Responses	**18**	

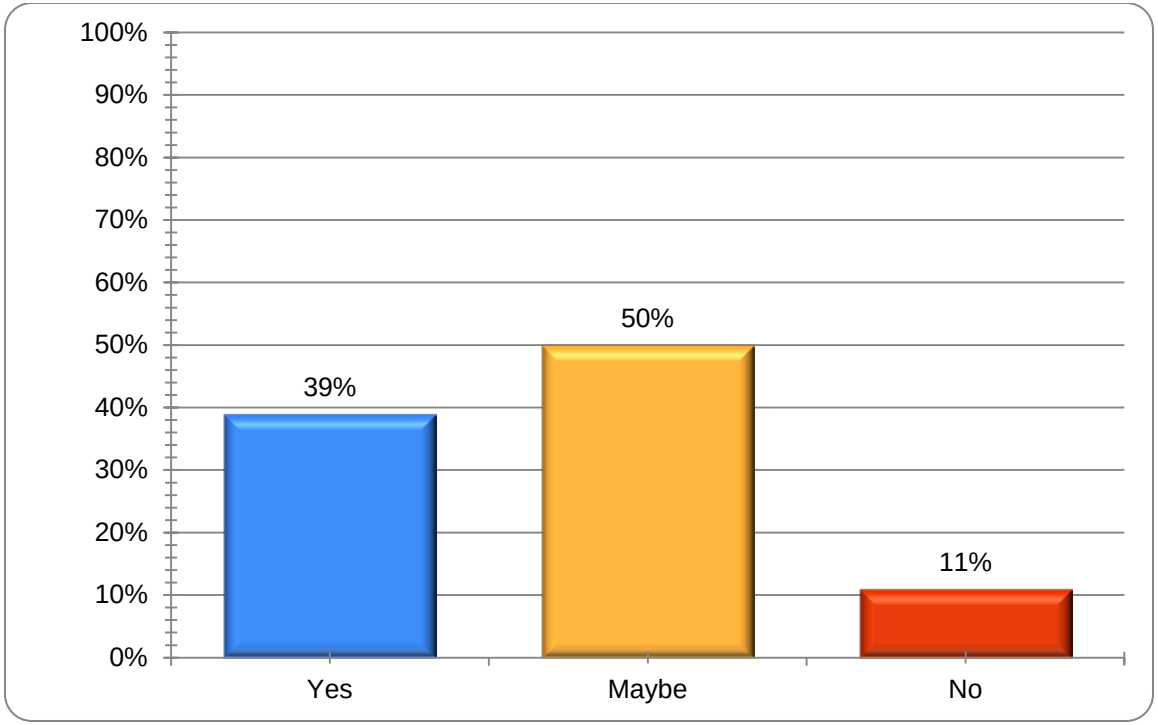


Council on Dental Practice Results

In the event that a smaller number of members were required for the [council], would rotating the open seats yearly among the 17 districts be an appropriate way of selecting members?

Response Rate: **100% (N=18)** Question Type: **Choose one** Tag: **Q7**

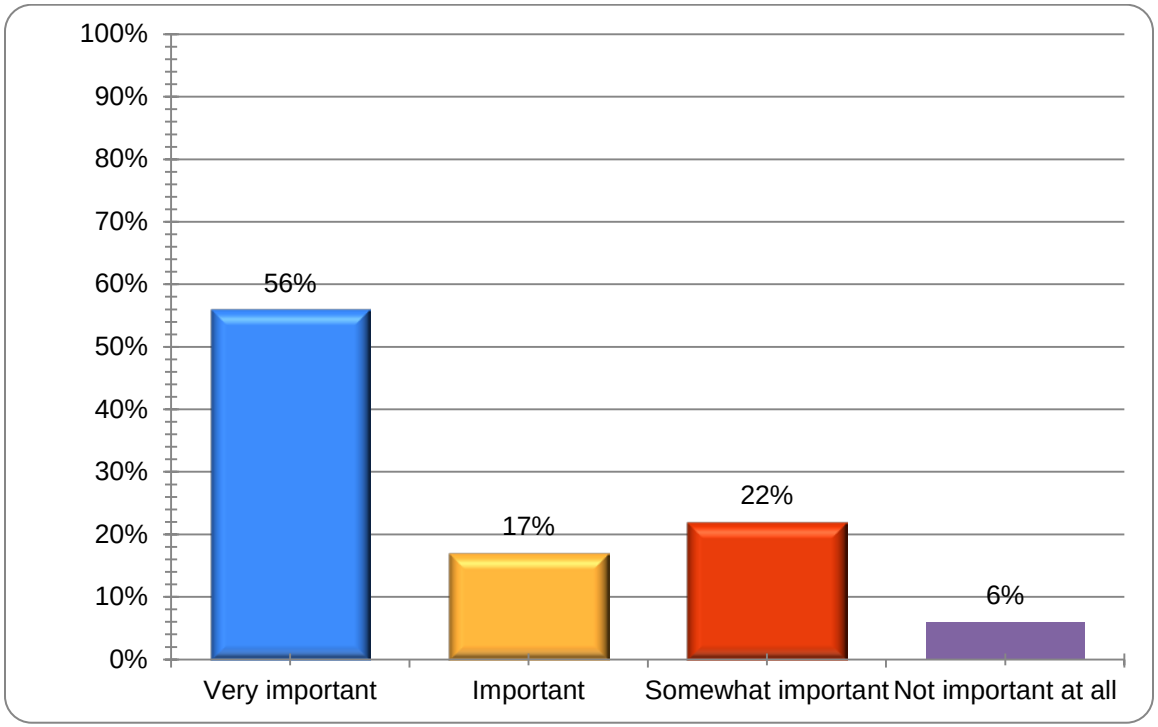
Yes	**7**	**39%**
Maybe	**9**	**50%**
No	**2**	**11%**
Total Responses	**18**	



Council on Dental Practice Results

How important is geographic representation for the [council]?
Response Rate: **100% (N=18)** Question Type: **Choose one** Tag: **Q10**

Very important	**10**	**56%**
Important	**3**	**17%**
Somewhat important	**4**	**22%**
Not important at all	**1**	**6%**
Total Responses	**18**	

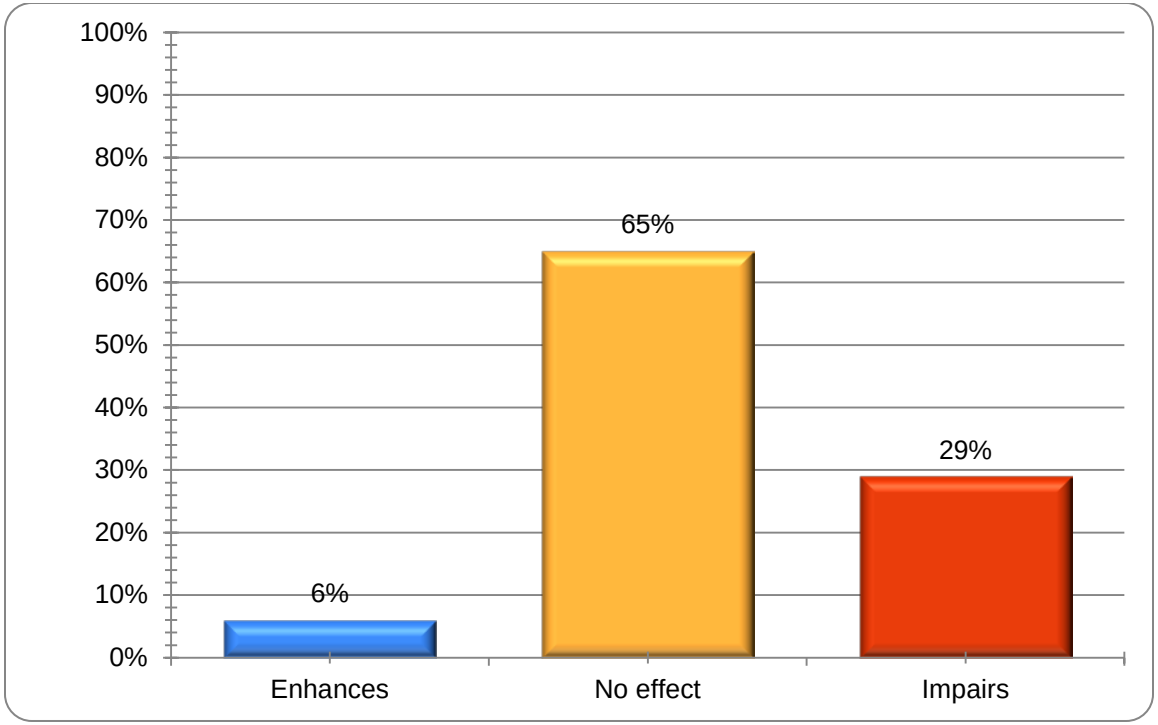


Council on Dental Practice Results

The [council] currently reports to the ADA House of Delegates. How does this reporting structure affect its ability to work with the ADA Board of Trustees?

Response Rate: **94% (N=17)** Question Type: **Choose one** Tag: **Q11**

Enhances	**1**	**6%**
No effect	**11**	**65%**
Impairs	**5**	**29%**
Total Responses	**17**	

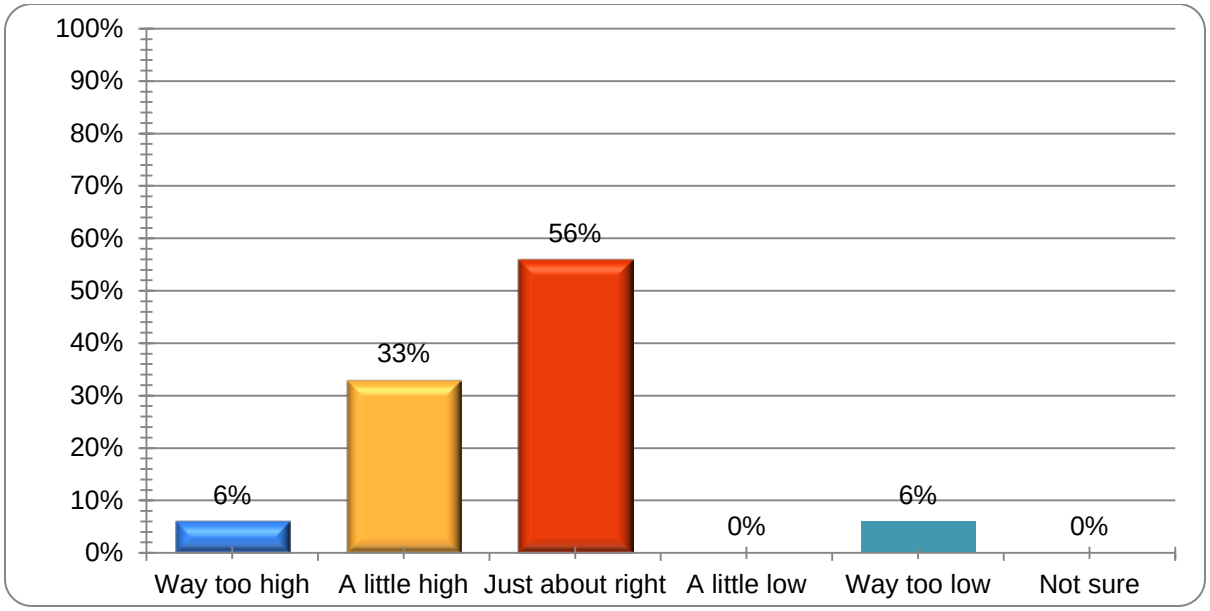


Council on Dental Practice Results

Please select the statement below that best describes the workload of the [council] (currently, or while you served on the council if you are no longer a member).

Response Rate: **100% (N=18)** Question Type: **Choose one** Tag: **Q12**

Way too high	**1**	**6%**
A little high	**6**	**33%**
Just about right	**10**	**56%**
A little low	**0**	**0%**
Way too low	**1**	**6%**
Not sure	**0**	**0%**
Total Responses	**18**	

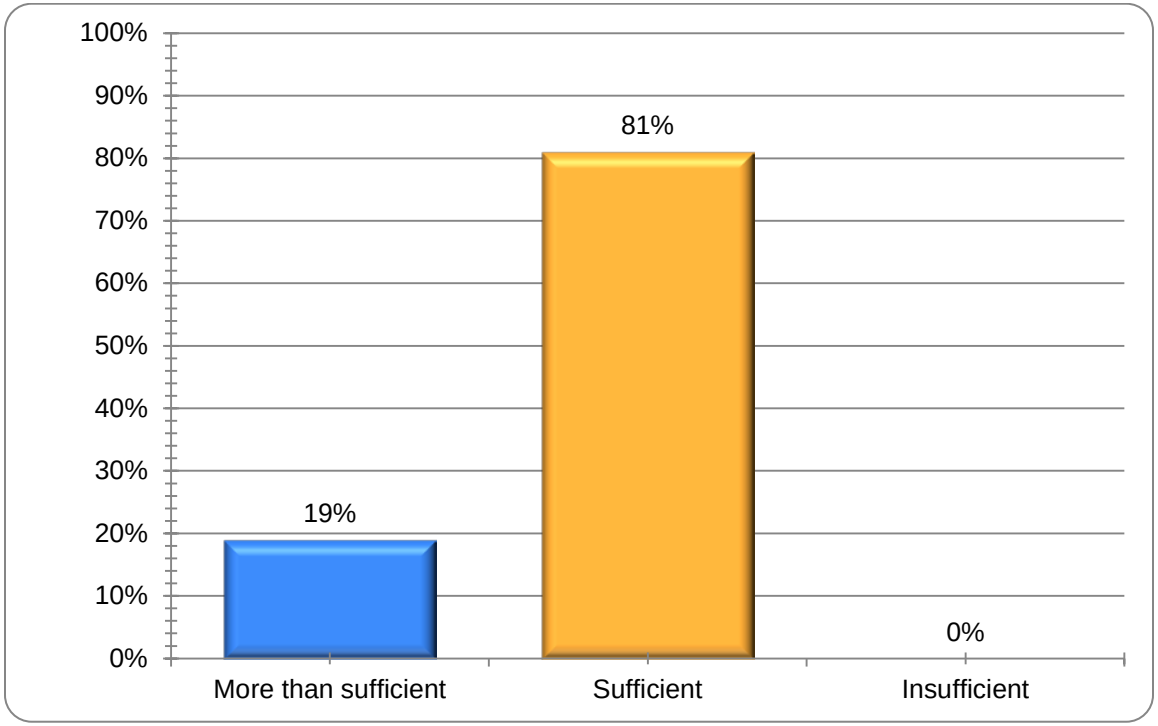


Council on Ethics, Bylaws, and Judicial Affairs Results

Council on Ethics, Bylaws, and Judicial Affairs Results

In your opinion, how sufficient is the current number of members on the [council]?
Response Rate: **100% (N=16)** Question Type: **Choose one** Tag: **Q1**

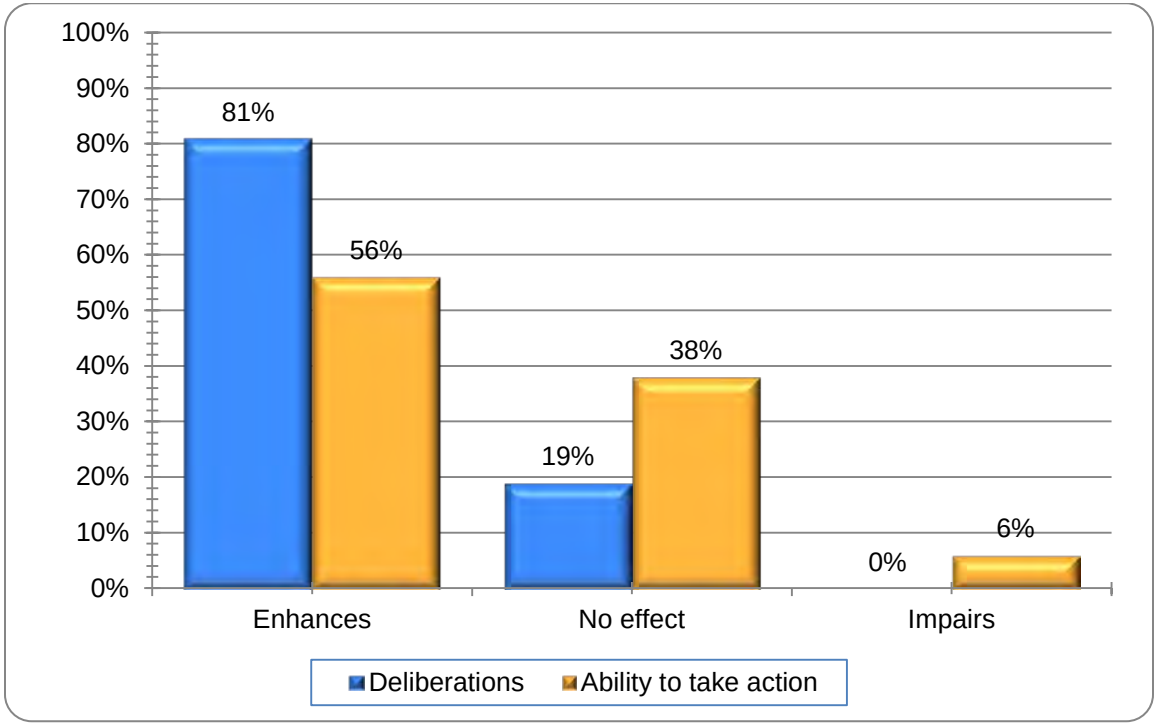
More than sufficient	3	19%
Sufficient	13	81%
Insufficient	0	0%
Total Responses	16	



Council on Ethics, Bylaws, and Judicial Affairs Results

How does your council's current size affect its deliberations/ability to take action?

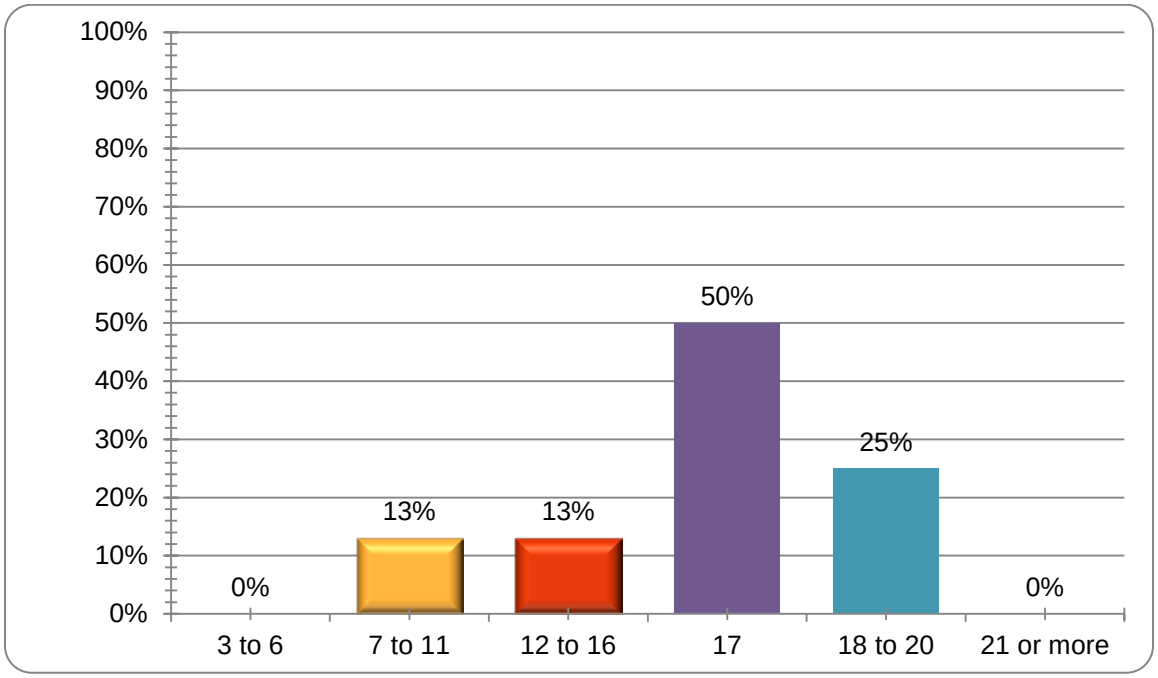
	Enhances	No effect	Impairs	Total Responses
Deliberations	13	3	0	16
	81%	19%	0%	
Ability to take action	9	6	1	16
	56%	38%	6%	
Total Responses	22	9	1	32



Council on Ethics, Bylaws, and Judicial Affairs Results

What do you think is the optimal number of members for the [council]?
Response Rate: **100% (N=16)** Question Type: **Choose one** Tag: **Q6**

3 to 6	0	0%
7 to 11	2	13%
12 to 16	2	13%
17	8	50%
18 to 20	4	25%
21 or more	0	0%
Total Responses	16	

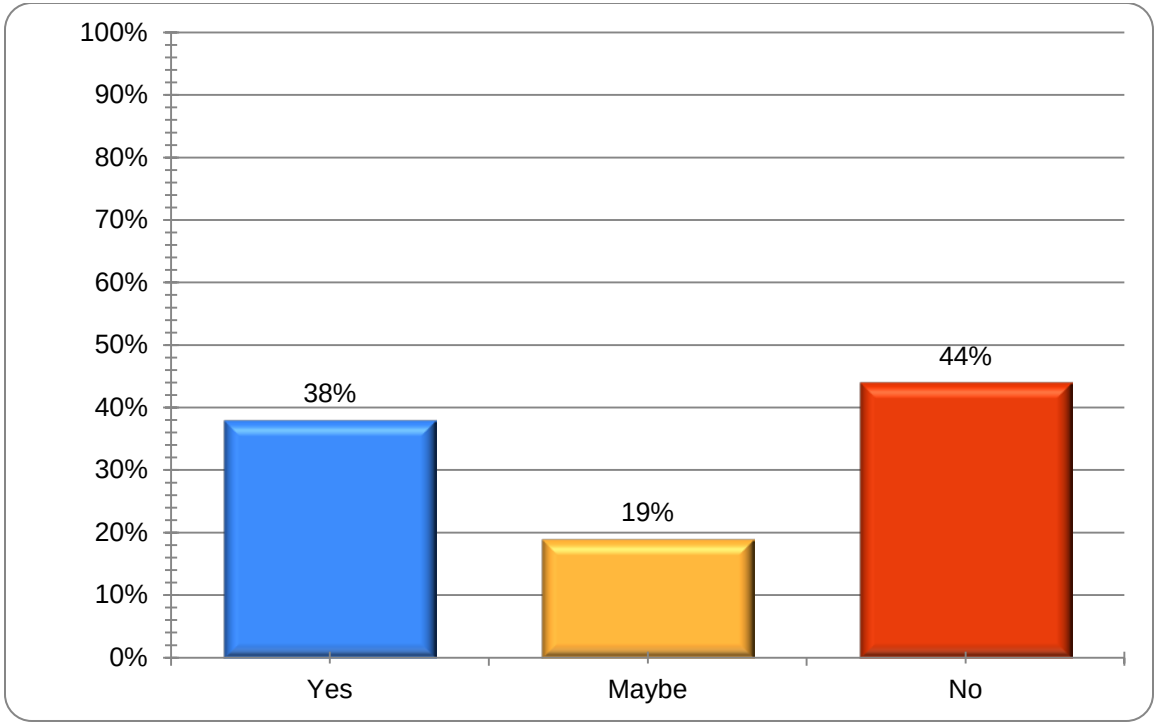


Council on Ethics, Bylaws, and Judicial Affairs Results

In the event that a smaller number of members were required for the [council], would rotating the open seats yearly among the 17 districts be an appropriate way of selecting members?

Response Rate: **100% (N=16)** Question Type: **Choose one** Tag: **Q7**

Yes	6	38%
Maybe	3	19%
No	7	44%
Total Responses	16	

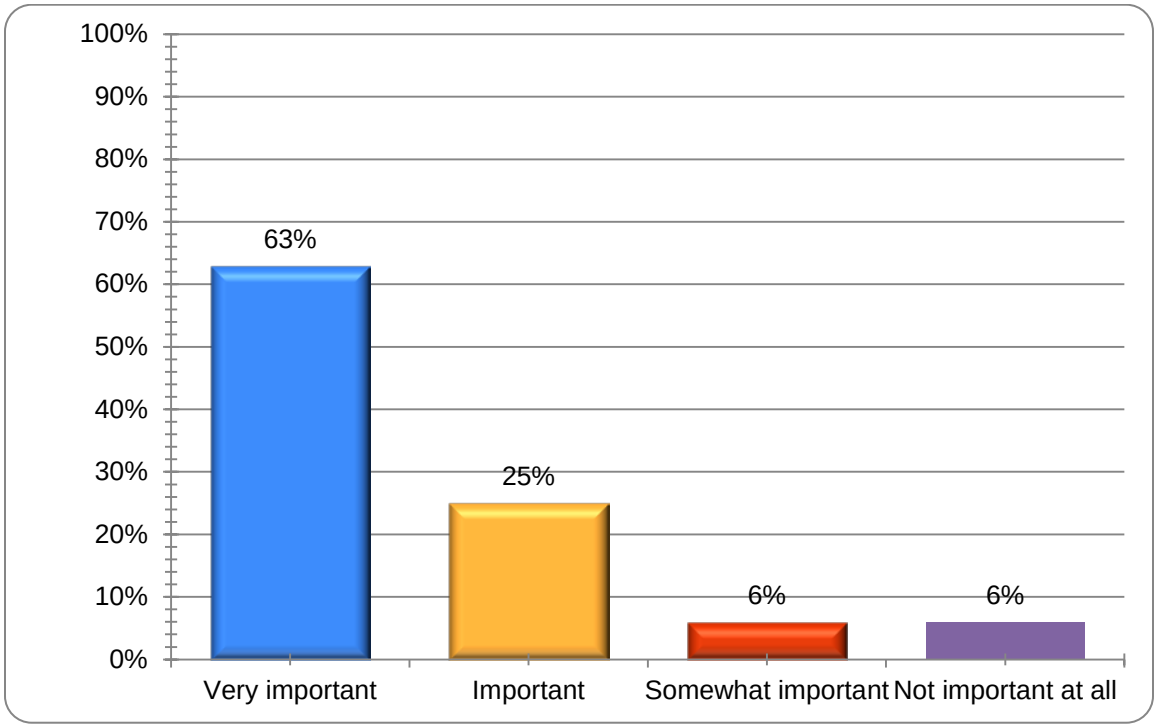


Council on Ethics, Bylaws, and Judicial Affairs Results

How important is geographic representation for the [council]?

Response Rate: **100% (N=16)** Question Type: **Choose one** Tag: **Q10**

Very important	10	63%
Important	4	25%
Somewhat important	1	6%
Not important at all	1	6%
Total Responses	16	

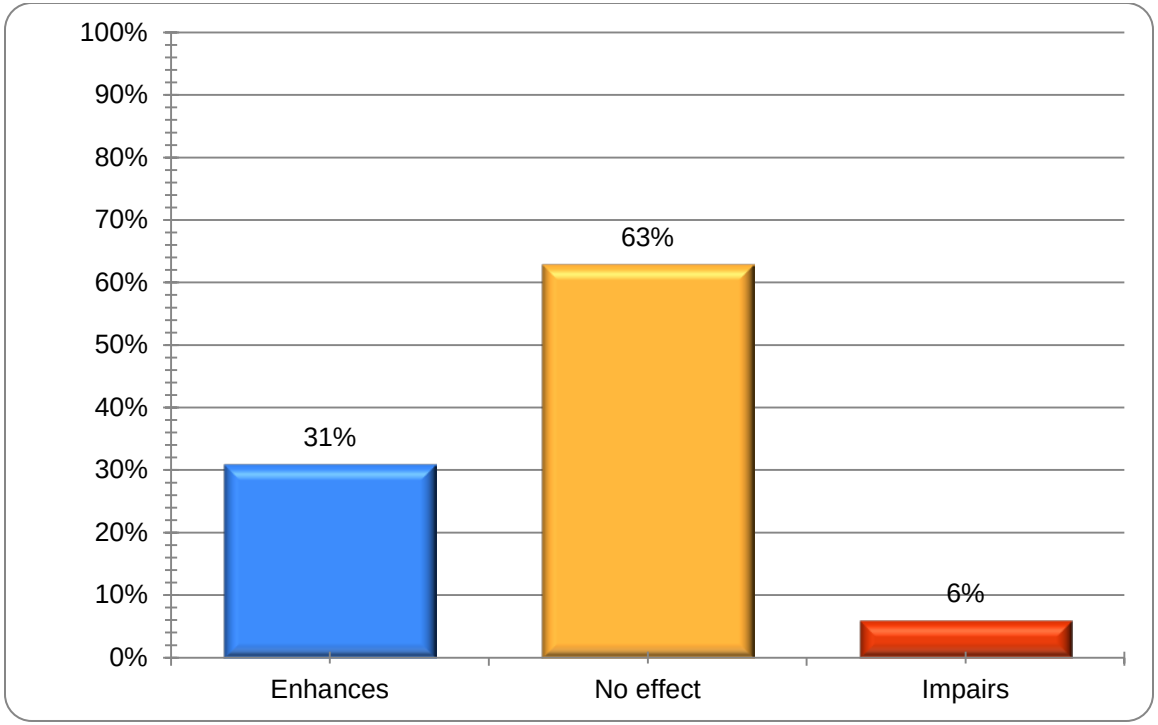


Council on Ethics, Bylaws, and Judicial Affairs Results

The [council] currently reports to the ADA House of Delegates. How does this reporting structure affect its ability to work with the ADA Board of Trustees?

Response Rate: **100% (N=16)** Question Type: **Choose one** Tag: **Q11**

Enhances	5	31%
No effect	10	63%
Impairs	1	6%
Total Responses	16	

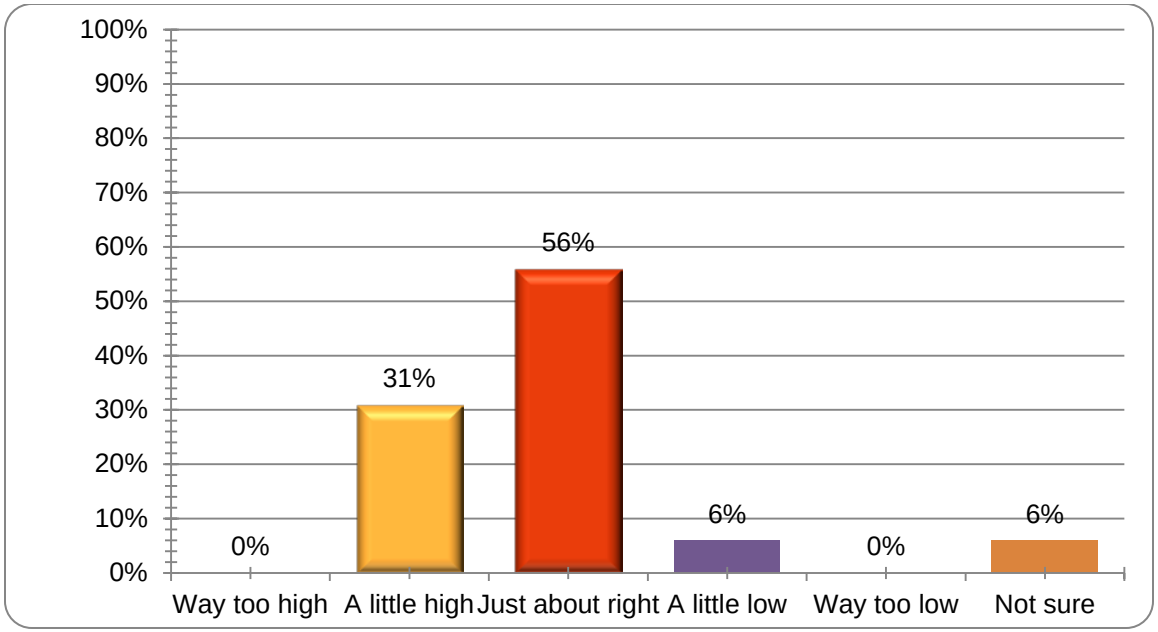


Council on Ethics, Bylaws, and Judicial Affairs Results

Please select the statement below that best describes the workload of the [council] (currently, or while you served on the council if you are no longer a member).

Response Rate: **100% (N=16)** Question Type: **Choose one** Tag: **Q12**

Way too high	0	0%
A little high	5	31%
Just about right	9	56%
A little low	1	6%
Way too low	0	0%
Not sure	1	6%
Total Responses	16	

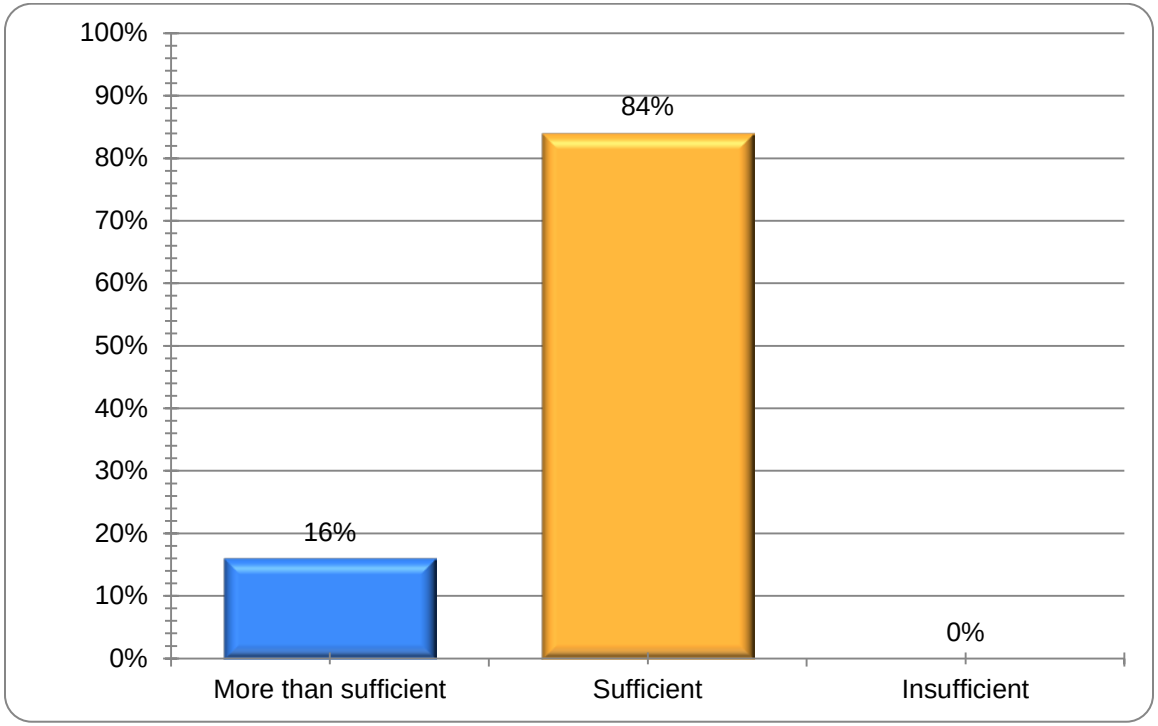


Council on Government Affairs Results

Council on Government Affairs Results

In your opinion, how sufficient is the current number of members on the [council]?
Response Rate: **100% (N=19)** Question Type: **Choose one** Tag: **Q1**

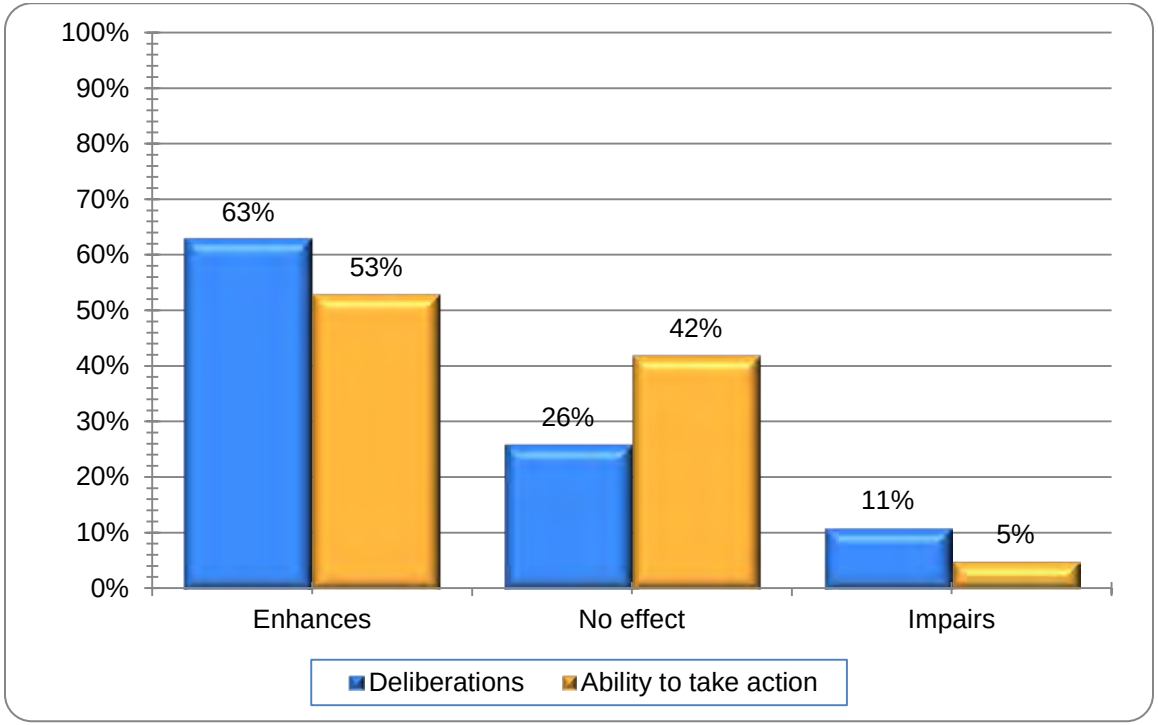
More than sufficient	**3**	**16%**
Sufficient	**16**	**84%**
Insufficient	**0**	**0%**
Total Responses	**19**	



Council on Government Affairs Results

How does your council's current size affect its deliberations/ability to take action?

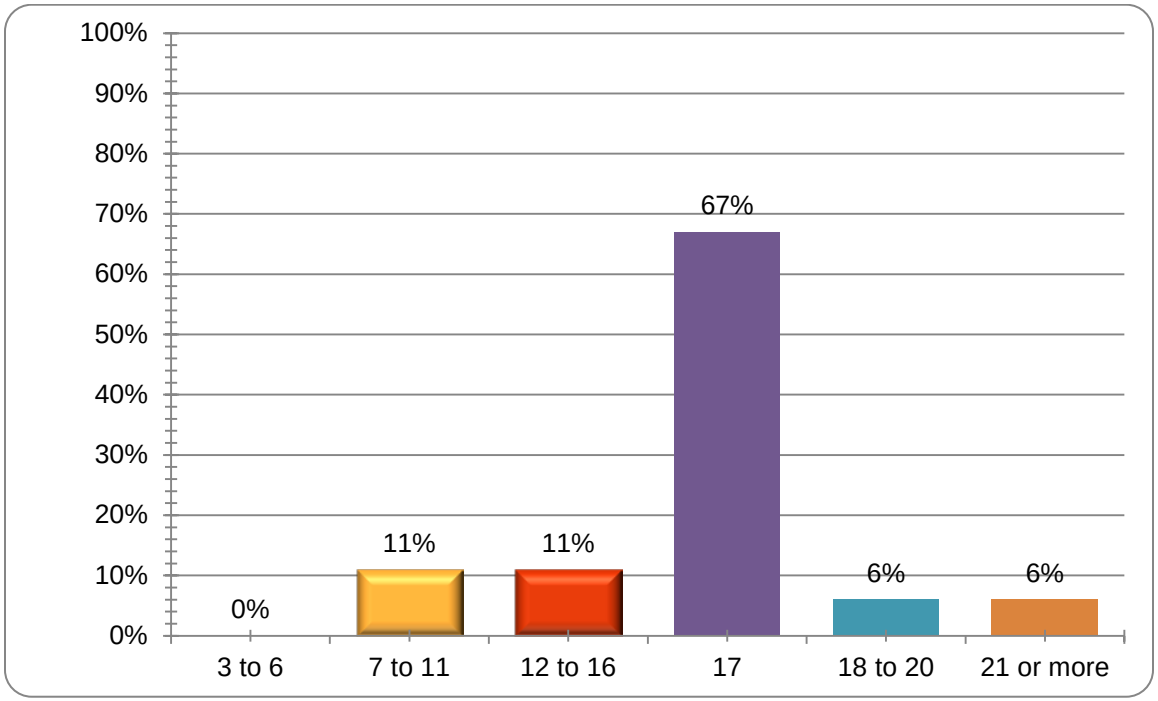
	Enhances	No effect	Impairs	**Total Responses**
Deliberations	12	5	2	**19**
	63%	26%	11%	
Ability to take action	10	8	1	**19**
	53%	42%	5%	
Total Responses	**22**	**13**	**3**	**38**



Council on Government Affairs Results

What do you think is the optimal number of members for the [council]?
Response Rate: **95% (N=18)** Question Type: **Choose one** Tag: **Q6**

3 to 6	**0**	**0%**
7 to 11	**2**	**11%**
12 to 16	**2**	**11%**
17	**12**	**67%**
18 to 20	**1**	**6%**
21 or more	**1**	**6%**
Total Responses	**18**	

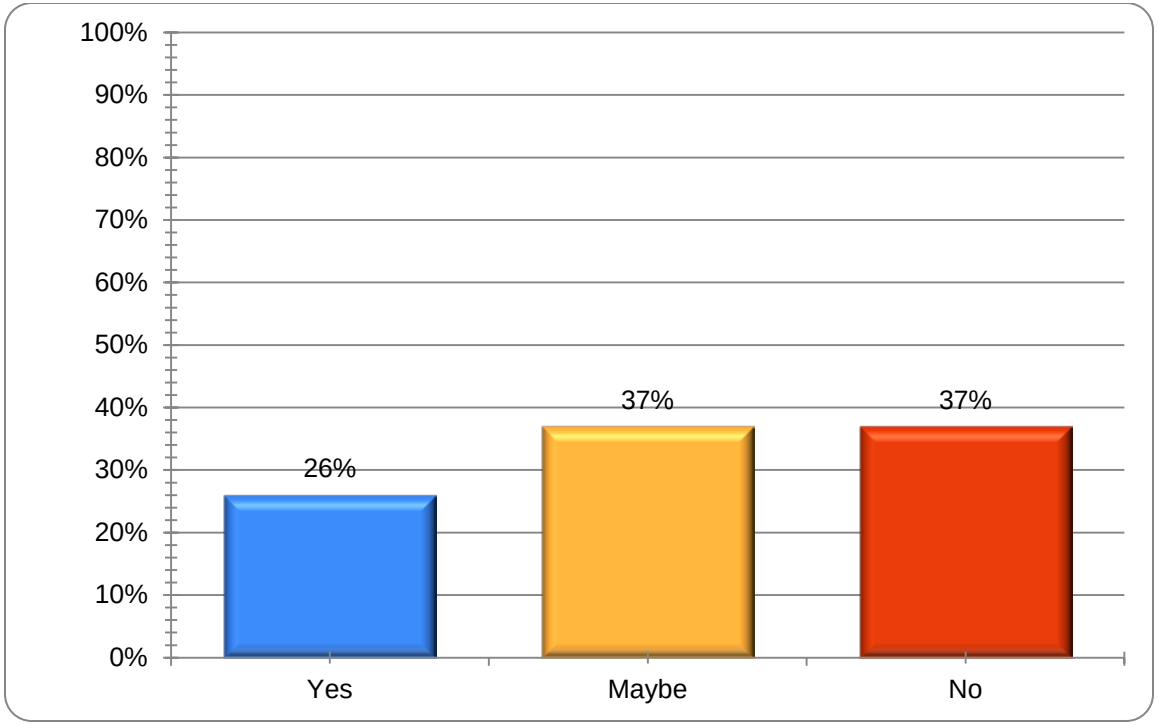


Council on Government Affairs Results

In the event that a smaller number of members were required for the [council], would rotating the open seats yearly among the 17 districts be an appropriate way of selecting members?

Response Rate: **100% (N=19)** Question Type: **Choose one** Tag: **Q7**

Yes	**5**	**26%**
Maybe	**7**	**37%**
No	**7**	**37%**
Total Responses	**19**	

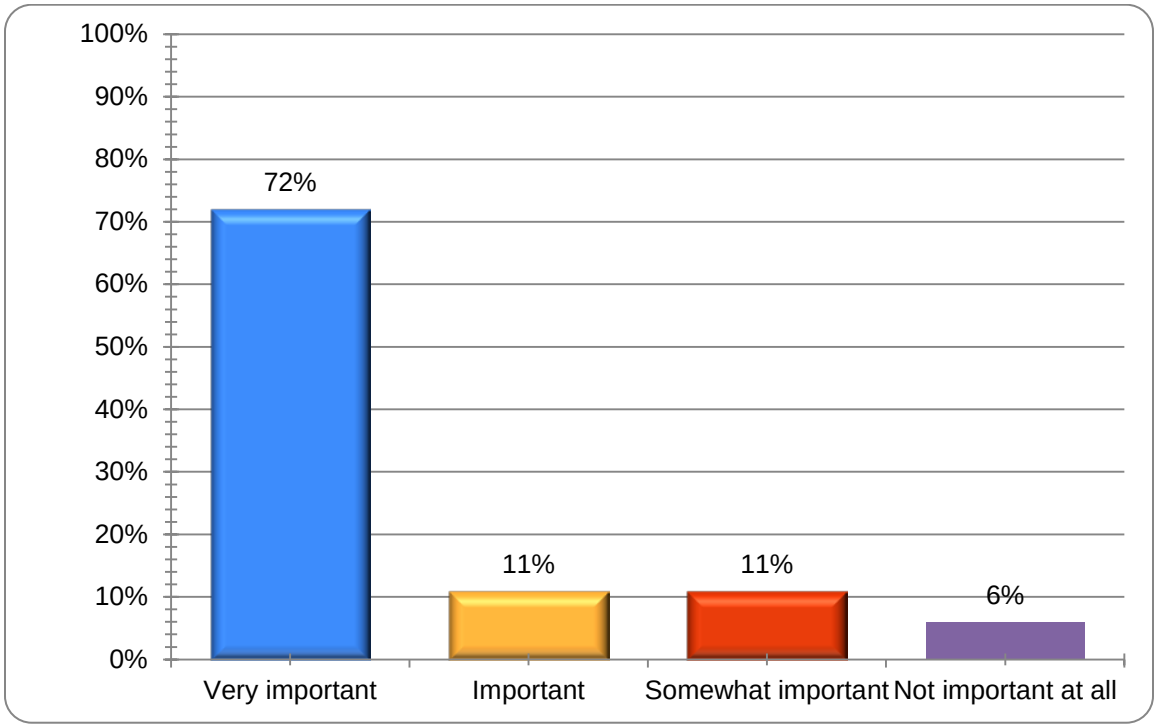


Council on Government Affairs Results

How important is geographic representation for the [council]?

Response Rate: **95% (N=18)** Question Type: **Choose one** Tag: **Q10**

Very important	**13**	**72%**
Important	**2**	**11%**
Somewhat important	**2**	**11%**
Not important at all	**1**	**6%**
Total Responses	**18**	

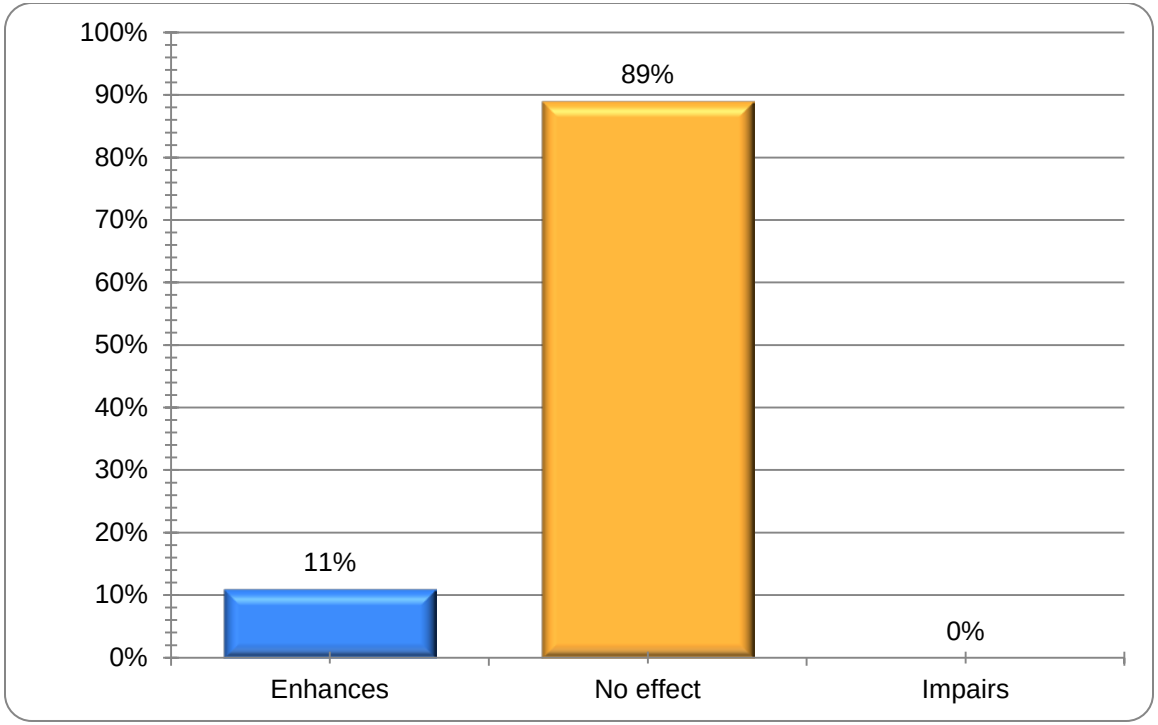


Council on Government Affairs Results

The [council] currently reports to the ADA House of Delegates. How does this reporting structure affect its ability to work with the ADA Board of Trustees?

Response Rate: **100% (N=19)** Question Type: **Choose one** Tag: **Q11**

Enhances	**2**	**11%**
No effect	**17**	**89%**
Impairs	**0**	**0%**
Total Responses	**19**	

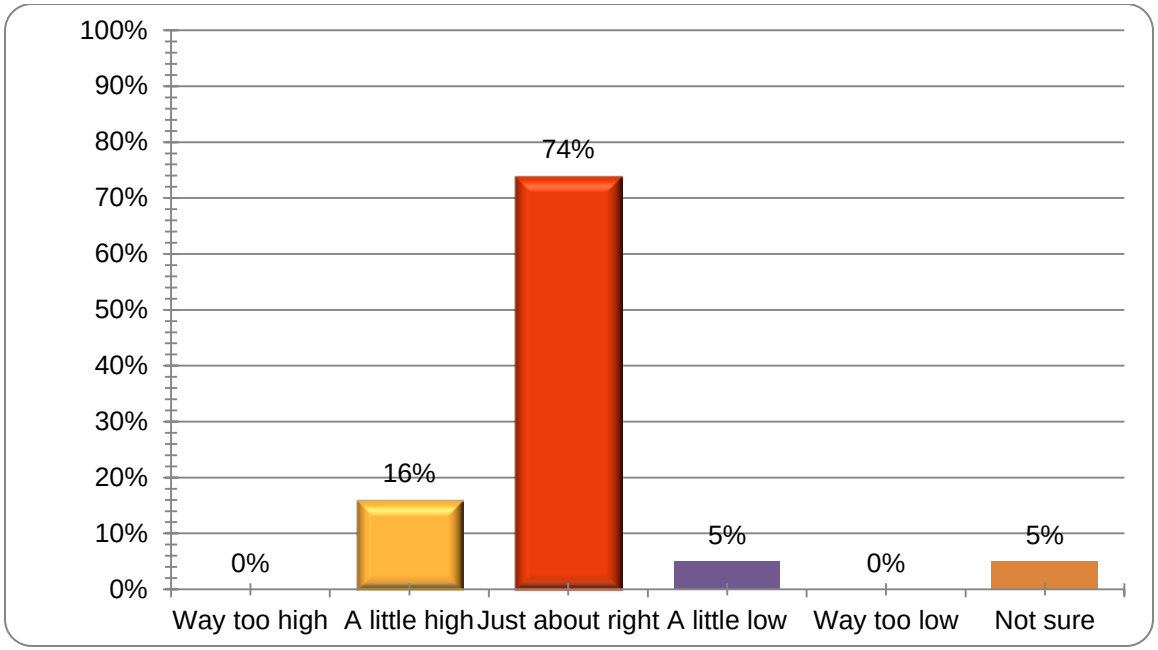


Council on Government Affairs Results

Please select the statement below that best describes the workload of the [council] (currently, or while you served on the council if you are no longer a member).

Response Rate: **100% (N=19)** Question Type: **Choose one** Tag: **Q12**

Way too high	**0**	**0%**
A little high	**3**	**16%**
Just about right	**14**	**74%**
A little low	**1**	**5%**
Way too low	**0**	**0%**
Not sure	**1**	**5%**
Total Responses	**19**	

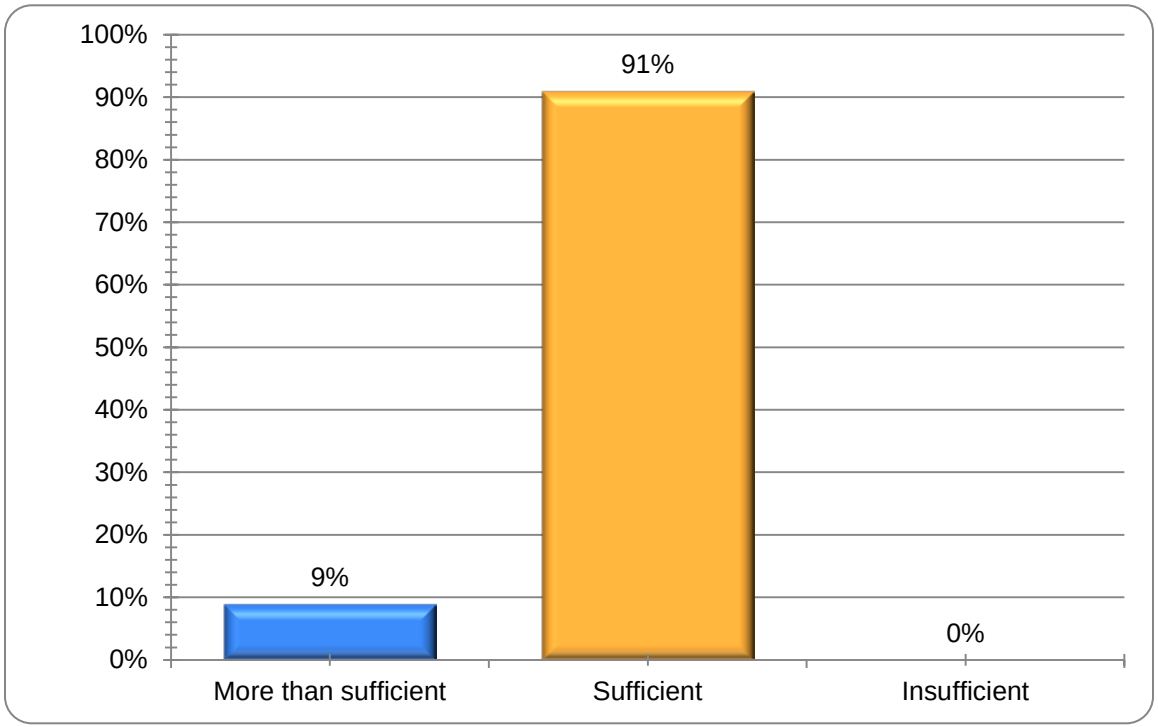


Council on Membership Results

Council on Membership Results

In your opinion, how sufficient is the current number of members on the [council]?
Response Rate: **100% (N=23)** Question Type: **Choose one** Tag: **Q1**

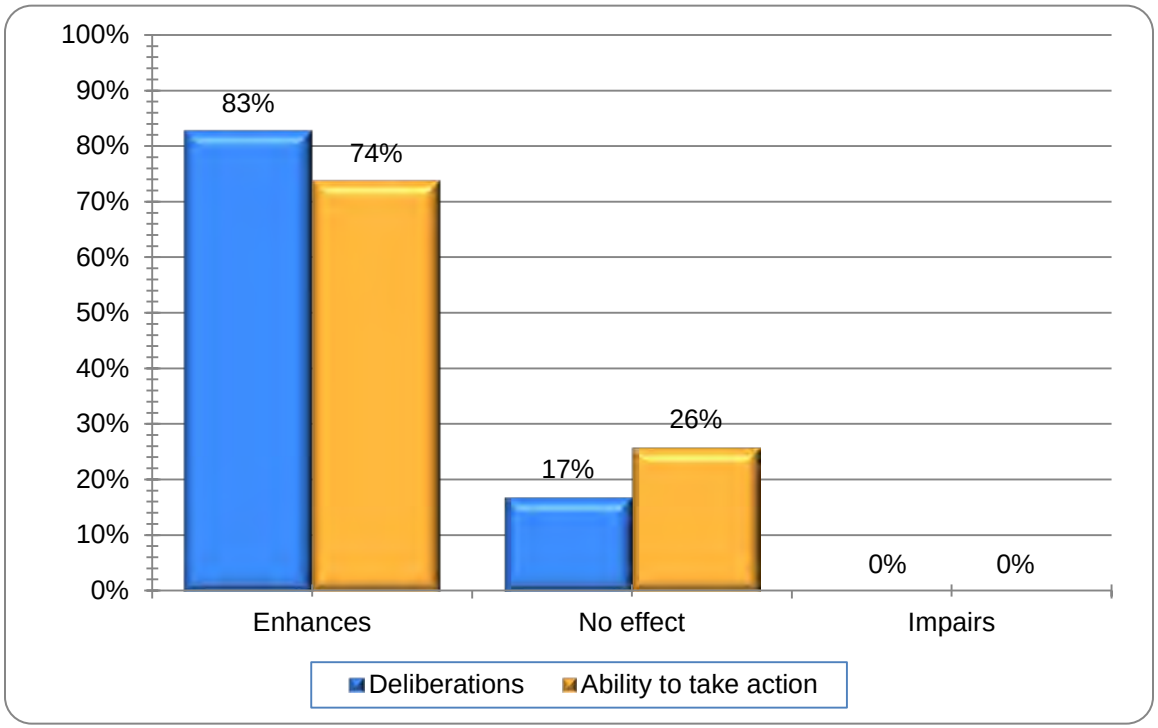
More than sufficient	**2**	**9%**
Sufficient	**21**	**91%**
Insufficient	**0**	**0%**
Total Responses	**23**	



Council on Membership Results

How does your council's current size affect its deliberations/ability to take action?

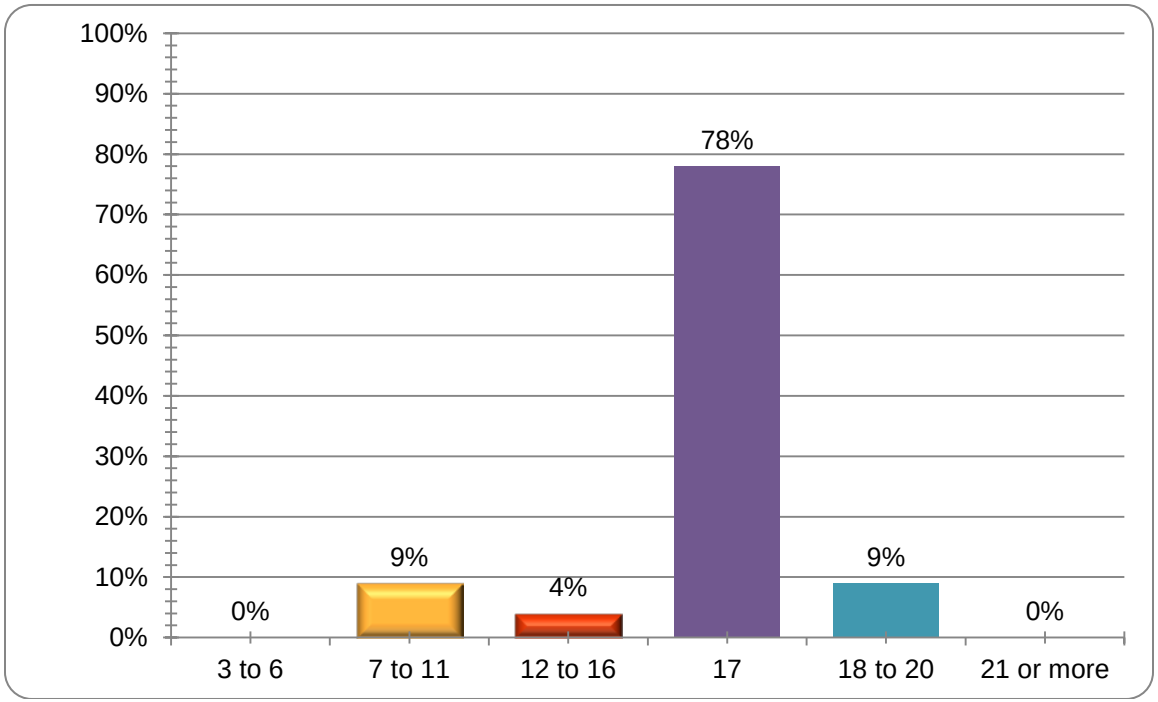
	Enhances	No effect	Impairs	**Total Responses**
Deliberations	19	4	0	**23**
	83%	17%	0%	
Ability to take action	17	6	0	**23**
	74%	26%	0%	
Total Responses	**36**	**10**	**0**	**46**



Council on Membership Results

What do you think is the optimal number of members for the [council]?
Response Rate: **100% (N=23)** Question Type: **Choose one** Tag: **Q6**

3 to 6	**0**	**0%**
7 to 11	**2**	**9%**
12 to 16	**1**	**4%**
17	**18**	**78%**
18 to 20	**2**	**9%**
21 or more	**0**	**0%**
Total Responses	**23**	

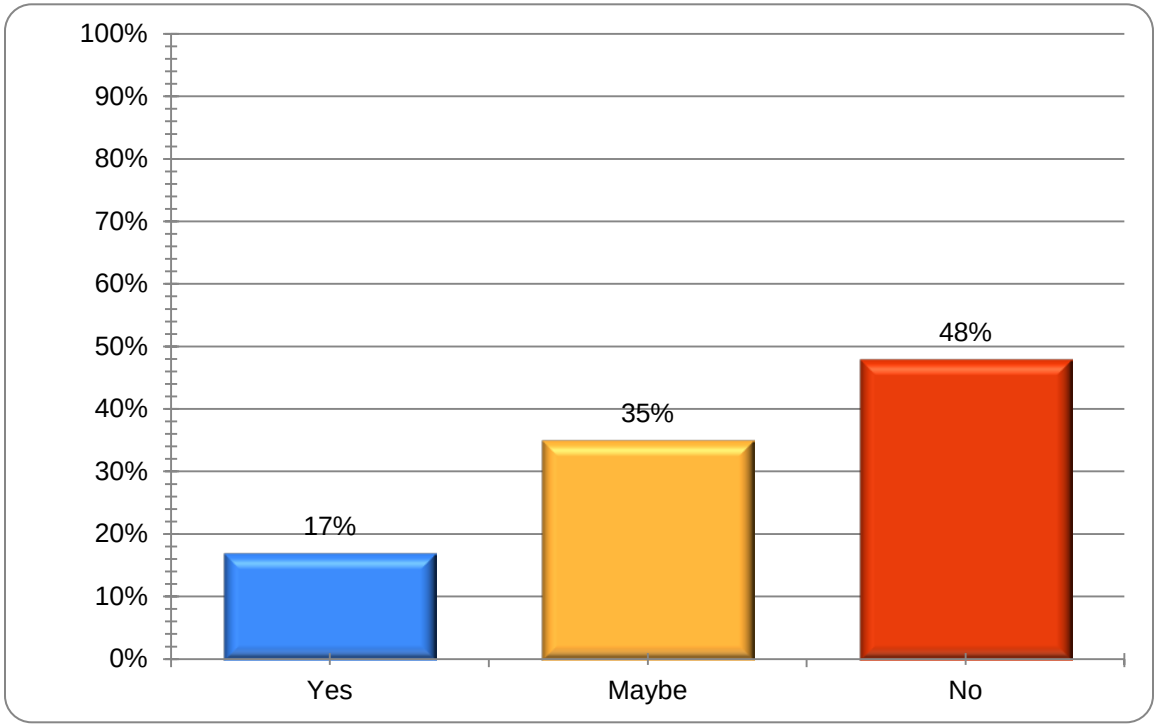


Council on Membership Results

In the event that a smaller number of members were required for the [council], would rotating the open seats yearly among the 17 districts be an appropriate way of selecting members?

Response Rate: **100% (N=23)** Question Type: **Choose one** Tag: **Q7**

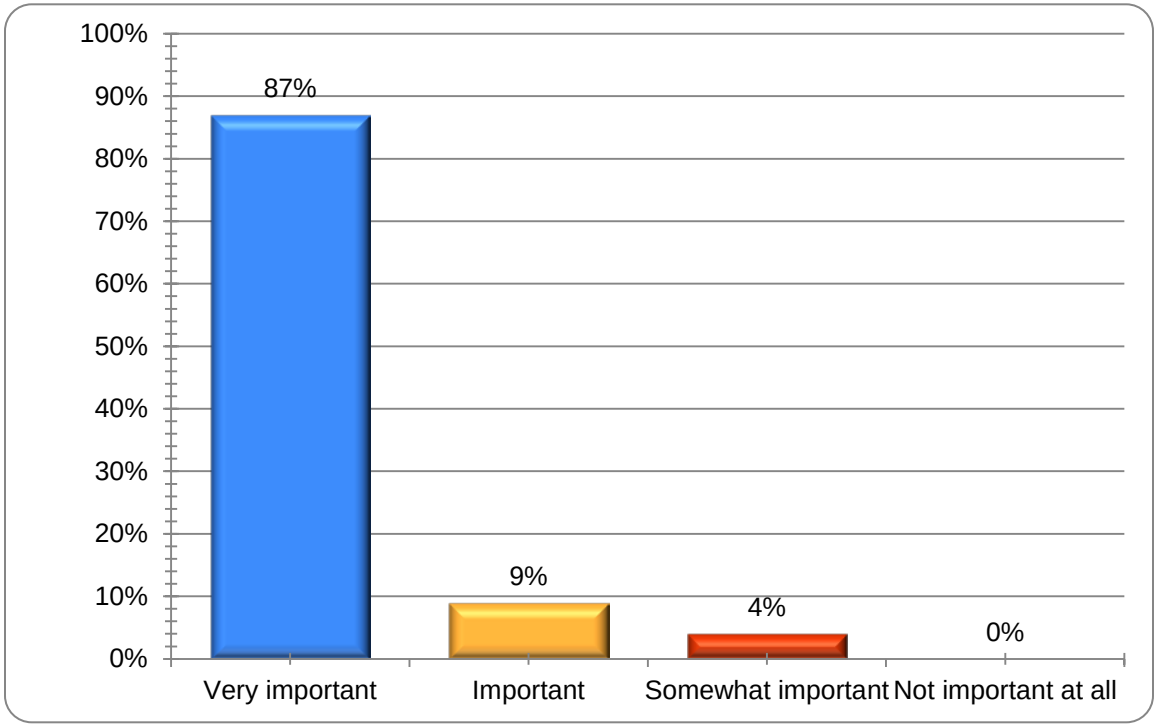
Yes	**4**	**17%**
Maybe	**8**	**35%**
No	**11**	**48%**
Total Responses	**23**	



Council on Membership Results

How important is geographic representation for the [council]?
Response Rate: **100% (N=23)** Question Type: **Choose one** Tag: **Q10**

Very important	**20**	**87%**
Important	**2**	**9%**
Somewhat important	**1**	**4%**
Not important at all	**0**	**0%**
Total Responses	**23**	

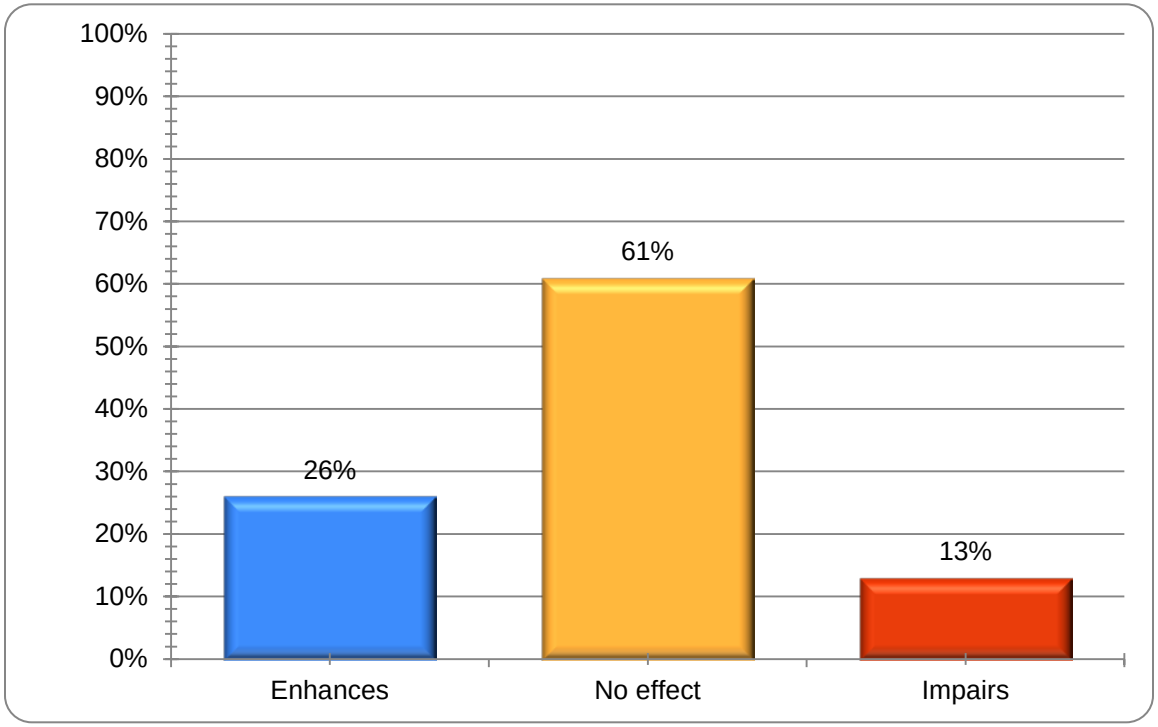


Council on Membership Results

The [council] currently reports to the ADA House of Delegates. How does this reporting structure affect its ability to work with the ADA Board of Trustees?

Response Rate: **100% (N=23)** Question Type: **Choose one** Tag: **Q11**

Enhances	**6**	**26%**
No effect	**14**	**61%**
Impairs	**3**	**13%**
Total Responses	**23**	

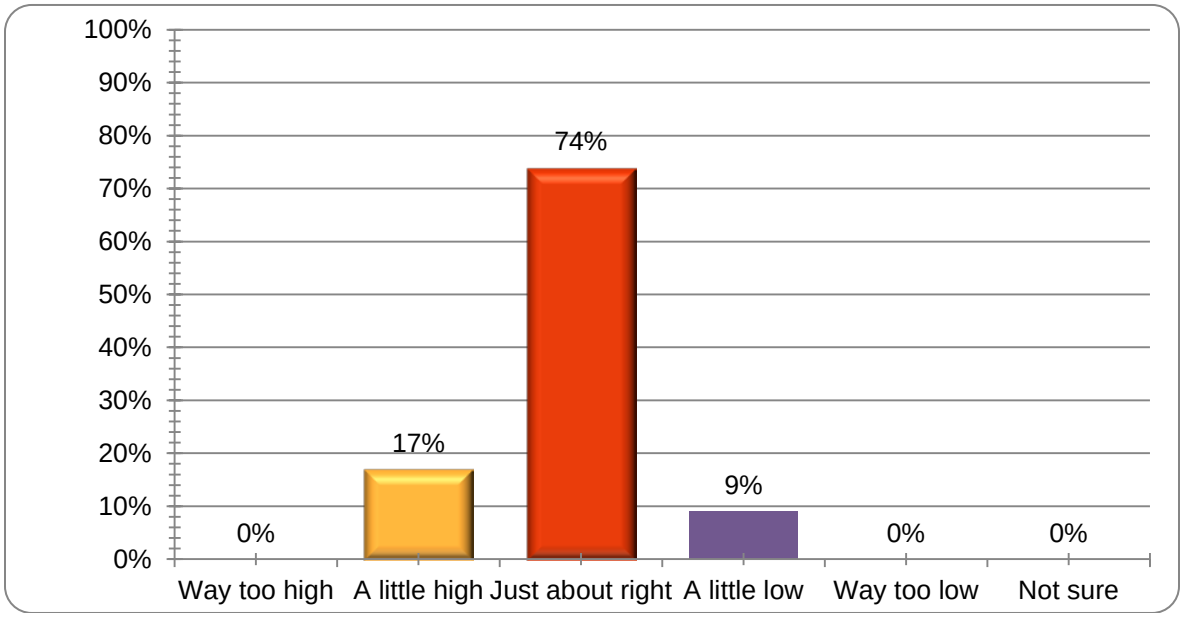


Council on Membership Results

Please select the statement below that best describes the workload of the [council] (currently, or while you served on the council if you are no longer a member).

Response Rate: **100% (N=23)** Question Type: **Choose one** Tag: **Q12**

Way too high	**0**	**0%**
A little high	**4**	**17%**
Just about right	**17**	**74%**
A little low	**2**	**9%**
Way too low	**0**	**0%**
Not sure	**0**	**0%**
Total Responses	**23**	

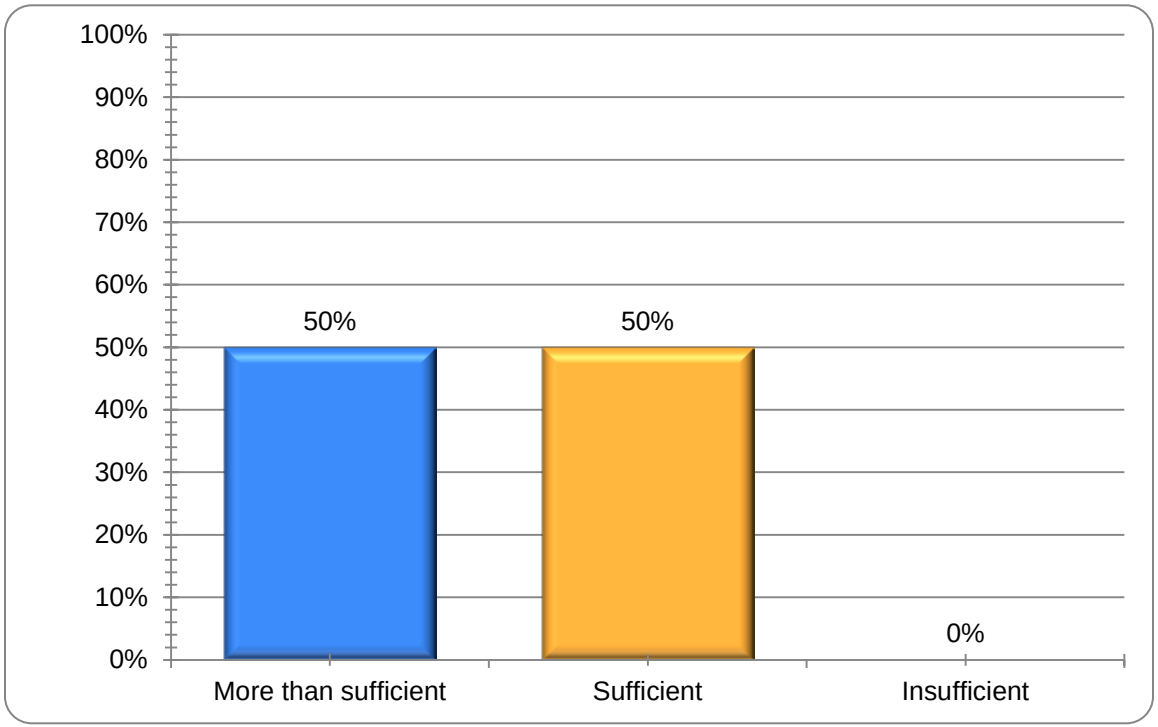


Council on Members Insurance and Retirement Programs Results

Council on Members Insurance and Retirement Programs Results

In your opinion, how sufficient is the current number of members on the [council]?
Response Rate: **100% (N=20)** Question Type: **Choose one** Tag: **Q1**

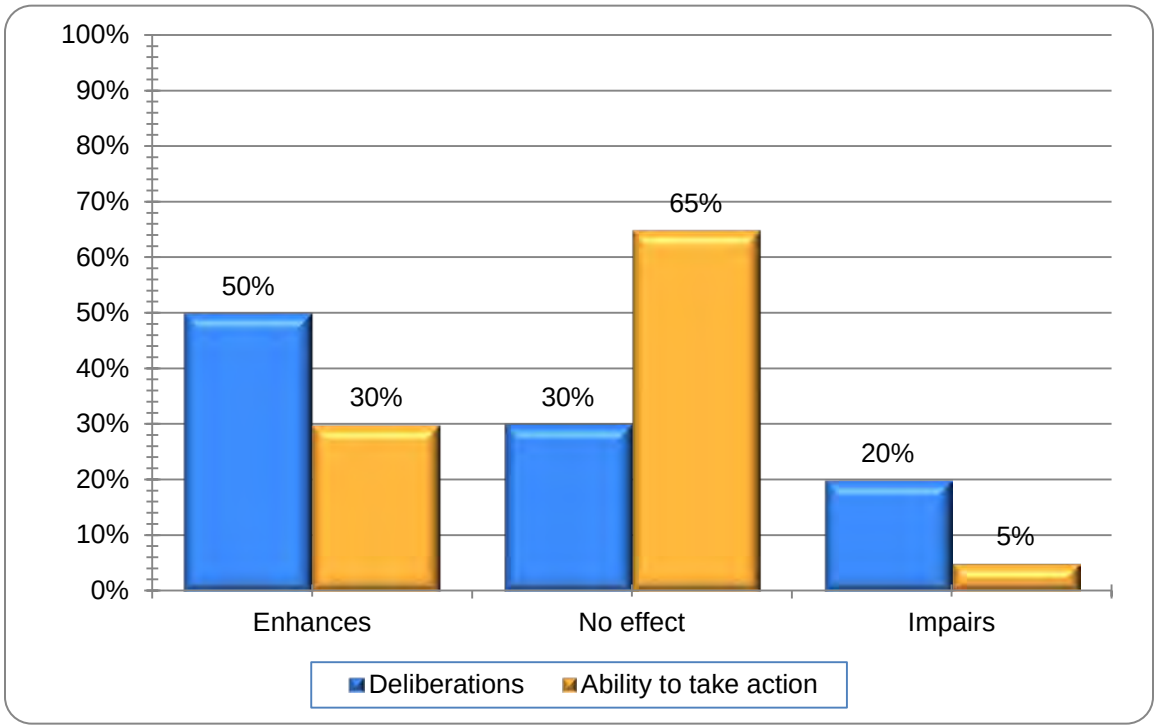
More than sufficient	**10**	**50%**
Sufficient	**10**	**50%**
Insufficient	**0**	**0%**
Total Responses	**20**	



Council on Members Insurance and Retirement Programs Results

How does your council's current size affect its deliberations/ability to take action?

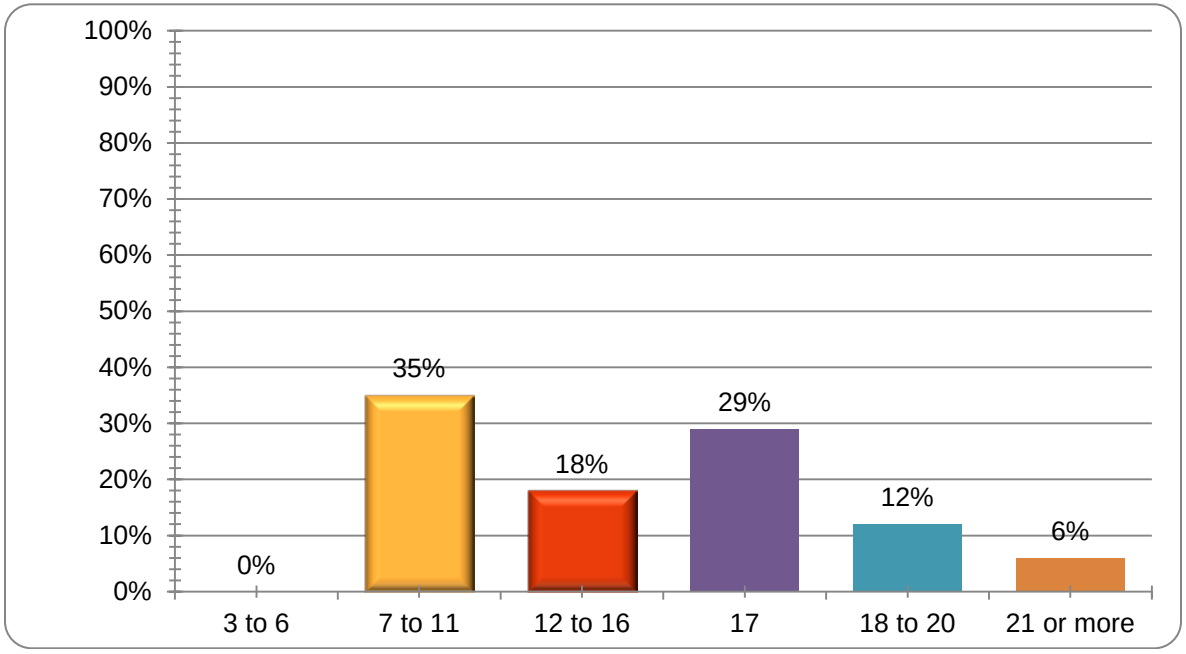
	Enhances	No effect	Impairs	**Total Responses**
Deliberations	10	6	4	**20**
	50%	30%	20%	
Ability to take action	6	13	1	**20**
	30%	65%	5%	
Total Responses	**16**	**19**	**5**	**40**



Council on Members Insurance and Retirement Programs Results

What do you think is the optimal number of members for the [council]?
Response Rate: **85% (N=17)** Question Type: **Choose one** Tag: **Q6**

3 to 6	**0**	**0%**
7 to 11	**6**	**35%**
12 to 16	**3**	**18%**
17	**5**	**29%**
18 to 20	**2**	**12%**
21 or more	**1**	**6%**
Total Responses	**17**	

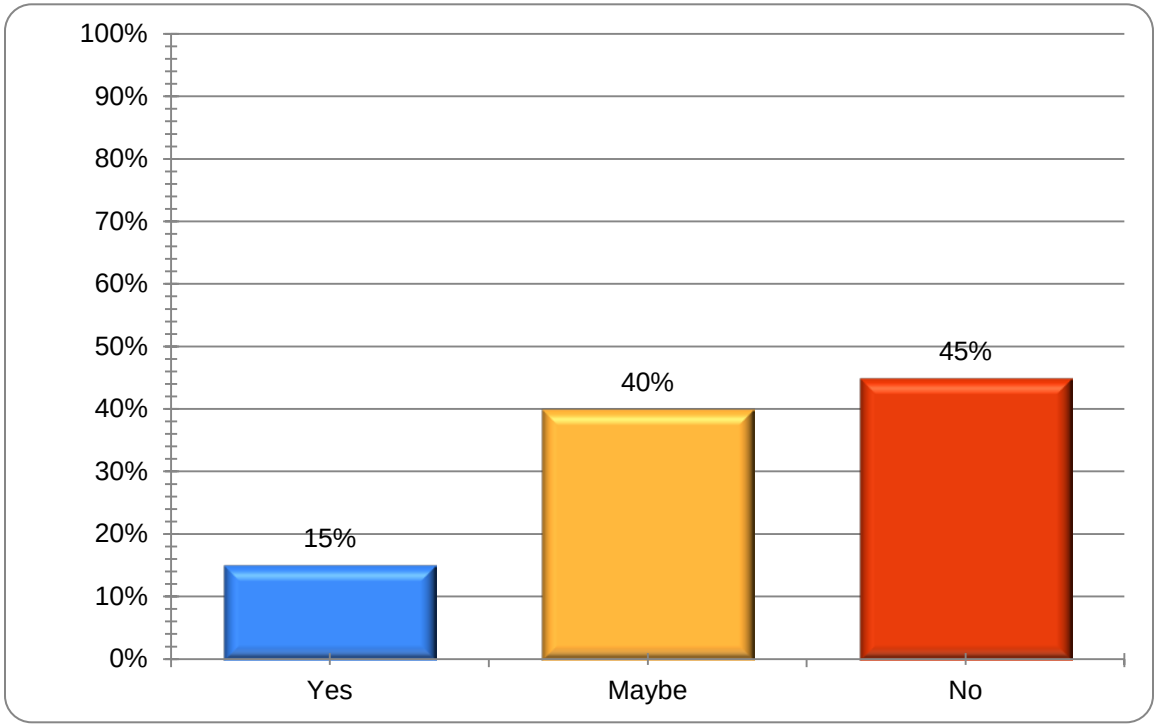


Council on Members Insurance and Retirement Programs Results

In the event that a smaller number of members were required for the [council], would rotating the open seats yearly among the 17 districts be an appropriate way of selecting members?

Response Rate: **100% (N=20)** Question Type: **Choose one** Tag: **Q7**

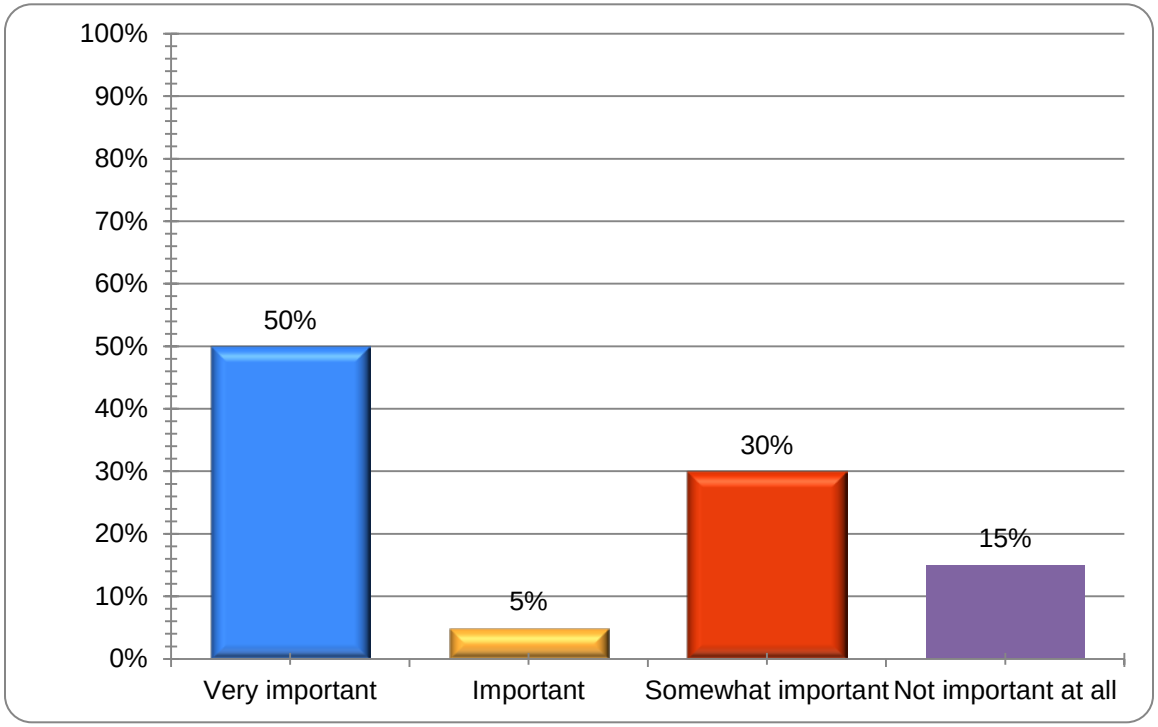
Yes	**3**	**15%**
Maybe	**8**	**40%**
No	**9**	**45%**
Total Responses	**20**	



Council on Members Insurance and Retirement Programs Results

How important is geographic representation for the [council]?
Response Rate: **100% (N=20)** Question Type: **Choose one** Tag: **Q10**

Very important	**10**	**50%**
Important	**1**	**5%**
Somewhat important	**6**	**30%**
Not important at all	**3**	**15%**
Total Responses	**20**	

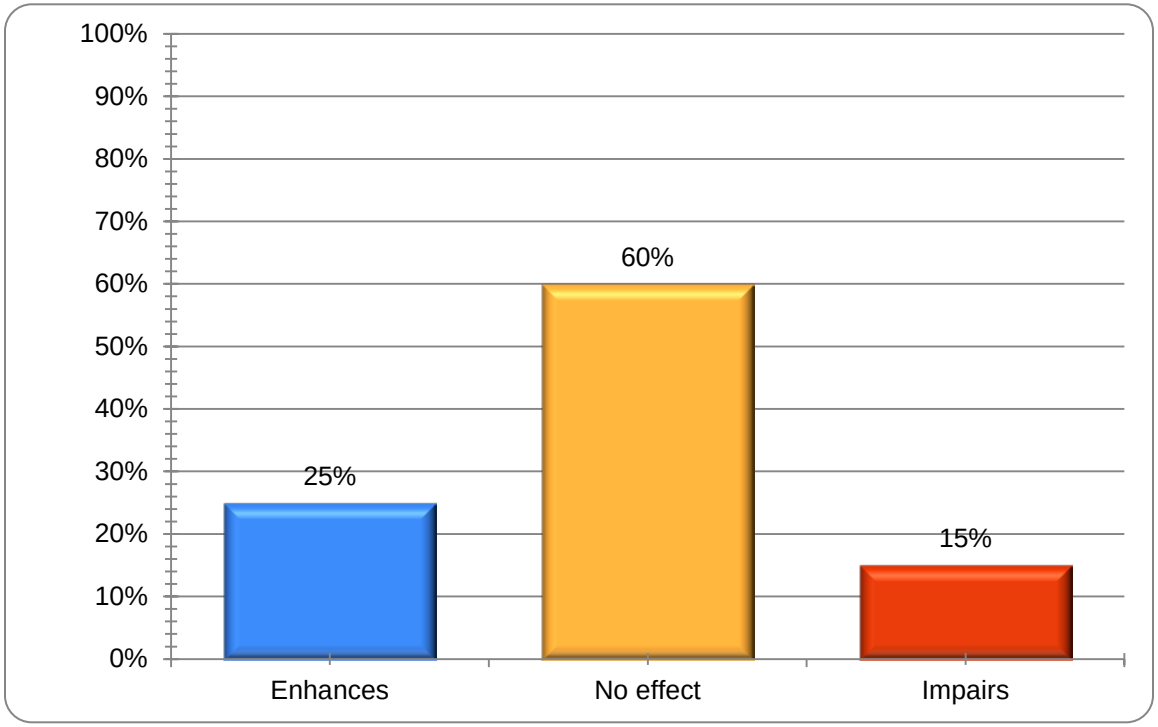


Council on Members Insurance and Retirement Programs Results

The [council] currently reports to the ADA House of Delegates. How does this reporting structure affect its ability to work with the ADA Board of Trustees?

Response Rate: **100% (N=20)** Question Type: **Choose one** Tag: **Q11**

Enhances	**5**	**25%**
No effect	**12**	**60%**
Impairs	**3**	**15%**
Total Responses	**20**	

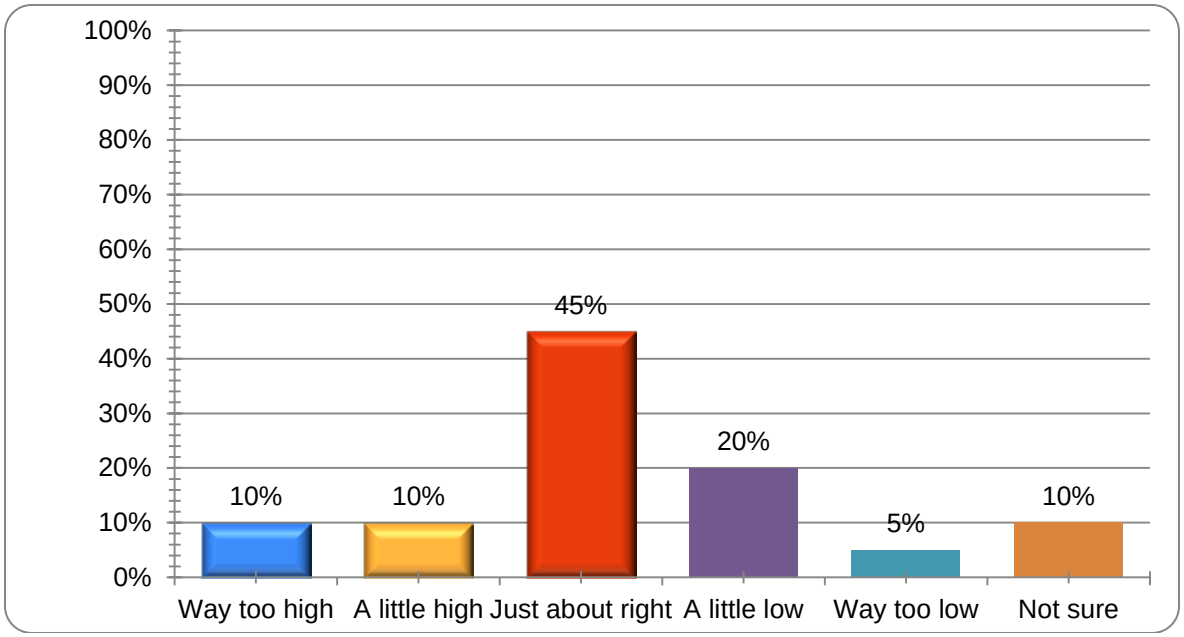


Council on Members Insurance and Retirement Programs Results

Please select the statement below that best describes the workload of the [council] (currently, or while you served on the council if you are no longer a member).

Response Rate: **100% (N=20)** Question Type: **Choose one** Tag: **Q12**

Way too high	**2**	**10%**
A little high	**2**	**10%**
Just about right	**9**	**45%**
A little low	**4**	**20%**
Way too low	**1**	**5%**
Not sure	**2**	**10%**
Total Responses	**20**	

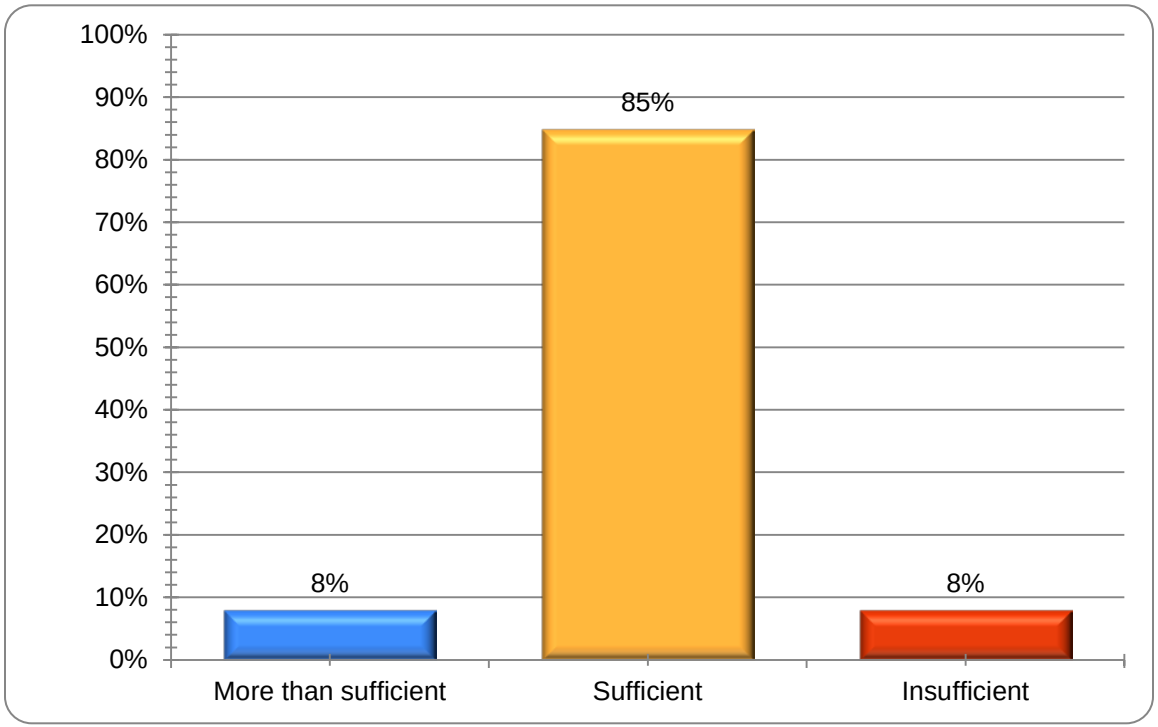


Council on Scientific Affairs Results

Council on Scientific Affairs Results

In your opinion, how sufficient is the current number of members on the [council]?
Response Rate: **100% (N=13)** Question Type: **Choose one** Tag: **Q1**

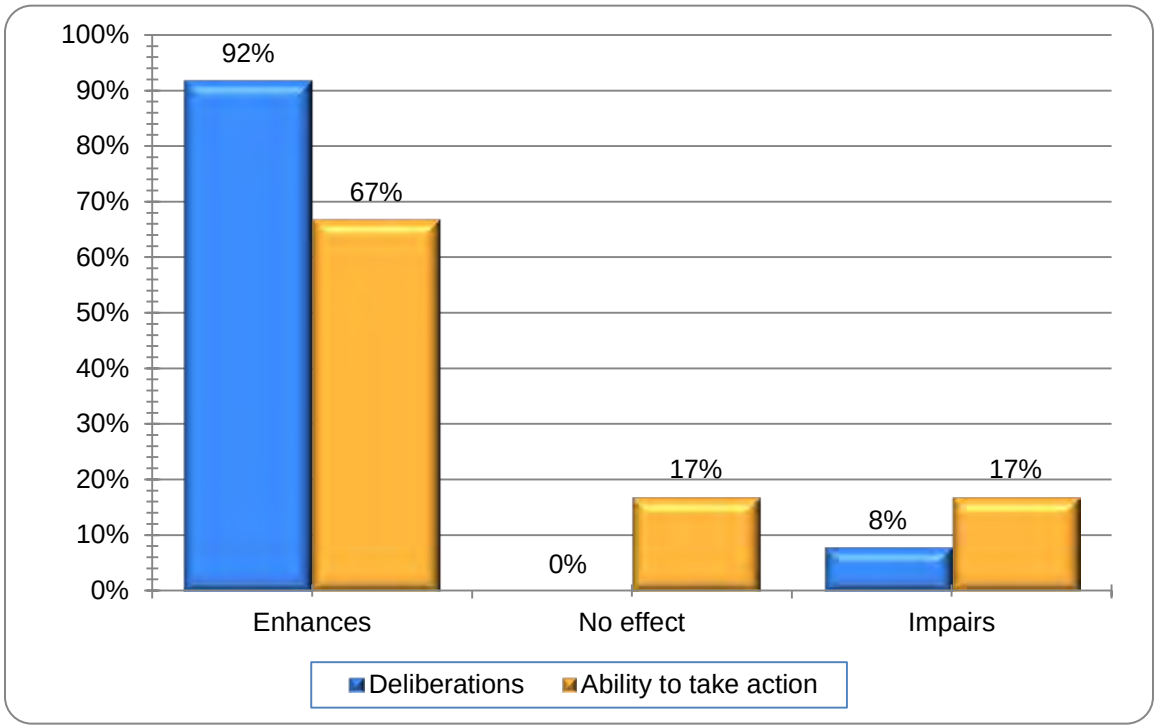
More than sufficient	**1**	**8%**
Sufficient	**11**	**85%**
Insufficient	**1**	**8%**
Total Responses	**13**	



Council on Scientific Affairs Results

How does your council's current size affect its deliberations/ability to take action?

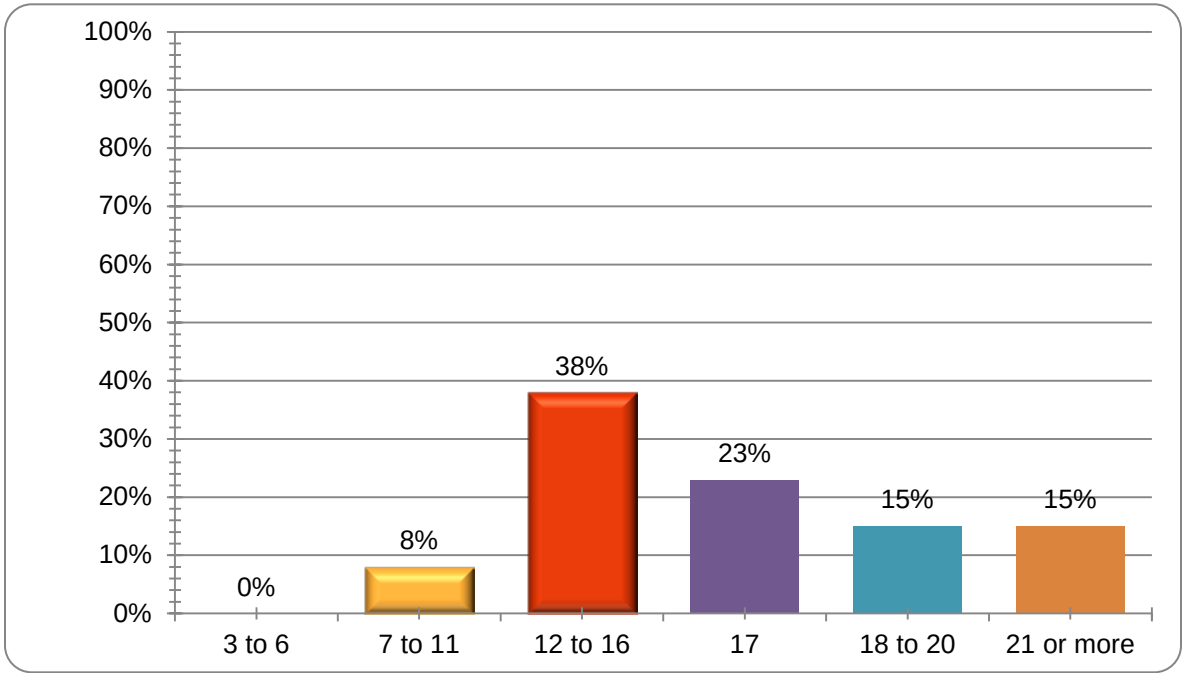
	Enhances	No effect	Impairs	**Total Responses**
Deliberations	12	0	1	**13**
	92%	0%	8%	
Ability to take action	8	2	2	**12**
	67%	17%	17%	
Total Responses	**20**	**2**	**3**	**25**



Council on Scientific Affairs Results

What do you think is the optimal number of members for the [council]?
Response Rate: **100% (N=13)** Question Type: **Choose one** Tag: **Q6**

3 to 6	**0**	**0%**
7 to 11	**1**	**8%**
12 to 16	**5**	**38%**
17	**3**	**23%**
18 to 20	**2**	**15%**
21 or more	**2**	**15%**
Total Responses	**13**	

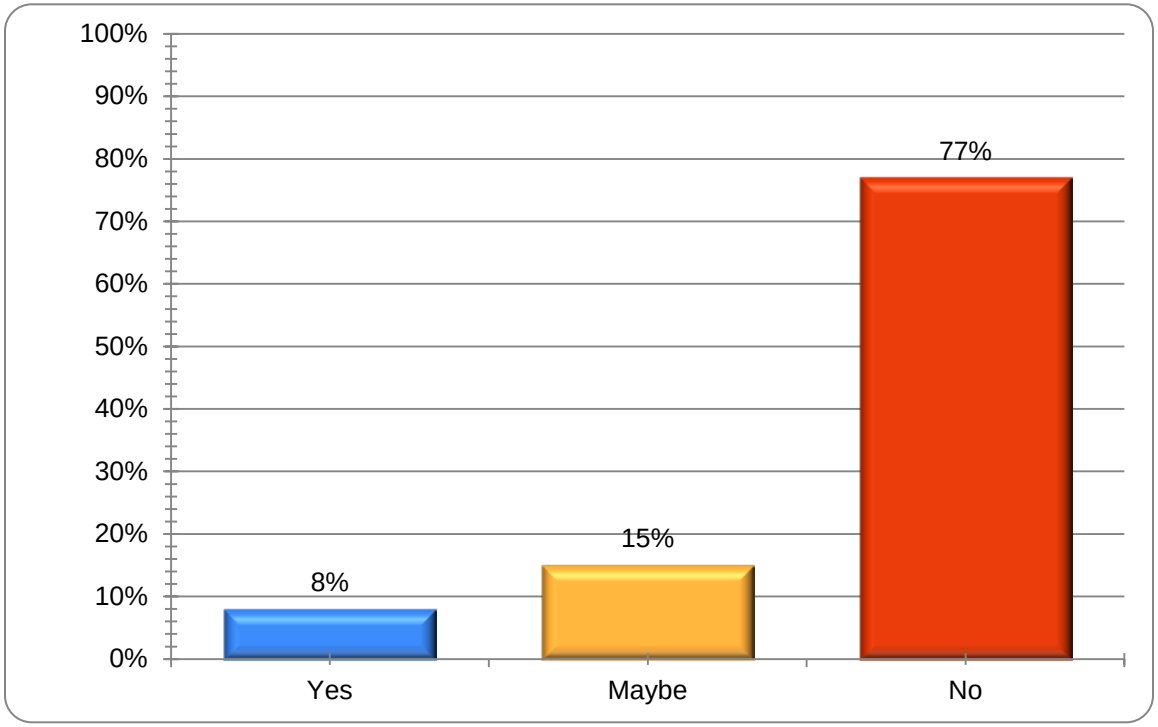


Council on Scientific Affairs Results

In the event that a smaller number of members were required for the [council], would rotating the open seats yearly among the 17 districts be an appropriate way of selecting members?

Response Rate: **100% (N=13)** Question Type: **Choose one** Tag: **Q7**

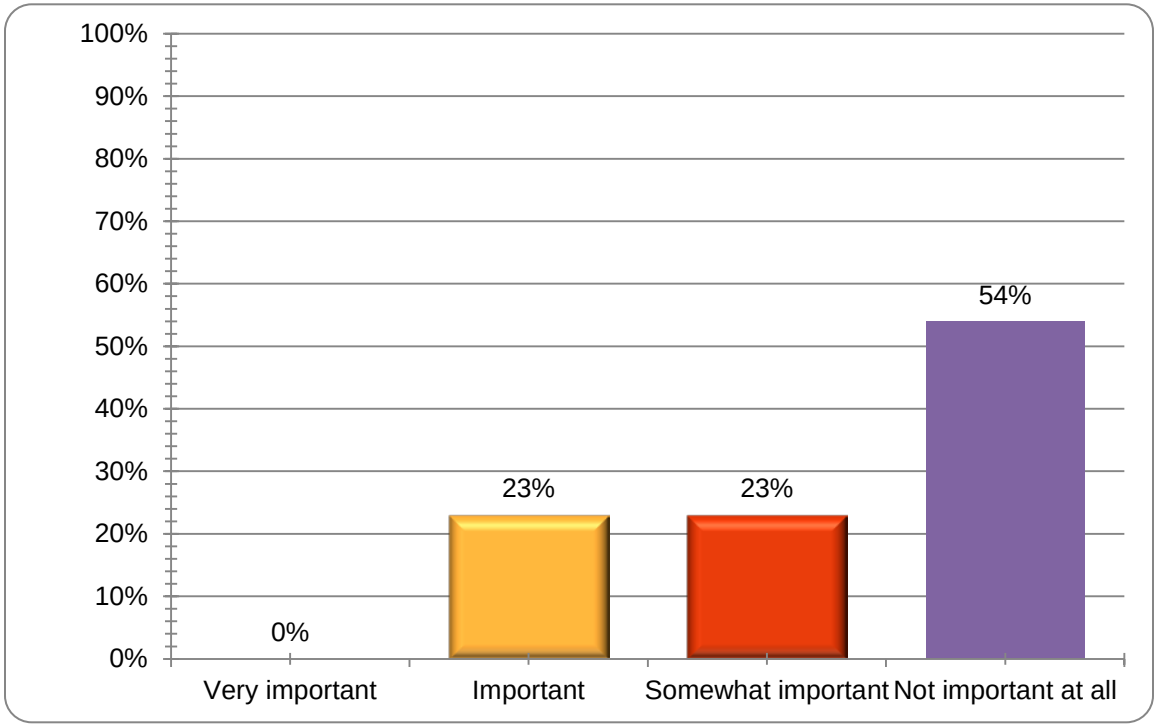
Yes	**1**	**8%**
Maybe	**2**	**15%**
No	**10**	**77%**
Total Responses	**13**	



Council on Scientific Affairs Results

How important is geographic representation for the [council]?
Response Rate: **100% (N=13)** Question Type: **Choose one** Tag: **Q10**

Very important	**0**	**0%**
Important	**3**	**23%**
Somewhat important	**3**	**23%**
Not important at all	**7**	**54%**
Total Responses	**13**	

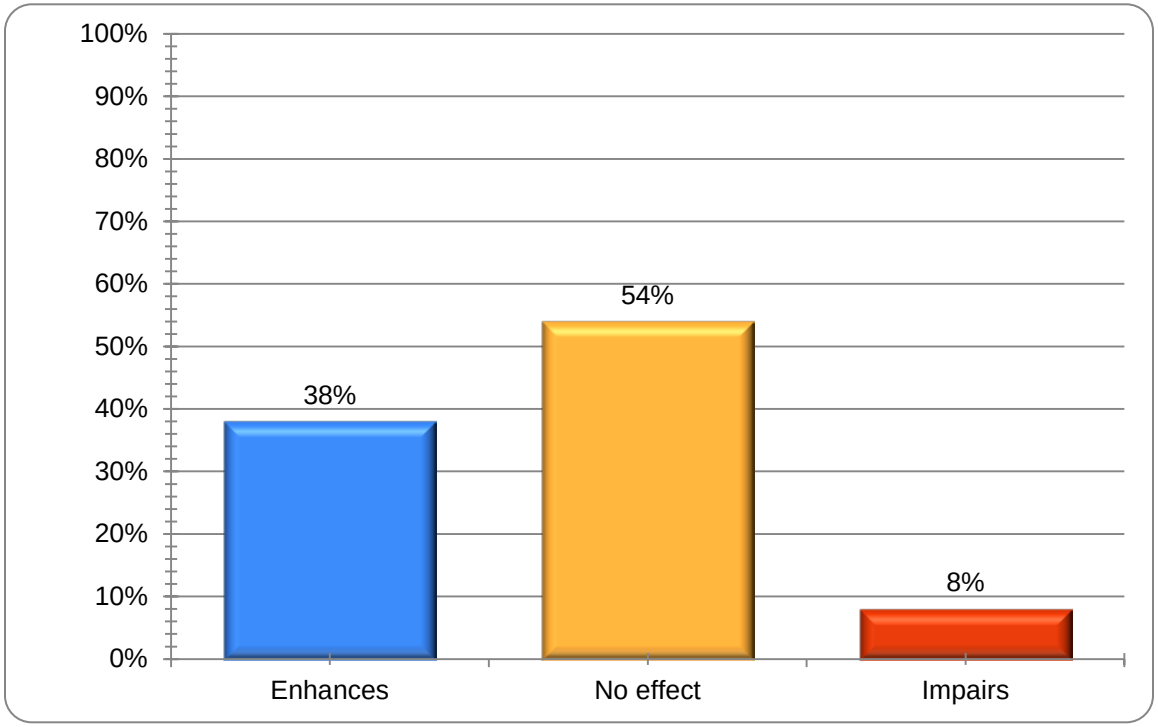


Council on Scientific Affairs Results

The [council] currently reports to the ADA House of Delegates. How does this reporting structure affect its ability to work with the ADA Board of Trustees?

Response Rate: **100% (N=13)** Question Type: **Choose one** Tag: **Q11**

Enhances	**5**	**38%**
No effect	**7**	**54%**
Impairs	**1**	**8%**
Total Responses	**13**	

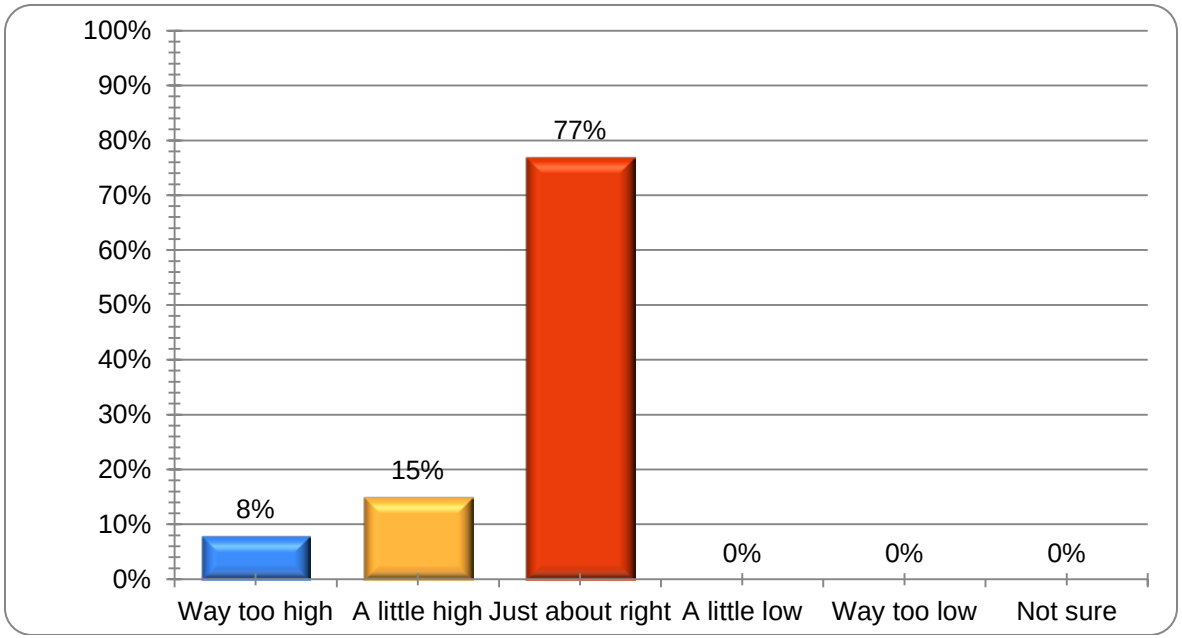


Council on Scientific Affairs Results

Please select the statement below that best describes the workload of the [council] (currently, or while you served on the council if you are no longer a member).

Response Rate: **100% (N=13)** Question Type: **Choose one** Tag: **Q12**

Way too high	**1**	**8%**
A little high	**2**	**15%**
Just about right	**10**	**77%**
A little low	**0**	**0%**
Way too low	**0**	**0%**
Not sure	**0**	**0%**
Total Responses	**13**	

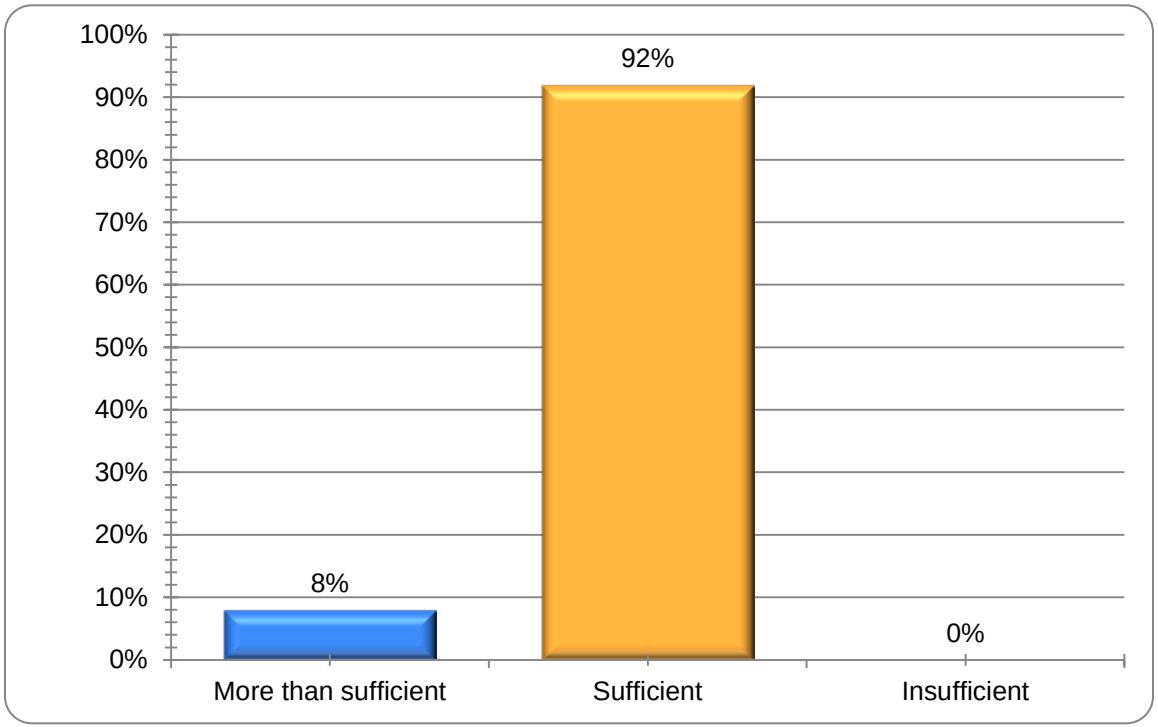


New Dentist Committee Results

New Dentist Committee Results

In your opinion, how sufficient is the current number of members on the [council]?
Response Rate: **100% (N=13)** Question Type: **Choose one** Tag: **Q1**

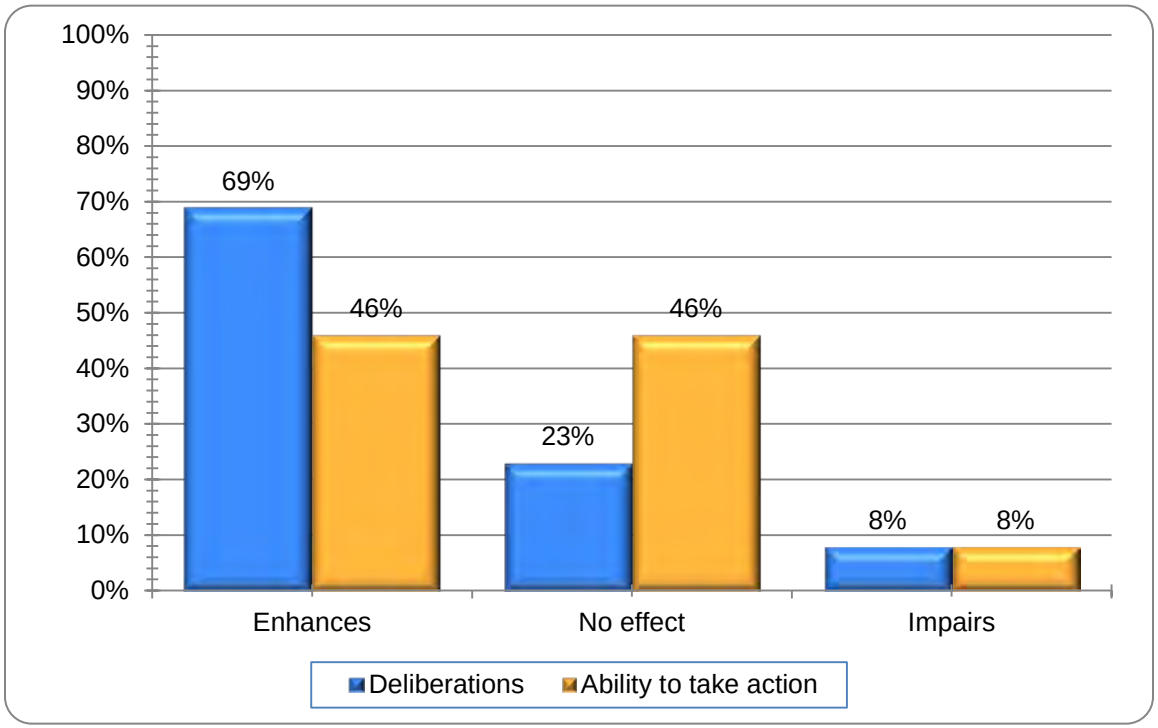
More than sufficient	**1**	**8%**
Sufficient	**12**	**92%**
Insufficient	**0**	**0%**
Total Responses	**13**	



New Dentist Committee Results

How does your council's current size affect its deliberations/ability to take action?

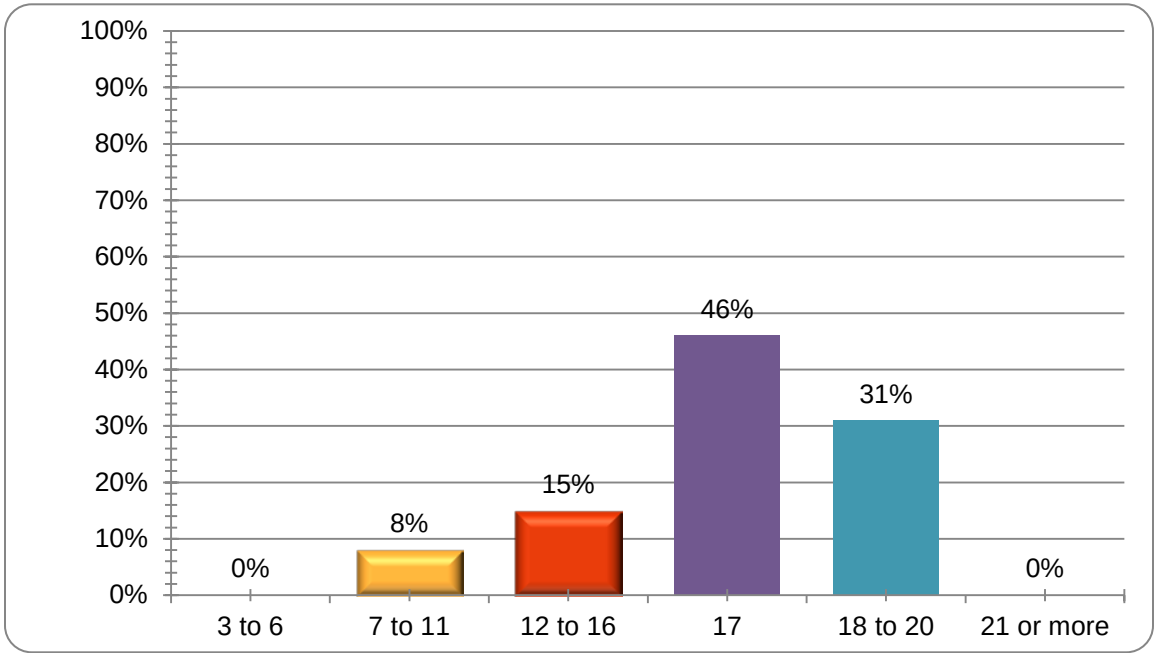
	Enhances	No effect	Impairs	**Total Responses**
Deliberations	9	3	1	**13**
	69%	23%	8%	
Ability to take action	6	6	1	**13**
	46%	46%	8%	
Total Responses	**15**	**9**	**2**	**26**



New Dentist Committee Results

What do you think is the optimal number of members for the [council]?
Response Rate: **100% (N=13)** Question Type: **Choose one** Tag: **Q6**

3 to 6	**0**	**0%**
7 to 11	**1**	**8%**
12 to 16	**2**	**15%**
17	**6**	**46%**
18 to 20	**4**	**31%**
21 or more	**0**	**0%**
Total Responses	**13**	

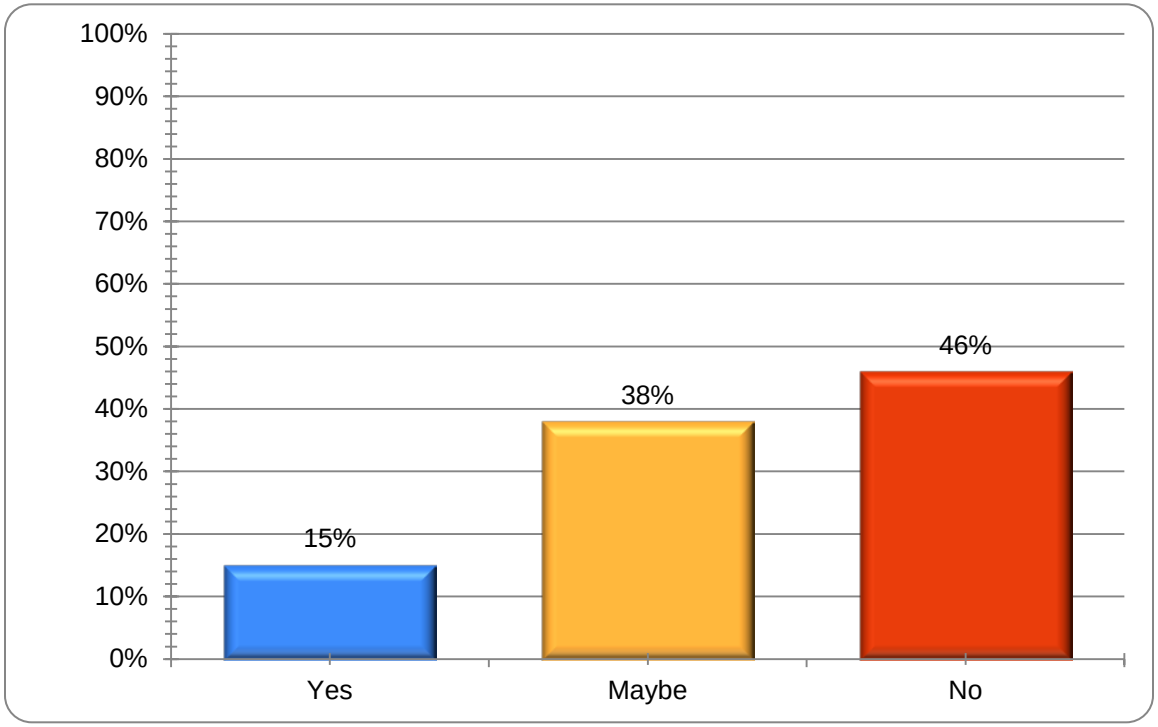


New Dentist Committee Results

In the event that a smaller number of members were required for the [council], would rotating the open seats yearly among the 17 districts be an appropriate way of selecting members?

Response Rate: **100% (N=13)** Question Type: **Choose one** Tag: **Q7**

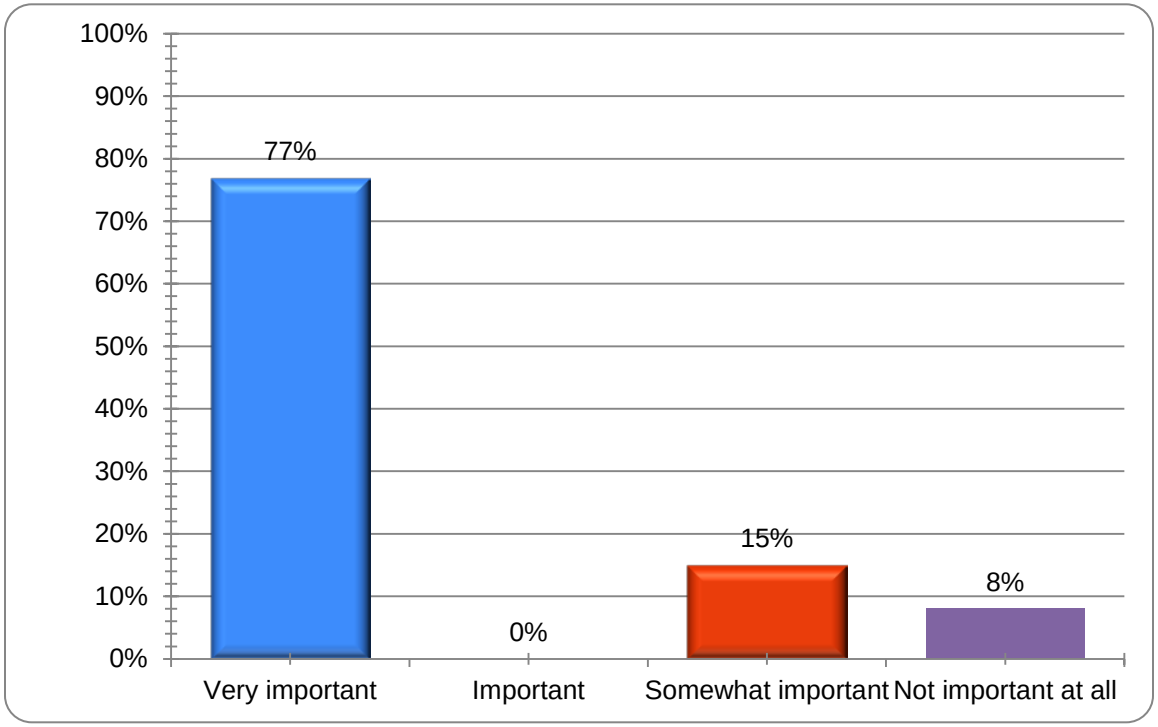
Yes	**2**	**15%**
Maybe	**5**	**38%**
No	**6**	**46%**
Total Responses	**13**	



New Dentist Committee Results

How important is geographic representation for the [council]?
Response Rate: **100% (N=13)** Question Type: **Choose one** Tag: **Q10**

Very important	**10**	**77%**
Important	**0**	**0%**
Somewhat important	**2**	**15%**
Not important at all	**1**	**8%**
Total Responses	**13**	

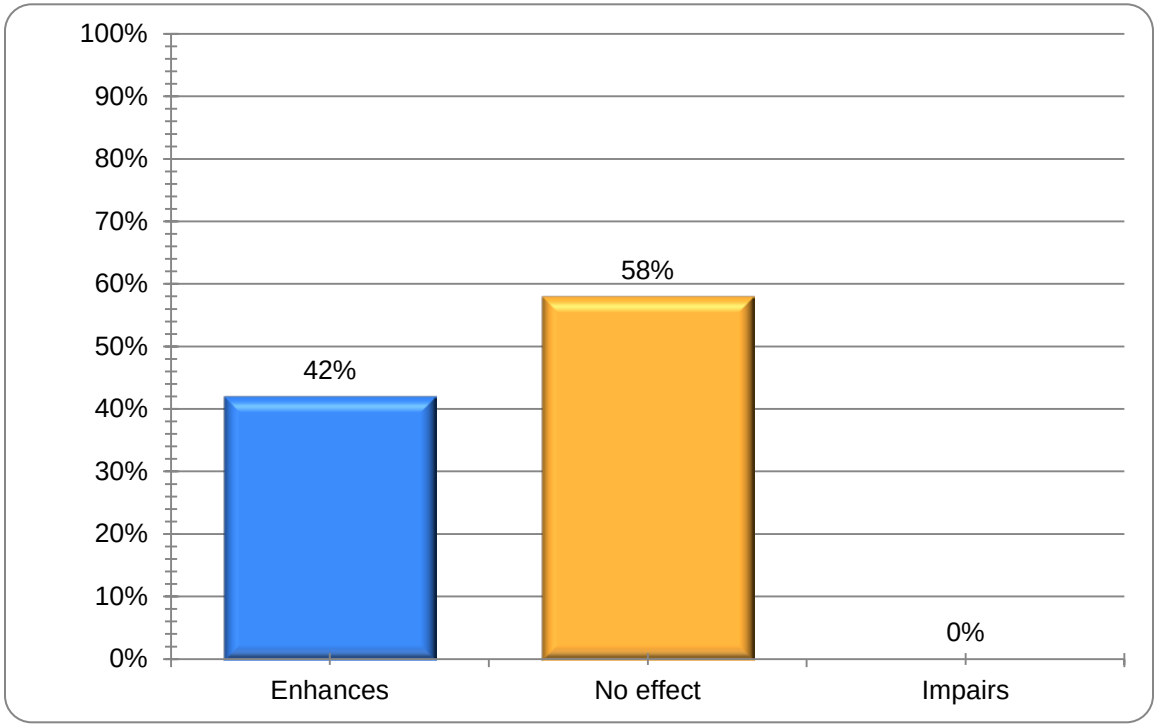


New Dentist Committee Results

The [council] currently reports to the ADA House of Delegates. How does this reporting structure affect its ability to work with the ADA Board of Trustees?

Response Rate: **92% (N=12)** Question Type: **Choose one** Tag: **Q11**

Enhances	**5**	**42%**
No effect	**7**	**58%**
Impairs	**0**	**0%**
Total Responses	**12**	

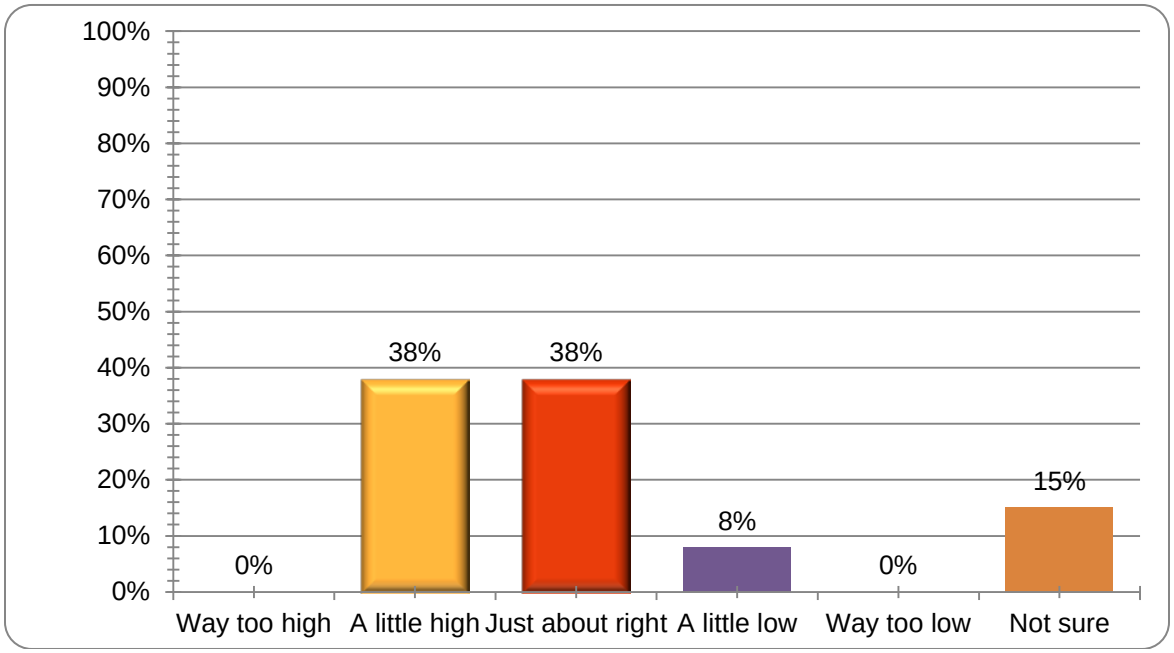


New Dentist Committee Results

Please select the statement below that best describes the workload of the [council] (currently, or while you served on the council if you are no longer a member).

Response Rate: **100% (N=13)** Question Type: **Choose one** Tag: **Q12**

Way too high	**0**	**0%**
A little high	**5**	**38%**
Just about right	**5**	**38%**
A little low	**1**	**8%**
Way too low	**0**	**0%**
Not sure	**2**	**15%**
Total Responses	**13**	



Resolution No. N/A N/A

Report: Board Report 4 Date Submitted: June 2013

Submitted By: Board of Trustees

Reference Committee: Legislative, Health, Governance and Related Matters

Total Net Financial Implication: None Net Dues Impact:

Amount One-time Amount On-going FTE 0

ADA Strategic Plan Goal: Members (Required)

REPORT 4 OF THE BOARD OF TRUSTEES TO THE HOUSE OF DELEGATES: RE-EXAMINATION OF CERTAIN SUGGESTIONS FROM WESTMAN GOVERNANCE STUDY

Background: In 2012 the House of Delegates referred Resolution 177 which states:

> **Resolved,** that suggestions 29 (Sunset the Council on Communications) and 31 (Sunset the Council on Membership) contained in the Governance Study submitted by Westman and Associates be reexamined by the Board of Trustees, and be it further
>
> **Resolved,** that the Board of Trustees report on the results of that reexamination to the 2013 House of Delegates, including a detailed explanation of the rationale for maintaining the Council on Membership and/or the Council on Communications if that is the conclusion reached by the Board of Trustees or a specific implementation plan if the conclusion is to sunset one or both of these councils.

Initially, this resolution was referred to the taskforce created pursuant to Resolution 94, relating to an examination of issues affecting councils. That task force, recognizing it was not in a position to undertake a new (and duplicative) governance study or to explain the choices made by the Board, asked that the Board's Governance Committee respond to Resolution 177-2012.

The Governance Committee took up this issue and reported to the Board, which now provides the House with this report.

In 2012, an exhaustive governance study was undertaken by the Board and overseen by the Governance Committee. A well-respected consultant was retained, input was sought from parties of interest, there was outreach to the House, and countless hours were spent addressing the very issues which are the subject of Resolution 177. The Board concluded that the Councils on Communication and Membership should not be sunset. That recommendation was made after a great deal of study and work and the Board continues to believe it is the correct path. No new information has been offered to justify overturning the Board's recommendation from last year. In fact, new information supports the continuation of these councils.

Because the issues relating to these two councils do differ, each is addressed in turn.

Council on Membership: The consultant last year recommended that this council be sunset. The Board responded to that suggestion in Board Report 3 (2012) as follows:

> *Board response*. The Board appreciates the fine work of the Council on Membership and applauds the dedication of every volunteer who has served on it. After carefully considering the Consultant's suggestion, the Board concludes the suggestion requires further study to assure a proper focus on

member value. Accordingly, following the close of the 2012 House, the President will ask the ad hoc task force on council issues proposed below to further investigate this issue.

In particular, that task force will be asked to review the bylaws responsibilities of the Council on Membership to better clarify the appropriate role of the council. For example, how should the council address retention and recruitment issues when those are primarily state and local issues? Should and can constituent society executive directors, being on the front lines of retention and recruitment, play a more direct role for the Association on these matters? How should the council address potentially conflicting priorities such as market share enhancement and total dues revenue which are implicated by some reduced dues member categories? How should the council fulfill its responsibilities for member benefit programs when many such programs are the responsibility of other Association agencies?

The House did not adopt the resolution proposed by the Board to study the Council and, instead adopted a resolution proposed by the Reference Committee on Governance which focused on issues of general applicability to councils. (That work is the subject of a separate report.) One of those issues is the process for self-evaluation by councils. The Board believes that every council should undertake a thorough self-evaluation. In this case, the Council on Membership has the most complete knowledge of its responsibilities and work, and is best positioned to give serious thought to its' future and its future operations and structure.

The Board's conclusion is bolstered by recent developments. The Association is at a critical point of declining membership market share. The insight and work of this council is needed more now than ever. In addition, this council will play a key role in addressing tripartite alignment to assure the success of the Association and each level of the tripartite. The Board's conclusion is also bolstered by House action from 2012. At that time, the Board proposed a number of governance reforms, including sun setting another council, and the House did not support most of those recommendations. The Board agrees with the House apparent conclusion that a top-down demand for reform of councils is not the best approach. Rather, the Board hopes that the House will support action proposed in another report calling for bottom-up renewal, by asking every council to undertake a serious self-assessment and to bring forward to the House changes identified by the councils as needed and helpful.

Council on Communications: In 2012, the governance consultant recommended that this council be sunset. The consultant's explanation and the Board's response to it were provided in 2012 Board Report 3:

Commentary. The Cost of Governance analysis undertaken by W&A indicates over $340,000 of expense is associated with this council. Council functions are mainly staff oriented and do not merit the need or expense of council involvement. The council could be eliminated and a smaller BOT communications committee could be established for oversight of communications initiatives undertaken by staff. Council members should be appreciated for what they have accomplished and be allowed to sunset their operation. The new committee could meet largely electronically to review and discuss branding and marketing initiatives. Interviewees and leadership survey narrative responses ranked the Communications Council as one that should be eliminated.

Board Response: The Board appreciates the suggestion of the Consultant but does not agree with it. The Board feels that direct oversight of communications by a council is beneficial to the Association.

The Board continues to believe that direct volunteer oversight through a council is important. As noted above, no new information has come forward to shake this conclusion. Furthermore, this year, a key initiative of the Association is the Call to Action, our framing of the access to care issue. The Council on Communications will play a key role in this initiative. In addition, in general terms, the Association's communications efforts are vital to its success. In many ways, these efforts constitute the public face of

the Association and, as a result, these efforts need to be shaped and overseen by volunteers. Finally, it is the Board's observation that the council has been effective in its work.

Conclusion: Of course, the Board agrees that there is always room for improvement and believes that how to accomplish this can best be managed by the councils themselves, through a self-assessment. The Board is pleased to note that some councils have already taken up the challenge of a serious self-assessment. The issue of council self-assessment will be addressed in a separate report. The Board is confident in the willingness and ability of councils to take a hard look at their own operations and structure and, as important, the House's willingness and ability to carefully scrutinize these self-assessments to assure they are thorough and well thought out.

Resolutions

This report is informational and no resolutions are presented.

BOARD RECOMMENDATION: Vote Yes to Transmit.

BOARD VOTE: UNANIMOUS.

Resolution No. 2 New

Report: Board Report 3 Date Submitted: June 2013

Submitted By: Board of Trustees

Reference Committee: Legislative, Health, Governance and Related Matters

Total Net Financial Implication: None Net Dues Impact:

Amount One-time Amount On-going FTE 0

ADA Strategic Plan Goal: Members (Required)

REPORT 3 OF THE BOARD OF TRUSTEES TO THE HOUSE OF DELEGATES: DELEGATE ALLOCATION

Background: The House is operating under a dated and inaccurate delegate allocation. It is currently based on 2007 membership counts. Under existing rules (CHAPTER V HOUSE OF DELEGATES, *Section* 10. COMPOSITION, Subsection C. 1 REPRESENTATIONAL REQUIREMENTS AND GOALS of the ADA *Bylaws*), delegates should be reallocated based on current membership numbers every three years. The Board is convinced the House delegate allocation must be made current and is, therefore, proposing an allocation method which will do that, provide the highest level of fairness possible, and will avoid repetition of this problem in the future.

In 2011, the Board proposed a delegate allocation to the House of Delegates and the House decided to defer action pending the outcome of the proposed governance study. In 2012, the governance study was conducted and the Board proposed a new allocation, and alternative allocations were also proposed. The 2012 House rejected every allocation proposed to it. The result was that the existing allocation continued in place.

The Board believes that action is needed this year in order to assure that the House continues to be a representative body. Accordingly, the Board is proposing this year an allocation with the following key features:

- It is based on 2012 membership numbers.
- It keeps the House at approximately its current size, using a base size of 473, which may fluctuate by up to 5 percent to allow for final allocation adjustments so as to assure a fair allocation based on membership numbers.
- It will prevent the House from continuing to grow in size by assuring that for future reallocations, the same base size of 473 is used, again subject to a 5 percent fluctuation.
- It calls for reallocation every four years instead of three in order to provide greater predictability for delegations.
- It continues to provide ASDA with five seats.
- It assures a minimum number of seats (of two) for small state societies and the District of Columbia.
- It provides a minimum seating of one (1) delegate each for Puerto Rico, the Virgin Islands and the five (5) federal dental services. If Puerto Rico, the Virgin Islands or any of the federal dental services achieve membership numbers equal to that of the smallest state society as of the time of reallocation, that entity will then be eligible for a minimum of two (2) seats.
- Under present membership totals, each of the five federal (5) dental services are entitled to two (2) delegates under the proposed allocation system.

- It amends the *Bylaws* to reflect the precise calculation methodology to be used (this is the same methodology proposed last year and is one designed to maximize fairness for every constituent society). The methodology description is set forth below in the proposed resolution.
- It further amends the *Bylaws* to require the Secretary of the House to apply the methodology to current membership numbers every four years, to publish the resulting allocation to every constituent society, and to include it in the Manual of the House. As a result, the *Bylaws* will no longer set forth the delegate counts for every constituent. Thus, reallocation will become a simple administrative function based on a specific methodology approved by the House.
- The Secretary will publish the revised allocation prior to the meeting of the House in the year before the allocation takes effect. The allocation will be based on the preceding year's membership numbers. For example, the 2014 (proposed) allocation was published in this report prior to the 2013 House and was based on 2012 membership numbers.
- A copy of the allocation to take effect in 2014 under this methodology is attached as Appendix A.

If the Resolution proposed in this report is adopted, the *Bylaws* will read as shown in Appendix B, a clean (no strikethrough or underscore) version of the amended *Bylaws*.

The Board believes this approach is a fair one and reflects the sentiment of the House expressed over the last two years. Moreover, by enshrining the specific methodology in the *Bylaws* and allowing the simple application of that methodology to become an administrative function, the House can be assured it will remain a representative body. Accordingly, the Board proposes the following resolution for the House' consideration:

Resolution

2. Resolved, that CHAPTER II. CONSTITUENT SOCIETIES, *Section* 100. PRIVILEGE OF REPRESENTATION, of the ADA *Bylaws* be amended as follows (additions underscored, deletions ~~stricken through~~):

Section 100. PRIVILEGE OF REPRESENTATION:

Each state constituent dental society and the District of Columbia Dental Society shall be entitled to a minimum of two (2) delegates in the House of Delegates. Each territorial constituent society and federal service shall be entitled to a minimum of two (2) delegates in the House of Delegates~~,~~ ~~except that~~ if its total membership is equal to or greater than the size that of the smallest state constituent society; otherwise the territorial society or service shall receive one (1) delegate~~ shall be allocated to the Virgin Islands Dental Association. The Air Force Dental Corps, the Army Dental Corps, the Navy Dental Corps, the Public Health Service and the Department of Veterans Affairs shall each be entitled to two (2) delegates, one of which shall be elected by the respective service, without regard to the number of members~~. The remaining number of delegates shall be allocated as provided in Chapter V, Sections 10C and 10D.

Each constituent society and each federal dental service may select from among its active, life and retired members the same number of alternate delegates as delegates and shall designate the alternate delegate who shall replace an absent delegate.

and be it further

Resolved, that CHAPTER V. HOUSE OF DELEGATES, *Section* 10. COMPOSITION, Subsection A. VOTING MEMBERS of the ADA *Bylaws* be amended as follows (additions underscored, deletions ~~stricken through~~):

Section 10. COMPOSITION.

A. VOTING MEMBERS. The House of Delegates~~ shall be limited to four hundred sixty (460) voting members for the two years 2004 to 2005 inclusive. Thereafter, the number of voting~~

~~members shall be determined by the methodologies set forth in Section 10C of this Chapter. It~~ shall be composed of the officially certified delegates of the constituent dental societies and of the five (5) federal dental services, who shall be active, life or retired members~~, two (2) officially certified delegates from each of the five (5) federal dental services, who shall be active, life or retired members~~ and five (5) student members of the American Student Dental Association who are officially certified delegates from the American Student Dental Association. Proxy voting is explicitly prohibited; 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.

and be it further

Resolved, that CHAPTER V. HOUSE OF DELEGATES, *Section* 10. COMPOSITION, Subsection C. REPRESENTATIONAL REQUIREMENTS AND GOALS of the ADA *Bylaws* be amended as follows (additions underscored, deletions ~~stricken through~~):

C. REPRESENTATIONAL REQUIREMENTS AND GOALS. Each constituent society and each of the five federal dental services shall be entitled to the minimum ~~two (2)~~ number of delegates set forth in CHAPTER II. CONSTITUENT SOCIETIES, *Section* 100. PRIVILEGE OF REPRESENTATION~~, except that one (1) delegate shall be allocated to the Virgin Islands Dental Association. The Air Force Dental Corps, the Army Dental Corps, the Navy Dental Corps, the Public Health Service and the Department of Veteran Affairs shall each be entitled to two (2) delegates, one of which shall be elected by the respective service, without regard to the number of members.~~ The American Student Dental Association shall be entitled to the number of delegates set forth in CHAPTER II. CONSTITUENT SOCIETIES, *Section* 100. PRIVILEGE OF REPRESENTATION.

The allocation of the remaining delegates shall be made pursuant to the delegate allocation methodology set forth in Subsection D. of this Section, with the goals of (i) achieving as close to proportional representation of active, life and retired members of the Association as possible while providing for the minimum representational requirements set forth in CHAPTER II. CONSTITUENT SOCIETIES, *Section* 100. PRIVILEGE OF REPRESENTATION; (ii) providing for representation of the American Student Dental Association; and (iii) maintaining the size of the House of Delegates as close to 473 delegates as possible while meeting the other goals recited in this Subsection. ~~For the two years 2004-2005 inclusive, the remaining number of delegates shall be allocated to the constituent societies, through their trustee districts based on the representational goals that each trustee district's representation in the House of Delegates shall vary by no more or less than 0.3% from its active, life or retired membership share in this Association, based on the Association's December 31, 2002 membership records, and that no district or constituent shall lose a delegate from its 2003 allocation. Thereafter, to allow for changes in the delegate allocation due to membership fluctuations, the Board of Trustees shall use this variance method of district delegate allocation (a variance of no more than 0.3% of its active, life and retired membership share in the Association) at subsequent intervals of three (3) years, with the first such review occurring for the 2006 House of Delegates. Such reviews shall be based on the Association's year-end membership records for the calendar year preceding the review period in question. No district shall lose a delegate unless their membership numbers are at least one percent less than their membership numbers of the prior three years. Any changes deemed necessary shall be presented to the House of Delegates in the form of a Bylaws' amendment to Section 10D of this Chapter.~~

and be it further

Resolved, that CHAPTER V. HOUSE OF DELEGATES, *Section* 10. COMPOSITION, Subsection D. DELEGATE ALLOCATION of the ADA *Bylaws* be amended as follows (additions underscored, deletions ~~stricken through~~):

D. DELEGATE ALLOCATION METHODOLOGY. Commencing in 2014, ~~Based~~ based on the representational requirements and goals set forth in Section 10C, ~~the~~ delegates shall be allocated according to the allocation methodology set forth below. Thereafter, to account for membership fluctuations, delegate allocations shall be reviewed and delegates shall be reallocated by the Secretary of the House of Delegates every four (4) years among the constituent dental societies, the five (5) federal dental services and the American Student Dental Association in accordance with that same methodology. Delegate allocations shall be based on the Association's year-end membership records for the second calendar year preceding the year in which the delegate allocations become effective. The review of delegates shall take place as soon as possible after the membership numbers on which the delegate allocations are based are available and the Secretary of the House of Delegates shall publish the new delegate allocations expeditiously thereafter to the constituent dental societies, the five (5) federal dental services and the American Student Dental Association. The delegate allocations shall also be published in the Manual of the House of Delegates. ~~are allocated as follows:~~ The delegate allocation methodology is as follows:

~~DISTRICT 1~~
~~Connecticut State Dental Association, The, 7 delegates~~
~~Maine Dental Association, 3 delegates~~
~~Massachusetts Dental Society, 13 delegates~~
~~New Hampshire Dental Society, 3 delegates~~
~~Rhode Island Dental Association, 3 delegates~~
~~Vermont State Dental Society, 2 delegates~~
~~District Total: 31 delegates~~

~~DISTRICT 2~~
~~New York State Dental Association, 41 delegates~~
~~District Total: 41 delegates~~

~~DISTRICT 3~~
~~Pennsylvania Dental Association, 18 delegates~~
~~District Total: 18 delegates~~

~~DISTRICT 4~~
~~Air Force Dental Corps, 2 delegates~~
~~Army Dental Corps, 2 delegates~~
~~Delaware State Dental Society, 2 delegates~~
~~District of Columbia Dental Society, The, 2 delegates~~
~~Maryland State Dental Association, 7 delegates~~
~~Navy Dental Corps, 2 delegates~~
~~New Jersey Dental Association, 12 delegates~~
~~Public Health Service, 2 delegates~~
~~Puerto Rico, Colegio de Cirujanos Dentistas de, 2 delegates~~
~~Veterans Affairs, 2 delegates~~
~~Virgin Islands Dental Association, 1delegate~~
~~District Total: 36 delegates~~

~~DISTRICT 5~~
~~Alabama Dental Association, 5 delegates~~
~~Georgia Dental Association, 10 delegates~~
~~Mississippi Dental Association, The, 3 delegates~~
~~District Total: 18 delegates~~

~~DISTRICT 6~~
~~Kentucky Dental Association, 6 delegates~~
~~Missouri Dental Association, 7 delegates~~

~~Tennessee Dental Association, 7 delegates~~
~~West Virginia Dental Association, 3 delegates~~
~~District Total: 23 delegates~~

~~DISTRICT 7~~
~~Indiana Dental Association, 9 delegates~~
~~Ohio Dental Association, 16 delegates~~
~~District Total: 25 delegates~~

~~DISTRICT 8~~
~~Illinois State Dental Society, 20 delegates~~
~~District Total: 20 delegates~~

~~DISTRICT 9~~
~~Michigan Dental Association, 17 delegates~~
~~Wisconsin Dental Association, 9 delegates~~
~~District Total: 26 delegates~~

~~DISTRICT 10~~
~~Iowa Dental Association, 5 delegates~~
~~Minnesota Dental Association, 9 delegates~~
~~Nebraska Dental Association, The, 3 delegates~~
~~North Dakota Dental Association, 2 delegates~~
~~South Dakota Dental Association, 2 delegates~~
~~District Total: 21 delegates~~

~~DISTRICT 11~~
~~Alaska Dental Society, 2 delegates~~
~~Idaho State Dental Association, 3 delegates~~
~~Montana Dental Association, 2 delegates~~
~~Oregon Dental Association, 6 delegates~~
~~Washington State Dental Association, 11 delegates~~
~~District Total: 24 delegates~~

~~DISTRICT 12~~
~~Arkansas State Dental Association, 4 delegates~~
~~Kansas Dental Association, 4 delegates~~
~~Louisiana Dental Association, The, 6 delegates~~
~~Oklahoma Dental Association, 5 delegates~~
~~District Total: 19 delegates~~

~~DISTRICT 13~~
~~California Dental Association, 67 delegates~~
~~District Total: 67 delegates~~

~~DISTRICT 14~~
~~Arizona Dental Association, 7 delegates~~
~~Colorado Dental Association, 8 delegates~~
~~Hawaii Dental Association, 3 delegates~~
~~Nevada Dental Association, 3 delegates~~
~~New Mexico Dental Association, 3 delegates~~
~~Utah Dental Association, 4 delegates~~
~~Wyoming Dental Association, 2 delegates~~
~~District Total: 30 delegates~~

~~DISTRICT 15~~
~~Texas Dental Association, 23 delegates~~
~~District Total: 23 delegates~~

~~DISTRICT 16~~
~~North Carolina Dental Society, The, 10 delegates~~
~~South Carolina Dental Association, 5 delegates~~
~~Virginia Dental Association, 10 delegates~~
~~District Total: 25 delegates~~

~~DISTRICT 17~~
~~Florida Dental Association, 21 delegates~~
~~District Total: 21 delegates~~

~~AMERICAN STUDENT DENTAL ASSOCIATION, 5 delegates~~

a. **The Target Delegate Number.** For purposes of allocating delegates, the target number of delegates to be used in calculating the allocation is four hundred seventy-three (473). From that target number two delegates will be deducted for each constituent society except that only a single delegate will be deducted from each of the Colegio de Cirujanos Dentistas de Puerto Rico and the Virgin Islands Dental Association unless the number of members in either of those societies is equal to or greater than the number of members in the smallest state constituent society, in which case a minimum of two (2) delegates will be deducted from the target delegate number for that society. One delegate is deducted from the target delegate number for each of the five (5) dental services, except that a minimum of two (2) delegates will be deducted for any federal dental service where the number of members is equal to or greater than the number of members in the smallest state constituent society. In addition, five (5) delegates will be deducted from the target delegate number for the American Student Dental Association. For purposes of the delegate allocation methodology set forth in these *Bylaws*, the remaining number of delegates in the target number of delegates following the deductions of delegates listed above from the target number of delegates shall be referred to as the net delegate allocation pool.
b. **Allocation to the American Student Dental Association.** Five (5) delegates shall be allocated to the American Student Dental Association regardless of the number of members.
c. **Determination of the True Proportional Delegate Counts for each Constituent and each Federal Dental Service.** Divide each constituent's and each federal dental service's total membership by the total membership of the Association. Multiply the resulting percentage of membership for each constituent and federal dental service by the target number of delegates set forth in paragraph a. of this Sub-section less the number of delegates allocated to the American Student Dental Association in paragraph b. of this Sub-section. The resulting true proportional delegate numbers will be used later in the delegate allocation methodology.
d. **Determination of Constituents and Federal Dental Services that Qualify to Receive More than the Minimum Delegate Allocation.**
    i. Divide the total constituent and federal dental service membership of the Association by the target number of delegates set forth in paragraph a. of this Sub-section less the number of delegates allocated to the American Student Dental Association in paragraph b. of this Sub-section. Compare the resulting number against the membership numbers for the Colegio de Cirujanos Dentistas de Puerto Rico, Virgin Islands Dental Association and Public Health Service if they received a single delegate pursuant to the review performed in paragraph a. of this Sub-section. If the membership numbers of any of those entities are less than the result of the calculation, allocate the number of delegates deducted from the target delegate allocation number for each such entity and exclude those entities from the remaining steps of the delegate allocation methodology.

ii. Take the result of the calculation performed in sub-paragraph i. of this paragraph d. and multiply it by two (2). Compare the resulting number against the membership numbers for each constituent society and each federal dental service for which two (2) delegates were deducted from the target delegate allocation number in paragraph a. of this Sub-section. If the membership of any of those constituent societies and federal dental services are less than that number, allocate the number of delegates deducted from the target delegate allocation number for each such entity and exclude those entities from the remaining steps of the delegate allocation methodology.

e. **Calculation of Non-Minimum Membership Total.** Subtract the total membership numbers of each constituent society and federal dental service identified as being excluded from the remaining steps of the delegate allocation methodology from the total membership of the Association. The resulting non-minimum membership total will be used in the remaining delegate allocation methodology steps.

f. **Allocation of Remaining Delegates.**

i. Divide each remaining constituent's and federal dental service's membership by the non-minimum membership total determined in paragraph e. of this Sub-section to arrive at their percentages of the non-minimum membership total.

ii. Calculate the remaining number of delegates to be allocated by subtracting from the target number of delegates listed in paragraph a. of this Sub-section the delegates allocated to the American Student Dental Association in paragraph b. of this Sub-section and the delegates allocated by the minimum allocation steps in paragraphs d.i and d.ii. of this Sub-section.

iii. For each remaining constituent and federal dental service, multiply its percentage of the non-minimum membership total determined by the calculation in paragraph f.i. of this Sub-section and the remaining number of delegates to be allocated as determined by the calculation in paragraph f.ii. of this Sub-section. Round the result to the nearest whole number.

iv. For each remaining constituent and federal dental service, multiply the result obtained in paragraph f.i. of this Subparagraph by the target number of delegates specified in paragraph a. of this Sub-section less the number of delegates allocated to the American Student Dental Association pursuant to paragraph b. of the Sub-section and round the result to the nearest whole number.

v. For each remaining constituent and federal dental service, subtract the result obtained in sub-paragraph f.iv. of this Sub-section from the result obtained in sub-paragraph f.iii. of this Sub-section. If the result is negative, use the result obtained in subparagraph f.iv. of this Sub-section as that constituent's allocated delegate total. If the result is zero or positive, use the result obtained in sub-paragraph f.iii. of this Sub-section as that constituent's allocated delegate total.

g. **Finalize the Delegate Allocation.** Add together the final delegate allocations for the constituent societies, federal dental services and the American Student Dental Association determined through the calculations of paragraph b., sub-paragraphs d.i. and d.ii. and sub-paragraph f.v. of this Subsection. The result is the total delegates allocated. The total delegates allocated should vary no more than 5% from the target number of delegates set forth in paragraph a. of this Subsection.

h. **Calculating the Fairness Ratio.** Divide each constituent's and each federal dental service's percentage of total delegates (the constituent's allocated delegates divided by the total delegates allocated as determined by the calculation set forth in sub-paragraph f.v. of this Sub-section) by its percentage of total membership as calculated in paragraph a. of this Sub-Section. Except for those constituents that only receive the minimum number of allocated delegates, the resulting "fairness ratio" should deviate by a small amount on either side of 1, with 1 representing a perfectly proportional delegate allocation. The fairness ratio for constituents and federal dental services that receive only the minimum allocation of delegates may deviate from 1 to a larger degree because those constituents and federal dental services may be slightly over-represented.

and be it further

Resolved, that CHAPTER VII. BOARD OF TRUSTEES, *Section* 100. DUTIES, Subsection N. of the ADA *Bylaws* be amended as follows (additions underscored):

Section 100. DUTIES: It shall be the duty of the Board of Trustees to:

N. Review the periodic delegate allocations to the House of Delegates performed pursuant to the methodology set forth in CHAPTER V. HOUSE OF DELEGATES, *Section* 10. COMPOSITION, Subsection D. DELEGATE ALLOCATION against the representational requirements and goals as provided in Chapter V, Section 10C, of these Bylaws.

BOARD RECOMMENDATION: Vote Yes.

Board Vote: Resolution 2

BUCKENHEIMER	Yes	FEINBERG	Yes	NORMAN	Yes	VERSMAN	Yes
CROWLEY	Yes	GOUNARDES	Yes	ROBERTS	Yes	WEBER	Yes
DOW	Yes	HAGENBRUCH	No	SCOTT	Yes	YONEMOTO	Yes
ENGEL	No	ISRAELSON	Yes	SEAGO	Yes	ZENK	Yes
FAIR	Yes	KIESLING	Yes	SUMMERHAYS	Yes	ZUST	Yes

Appendix A
Proposed House of Delegates Allocation

Calculation with Target Distribution of House Delegates by Constituent
Allocation Method with Replacement
Compared to Percent of Total Membership (PTM) Allocation Method

Constituent Society	ADA Trustee District	Number of Members	Number of Delegates if Allocated Based on Percent of Total Membership (PTM)	Percent of Total ADA Membership	**Proposed Number of Delegates Allocated by Method**	Percent of Delegates Allocated by Method	Difference in Delegates Allocation Method Minus PTM Method	Percent Delegate Change Allocation Method Compared to PTM Method	Fairness Ratio
ALABAMA DENTAL ASSOCIATION	5th	1,664	5	1.09%	**5**	1.05%	0	0.00%	0.96
ARIZONA DENTAL ASSOCIATION	14th	2,350	7	1.54%	**7**	1.47%	0	0.00%	0.96
ARKANSAS STATE DENTAL ASSOCIATION	12th	1,075	3	0.70%	**3**	0.63%	0	0.00%	0.90
CALIFORNIA DENTAL ASSOCIATION	13th	22,763	70	14.92%	**70**	14.74%	0	0.00%	0.99
COLORADO DENTAL ASSOCIATION	14th	3,165	10	2.08%	**10**	2.11%	0	0.00%	1.01
CONNECTICUT STATE DENTAL ASSOCIATION	1st	2,394	7	1.57%	**7**	1.47%	0	0.00%	0.94
DELAWARE STATE DENTAL SOCIETY	4th	405	1	0.27%	**2**	0.42%	1	50.00%	1.59
DISTRICT OF COLUMBIA DENTAL SOCIETY	4th	451	1	0.30%	**2**	0.42%	1	50.00%	1.42
FLORIDA DENTAL ASSOCIATION	17th	6,442	20	4.22%	**20**	4.21%	0	0.00%	1.00
GEORGIA DENTAL ASSOCIATION	5th	3,365	10	2.21%	**10**	2.11%	0	0.00%	0.95
HAWAII DENTAL ASSOCIATION	14th	964	3	0.63%	**3**	0.63%	0	0.00%	1.00
IDAHO STATE DENTAL ASSOCIATION	11th	827	3	0.54%	**3**	0.63%	0	0.00%	1.16
ILLINOIS STATE DENTAL SOCIETY	8th	6,637	20	4.35%	**20**	4.21%	0	0.00%	0.97
INDIANA DENTAL ASSOCIATION	7th	2,895	9	1.90%	**9**	1.89%	0	0.00%	1.00
IOWA DENTAL ASSOCIATION	10th	1,755	5	1.15%	**5**	1.05%	0	0.00%	0.91
KANSAS DENTAL ASSOCIATION	12th	1,217	4	0.80%	**4**	0.84%	0	0.00%	1.06
KENTUCKY DENTAL ASSOCIATION	6th	1,681	5	1.10%	**5**	1.05%	0	0.00%	0.96
LOUISIANA DENTAL ASSOCIATION	12th	1,887	6	1.24%	**6**	1.26%	0	0.00%	1.02
MAINE DENTAL ASSOCIATION	1st	717	2	0.47%	**2**	0.42%	0	0.00%	0.90

Constituent Society	ADA Trustee District	Number of Members	Number of Delegates if Allocated Based on Percent of Total Membership (PTM)	Percent of Total ADA Membership	**Proposed Number of Delegates Allocated by Method**	Percent of Delegates Allocated by Method	Difference in Delegates Allocation Method Minus PTM Method	Percent Delegate Change Allocation Method Compared to PTM Method	Fairness Ratio
MARYLAND STATE DENTAL ASSOCIATION	4th	2,461	8	1.61%	**8**	1.68%	0	0.00%	1.04
MASSACHUSETTS DENTAL SOCIETY	1st	5,076	16	3.33%	**16**	3.37%	0	0.00%	1.01
MICHIGAN DENTAL ASSOCIATION	9th	5,571	17	3.65%	**17**	3.58%	0	0.00%	0.98
MINNESOTA DENTAL ASSOCIATION	10th	3,074	9	2.02%	**9**	1.89%	0	0.00%	0.94
MISSISSIPPI DENTAL ASSOCIATION	5th	996	3	0.65%	**3**	0.63%	0	0.00%	0.97
MISSOURI DENTAL ASSOCIATION	6th	2,326	7	1.53%	**7**	1.47%	0	0.00%	0.97
MONTANA DENTAL ASSOCIATION	11th	663	2	0.43%	**2**	0.42%	0	0.00%	0.97
NEBRASKA DENTAL ASSOCIATION	10th	988	3	0.65%	**3**	0.63%	0	0.00%	0.97
NEVADA DENTAL ASSOCIATION	14th	863	3	0.57%	**3**	0.63%	0	0.00%	1.12
NEW HAMPSHIRE DENTAL SOCIETY	1st	762	2	0.50%	**2**	0.42%	0	0.00%	0.84
NEW JERSEY DENTAL ASSOCIATION	4th	4,559	14	2.99%	**14**	2.95%	0	0.00%	0.99
NEW MEXICO DENTAL ASSOCIATION	14th	690	2	0.45%	**2**	0.42%	0	0.00%	0.93
NEW YORK STATE DENTAL ASSOCIATION	2nd	12,371	38	8.11%	**38**	8.00%	0	0.00%	0.99
NORTH CAROLINA DENTAL SOCIETY	16th	3,401	10	2.23%	**10**	2.11%	0	0.00%	0.94
NORTH DAKOTA DENTAL ASSOCIATION	10th	380	1	0.25%	**2**	0.42%	1	50.00%	1.69
OHIO DENTAL ASSOCIATION	7th	5,435	17	3.56%	**17**	3.58%	0	0.00%	1.00
OKLAHOMA DENTAL ASSOCIATION	12th	1,633	5	1.07%	**5**	1.05%	0	0.00%	0.98
OREGON DENTAL ASSOCIATION	11th	2,107	6	1.38%	**6**	1.26%	0	0.00%	0.91
PENNSYLVANIA DENTAL ASSOCIATION	3rd	5,473	17	3.59%	**17**	3.58%	0	0.00%	1.00
COLEGIO DE CIRUJANOS DENTISTAS DE PUERTO	4th	184	1	0.12%	**1**	0.21%	0	0.00%	1.75
RHODE ISLAND DENTAL ASSOCIATION	1st	552	2	0.36%	**2**	0.42%	0	0.00%	1.16
SOUTH DAKOTA DENTAL ASSOCIATION	10th	464	1	0.30%	**2**	0.42%	1	50.00%	1.38
TENNESSEE DENTAL ASSOCIATION	6th	2,392	7	1.57%	**7**	1.47%	0	0.00%	0.94

Constituent Society	ADA Trustee District	Number of Members	Number of Delegates if Allocated Based on Percent of Total Membership (PTM)	Percent of Total ADA Membership	**Proposed Number of Delegates Allocated by Method**	Percent of Delegates Allocated by Method	Difference in Delegates Allocation Method Minus PTM Method	Percent Delegate Change Allocation Method Compared to PTM Method	Fairness Ratio
SOUTH CAROLINA DENTAL ASSOCIATION	16th	1,846	6	1.21%	**6**	1.26%	0	0.00%	1.04
VERMONT STATE DENTAL SOCIETY	1st	385	1	0.25%	**2**	0.42%	1	50.00%	1.67
WYOMING DENTAL ASSOCIATION	14th	295	1	0.19%	**2**	0.42%	1	50.00%	2.18
TEXAS DENTAL ASSOCIATION	15th	8,860	27	5.81%	**27**	5.68%	0	0.00%	0.98
UTAH DENTAL ASSOCIATION	14th	1,557	5	1.02%	**5**	1.05%	0	0.00%	1.03
VIRGIN ISLANDS DENTAL ASSOCIATION	4th	21	0	0.01%	**1**	0.21%	1	100.0%	15.29
VIRGINIA DENTAL ASSOCIATION	16th	3,523	11	2.31%	**11**	2.32%	0	0.00%	1.00
WASHINGTON STATE DENTAL ASSOCIATION	11th	4,029	12	2.64%	**12**	2.53%	0	0.00%	0.96
WEST VIRGINIA DENTAL ASSOCIATION	6th	740	2	0.49%	**2**	0.42%	0	0.00%	0.87
WISCONSIN DENTAL ASSOCIATION	9th	3,040	9	1.99%	**9**	1.89%	0	0.00%	0.95
ALASKA DENTAL SOCIETY	11th	341	1	0.22%	**2**	0.42%	1	50.00%	1.88
AIR FORCE	4th	707	2	0.46%	**2**	0.42%	0	0.00%	0.91
ARMY	4th	643	2	0.42%	**2**	0.42%	0	0.00%	1.00
NAVY	4th	633	2	0.42%	**2**	0.42%	0	0.00%	1.01
PUBLIC HEALTH SERVICE	4th	316	1	0.21%	**2**	0.42%	1	50.00%	2.03
VETERANS AFFAIRS	4th	511	2	0.34%	**2**	0.42%	0	0.00%	1.26
Total		152,522	466	100.0%	**475**	100.0%	9		
Total delegates with ASDA		NA	NA	NA	**480**	NA	NA		NA
Number of ADA constituencies=58									

A value of one is a perfect Fairness Ratio. A fairness value greater than one indicates over-representation and less than one is under-representation
The ASDA constituent receives 5 delegates and is not considered further in any of the allocation statistics
The soft delegate target is 473

Distribution of House Delegates by Trustee District
Allocation Method with Replacement
Compared to Percent of Total Membership (PTM) Allocation Method

ADA Trustee District=1

Constituent Society	ADA Trustee District	Number of Members	Number of Delegates if Allocated Based on Percent of Total Membership (PTM)	Percent of Total ADA Membership	**Proposed Number of Delegates Allocated by Method**	Percent of Delegates Allocated by Method	Difference in Delegates Allocation Method Minus PTM Method
CONNECTICUT STATE DENTAL ASSOCIATION	1st	2,394	7	1.57%	**7**	1.47%	0
MAINE DENTAL ASSOCIATION	1st	717	2	0.47%	**2**	0.42%	0
MASSACHUSETTS DENTAL SOCIETY	1st	5,076	16	3.33%	**16**	3.37%	0
NEW HAMPSHIRE DENTAL SOCIETY	1st	762	2	0.50%	**2**	0.42%	0
RHODE ISLAND DENTAL ASSOCIATION	1st	552	2	0.36%	**2**	0.42%	0
VERMONT STATE DENTAL SOCIETY	1st	385	1	0.25%	**2**	0.42%	1
Total		9,886	30	6.48%	**31**	6.53%	1

ADA Trustee District=2

Constituent Society	ADA Trustee District	Number of Members	Number of Delegates if Allocated Based on Percent of Total Membership (PTM)	Percent of Total ADA Membership	**Proposed Number of Delegates Allocated by Method**	Percent of Delegates Allocated by Method	Difference in Delegates Allocation Method Minus PTM Method
NEW YORK STATE DENTAL ASSOCIATION	2nd	12,371	38	8.11%	**38**	8.00%	0

ADA Trustee District=3

Constituent Society	ADA Trustee District	Number of Members	Number of Delegates if Allocated Based on Percent of Total Membership (PTM)	Percent of Total ADA Membership	**Proposed Number of Delegates Allocated by Method**	Percent of Delegates Allocated by Method	Difference in Delegates Allocation Method Minus PTM Method
PENNSYLVANIA DENTAL ASSOCIATION	3rd	5,473	17	3.59%	**17**	3.58%	0

ADA Trustee District=4

Constituent Society	ADA Trustee District	Number of Members	Number of Delegates if Allocated Based on Percent of Total Membership (PTM)	Percent of Total ADA Membership	**Proposed Number of Delegates Allocated by Method**	Percent of Delegates Allocated by Metho d	Difference in Delegates Allocation Method Minus PTM Method
DELAWARE STATE DENTAL SOCIETY	4th	405	1	0.27%	**2**	0.42%	1
DISTRICT OF COLUMBIA DENTAL SOCIETY	4th	451	1	0.30%	**2**	0.42%	1
MARYLAND STATE DENTAL ASSOCIATION	4th	2,461	8	1.61%	**8**	1.68%	0
NEW JERSEY DENTAL ASSOCIATION	4th	4,559	14	2.99%	**14**	2.95%	0
COLEGIO DE CIRUJANOS DENTISTAS DE PUERTO	4th	184	1	0.12%	**1**	0.21%	0
VIRGIN ISLANDS DENTAL ASSOCIATION	4th	21	0	0.01%	**1**	0.21%	1
AIR FORCE	4th	707	2	0.46%	**2**	0.42%	0
ARMY	4th	643	2	0.42%	**2**	0.42%	0
NAVY	4th	633	2	0.42%	**2**	0.42%	0
PUBLIC HEALTH SERVICE	4th	316	1	0.21%	**2**	0.42%	1
VETERANS AFFAIRS	4th	511	2	0.34%	**2**	0.42%	0
Total		0,891	34	7.14%	**38**	8.00%	4

ADA Trustee District=5

Constituent Society	ADA Trustee District	Number of Members	Number of Delegates if Allocated Based on Percent of Total Membership (PTM)	Percent of Total ADA Membership	**Proposed Number of Delegates Allocated by Method**	Percent of Delegates Allocated by Method	Difference in Delegates Allocation Method Minus PTM Method
ALABAMA DENTAL ASSOCIATION	5th	1,664	5	1.09%	**5**	1.05%	0
GEORGIA DENTAL ASSOCIATION	5th	3,365	10	2.21%	**10**	2.11%	0
MISSISSIPPI DENTAL ASSOCIATION	5th	996	3	0.65%	**3**	0.63%	0
Total		6,025	18	3.95%	**18**	3.79%	0

ADA Trustee District=6

Constituent Society	ADA Trustee District	Number of Members	Number of Delegates if Allocated Based on Percent of Total Membership (PTM)	Percent of Total ADA Membership	**Proposed Number of Delegates Allocated by Method**	Percent of Delegates Allocated by Method	Difference in Delegates Allocation Method Minus PTM Method
KENTUCKY DENTAL ASSOCIATION	6th	1,681	5	1.10%	**5**	1.05%	0
MISSOURI DENTAL ASSOCIATION	6th	2,326	7	1.53%	**7**	1.47%	0
TENNESSEE DENTAL ASSOCIATION	6th	2,392	7	1.57%	**7**	1.47%	0
WEST VIRGINIA DENTAL ASSOCIATION	6th	740	2	0.49%	**2**	0.42%	0
Total		7,139	21	4.68%	**21**	4.42%	0

ADA Trustee District=7

Constituent Society	ADA Trustee District	Number of Members	Number of Delegates if Allocated Based on Percent of Total Membership (PTM)	Percent of Total ADA Membership	**Proposed Number of Delegates Allocated by Method**	Percent of Delegates Allocated by Method	Difference in Delegates Allocation Method Minus PTM Method
INDIANA DENTAL ASSOCIATION	7th	2,895	9	1.90%	**9**	1.89%	0
OHIO DENTAL ASSOCIATION	7th	5,435	17	3.56%	**17**	3.58%	0
Total		8,330	26	5.46%	**26**	5.47%	0

ADA Trustee District=8

Constituent Society	ADA Trustee District	Number of Members	Number of Delegates if Allocated Based on Percent of Total Membership (PTM)	Percent of Total ADA Membership	**Proposed Number of Delegates Allocated by Method**	Percent of Delegates Allocated by Method	Difference in Delegates Allocation Method Minus PTM Method
ILLINOIS STATE DENTAL SOCIETY	8th	6,637	20	4.35%	**20**	4.21%	0

ADA Trustee District=9

Constituent Society	ADA Trustee District	Number of Members	Number of Delegates if Allocated Based on Percent of Total Membership (PTM)	Percent of Total ADA Membership	**Proposed Number of Delegates Allocated by Method**	Percent of Delegates Allocated by Method	Difference in Delegates Allocation Method Minus PTM Method
MICHIGAN DENTAL ASSOCIATION	9th	5,571	17	3.65%	**17**	3.58%	0
WISCONSIN DENTAL ASSOCIATION	9th	3,040	9	1.99%	**9**	1.89%	0
Total		8,611	26	5.65%	**26**	5.47%	0

ADA Trustee District=10

Constituent Society	ADA Trustee District	Number of Members	Number of Delegates if Allocated Based on Percent of Total Membership (PTM)	Percent of Total ADA Membership	**Proposed Number of Delegates Allocated by Method**	Percent of Delegates Allocated by Method	Difference in Delegates Allocation Method Minus PTM Method
IOWA DENTAL ASSOCIATION	10th	1,755	5	1.15%	**5**	1.05%	0
MINNESOTA DENTAL ASSOCIATION	10th	3,074	9	2.02%	**9**	1.89%	0
NEBRASKA DENTAL ASSOCIATION	10th	988	3	0.65%	**3**	0.63%	0
NORTH DAKOTA DENTAL ASSOCIATION	10th	380	1	0.25%	**2**	0.42%	1
SOUTH DAKOTA DENTAL ASSOCIATION	10th	464	1	0.30%	**2**	0.42%	1
Total		6,661	19	4.37%	**21**	4.42%	2

ADA Trustee District=11

Constituent Society	ADA Trustee District	Number of Members	Number of Delegates if Allocated Based on Percent of Total Membership (PTM)	Percent of Total ADA Membership	**Proposed Number of Delegates Allocated by Method**	Percent of Delegates Allocated by Method	Difference in Delegates Allocation Method Minus PTM Method
IDAHO STATE DENTAL ASSOCIATION	11th	827	3	0.54%	**3**	0.63%	0
MONTANA DENTAL ASSOCIATION	11th	663	2	0.43%	**2**	0.42%	0
OREGON DENTAL ASSOCIATION	11th	2,107	6	1.38%	**6**	1.26%	0
WASHINGTON STATE DENTAL ASSOCIATION	11th	4,029	12	2.64%	**12**	2.53%	0
ALASKA DENTAL SOCIETY	11th	341	1	0.22%	**2**	0.42%	1
Total		7,967	24	5.22%	**25**	5.26%	1

ADA Trustee District=12

Constituent Society	ADA Trustee District	Number of Members	Number of Delegates if Allocated Based on Percent of Total Membership (PTM)	Percent of Total ADA Membership	**Proposed Number of Delegates Allocated by Method**	Percent of Delegates Allocated by Method	Difference in Delegates Allocation Method Minus PTM Method
ARKANSAS STATE DENTAL ASSOCIATION	12th	1,075	3	0.70%	**3**	0.63%	0
KANSAS DENTAL ASSOCIATION	12th	1,217	4	0.80%	**4**	0.84%	0
LOUISIANA DENTAL ASSOCIATION	12th	1,887	6	1.24%	**6**	1.26%	0
OKLAHOMA DENTAL ASSOCIATION	12th	1,633	5	1.07%	**5**	1.05%	0
Total		5,812	18	3.81%	**18**	3.79%	0

ADA Trustee District=13

Constituent Society	ADA Trustee District	Number of Members	Number of Delegates if Allocated Based on Percent of Total Membership (PTM)	Percent of Total ADA Membership	**Proposed Number of Delegates Allocated by Method**	Percent of Delegates Allocated by Method	Difference in Delegates Allocation Method Minus PTM Method
CALIFORNIA DENTAL ASSOCIATION	13th	22,763	70	14.92%	**70**	14.74%	0

ADA Trustee District=14

Constituent Society	ADA Trustee District	Number of Members	Number of Delegates if Allocated Based on Percent of Total Membership (PTM)	Percent of Total ADA Membership	**Proposed Number of Delegates Allocated by Method**	Percent of Delegates Allocated by Method	Difference in Delegates Allocation Method Minus PTM Method
ARIZONA DENTAL ASSOCIATION	14th	2,350	7	1.54%	**7**	1.47%	0
COLORADO DENTAL ASSOCIATION	14th	3,165	10	2.08%	**10**	2.11%	0
HAWAII DENTAL ASSOCIATION	14th	964	3	0.63%	**3**	0.63%	0
NEVADA DENTAL ASSOCIATION	14th	863	3	0.57%	**3**	0.63%	0
NEW MEXICO DENTAL ASSOCIATION	14th	690	2	0.45%	**2**	0.42%	0
WYOMING DENTAL ASSOCIATION	14th	295	1	0.19%	**2**	0.42%	1
UTAH DENTAL ASSOCIATION	14th	1,557	5	1.02%	**5**	1.05%	0
Total		9,884	31	6.48%	**32**	6.74%	1

ADA Trustee District=15

Constituent Society	ADA Trustee District	Number of Members	Number of Delegates if Allocated Based on Percent of Total Membership (PTM)	Percent of Total ADA Membership	**Proposed Number of Delegates Allocated by Method**	Percent of Delegates Allocated by Method	Difference in Delegates Allocation Method Minus PTM Method
TEXAS DENTAL ASSOCIATION	15th	8,860	27	5.81%	**27**	5.68%	0

ADA Trustee District=16

Constituent Society	ADA Trustee District	Number of Members	Number of Delegates if Allocated Based on Percent of Total Membership (PTM)	Percent of Total ADA Membership	**Proposed Number of Delegates Allocated by Method**	Percent of Delegates Allocated by Method	Difference in Delegates Allocation Method Minus PTM Method
NORTH CAROLINA DENTAL SOCIETY	16th	3,401	10	2.23%	**10**	2.11%	0
SOUTH CAROLINA DENTAL ASSOCIATION	16th	1,846	6	1.21%	**6**	1.26%	0
VIRGINIA DENTAL ASSOCIATION	16th	3,523	11	2.31%	**11**	2.32%	0
Total		8,770	27	5.75%	**27**	5.68%	0

ADA Trustee District=17

Constituent Society	ADA Trustee District	Number of Members	Number of Delegates if Allocated Based on Percent of Total Membership (PTM)	Percent of Total ADA Membership	**Proposed Number of Delegates Allocated by Method**	Percent of Delegates Allocated by Method	Difference in Delegates Allocation Method Minus PTM Method
FLORIDA DENTAL ASSOCIATION	17th	6,442	20	4.22%	**20**	4.21%	0
Total		152,522	466	100.0%	**475**	100.0%	9

The ASDA constituent receives 5 delegates and is not considered further in any of the allocation statistics
The soft delegate target is 473

Appendix B
Revised Bylaws

CHAPTER II. CONSTITUENT SOCIETIES, *Section* 100. PRIVILEGE OF REPRESENTATION

Section 100. PRIVILEGE OF REPRESENTATION:

Each state constituent dental society and the District of Columbia Dental Society shall be entitled to a minimum of two (2) delegates in the House of Delegates. Each territorial constituent society and federal service shall be entitled to a minimum of two (2) delegates in the House of Delegates if its total membership is equal to or greater than the size that of the smallest state constituent society; otherwise the territorial society or service shall receive one (1) delegate. The remaining number of delegates shall be allocated as provided in Chapter V, Sections 10C and 10D.

Each constituent society and each federal dental service may select from among its active, life and retired members the same number of alternate delegates as delegates and shall designate the alternate delegate who shall replace an absent delegate.

CHAPTER V. HOUSE OF DELEGATES, *Section* 10. COMPOSITION, Subsection A. VOTING MEMBERS

Section 10. COMPOSITION.

A. VOTING MEMBERS. The House of Delegates shall be composed of the officially certified delegates of the constituent dental societies and of the five (5) federal dental services, who shall be active, life or retired members and five (5) student members of the American Student Dental Association who are officially certified delegates from the American Student Dental Association. Proxy voting is explicitly prohibited; 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.

CHAPTER V. HOUSE OF DELEGATES, *Section* 10. COMPOSITION, Subsection C. REPRESENTATIONAL REQUIREMENTS AND GOALS

C. REPRESENTATIONAL REQUIREMENTS AND GOALS. Each constituent society and each of the five federal dental services shall be entitled to the minimum number of delegates set forth in CHAPTER II. CONSTITUENT SOCIETIES, *Section* 100. PRIVILEGE OF REPRESENTATION. The American Student Dental Association shall be entitled to the number of delegates set forth in CHAPTER II. CONSTITUENT SOCIETIES, *Section* 100. PRIVILEGE OF REPRESENTATION.

The allocation of the remaining delegates shall be made pursuant to the delegate allocation methodology set forth in Subsection D. of this Section, with the goals of (i) achieving as close to proportional representation of active, life and retired members of the Association as possible while providing for the minimum representational requirements set forth in CHAPTER II. CONSTITUENT SOCIETIES, *Section* 100. PRIVILEGE OF REPRESENTATION; (ii) providing for representation of the American Student Dental Association; and (iii)

maintaining the size of the House of Delegates as close to 473 delegates as possible while meeting the other goals recited in this Subsection.

CHAPTER V. HOUSE OF DELEGATES, *Section* 10. COMPOSITION, Subsection D. DELEGATE ALLOCATION

D. DELEGATE ALLOCATION METHODOLOGY. Commencing in 2014, based on the representational requirements and goals set forth in Section 10C, delegates shall be allocated according to the allocation methodology set forth below. Thereafter, to account for membership fluctuations, delegate allocations shall be reviewed and delegates shall be reallocated by the Secretary of the House of Delegates every four (4) years among the constituent dental societies, the five (5) federal dental services and the American Student Dental Association in accordance with that same methodology. Delegate allocations shall be based on the Association's year-end membership records for the second calendar year preceding the year in which the delegate allocations become effective. The review of delegates shall take place as soon as possible after the membership numbers on which the delegate allocations are based are available and the Secretary of the House of Delegates shall publish the new delegate allocations expeditiously thereafter to the constituent dental societies, the five (5) federal dental services and the American Student Dental Association. The delegate allocations shall also be published in the Manual of the House of Delegates. The delegate allocation methodology is as follows:

a. **The Target Delegate Number.** For purposes of allocating delegates, the target number of delegates to be used in calculating the allocation is four hundred seventy-three (473). From that target number two delegates will be deducted for each constituent society except that only a single delegate will be deducted from each of the Colegio de Cirujanos Dentistas de Puerto Rico and the Virgin Islands Dental Association unless the number of members in either of those societies is equal to or greater than the number of members in the smallest state constituent society, in which case a minimum of two (2) delegates will be deducted from the target delegate number for that society. One delegate is deducted from the target delegate number for each of the five (5) dental services, except that a minimum of two (2) delegates will be deducted for any federal dental service where the number of members is equal to or greater than the number of members in the smallest state constituent society. In addition, five (5) delegates will be deducted from the target delegate number for the American Student Dental Association. For purposes of the delegate allocation methodology set forth in these *Bylaws*, the remaining number of delegates in the target number of delegates following the deductions of delegates listed above from the target number of delegates shall be referred to as the net delegate allocation pool.
b. **Allocation to the American Student Dental Association.** Five (5) delegates shall be allocated to the American Student Dental Association regardless of the number of members.
c. **Determination of the True Proportional Delegate Counts for each Constituent and each Federal Dental Service.** Divide each constituent's and each federal dental service's total membership by the total membership of the Association. Multiply the resulting percentage of membership for each constituent and federal dental service by the target number of delegates set forth in paragraph a. of this Sub-section less the number of delegates allocated to the American Student Dental Association in paragraph b. of this Sub-section. The resulting true proportional delegate numbers will be used later in the delegate allocation methodology.
d. **Determination of Constituents and Federal Dental Services that Qualify to Receive More than the Minimum Delegate Allocation.**
    i. Divide the total constituent and federal dental service membership of the Association by the target number of delegates set forth in paragraph a. of this Sub-section less the number of delegates allocated to the American Student Dental Association in paragraph b. of this Sub-section. Compare the resulting number against the membership numbers for the Colegio de Cirujanos Dentistas de Puerto Rico, Virgin Islands Dental Association and Public Health Service if they received a single delegate

pursuant to the review performed in paragraph a. of this Sub-section. If the membership numbers of any of those entities are less than the result of the calculation, allocate the number of delegates deducted from the target delegate allocation number for each such entity and exclude those entities from the remaining steps of the delegate allocation methodology.

ii. Take the result of the calculation performed in sub-paragraph i. of this paragraph d. and multiply it by two (2). Compare the resulting number against the membership numbers for each constituent society and each federal dental service for which two (2) delegates were deducted from the target delegate allocation number in paragraph a. of this Sub-section. If the membership of any of those constituent societies and federal dental services are less than that number, allocate the number of delegates deducted from the target delegate allocation number for each such entity and exclude those entities from the remaining steps of the delegate allocation methodology.

e. **Calculation of Non-Minimum Membership Total.** Subtract the total membership numbers of each constituent society and federal dental service identified as being excluded from the remaining steps of the delegate allocation methodology from the total membership of the Association. The resulting non-minimum membership total will be used in the remaining delegate allocation methodology steps.

f. **Allocation of Remaining Delegates.**

i Divide each remaining constituent's and federal dental service's membership by the non-minimum membership total determined in paragraph e. of this Sub-section to arrive at their percentages of the non-minimum membership total.

ii. Calculate the remaining number of delegates to be allocated by subtracting from the target number of delegates listed in paragraph a. of this Sub-section the delegates allocated to the American Student Dental Association in paragraph b. of this Sub-section and the delegates allocated by the minimum allocation steps in paragraphs d.i and d.ii. of this Sub-section.

iii. For each remaining constituent and federal dental service, multiply its percentage of the non-minimum membership total determined by the calculation in paragraph f.i. of this Sub-section and the remaining number of delegates to be allocated as determined by the calculation in paragraph f.ii. of this Sub-section. Round the result to the nearest whole number.

iv. For each remaining constituent and federal dental service, multiply the result obtained in paragraph f.i. of this Subparagraph by the target number of delegates specified in paragraph a. of this Sub-section less the number of delegates allocated to the American Student Dental Association pursuant to paragraph b. of the Sub-section and round the result to the nearest whole number.

v. For each remaining constituent and federal dental service, subtract the result obtained in sub-paragraph f.iv. of this Sub-section from the result obtained in sub-paragraph f.iii. of this Sub-section. If the result is negative, use the result obtained in subparagraph f.iv. of this Sub-section as that constituent's allocated delegate total. If the result is zero or positive, use the result obtained in sub-paragraph f.iii. of this Sub-section as that constituent's allocated delegate total.

g. **Finalize the Delegate Allocation.** Add together the final delegate allocations for the constituent societies, federal dental services and the American Student Dental Association determined through the calculations of paragraph b., sub-paragraphs d.i. and d.ii. and sub-paragraph f.v. of this Subsection. The result is the total delegates allocated. The total delegates allocated should vary no more than 5% from the target number of delegates set forth in paragraph a. of this Subsection.

h. **Calculating the Fairness Ratio.** Divide each constituent's and each federal dental service's percentage of total delegates (the constituent's allocated delegates divided by the total delegates allocated as determined by the calculation set forth in sub-paragraph f.v. of this Sub-section) by its percentage of total membership as calculated in paragraph a. of this Sub-Section. Except for those constituents that only receive the minimum number of allocated delegates, the resulting "fairness ratio" should deviate by a small amount on either side of 1, with 1 representing a perfectly proportional delegate allocation. The fairness ratio for constituents and federal dental services that receive only the minimum allocation of delegates may deviate from 1 to a larger degree because those constituents and federal dental services may be slightly over-represented.

CHAPTER VII. BOARD OF TRUSTEES, *Section* 100. DUTIES, Subsection N.

Section 100. DUTIES: It shall be the duty of the Board of Trustees to:

N. Review the periodic delegate allocations to the House of Delegates performed pursuant to the methodology set forth in CHAPTER V. HOUSE OF DELEGATES, *Section* 10. COMPOSITION, Subsection D. DELEGATE ALLOCATION against the representational requirements and goals as provided in Chapter V, Section 10C, of these Bylaws.

Resolution No. 2S-1 Substitute

Report: Board Report 3 Date Submitted: October 2013

Submitted By: Twelfth Trustee District

Reference Committee: Legislative, Health, Governance and Related Matters

Total Net Financial Implication: None Net Dues Impact:

Amount One-time Amount On-going FTE 0

ADA Strategic Plan Goal: Members (Required)

SUBSTITUTE FOR RESOLUTION 2: DELEGATE ALLOCATION

The following substitute to Resolution 2 (Worksheet:5018) was submitted by the Twelfth Trustee District and transmitted on October 24, 2013, by Mr. Ward Blackwell, executive director/ceo, Louisiana Dental Association/Louisiana Dental Services, Inc.

Background: Resolution 2 as introduced has inherent conflicts among its stated goals that make it impossible to fully attain all of them at once. This is not to say the Board has brought forth a bad proposal. Quite the contrary. It is simply recognition that ANY proposal to re-allocate delegates will have imperfections.

One question then is whether the proposal advances vital organizational goals sufficiently to make up for those imperfections. In the view of the Twelfth District, there is no goal of the ADA that is currently more important than stemming the tide of decreasing market share. There currently are two major initiative focused squarely on this goal, as noted by Drs. Faiella and O'Loughlin in recent Leadership Updates:

> "The Power of 3 will help the ADA and all tripartite dental societies reverse the membership market share decline, build a compelling rationale for membership, and deliver outstanding resources and service to members." (*Leadership Update* e-mail, August 25, 2013)

> "The MPG was established by the ADA's Council on Membership in 2010 to provide a process for identification, support and replication of those activities that lead to an increase in overall ADA membership market share." (*Leadership Update* e-mail, October 4, 2013)

Accordingly, it simply makes sense that incentivizing the preservation of market share would be a part of everything the ADA does, including governance. It does NOT make sense to effectively penalize any part of the tripartite that is doing its part in that regard.

Therefore, the Twelfth District proposes that the allocation of delegates take into account preservation of market share as a "goal." Under this proposal, the benchmark for measuring against shall be based on the ADA's actual overall market share change over the three most recent completed membership years (2010-2012). In that time, ADA market share declined by 2%, from 68.2% to 66.2%. So, this substitute resolution would add an additional review to the process AFTER all other calculations in the original Resolution 2 methodology have been completed. In essence, this final review would ensure that no constituent would have its representation reduced if it had done better in preserving market share than the ADA did overall for this benchmark period.

It should be noted that this substitute resolution preserves virtually the ENTIRE process of calculation in the original Resolution 2. Thus, it also preserves all the positive points achieved by the

original Resolution 2 with one exception: it cannot provide the same degree of assurance that the size of the House will vary no more than 5 percent from 473 members. However, it is highly unlikely that the provisions of the substitute resolution will lead to growth in the size of the House that would cause the total number of delegates to vary *significantly* more than 5 percent from the target of 473.

To reiterate, the original Resolution 2 is a balancing act among competing goals that had a certain degree of mutual exclusivity. This substitute resolution does the same thing, but merely adds one more goal to balance. The Twelfth believes that whatever small additional tradeoffs are required to include this one additional goal in the allocation methodology are well worth it, given the principle that goal reinforces.

Resolution

2S-1. Resolved, that CHAPTER II. CONSTITUENT SOCIETIES, *Section* 100. PRIVILEGE OF REPRESENTATION, of the ADA *Bylaws* be amended as follows (additions underscored, deletions ~~stricken through~~):

Section 100. PRIVILEGE OF REPRESENTATION:

Each state constituent dental society and the District of Columbia Dental Society shall be entitled to a minimum of two (2) delegates in the House of Delegates. Each territorial constituent society and federal service shall be entitled to a minimum of two (2) delegates in the House of Delegates~~, except that~~ if its total membership is equal to or greater than the size that of the smallest state constituent society; otherwise the territorial society or service shall receive one (1) delegate ~~shall be allocated to the Virgin Islands Dental Association~~. ~~The Air Force Dental Corps, the Army Dental Corps, the Navy Dental Corps, the Public Health Service and the Department of Veterans Affairs shall each be entitled to two (2) delegates, one of which shall be elected by the respective service, without regard to the number of members~~. The remaining number of delegates shall be allocated as provided in Chapter V, Sections 10C and 10D.

Each constituent society and each federal dental service may select from among its active, life and retired members the same number of alternate delegates as delegates and shall designate the alternate delegate who shall replace an absent delegate.

and be it further

Resolved, that CHAPTER V. HOUSE OF DELEGATES, *Section* 10. COMPOSITION, Subsection A. VOTING MEMBERS of the ADA *Bylaws* be amended as follows (additions underscored, deletions ~~stricken through~~):

Section 10. COMPOSITION.

A. VOTING MEMBERS. The House of Delegates ~~shall be limited to four hundred sixty (460) voting members for the two years 2004 to 2005 inclusive. Thereafter, the number of voting members shall be determined by the methodologies set forth in Section 10C of this Chapter. It~~ shall be composed of the officially certified delegates of the constituent dental societies and of the five (5) federal dental services, who shall be active, life or retired members~~, two (2) officially certified delegates from each of the five (5) federal dental services, who shall be active, life or retired members~~ and five (5) student members of the American Student Dental Association who are officially certified delegates from the American Student Dental Association. Proxy voting is explicitly prohibited; 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.

and be it further

Resolved, that CHAPTER V. HOUSE OF DELEGATES, *Section* 10. COMPOSITION, Subsection C. REPRESENTATIONAL REQUIREMENTS AND GOALS of the ADA *Bylaws* be amended as follows (additions underscored, deletions ~~stricken through~~):

C. REPRESENTATIONAL REQUIREMENTS AND GOALS. Each constituent society and each of the five federal dental services shall be entitled to the minimum ~~two (2)~~ number of delegates set forth in CHAPTER II. CONSTITUENT SOCIETIES, *Section* 100. PRIVILEGE OF REPRESENTATION~~, except that one (1) delegate shall be allocated to the Virgin Islands Dental Association. The Air Force Dental Corps, the Army Dental Corps, the Navy Dental Corps, the Public Health Service and the Department of Veteran Affairs shall each be entitled to two (2) delegates, one of which shall be elected by the respective service, without regard to the number of members.~~ The American Student Dental Association shall be entitled to the number of delegates set forth in CHAPTER V. HOUSE OF DELEGATES, *Section* 10. COMPOSITION *Subsection*.A. VOTING MEMBERS

The allocation of the remaining delegates shall be made pursuant to the delegate allocation methodology set forth in Subsection D. of this Section, with the goals of (i) achieving as close to proportional representation of active, life and retired members of the Association as possible while providing for both the minimum representational requirements set forth in CHAPTER II. CONSTITUENT SOCIETIES, *Section* 100. PRIVILEGE OF REPRESENTATION, as well as assurance that no constituent society shall be allocated fewer delegates if it has maintained market share, consistent with the membership objectives of this association and the methodology detailed in Subsection D, paragraph h of this Section; (ii) providing for representation of the American Student Dental Association; and (iii) maintaining the size of the House of Delegates as close to 473 delegates as possible while meeting the other goals recited in this Subsection.

~~For the two years 2004-2005 inclusive, the remaining number of delegates shall be allocated to the constituent societies, through their trustee districts based on the representational goals that each trustee district's representation in the House of Delegates shall vary by no more or less than 0.3% from its active, life or retired membership share in this Association, based on the Association's December 31, 2002 membership records, and that no district or constituent shall lose a delegate from its 2003 allocation. Thereafter, to allow for changes in the delegate allocation due to membership fluctuations, the Board of Trustees shall use this variance method of district delegate allocation (a variance of no more than 0.3% of its active, life and retired membership share in the Association) at subsequent intervals of three (3) years, with the first such review occurring for the 2006 House of Delegates. Such reviews shall be based on the Association's year-end membership records for the calendar year preceding the review period in question. No district shall lose a delegate unless their membership numbers are at least one percent less than their membership numbers of the prior three years. Any changes deemed necessary shall be presented to the House of Delegates in the form of a Bylaws' amendment to Section 10D of this Chapter.~~

and be it further

Resolved, that CHAPTER V. HOUSE OF DELEGATES, *Section* 10. COMPOSITION, Subsection D. DELEGATE ALLOCATION of the ADA *Bylaws* be amended as follows (additions underscored, deletions ~~stricken through~~):

D. DELEGATE ALLOCATION METHODOLOGY. Commencing in 2014, ~~Based~~ based on the representational requirements and goals set forth in Section 10C, ~~the~~ delegates shall be allocated according to the allocation methodology set forth below. Thereafter, to account for membership fluctuations, delegate allocations shall be reviewed and delegates shall be reallocated by the Secretary of the House of Delegates every four (4)

years among the constituent dental societies, the five (5) federal dental services and the American Student Dental Association in accordance with that same methodology. Delegate allocations shall be based on the Association's year-end membership records for the second calendar year preceding the year in which the delegate allocations become effective. The review of delegates shall take place as soon as possible after the membership numbers on which the delegate allocations are based are available and the Secretary of the House of Delegates shall publish the new delegate allocations expeditiously thereafter to the constituent dental societies, the five (5) federal dental services and the American Student Dental Association. The delegate allocations shall also be published in the Manual of the House of Delegates. ~~are allocated as follows:~~ The delegate allocation methodology is as follows:

~~DISTRICT 1~~
~~Connecticut State Dental Association, The, 7 delegates~~
~~Maine Dental Association, 3 delegates~~
~~Massachusetts Dental Society, 13 delegates~~
~~New Hampshire Dental Society, 3 delegates~~
~~Rhode Island Dental Association, 3 delegates~~
~~Vermont State Dental Society, 2 delegates~~
~~District Total: 31 delegates~~

~~DISTRICT 2~~
~~New York State Dental Association, 41 delegates~~
~~District Total: 41 delegates~~

~~DISTRICT 3~~
~~Pennsylvania Dental Association, 18 delegates~~
~~District Total: 18 delegates~~

~~DISTRICT 4~~
~~Air Force Dental Corps, 2 delegates~~
~~Army Dental Corps, 2 delegates~~
~~Delaware State Dental Society, 2 delegates~~
~~District of Columbia Dental Society, The, 2 delegates~~
~~Maryland State Dental Association, 7 delegates~~
~~Navy Dental Corps, 2 delegates~~
~~New Jersey Dental Association, 12 delegates~~
~~Public Health Service, 2 delegates~~
~~Puerto Rico, Colegio de Cirujanos Dentistas de, 2 delegates~~
~~Veterans Affairs, 2 delegates~~
~~Virgin Islands Dental Association, 1delegate~~
~~District Total: 36 delegates~~

~~DISTRICT 5~~
~~Alabama Dental Association, 5 delegates~~
~~Georgia Dental Association, 10 delegates~~
~~Mississippi Dental Association, The, 3 delegates~~
~~District Total: 18 delegates~~

~~DISTRICT 6~~
~~Kentucky Dental Association, 6 delegates~~
~~Missouri Dental Association, 7 delegates~~
~~Tennessee Dental Association, 7 delegates~~
~~West Virginia Dental Association, 3 delegates~~

~~District Total: 23 delegates~~

~~DISTRICT 7~~
~~Indiana Dental Association, 9 delegates~~
~~Ohio Dental Association, 16 delegates~~
~~District Total: 25 delegates~~

~~DISTRICT 8~~
~~Illinois State Dental Society, 20 delegates~~
~~District Total: 20 delegates~~

~~DISTRICT 9~~
~~Michigan Dental Association, 17 delegates~~
~~Wisconsin Dental Association, 9 delegates~~
~~District Total: 26 delegates~~

~~DISTRICT 10~~
~~Iowa Dental Association, 5 delegates~~
~~Minnesota Dental Association, 9 delegates~~
~~Nebraska Dental Association, The, 3 delegates~~
~~North Dakota Dental Association, 2 delegates~~
~~South Dakota Dental Association, 2 delegates~~
~~District Total: 21 delegates~~

~~DISTRICT 11~~
~~Alaska Dental Society, 2 delegates~~
~~Idaho State Dental Association, 3 delegates~~
~~Montana Dental Association, 2 delegates~~
~~Oregon Dental Association, 6 delegates~~
~~Washington State Dental Association, 11 delegates~~
~~District Total: 24 delegates~~

~~DISTRICT 12~~
~~Arkansas State Dental Association, 4 delegates~~
~~Kansas Dental Association, 4 delegates~~
~~Louisiana Dental Association, The, 6 delegates~~
~~Oklahoma Dental Association, 5 delegates~~
~~District Total: 19 delegates~~

~~DISTRICT 13~~
~~California Dental Association, 67 delegates~~
~~District Total: 67 delegates~~

~~DISTRICT 14~~
~~Arizona Dental Association, 7 delegates~~
~~Colorado Dental Association, 8 delegates~~
~~Hawaii Dental Association, 3 delegates~~
~~Nevada Dental Association, 3 delegates~~
~~New Mexico Dental Association, 3 delegates~~
~~Utah Dental Association, 4 delegates~~
~~Wyoming Dental Association, 2 delegates~~
~~District Total: 30 delegates~~

~~DISTRICT 15~~

~~Texas Dental Association, 23 delegates~~
~~District Total: 23 delegates~~

~~DISTRICT 16~~
~~North Carolina Dental Society, The, 10 delegates~~
~~South Carolina Dental Association, 5 delegates~~
~~Virginia Dental Association, 10 delegates~~
~~District Total: 25 delegates~~

~~DISTRICT 17~~
~~Florida Dental Association, 21 delegates~~
~~District Total: 21 delegates~~

~~AMERICAN STUDENT DENTAL ASSOCIATION, 5 delegates~~

a. **The Target Delegate Number.** For purposes of allocating delegates, the target number of delegates to be used in calculating the allocation is four hundred seventy-three (473). From that target number two delegates will be deducted for each constituent society except that only a single delegate will be deducted from each of the Colegio de Cirujanos Dentistas de Puerto Rico and the Virgin Islands Dental Association unless the number of members in either of those societies is equal to or greater than the number of members in the smallest state constituent society, in which case a minimum of two (2) delegates will be deducted from the target delegate number for that society. One delegate is deducted from the target delegate number for each of the five (5) dental services, except that a minimum of two (2) delegates will be deducted for any federal dental service where the number of members is equal to or greater than the number of members in the smallest state constituent society. In addition, five (5) delegates will be deducted from the target delegate number for the American Student Dental Association. For purposes of the delegate allocation methodology set forth in these *Bylaws*, the remaining number of delegates in the target number of delegates following the deductions of delegates listed above from the target number of delegates shall be referred to as the net delegate allocation pool.

b. **Allocation to the American Student Dental Association.** Five (5) delegates shall be allocated to the American Student Dental Association regardless of the number of members.

c. **Determination of the True Proportional Delegate Counts for each Constituent and each Federal Dental Service.** Divide each constituent's and each federal dental service's total membership by the total membership of the Association. Multiply the resulting percentage of membership for each constituent and federal dental service by the target number of delegates set forth in paragraph a. of this Sub-section less the number of delegates allocated to the American Student Dental Association in paragraph b. of this Sub-section. The resulting true proportional delegate numbers will be used later in the delegate allocation methodology.

d. **Determination of Constituents and Federal Dental Services that Qualify to Receive More than the Minimum Delegate Allocation.**

i. Divide the total constituent and federal dental service membership of the Association by the target number of delegates set forth in paragraph a. of this Sub-section less the number of delegates allocated to the American Student Dental Association in paragraph b. of this Sub-section. Compare the resulting number against the membership numbers for the Colegio de Cirujanos Dentistas de Puerto Rico, Virgin Islands Dental Association and Public Health Service if

they received a single delegate pursuant to the review performed in paragraph a. of this Sub-section. If the membership numbers of any of those entities are less than the result of the calculation, allocate the number of delegates deducted from the target delegate allocation number for each such entity and exclude those entities from the remaining steps of the delegate allocation methodology.

ii. Take the result of the calculation performed in sub-paragraph i. of this paragraph d. and multiply it by two (2). Compare the resulting number against the membership numbers for each constituent society and each federal dental service for which two (2) delegates were deducted from the target delegate allocation number in paragraph a. of this Sub-section. If the membership of any of those constituent societies and federal dental services are less than that number, allocate the number of delegates deducted from the target delegate allocation number for each such entity and exclude those entities from the remaining steps of the delegate allocation methodology.

e. **Calculation of Non-Minimum Membership Total.** Subtract the total membership numbers of each constituent society and federal dental service identified as being excluded from the remaining steps of the delegate allocation methodology from the total membership of the Association. The resulting non-minimum membership total will be used in the remaining delegate allocation methodology steps.

f. **Allocation of Remaining Delegates.**

i. Divide each remaining constituent's and federal dental service's membership by the non-minimum membership total determined in paragraph e. of this Sub-section to arrive at their percentages of the non-minimum membership total.

ii. Calculate the remaining number of delegates to be allocated by subtracting from the target number of delegates listed in paragraph a. of this Sub-section the delegates allocated to the American Student Dental Association in paragraph b. of this Sub-section and the delegates allocated by the minimum allocation steps in paragraphs d.i and d.ii. of this Sub-section.

iii. For each remaining constituent and federal dental service, multiply its percentage of the non-minimum membership total determined by the calculation in paragraph f.i. of this Sub-section and the remaining number of delegates to be allocated as determined by the calculation in paragraph f.ii. of this Sub-section. Round the result to the nearest whole number.

iv. For each remaining constituent and federal dental service, multiply the result obtained in paragraph f.i. of this Subparagraph by the target number of delegates specified in paragraph a. of this Sub-section less the number of delegates allocated to the American Student Dental Association pursuant to paragraph b. of the Sub-section and round the result to the nearest whole number.

v. For each remaining constituent and federal dental service, subtract the result obtained in sub-paragraph f.iv. of this Sub-section from the result obtained in sub-paragraph f.iii. of this Sub-section. If the result is negative, use the result obtained in subparagraph f.iv. of this Sub-section as that constituent's allocated delegate total. If the result is zero or positive, use the result obtained in sub-paragraph f.iii. of this Sub-section as that constituent's allocated delegate total.

g. **Base Delegate Allocation.** Add together the final delegate allocations for the constituent societies, federal dental services and the American Student Dental Association determined through the calculations of paragraph b., sub-paragraphs d.i. and d.ii. and sub-paragraph f.v. of this Subsection. The result is the Base Delegate Allocation.

h. **Allowance for Maintenance of Market Share/Final Delegate Allocation**. Should the Base Delegate Allocation as determined in accordance with paragraph g. of this SubSection result in a reduction in the number of delegates allocated to any constituent society compared to the prior year, the following review shall apply for those constituent societies: if in the three-year period ending on December 31 prior to the performance of calculations as provided in this Subsection, the constituent society's market share among licensed, actively practicing dentists did not decline more than 2% (i.e., the market share on December 31 was not more than 2% less than the market share at the beginning of the three-year period), then the total number of delegates allocated to that constituent society in the Base Delegate Allocation shall be increased to match the number of delegates allocated to that society in the prior year. The resulting delegate allocation after performing this review shall be the Final Delegate Allocation.

and be it further

Resolved, that CHAPTER VII. BOARD OF TRUSTEES, *Section* 100. DUTIES, Subsection N. of the ADA *Bylaws* be amended as follows (additions underscored):

Section 100. DUTIES: It shall be the duty of the Board of Trustees to:

N. Review the periodic delegate allocations to the House of Delegates performed pursuant to the methodology set forth in CHAPTER V. HOUSE OF DELEGATES, *Section* 10. COMPOSITION, Subsection D. DELEGATE ALLOCATION against the representational requirements and goals as provided in Chapter V., Section 10C of these *Bylaws*.

BOARD RECOMMENDATION: Received after the October Board of Trustees session.

NOTES

Resolution No. 175-2012 New

Report: N/A Date Submitted: October 2012

Submitted By: Seventeenth Trustee District

Reference Committee: Legislative, Health, Governance and Related Matters

Total Net Financial Implication: None Net Dues Impact:

Amount One-time Amount On-going FTE 0

ADA Strategic Plan Goal: Financial (Required)

AMENDMENT OF THE ADA CONSTITUTION, SECTION 20. ADMINISTRATIVE BODY

The following resolution was submitted by the Seventeenth Trustee District and transmitted on October 19, 2012, by Dr. Kim Jernigan, Seventeenth District Caucus Chair.

Background: Since the ADA meeting in Hawaii, many hours have been spent contemplating how best for the House to exercise its fiduciary responsibility and its supreme governing authority, especially regarding the adoption of the budget and to address the undesirable method of the Board "going behind the curtain" to balance the budget in the waning moments of the House.

To ensure that we achieve the necessary and adequate checks and balances while accomplishing strategic budgeting, the right and privilege of developing and adopting the budget should be accomplished by both the House and the Board, with the understanding that the *Bylaws* will later define more clearly the responsibilities of each.

In lieu of our repeated efforts to accomplish these goals, the roadblock has been the current Constitution which prohibits the House from performing any administrative duties. Therefore in consultation with the Speaker of the House and General Counsel, a limited exception to the administrative duties section of the Constitution is proposed. This resolution attempts to open a narrow window to allow the House and Board to work together to accomplish a budgetary process that is in the best interest of the ADA.

Resolution

175-2012. Resolved, that the ADA *Constitution* be amended by addition to Article IV Government, Section 20, in line 52 after the word "Board" the following: "with the exception that the Board and the House of Delegates shall have joint responsibility for development and adoption of the annual budget" so that Section 20 reads:

> Section 20. ADMINISTRATIVE BODY: The administrative body of the Association shall be a Board of Trustees, which may be referred to as 'the Board" or "this Board," <u>with the exception that the Board and the House of Delegates shall have joint responsibility for development and adoption of the annual budget.</u>

BOARD COMMENT: The Board appreciates the intent behind this resolution last year as a means to leave parliamentary options open, in light of the anticipated work of the Resolution 97 Task Force. The Board is recommending a no vote on this resolution due to the fact that it is inconsistent with the substitute resolution proposed by the Board in response to Resolutions 64 and 65.

BOARD RECOMMENDATION: Vote No.

Board Vote: Resolution 175-2012

BUCKENHEIMER	Yes	FEINBERG	No	NORMAN	No	VERSMAN	No
CROWLEY	No	GOUNARDES	No	ROBERTS	No	WEBER	No
DOW	No	HAGENBRUCH	No	SCOTT	No	YONEMOTO	No
ENGEL	No	ISRAELSON	No	SEAGO	No	ZENK	No
FAIR	No	KIESLING	No	SUMMERHAYS	No	ZUST	No

Resolution No. 39 New

Report: NA Date Submitted: August 2013

Submitted By: Council on Ethics, Bylaws and Judicial Affairs

Reference Committee: Legislative, Health, Governance and Related Matters

Total Net Financial Implication: None Net Dues Impact:

Amount One-time Amount On-going FTE 0

ADA Strategic Plan Goal: Members (Required)

AMENDMENT OF THE POLICY, ELIMINATING USE OF HUMAN SUBJECTS IN BOARD EXAMINATIONS

Background: (*Reports*:73).

Amendment of the Policy, Eliminating Use of Human Subjects in Board Examinations: Following debate, the House of Delegates referred Resolution 29-2012 to appropriate agencies to evaluate the second resolving clause for accuracy and relevance. In December 2012, the resolution was assigned to the Division of Legal Affairs (the Council) and the Division of Education/Professional Affairs (Council on Dental Education and Licensure or CDEL). The referred resolution as it was amended by the 2012 House of Delegates before referral appears in Appendix A.

The Council would like to acknowledge with sincere appreciation the thorough and thoughtful review performed by CDEL on Resolution 29-2012 and the Council's proposed revisions to the Resolution. The Council and CDEL have reached agreement on all but one of the revisions to the substitute for Resolution 29-2012 proposed, as indicated below and in correspondence between the Chair of the Council on Dental Education and Licensure and the Council's chair (Appendix B).

The Council, through a workgroup and assisted by a liaison from CDEL, conducted an in-depth review of the resolution, focusing much of its attention on the accuracy and relevance of the second resolving clause of the policy. Initially, a level of discomfort was expressed in labeling the clinical licensure examination process "ethical" or "not unethical." However, as the Council's review progressed, the Council came to believe that the policy expressed by the resolution remains valid. It was recognized that it is not the employment of patients in clinical examinations that is unethical; rather, it is in the areas of the identification of patients to participate in clinical examinations and the provision of follow-up or necessary ongoing treatment subsequent to the participation in the clinical licensure examination process where conduct considered to be unethical may take place. For that reason, the Council deemed it important that the policy reference the Council's 2008 statement entitled "Ethical Considerations When Using Patients in the Examination Process" (http://www.ada.org/sections/educationAndCareers/pdfs/ethics_clinical_exam.pdf).*

* *This Council statement was originally entitled "Ethical Considerations When Using Human Subjects/Patients in the Examination Process." In view of the observation expressed in correspondence between the chair of the Council on Dental Education and Licensure and the Council's chair (Appendix B) that "human subjects" has biomedical research connotations not appropriate to the subject of the statement, the Council approved revising its 2008 statement to replace the phrase "human subjects/patients" with the term "patients."*

Additionally, concern was expressed regarding the specific wording of the second resolving clause of the policy because of the use of a double negative ("not … unethical"). It was also felt that a stronger distinction needed to be made between the clinical licensure process itself and the procurement and post-treatment care of patients who participate in the examination process. Consequently, the Council approved a new resolution that does away with the problematic double negative and clearly differentiates between the clinical licensure examination itself and the unethical practices that may arise during patient identification and post-treatment care referenced in the Council's 2008 statement.

During its review of the resolution, the Council received information concerning the frequency with which curriculum integrated format examinations are available. That information led the Council to understand that curriculum integrated format examinations as defined by the ADA—involving patients of record who have received care properly sequenced with a treatment plan and with assessments of candidates' skills being available at multiple times—are relatively rare given the number of variables that must be aligned to meet the ADA definition. The Council was also informed that the phrase "curriculum integrated format" is used to refer to examinations that do not meet the ADA's definition found in 1H-2007 (*Trans.*2007:389) (for example, when multiple assessments of students' clinical skills are not available). This information led the Council to insert the phrase "as defined by the ADA" following the recitation of "curriculum integrated format" in the fourth resolving clause of the policy.

Further, the Council was alerted to the fact that a patient of record is <u>not</u> a requirement in a curriculum integrated format examination. Rather, a patient of record is only used "whenever possible," to quote the words of the ADA definition. This greatly concerned the Council because the same ethical issues discussed in the Council's 2008 statement may arise when a patient not of record is used during the clinical examination, even though it is categorized as a curriculum integrated format examination.

This concern led the Council to discuss other examination formats and, in particular, the portfolio style format. Because that format relies on an assessment of a portfolio of a candidate's clinical treatment completed during dental school on patients of record of the dental school clinic, the Council believed that the portfolio style format clinical examination provides an assessment mechanism free of the ethical concerns that are present when patients not of record are used during clinical licensure examinations including patient solicitation, selection, involvement, consent, care and follow-up treatment. Consequently, the Council proposed the inclusion of the phrase "or a portfolio style format" in the penultimate resolving clause of a new resolution.

That revision is the one revision to Resolution 29-2012 that has not been agreed upon between the Council and CDEL. CDEL's objections to the revision are that the House of Delegates has not as yet approved a formal definition for the phrase "portfolio style examination" and that no jurisdictions as yet grant initial licensure based on a portfolio style examination (Appendix B).

Following the receipt of the correspondence from the CDEL chair, the Council carefully considered and weighed CDEL's objections to the inclusion of the phrase "or a portfolio style format." The Council believed that irrespective of any formal definition of the term portfolio style that might be adopted it will include the feature that makes the examination format singularly attractive from an ethics perspective—it will assess treatment of patients of record, thus avoiding the ethical pitfalls in patient identification, care and follow-up that can arise when non-record patients are used in the clinical examination process. It should also be noted that the lack of a formal definition did not deter the ADA Board of Trustees from convening a task force to study portfolio style examinations. Concerning CDEL's second objection, the Council did not feel the fact that no states are using portfolio style format clinical examinations detracts from its proposed revision. Instead the Council believed that the revision proposed may supply the impetus needed for states to adopt portfolio style clinical examinations in their licensure processes. As the ethical conscience of the ADA, it is incumbent on the Council to lead on this issue.

As a result of the Council's review of referred Resolution 29-2012, the Council is not offering Resolution 29-2012 to the House. Instead, the Council recommends that the following resolution be adopted:

Resolution

39. Resolved, that the ADA policy "Eliminating Use of Human Subjects in Board Examinations" (*Trans.*2005:335) be amended as follows (additions are underscored and deletions are ~~stricken~~):

Eliminating Use of ~~Human Subjects~~ Patients in Board Examinations

Resolved, that dental students providing patient care under the direct and/or indirect supervision of qualified faculty is an essential method of learning clinical skills including the ability to manage the anxieties, fears, reflexes and other emotions related to dental treatment, and be it further

Resolved, that the Association recognizes that ethical considerations, including those identified in the ADA Council on Ethics, Bylaws and Judicial Affairs statement entitled *Ethical Considerations When Using Patients in the Examination Process* (Annual Reports and Resolutions 2008:103), arise from the use of patients in the clinical licensure examination process, even though the clinical examination process is itself ethical, and be it further

Resolved, that the ADA supports the elimination of ~~human subjects/~~patients in the clinical licensure examination process with the exception of the curriculum integrated format, as defined by the ADA, or a portfolio-style format within dental schools, and be it further

Resolved, that the Association encourages all states to adopt methodologies for licensure that are consistent with this policy.

and be it further

Resolved, that Resolution 147H-1996, Use of Human Subjects in Clinical Examinations (*Trans.*1996:712), be rescinded.

BOARD RECOMMENDATION: Vote Yes.

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

Appendix A

Resolution 29-2012. Eliminating Use of Human Subjects in Board Examinations (Trans.2012:478)

29. Resolved, that the ADA policy "Eliminating Use of Human Subjects in Board Examinations" (*Trans*.2005:335) be amended by inserting language from the policy "Use of Human Subjects in Clinical Licensure Exams" before the first resolving clause of the policy so the new, comprehensive policy "Eliminating Use of Human Subjects in Board Examinations" reads: (additions are underscored):

Eliminating Use of Human Subjects in Board Examinations

Resolved, that dental students providing patient care under the direct and/or indirect supervision of qualified faculty is an essential method of learning clinical skills including the ability to manage the anxieties, fears, reflexes and other emotions related to dental treatment, and be it further

Resolved, that although the use of human subjects in licensure examinations raises certain ethical concerns, the practice is not in and of itself unethical as determined by the ADA Council on Ethics, Bylaws and Judicial Affairs (*Trans*.1993:109), and be it further

Resolved, that the Association supports the elimination of human subjects/patients in the clinical licensure examination process with the exception of the curriculum integrated format within dental schools, and be it further

Resolved, that the Association encourages all states to adopt methodologies for licensure that are consistent with this policy, and be it further

Resolved, that Resolution 147H-1996, Use of Human Subject in Clinical Examinations (*Trans*.1996:712), be rescinded.

Appendix B

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May 2, 2013

Dr. Kevin A Henner
Chair
Council on Ethics, Bylaws and Judicial Affairs
163 Half Hollow Road, Suite 1
Deer Park, New York 11729

Dear Doctor Henner:

At our recent meeting, the Council on Dental Education and Licensure (CDEL) considered amendments to the ADA policy, Eliminating Use of Human Subjects in Board Examinations as proposed by the Council on Ethics, Bylaws and Judicial Affairs (CEBJA). As you know, changes to this policy were first proposed by CDEL to the 2012 House of Delegates via Resolution 29-2012. The House referred this resolution to the appropriate ADA agencies for evaluation of the accuracy and relevance of the second resolving clause. The referred resolution was assigned to CEBJA and CDEL. On behalf of CDEL, I want to thank CEBJA for its thoughtful work on Resolution 29-2012.

First, CDEL concurs with the revised second resolving clause as proposed by CEBJA. We believe the revised text accurately conveys the intent of the original policy, cites CEBJA's most recent work on pertinent ethical considerations, and eliminates cumbersome wording. CDEL also concurs with the addition of the phrase "as defined by the ADA" to describe the curriculum integrated format in the third resolving clause. We believe this appropriately highlights the ADA's conclusion that, if properly designed and implemented, this examination format has great potential to address the ethical implications of the use of patients in clinical licensure examinations.

However, CDEL has adopted several revisions to the proposed resolution as it was forwarded to us by CEBJA. First, CDEL recommends use of the term "patients" rather than "human subjects" in the title of the resolution and rather than "human subjects/patients" in the body of the resolution. While we understand that each of these terms can have multiple connotations, we believe the term "human subjects" improperly equates clinical licensure examinations with biomedical research protocols. We recognize that the term "human subjects" is contained in the title of a published CEBJA statement and ask that CEBJA consider revising the title of that statement, *Ethical Considerations When Using Human Subjects/Patients in the Examination Process*.

In addition, CDEL does not support the proposed addition of the phrase "or the portfolio-style format" in the third resolving clause. I want to be clear that this does not mean that CDEL is opposed to the concept of a portfolio-style examination. We simply have yet to take a formal position – in large part because the ADA House has not yet adopted a formal definition of a portfolio-style examination. Nor are there any states that currently grant initial licensure via a portfolio-style examination. As a result, CDEL believes it is premature to include a reference to the portfolio-style format in this resolution.

Finally, CDEL supports maintaining the word "adopt" in the last resolving clause. We believe that word more accurately reflects the fact that states adopt licensure methodologies via enactment of laws and regulations rather than simply recognize them.

At our recent meeting, CDEL (1) adopted revisions to Resolution 29-2012 as it was approved by CEBJA at its April 4-5 meeting, (2) asks that CEBJA also support CDEL's revised language, and (3) recommends that this proposed resolution (below) be transmitted jointly by our two Councils to the 2013 House of Delegates.

29. Resolved, that the ADA policy "Eliminating Use of Human Subjects in Board Examinations" (Trans.2005:335) be amended ~~by inserting language from the policy "Use of Human Subject in Clinical Licensure Exams" before the first resolving clause of the policy so the new, comprehensive policy "Eliminating Use of Human Subjects in Board Examinations" reads~~ as follows: (additions are underscored and deletions are stricken):

Eliminating Use of ~~Human Subjects~~ Patients in Board Examinations

Resolved, that dental students providing patient care under the direct and/or indirect supervision of qualified faculty is an essential method of learning clinical skills including the ability to manage the anxieties, fears, reflexes and other emotions related to dental treatment, and be it further

~~**Resolved,** that although the use of human subjects in licensure examinations raises certain ethical concerns, the practice is not in and of itself unethical as determined by the ADA Council on Ethics, Bylaws and Judicial Affairs (Trans.1993:109), and be it further~~

Resolved, that the Association recognizes that ethical considerations, including those identified in the ADA Council on Ethics, Bylaws and Judicial Affairs statement entitled *Ethical Considerations When Using ~~Human Subjects/~~Patients in the Examination Process* (Annual Reports and Resolutions 2008:103), arise from the use of patients in the clinical licensure examination process, even though the clinical examination process is itself ethical, and be it further

Resolved, that the ADA supports the elimination of ~~human subjects/~~patients in the clinical licensure examination process with the exception of the curriculum integrated format, as defined by the ADA, within dental schools, and be it further

Resolved, that the Association encourages all states to adopt methodologies for licensure that are consistent with this policy

and be it further

Resolved, that Resolution 147H-1996, Use of Human Subject in Clinical Examinations (Trans.1996:712), be rescinded.

We appreciate the opportunity to collaborate with CEBJA on this important ADA policy. We also look forward to many more opportunities to work together on issues of mutual interest. In the meantime, please contact me if I can provide any additional information.

Sincerely,

Ronald Venezie, DDS, MS
Chair
Council on Dental Education and Licensure

RV/jfj:eg

cc: Mr. Thomas C. Elliott, Jr., director, CEBJA
Ms. Karen M. Hart, director, CDEL

Resolution No. 39S-1 Substitute

Report: N/A Date Submitted: October 2013

Submitted By: Sixteenth Trustee District

Reference Committee: Legislative, Health, Governance and Related Matters

Total Net Financial Implication: None Net Dues Impact:

Amount One-time Amount On-going FTE 0

ADA Strategic Plan Goal: Members (Required)

SUBSTITUTE FOR RESOLUTION 39: AMENDMENT OF THE POLICY, ELIMINATING USE OF HUMAN SUBJECTS IN BOARD EXAMINATIONS

The following substitute to Resolution 39 (Worksheet:5029) was submitted by the Sixteenth Trustee District and transmitted on October 16, 2013, by Mr. Phil Latham, executive director, South Carolina Dental Association.

Resolution

39S-1. Resolved, that the ADA policy "Eliminating Use of Human Subjects in Board Examinations" (*Trans.*2005:335) be amended as follows (additions are underscored and deletions are ~~stricken~~):

Eliminating Use of ~~Human Subjects~~ Patients in Board Examinations

Resolved, that dental students providing patient care under the direct and/or indirect supervision of qualified faculty is an essential method of learning clinical skills including the ability to manage the anxieties, fears, reflexes and other emotions related to dental treatment, and be it further

Resolved, that the Association recognizes that ethical considerations, including those identified in the ADA Council on Ethics, Bylaws and Judicial Affairs statement entitled *Ethical Considerations When Using Patients in the Examination Process* (Annual Reports and Resolutions 2008:103), arise from the use of patients in the clinical licensure examination process, even though the clinical examination process is itself ethical, and be it further

Resolved, that the ADA supports the elimination of ~~human subjects/~~patients in the clinical licensure examination process with the exception of the curriculum integrated format, as defined by the ADA, within dental schools, and be it further

Resolved, that the Association encourages all states to adopt methodologies for licensure that are consistent with this policy.

and be it further

Resolved, that Resolution 147H-1996, Use of Human Subjects in Clinical Examinations (*Trans.*1996:712), be rescinded.

BOARD RECOMMENDATION: Received after the October Board of Trustees session.

NOTES

Resolution No. 40 New

Report: NA Date Submitted: August 2013

Submitted By: Council on Ethics, Bylaws and Judicial Affairs

Reference Committee: Legislative, Health, Governance and Related Matters

Total Net Financial Implication: None Net Dues Impact:

Amount One-time Amount On-going FTE 0

ADA Strategic Plan Goal: Members (Required)

STATEMENT REGARDING EMPLOYMENT OF A DENTIST

Background: (*Reports*:74).

Statement Regarding Employment of a Dentist: Following debate on Resolution 165-2012 and amendment of the resolution, the House of Delegates voted to refer the resolution to the appropriate agencies for study and report to the 2013 House. Subsequently, the Board of Trustees forwarded the resolution to the Division of Legal Affairs (Council on Ethics, Bylaws and Judicial Affairs) and the Division of Dental Practice/Professional Affairs (Council on Dental Practice). The referred resolution, as amended, appears in Appendix A.

The Council acknowledges with thanks the thoughtful work and collaboration of the Council on Dental Practice on the referral of Resolution 165-2012.

The Council agrees with the concept of Resolution 165-2012. However, in examining the referred resolution, the Council was concerned that identifying the listed items as “rights” might inadvertently convey to employed dentists or employers that the items were stringent requirements and that employed dentists would be able to enforce the enumerated rights through a corresponding legal remedy when such might not be the case. For this reason, the Council recast the statement to provide guidelines to both dentists entering into or in an employment relationship and employers.

The Council also believes that it would be beneficial for the statement to focus on employers as well as employed dentists and to broaden the scope of the statement so that it is applicable to dentists working as independent contractors as well as employees. The Council also thinks the guidelines on the employment of dentists would be more useful if the individual guidelines presented were grouped under three unifying core principles: (1) dentists’ paramount responsibility to their patients, (2) the employers’ and dentists’ joint obligations to obey applicable laws and regulations, and (3) the status of the dentist as a member of a learned profession.

As a result of the study and consideration of referred Resolution 165-2012 by the Council and the Council on Dental Practice, it is recommended that Resolution 165-2012 not be adopted. Rather, the Council recommends that the following resolution be adopted, and understands that the Council on Dental Practice joins in the Council’s recommendation:

Resolution

40. Resolved, that the American Dental Association adopts the following as a statement of fair practices in employing a dentist:

Statement Regarding Employment of a Dentist*

These guidelines provide guidance for practice owners or management companies (collectively "employers") in their working relationships with dentists associated with their practices, either as employees or independent contractors (collectively "employees"). The purpose of these guidelines is to protect the public in the provision of safe, high-quality and cost-effective patient care. Employers and employees should recognize and honor each of the guidelines set forth in this policy statement.

I. As described in the *ADA Principles of Ethics and Code of Professional Conduct*, dentists' paramount responsibility is to their patients. An employee dentist should not be disciplined or retaliated against for exercising independent professional judgment in patient assessment, diagnosis, treatment and comprehensive management, including with respect to but not limited to:

   a. The use of any materials, or the delivery of a prosthetic device, that represents an acceptable standard of care or the refusal to use materials or deliver a prosthetic device that does not represent an acceptable standard of care;

   b. The use of techniques that are reasonably believed to be within the standard of care and are in the patient's best interest or the refusal to use techniques that are not within the standard of care and are not in the patient's best interests (recognizing the patient's right to select among treatment options);

   c. The mandated provision of treatment that the employee dentist feels unqualified to deliver; and

   d. The provision of treatment that is not justified by the employee dentist's personal diagnosis for the specific patient.

II. Because all employers and employee dentists must conform to applicable federal, state, and local laws, rules and regulations, an employed dentist should not be disciplined or retaliated against for 1) adherence to legal standards and 2) reporting to appropriate legal authorities suspected illegal behavior by employers. Employers should make certain that, for example:

   a. Appropriate business practices, including but not limited to billing practices, are followed;

   b. Facilities and equipment are maintained to accepted standards;

   c. Employment contractual obligations are adhered to.

III. Because a dentist is functioning within a professional domain, anyone employing a dentist should, for example:

   a. Guard against lay interference in the exercise of a dentist's independent professional judgment in patient assessment, diagnosis, treatment and comprehensive management;

   b. To the extent permitted by law, promptly provide the dentist access to all relevant patient records in the event of peer review, board complaint or lawsuit, both during and subsequent to the dentist's employment; and

   c. Recognize and honor the dentist's commitment, as an ADA member, to comply with the *ADA Principles of Ethics and Code of Professional Conduct*.

* Dentists are advised that employment contracts may have provisions that conflict with these guidelines and the ADA recommends that dentists seek legal counsel when considering how contracts affect their professional rights and responsibilities.

and be it further

Resolved, that the Association publish and promote this statement to dentist employers and employees, and be it further

Resolved, that the Association encourage constituent societies to utilize this statement to facilitate legislative and regulatory measures to ensure the fair and ethical treatment of dentist employees and the patients that they treat.

BOARD RECOMMENDATION: Vote Yes.

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

Appendix A

Resolution 165-2012. Declaring an Employee Dentist's Bill of Rights (Trans.2012:505)

165. Resolved, that the American Dental Association adopts the following as a statement of fair practices in employing dentists:

The Employee Dentist's Bill of Rights*

1. An employee dentist has the right not to be penalized or terminated for exercising appropriate professional judgment in patient assessment, diagnosis or treatment.

2. An employee dentist has the right to refuse to deliver a prosthetic device that he/she believes does not represent an acceptable standard of care.

3. An employee dentist has the right to participate in selecting a lab to fabricate prostheses for which they are responsible.

4. An employee dentist has the right to refuse to use materials and techniques which he/she finds unacceptable or for which they feel unqualified.

~~5. An employee dentist has the right and responsibility to report unethical or illegal behavior by employers and other employees with the protection of whistleblower laws.~~

~~6. An employee dentist has the right to refuse to provide care for which he/she will not be compensated.~~

5. An employee dentist has the right to expect their employer to comply with applicable dental practice statutes and regulations.

6. An employee dentist has the right to expect appropriate and ethical business and billing practices by his/her employer.

7. An employee dentist has the right to expect employers to maintain facilities and equipment to accepted standards.

8. An employee dentist has the right to expect that HIPAA, OSHA and CDC guidelines are being enforced and adhered to.

9. An employee dentist has the right to perpetual access to the records of a patient he/she has treated, in the event of peer review, board complaint or lawsuit.

10. An employee dentist has the right to be a member of the professional organization of his/her choice.

11. An employee dentist has the right to abide by ADA Principles of Ethics and Code of Professional Conduct without obstruction by their employers.

12. An employee dentist has the right to refuse to perform treatment not justified by his/her own diagnosis.

**Dentists are advised that employment contracts may have provisions that conflict with these rights and the ADA recommends that dentists seek legal counsel when considering how contracts affect their professional rights and responsibilities.*

and be it further

Resolved, that the Association will publish and promote this statement to dentist employers and employees, and be it further

Resolved, that the Association encourages constituent societies to utilize this statement to facilitate legislative and regulatory measures to ensure the fair and ethical treatment of dentist employees and the patients that they treat.

Resolution No. 41 New

Report: NA Date Submitted: August 2013

Submitted By: Council on Ethics, Bylaws and Judicial Affairs

Reference Committee: Legislative, Health, Governance and Related Matters

Total Net Financial Implication: None Net Dues Impact:

Amount One-time Amount On-going FTE 0

ADA Strategic Plan Goal: Members (Required)

AMENDMENTS TO CHAPTER VIII, SECTIONS 30. B AND C, 50 AND 80. A OF THE ADA BYLAWS (NOMINATIONS, TERMS OF OFFICE AND VACANCIES FOR THE OFFICES OF TREASURER AND SPEAKER)

Background: (*Reports*:75).

Amendments to Chapter VIII, Sections 30.B and C, 50 and 80.A of the *ADA Bylaws* (Nominations, Terms of Office and Vacancies for the Offices of Treasurer and Speaker)*:* While performing its perennial review of the ADA *Constitution and Bylaws,* the Council recognized that the amendments to the term provisions for the office of Speaker of the House of Delegates passed by the 2012 House, which imposed term limits, created the potential for issues relating to vacancies in the position should an incumbent Speaker of the House of Delegates fail to complete a term of office or if no eligible candidate for the position is identified. Following consideration of alternatives for addressing those issues, the Council believes that should such a vacancy or lack of eligible candidates occur, there should be an exception to the term limit provisions created to allow a former Speaker of the House to serve as Speaker in a temporary capacity or, in the case of there being no eligible candidate, to allow the incumbent Speaker of the House of Delegates to continue in office. Because some of the same issues arise with respect to vacancies in the office of Treasurer, the Council is proposing amendments to the nomination provisions for that office to parallel the provisions being proposed for the Speaker of the House of Delegates.

In view of the foregoing, the Council recommends that the following amendment of the ADA *Bylaws* be made:

Resolution

41. Resolved, that CHAPTER VIII. ELECTIVE OFFICERS, Section 30. NOMINATIONS, Subsection B of the ADA *Bylaws* be amended as follows (additions underscored, deletions ~~stricken through~~):

B. Nominations for the office of Treasurer shall be made in accordance with the order of business. The search for Treasurer shall be announced in an official publication of the Association in November of the final year of the incumbent Treasurer's term, together with the recommended qualifications for that position as provided in Chapter VII, Section 100G of these *Bylaws*. Candidates for the office of Treasurer shall apply by submitting a standardized Treasurer Curriculum Vitae form to the Executive Director at least one hundred twenty (120) days prior to the convening of the House of Delegates. Each candidate's application shall be reviewed by the Board of Trustees. The Executive Director shall provide all members of the House of Delegates, at least sixty (60) days prior to the convening of the House of Delegates, with each candidate's

standardized Treasurer Curriculum Vitae and the determination of the Board of Trustees as to whether the candidate meets the recommended qualifications for the office of Treasurer. Only those candidates shall be nominated from the floor of the House of Delegates. The nominations may be followed by an acceptance speech not to exceed four (4) minutes by each candidate from the podium, according to the protocol established by the Speaker of the House of Delegates. Seconding a nomination is not permitted. No further nominations for the office of Treasurer shall be accepted from the floor of the House of Delegates. If there are no eligible candidates for the office of Treasurer when the House of Delegates meets, the term of the incumbent Treasurer shall be extended by one (1) year. Should the incumbent Treasurer be unwilling or unable to serve an additional one (1) year term, the office of Treasurer shall be filled in the same manner as provided in Chapter VIII, Section 80 of these *Bylaws*. Under these circumstances, former Treasurers of this Association not otherwise eligible to serve as Treasurer would be eligible to serve as Treasurer ~~*pro tem* for one (1) additional year~~ until the House of Delegates can elect a Treasurer.

and be it further

Resolved, that CHAPTER VIII. ELECTIVE OFFICERS, Section 30. NOMINATIONS, Subsection C of the ADA *Bylaws* be amended as follows (additions underscored, deletions ~~stricken through~~):

C. Nominations for the office of Speaker of the House shall be made in accordance with the order of business. The search for Speaker of the House shall be announced in an official publication of the Association in ~~January~~ November of the final year of the incumbent Speaker of the House's term. Candidates for the office of Speaker of the House shall apply by submitting curriculum vitae along with a statement supporting their qualifications to the Executive Director at least one hundred twenty (120) days prior to the convening of the House of Delegates. The Executive Director shall provide all members of the House of Delegates, at least sixty (60) days prior to the convening of the House of Delegates, with each candidate's curriculum vitae and statement of qualifications for the office of Speaker of the House. If no candidate has applied, or if there is no remaining eligible candidate for election, then the Association shall inform all delegates of this circumstance and the period to apply shall be extended to thirty (30) days prior to the convening of the House of Delegates. If thirty (30) days prior to the convening of the House of Delegates there is no remaining candidate for election then the Association shall inform all delegates of this circumstance and also inform them that nominations shall be permitted from the floor of the House of Delegates. Only those candidates shall be nominated from the floor of the House of Delegates. The nominations may be followed by an acceptance speech not to exceed four (4) minutes by each candidate from the podium, according to the protocol established by the Election Commission. Seconding a nomination is not permitted. No further nominations for the office of Speaker of the House shall be accepted from the floor of the House of Delegates. If there are no eligible candidates for the office of Speaker of the House when the House of Delegates meets, the term of the incumbent Speaker of the House shall be extended by one (1) year. Should the incumbent Speaker of the House be unwilling or unable to serve an additional one (1) year term, the office of Speaker of the House shall be filled in the same manner as provided in Chapter VIII, Section 80 of these *Bylaws*. Under these circumstances, former Speakers of the House of this Association not otherwise eligible to serve as Speaker of the House would be eligible to serve as Speaker of the House until the House of Delegates can elect a Speaker of the House of Delegates.

and be it further

Resolved, that CHAPTER VIII. ELECTIVE OFFICERS, Section 50. TERM OF OFFICE of the ADA *Bylaws* be amended as follows (additions underscored, deletions ~~stricken through~~):

Section 50. TERM OF OFFICE: The President, President-elect, First Vice President and Second Vice President shall serve for a term of one (1) year, except as otherwise provided in this chapter of the *Bylaws*, or until their successors are elected and installed. The Speaker of the House of Delegates shall be limited to two (2) terms of three (3) years each in total, consecutive or otherwise, excepting the case of a former Speaker of the House who has been elected Speaker of the House as provided in Chapter VIII, Section 30 of these *Bylaws*, who may serve until the House of Delegates can elect a Speaker of the House of Delegates. Serving any portion of a three (3) year term shall be considered service of a full three (3) year term. The term of office of the Treasurer shall be three (3) years, or until a successor is elected and installed. The Treasurer shall be limited to two (2) consecutive terms of three (3) years each, excepting the case of a former Treasurer who has been elected Treasurer ~~*pro tem*~~ as provided in Chapter VIII, Section 30 of these *Bylaws*, who may serve ~~one (1) additional year~~ until the House of Delegates can elect a Treasurer. Serving any portion of a three (3) year term shall be considered service of a full three (3) year term.

and be it further

Resolved, that CHAPTER VIII. ELECTIVE OFFICERS, Section 80. VACANCIES, Subsection A. VACANCY OF ELECTIVE OFFICE of the ADA *Bylaws* be amended as follows (additions underscored, deletions ~~stricken through~~):

A. VACANCY OF ELECTIVE OFFICE: In the event the office of President becomes vacant, the President-elect shall become President for the unexpired portion of the term. In the event the office of President becomes vacant for the second time in the same term or at a time when the office of President-elect is also vacant, the First Vice President shall become President for the unexpired portion of the term. In the event the office of First Vice President becomes vacant, the Second Vice President shall become the First Vice President for the unexpired portion of the term. A vacancy in the office of the Second Vice President shall be filled by a majority vote of the Board of Trustees. In the event of a vacancy in the office of Speaker of the House of Delegates, the President, with approval of the Board of Trustees, shall appoint a Speaker ~~*pro tem*~~ who shall serve until the House of Delegates can elect a Speaker of the House of Delegates for a three (3) year term. Service as an interim Speaker shall not count toward the term of office limitation for Speaker of the House as set forth in Section 50 of this Chapter. In the event the office of President-elect becomes vacant by reason other than the President-elect succeeding to the office of the President earlier than the next annual session, the office of President for the ensuing year shall be filled at the next annual session of the House of Delegates in the same manner as that provided for the nomination and election of elective officers, except that the ballot shall read “President for the Ensuing Year.” A vacancy in the office of Treasurer shall be filled by a majority vote of the Board of Trustees until the process of inviting applications, screening and nominating candidates and electing a new Treasurer has been completed by the Board of Trustees and the House of Delegates. ~~The Treasurer *pro tem* shall be eligible for election to a new consecutive three (3) year term.~~ Service as an interim Treasurer shall not count toward the term of office limitation for Treasurer as set forth in Section 50 of this Chapter. The newly elected Treasurer shall be limited to two (2) consecutive terms of three (3) years each, excepting the case of a former Treasurer who has been elected Treasurer ~~*pro tem*~~ as provided in Chapter VIII, Section 30 of these *Bylaws* ~~who may serve one (1) additional year~~.

BOARD RECOMMENDATION: Vote Yes.

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

Resolution No. 42 New

Report: NA Date Submitted: August 2013

Submitted By: Council on Ethics, Bylaws and Judicial Affairs

Reference Committee: Legislative, Health, Governance and Related Matters

Total Net Financial Implication: None Net Dues Impact:

Amount One-time Amount On-going FTE 0

ADA Strategic Plan Goal: Members (Required)

AMENDMENT OF CHAPTER X, SECTION 120, SUBSECTION G, PARAGRAPH I OF THE ADA BYLAWS (DUTIES OF THE COUNCIL ON ETHICS, BYLAWS AND JUDICIAL AFFAIRS)

Background: (*Reports*:77)

Amendment to Chapter X, Section 120, Subsection G, Paragraph i of the *ADA Bylaws* (Duties of the Council on Ethics, Bylaws and Judicial Affairs): Paragraph i of the Council's enumerated *Bylaws* duties give the Council, upon unanimous vote, the authority to make corrections in punctuation, grammar, spelling, name changes, gender references, and similar editorial corrections in the *Bylaws*. Frequently, when considering the ADA *Bylaws*, there is a difference of opinion concerning whether the proposed revision is editorial or substantive in nature. Consequently, the Council proposes the following amendment to CHAPTER X, Section 120, Subsection G, Paragraph i of the ADA *Bylaws* to provide the Council with additional clarification on what is considered a non-substantive *Bylaws* amendment that can be made on unanimous vote of the Council without taking the valuable time of the House of Delegates.

Accordingly, the Council recommends that the following amendment of the ADA *Bylaws* be made:

Resolution

42. Resolved, that CHAPTER X COUNCILS, Section 120 DUTIES, Subsection G COUNCIL ON ETHICS, BYLAWS AND JUDICIAL AFFAIRS, Paragraph i of the ADA *Bylaws* be amended as follows (additions underscored):

G. COUNCIL ON ETHICS, BYLAWS AND JUDICIAL AFFAIRS. The duties of the Council shall be to:

* * *

i. Notwithstanding paragraph g of this subsection, the Council shall have the authority to make corrections in punctuation, grammar, spelling, name changes, gender references, change syntax, delete moot material and make similar editorial corrections in the *Bylaws* which do not alter its context or meaning. Such corrections shall be made only by a unanimous vote of the Council members present and voting.

BOARD RECOMMENDATION: Vote Yes.

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

Resolution No. 43 New

Report: NA Date Submitted: August 2013

Submitted By: Council on Ethics, Bylaws and Judicial Affairs

Reference Committee: Legislative, Health, Governance and Related Matters

Total Net Financial Implication: None Net Dues Impact:

Amount One-time Amount On-going FTE 0

ADA Strategic Plan Goal: Members (Required)

AMENDMENT OF ADA POLICY ENTITLED DEFINITION OF COMMITTEES

Background: (Reports:79).

Amendment of ADA Policy Entitled Definition of Committees: The Council recommends amendment of the policy entitled Definition of Committees for clarity and conciseness (*Trans.*2001:447).

Resolution

43. Resolved, that the ADA policy on Definitions of Committees (*Trans.*2001:447) be amended so that the amended policy reads as follows (additions are underscored; deletions are ~~stricken through~~):

Resolved, that the American Dental Association accepts the following definitions for the terms standing committee, special committee~~, task force,~~ and subcommittee~~, and ad hoc advisory committee~~:

Standing committee—A standing committee is ~~ongoing and performs any~~ a group of members whose work, assignments, or tasks are ongoing and that performs any work within its particular field either assigned to it by the *Bylaws* or referred to it by the House of Delegates or Board of Trustees. ~~The councils and commissions of the Association are standing committees of the House of Delegates. The Board of Trustees has standing committees of its own members, and the Committee on the New Dentist composed of one new dentist from each trustee district.~~

Special committee (also known as a Task Force)—A special committee or task force is a group of members ~~selected to perform a specific task and automatically ceases to exist once the task is completed. Special committees of the American Dental Association may be~~ created by the House of Delegates or, when the House is not in session, by the Board of Trustees, ~~for the purpose of~~ to perform~~ing~~ specific tasks ~~duties~~ not otherwise assigned by the *Bylaws*~~. The Association's parliamentary authority, The Standard Code of Parliamentary Procedure (4th edition) by Alice Sturgis also refers to special committees as ad hoc committees~~, and which ceases to exist either when its assigned task is completed or with the adjournment *sine die* of the annual session of the House of Delegates following its creation.

~~Task force—A task force is a type of special committee.~~

Subcommittee—A subcommittee is a ~~subdivision of a committee~~ subgroup of a body which is ~~organized~~ created for a specific purpose within the jurisdiction of that body, ~~and reports only to the committee that established it. ADA councils and commissions~~ may ~~establish one or more~~

~~ongoing subcommittees of their own members to which they may delegate~~ have authority delegated to it by the body, and which reports and is ~~are directly~~ responsible to only the delegating body, which may be a ~~the~~ council, committee or commission.

~~Ad hoc advisory committee—An ad hoc advisory committee is established by an ADA council or commission for a singular purpose and limited duration. An ad hoc advisory committee is composed of subject matter experts who assist the council or commission with a specific matter.~~

BOARD RECOMMENDATION: Vote Yes.

BOARD VOTE: UNANIMOUS.

Resolution No. 61-62 New

Report: CC Supplemental Report 1 Date Submitted: August 2013

Submitted By: Council on Communications

Reference Committee: Legislative, Health, Governance and Related Matters

Total Net Financial Implication: None Net Dues Impact:

Amount One-time Amount On-going FTE 0

ADA Strategic Plan Goal: Members (Required)

COUNCIL ON COMMUNICATIONS SUPPLEMENTAL REPORT 1 TO THE HOUSE OF DELEGATES:
ADA POLICY REVIEW

Background: In accordance with Resolutions 111H-2010 Regular Comprehensive Policy Review, and 170H-2012 Reaffirming Existing ADA Policy, the Council on Communications was assigned 18 ADA policies to review. Of the 18 policies, four were reviewed in 2012. In 2013, the Council reviewed the remaining policies, reaffirming seven, and recommending rescission of two policies. The Council also recommends that five ADA policies would be more appropriately assigned to other councils or committees, and is working to have them reassigned.

Recommendations—Policies to be Maintained

Guidelines for an Advertising Code (*Trans.*1971:108, 563; 1997:659)
Statement on Policy on Use of Name of American Dental Association (*Trans.*1962:210, 284; 1999:974)
Standards for Dental Society Publications (*Trans.*1997:303, 660; 2010:602)
ADA Positions, Policies and Definitions of ADA Publications (*Trans.*1996:732)
Preferred Professional Terminology (*Trans.*1977:914; 1997:661)
Clarification of Dental Professional Credentials (*Trans*.2003:354)
Non-de minimis grants by the ADA regarding ADA intellectual property (*Trans*.2008:495)

Recommendations—Policies to be Rescinded

ADA policy "Use of ADA Logo" (*Trans.*1984:520) urges "all constituent and component societies using telephone yellow pages display ads regarding emergency and referral services, to prominently display the ADA logo and the legend 'American Dental Association'…" The Council on Communications believes that newer policies and protocols replace and update the intent of this policy.

ADA policy "Placement of Paid Education Television Messages upon Request" (*Trans*.1984:534) asks "that the Board of Trustees help implement the placement of paid public education television messages in those states that request it" and that the "program be funded by the individual constituent societies involved…" As with the previous policy, newer policies replace and update this policy.

The Council believes that the policy "Use of ADA Logo" (*Trans.*1984:520) should be rescinded because it is no longer applicable.

61. Resolved, that the policy "Use of ADA Logo" (*Trans.*1984:520) be rescinded.

The Council believes that the policy "Placement of Paid Education Television Messages upon Request" (*Trans*.1984:534) should be rescinded because it is no longer applicable.

62. Resolved, that the policy "Placement of Paid Education Television Messages upon Request" (*Trans*.1984:534) be rescinded.

Resolutions

(Resolution 61:Worksheet:5041)
(Resolution 62:Worksheet:5043)

Resolution No. 61 New

Report: CC Supplemental Report 1 Date Submitted: August 2013

Submitted By: Council on Communications

Reference Committee: Legislative, Health, Governance and Related Matters

Total Net Financial Implication: None Net Dues Impact:

Amount One-time Amount On-going FTE 0

ADA Strategic Plan Goal: Members (Required)

RESCISSION OF POLICY ON USE OF ADA LOGO

Background: (See CC Supplemental Report 1 to the House of Delegates, Worksheet:5039)

Resolution

61. Resolved, that the policy "Use of ADA Logo" (*Trans.*1984:520) be rescinded.

BOARD RECOMMENDATION: Vote Yes.

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

WORKSHEET ADDENDUM
COUNCIL ON COMMUNICATIONS
ADA POLICY TO BE RESCINDED

Use of ADA Logo (*Trans.*1984:520)

Resolved, that the ADA urge all constituent and component societies using telephone yellow pages display ads regarding emergency and referral services, to prominently display the ADA logo and the legend “American Dental Association” in such announcements when legal under state regulations.

Resolution No. 62 New

Report: CC Supplemental Report 1 Date Submitted: August 2013

Submitted By: Council on Communications

Reference Committee: Legislative, Health, Governance and Related Matters

Total Net Financial Implication: None Net Dues Impact:

Amount One-time Amount On-going FTE 0

ADA Strategic Plan Goal: Members (Required)

RESCISSION OF POLICY ON PLACEMENT OF PAID EDUCATION TELEVISION MESSAGES UPON REQUEST

Background: (See CC Supplemental Report 1 to the House of Delegates, Worksheet:5040)

Resolution

62. Resolved, that the policy "Placement of Paid Education Television Messages upon Request" (*Trans*.1984:534) be rescinded.

BOARD RECOMMENDATION: Vote Yes.

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

WORKSHEET ADDENDUM
COUNCIL ON COMMUNICATIONS
ADA POLICY TO BE RESCINDED

Placement of Paid Education Television Messages upon Request (*Trans*.1984:534)

Resolved, that the Board of Trustees help implement the placement of paid public education television messages in those states that request it on a voluntary basis, and be it further

Resolved, that this program be funded by the individual constituent societies involved using a formula to be developed by the Board to cover costs on a pay-as-used basis.

Resolution No. 63 New

Report: N/A Date Submitted: August 2013

Submitted By: Board of Trustees

Reference Committee: Legislative, Health, Governance and Related Matters

Total Net Financial Implication: None Net Dues Impact:

Amount One-time Amount On-going FTE 0

ADA Strategic Plan Goal: Members (Required)

CONFLICT OF INTEREST (DISCLOSURE POLICY) REVISION

Background: Often at ADA meetings participants will only attend a portion of the meeting and will not have heard the reading of the Disclosure Policy. By including the Disclosure Policy as a written part of each agenda, anyone attending the meeting will have been advised well in advance by virtue of the agenda. The type of conflict to be disclosed has also been slightly expanded to include professional organizations. Accordingly, the Board of Trustees proposes the following resolution to amend the existing policy:

Resolution

63. Resolved, that the ADA Disclosure Policy (*Trans*.2010:624; 2011:537) be amended as follows (additions are underscored; deletions ~~stricken~~):

Resolved, that chairs of any meeting of the ADA, including Executive Committee, Board of Trustees, councils, committees and the House of Delegates ~~read the following at the opening of~~ include the disclosure policy as a written part of the agenda at each meeting:

> In accordance with the ADA Disclosure Policy, at this time anyone present at this meeting is obligated to disclose any personal, professional or business relationship that they or their immediate family may have with a company, professional organization or individual doing business with the ADA, when such company, professional organization or person is being discussed. This includes, but is not limited to insurance companies, sponsors, exhibitors, vendors and contractors.

and be it further

Resolved, that the disclosure policy be read at the opening of each meeting of the House of Delegates, and be it further

Resolved, that when speaking on the floor of the House of Delegates or in Reference Committees, those individuals/members shall first identify those relationships before speaking on an issue related to such conflict of interest.

1 **BOARD RECOMMENDATION: Vote Yes.**

2 **Vote: Resolution 63**

BUCKENHEIMER	Yes	FEINBERG	Yes	NORMAN	Yes	VERSMAN	Yes
CROWLEY	Yes	GOUNARDES	Yes	ROBERTS	Yes	WEBER	Yes
DOW	Yes	HAGENBRUCH	Yes	SCOTT	No	YONEMOTO	Yes
ENGEL	Yes	ISRAELSON	Yes	SEAGO	Yes	ZENK	Yes
FAIR	Yes	KIESLING	Yes	SUMMERHAYS	Yes	ZUST	Yes

Resolution No. 64-66 New

Report: 97H Workgroup Date Submitted: August 2013

Submitted By: Workgroup to Study Approval Authority for the ADA Budget

Reference Committee: Legislative, Health, Governance and Related Matters

Total Net Financial Implication: None Net Dues Impact:

Amount One-time Amount On-going FTE 0

ADA Strategic Plan Goal: Financial (Required)

REPORT OF THE 97H WORKGROUP TO THE HOUSE OF DELEGATES: RESPONSE TO RESOLUTION 97H-2012: BUDGET GOVERNANCE

Background: This report is in response to House of Delegates Resolution 97H-2012 (*Trans.*2012:434).

Resolution 97H-2012 reads as follows:

> **97H-2012. Resolved,** that an ad hoc committee of the House of Delegates be established to study the approval authority for the ADA budget, and be it further
>
> **Resolved,** that the ad hoc committee be comprised of the Treasurer, an ADA Trustee, and five members of the House of Delegates, with demonstrated skills in ADA strategic planning and/or budget process, who shall be appointed by the ADA President, and be it further
>
> **Resolved,** that the committee be charged with the following:
>
> a. Thorough review of the work of Westman and Associates and the Board of Trustees relating to the ADA budget approval process,
> b. Identification and determination of alternatives (including the committee's own) in the context of the responsibility of the respective governing bodies' constitutional rights and the role of each relating to the ADA budget approval process and ADA Strategic Plan,
> c. Development of recommendations addressing the ADA budget approval authority and strategic planning for report to the 2013 House of Delegates.

Led by the ADA Treasurer, Dr. Ron Lemmo, the members of the ad hoc committee were: Dr. Wendy Brown, Dr. Steve Gounardes, Dr. J. Barry Howell, Dr. Steven Kend, Dr. Ted Sherwin, and Dr. Paul Zimmerman.

In addition to the Westman and Associates governance study which had been part of a large report to the 2012 House of Delegates, the Committee through the course of its work on this initiative also reviewed many other documents and communications to build a comprehensive understanding of the issues, opportunities, and risks associated with ADA's budget approval process. These sources included:

a. The full original House Governance report including ALL resolutions and the supporting Westman consultants study,
b. All proposed iterations of 2012 Resolution 97 including
    i. Original Res 97
    ii. Resolution 97RC

iii. Resolution 97S-1
iv. 97H House approved

c. Related 2012 resolution 98S-1
d. Governance Study eMemo dated 8/23/2012
e. Board 2012 talking points for original Res 97
f. ADA Constitution and Bylaws
g. ADA Board Rules
h. Strategic Plan Committee Charter
i. Other resolutions and communications
j. Consultations with Speaker of House, ADA legal and other staff

This basic research provided a foundation of knowledge which helped the Committee to develop goals which served as criteria for deciding which options should be considered and ultimately which one provided the most benefit and least risk to the Association.

Review of the work of Westman and Associates and the Board of Trustees relating to the ADA budget approval process: The Committee reviewed Board Report 3 which was sent to the 2012 House of Delegates based on the Westman and Associates governance study with particular attention the following Westman Suggestion which were directly related to the ADA budget approval process:

> ***Westman Suggestion # 49:*** *Delegate more fiduciary responsibilities to the BOT, such as approving the budget.*
>
> *Commentary: W&A strongly believes that this represents "best practice" in association governance. The HOD meets infrequently, is large/cumbersome, and members simply do not have the requisite time, knowledge, and expertise to undertake the budgeting role effectively – especially for an organization as large and complex as ADA.*
>
> *Most associations have come to realize that the HOD is not in the best position to undertake key fiduciary responsibilities. Of benchmark associations, the BOT has been delegated authority to approve the association's budget by more than 80% of respondents.*
>
> *In the leadership survey, 54% either fully supported or may support transferring budget authority to the Board.*

While this Westman Suggestion served as the basis for a 2012 House resolution which failed to attract the required 2/3rd majority vote to change the ADA Bylaws, the resolution did receive 56% vote which indicates a simple majority of House members favored this approach. As a result, Resolution 97H-2012 which formed this group was created to allow further evaluation of this and other potential options for improvements to the ADA budget approval process.

The Westman governance study also provided guidance on best practices that were noted by the Committee as additional support for its recommendations.

Identification and determination of alternatives: Early in the Committee's deliberations, the group brainstormed a list of different ways to structure the ADA's budget review and approval process. These options included:

a. Support the original Board Resolution 97 which was initially sent to the House which delegated full authority for approval of the annual operating budget to the Board of Trustees with the House having approval of the high level strategic goals of the association.

b. Delegation of budget approval authority to a new Standing Committee of the House.

c. Reconvene the Administrative Review Committee as a Committee of the House, with timing after the House, with a group that includes additional House members.

d. Leave current process as it is today, with full House approval of the annual budget.

e. Deliver Budget and Strategic Plan via use of 2 separate groups, one for each process. These hybrid groups would include both Board and House member representatives, one for each.

As discussion began on the form and function of each of these options, the Committee weighed the costs and benefits, as well as the opportunities and risks of each alternative. Through these deliberations, the Committee defined the following goals which became criteria that led to the final recommendation.

Goals for the "ideal" budget approval entity: The Committee agreed that the following were goals of the ideal solution:

- a smaller group, ideally with a maximum of 9 members, would be a more efficient decision-making body
- a group with delegated authority from the House to approve changes AFTER the annual session which would enable high quality decisions as an alternative to current practice of the Board going "behind the curtain;"
- a shorter budget process started later/closer to the start of the budget year (which enables more accurate estimates and takes less time and resources); The reduction of the dues notification period through pending Resolution 99-2012 to Amend ADA Bylaws Re: Notice for Dues was also recognized as a potentially significant improvement to the budget process.
- a hybrid group with equal representation from both the House of Delegates and the Board of Trustees because:
    - Board members have full access to confidential actions of the Board; and
    - House members also helps ensure House engagement and participation and more likely acceptance of the process;
- leadership by the Treasurer who has bylaws authority related to the budget;
- group members should be selected with the best skill sets available to oversee the budget process;
- House members on the Budget Committee should also attend all Finance Committee meetings during the year to provide them with added knowledge of ADA operations and better equip them with more detailed knowledge to make budget decisions.
- The Strategic Plan should drive the budget process and the House should have input to and high level approval of strategic plan goals.

Development of recommendations addressing the ADA budget approval authority and strategic planning for report to the 2013 House of Delegates.

Because there has been significant progress on plans to improve the ADA budget process which have established a framework for prioritizing budget resources in alignment with strategic plan goals, transfer of the ADA's budget approval authority could be executed and the new hybrid committee could continue to build on this new budget approach.

Specifically, Resolution 44H-2011 asked that the Board develop a set of universal assessment criteria and that each council use the criteria to evaluate its programs and report to the Administrative Review Committee. Resolution 52H-2011 specifically directed the Board to develop and follow a set of short and long-term financial strategies that identify existing programs, services and products to be sunset so that existing finite human and financial resources may be redeployed for new initiatives that align with the Strategic Plan of the ADA and that deliver greater member value or public health impact.
A new hybrid budget approval Committee could use these same guidelines to review and approve the ADA's annual operating budget on behalf of the House of Delegates. This Committee of the House would

benefit from the annual program rating process in which senior council representatives score all programs against the universal assessment criteria.

Strategic Plan Development and Approval Process: In addition to the budget approval process, Resolution 97H-2012 charged the Committee with identification and determination of alternatives relating to the ADA Strategic Plan, as well as development of recommendations addressing strategic planning for report to the 2013 House of Delegates. Because some of the initial alternatives evaluated by the 97H Committee included strategic plan development as an integral role in driving the budget process, it was discussed in detail.

The Committee agreed that the Strategic Plan goals should drive the budget. Resolution 104H-1990 was used as an initial reference, because this resolved that the Board of Trustees develop a mission statement for the Association, and further resolved that following this, the Board appoint a Strategic Planning Committee comprised of ADA Board of Trustees, ADA members and key ADA staff for the purpose of developing a strategic plan for the Association.

It was noted that this was the basic structure that was now in process to create the ADA's next strategic plan which would start in 2015. The Committee consulted with the chair of the current Strategic Plan Steering Committee (SPSC) as well as staff working on the new plan and they explained their vision for future strategic plan development.

Acknowledging the extent of the work already in process for development of the next strategic plan, the Committee agreed to allow the SPSC and the Board to finish its work.

The consensus of the Committee was that the House needed to be involved, to some extent, in the approval process for both the strategic plan and the budget. House involvement at a high level enables both oversight and buy-in of key stakeholders.

The Committee recognized that having 400+ House members involved in detailed review and approval of the budget and strategic plan is not necessarily practical or the best use of delegate time. Yet at the same time the Committee believes, after substantial deliberation, that the House may wish to maintain some level of approval over both the strategic plan and the Budget in order to maintain its oversight duties as the supreme authoritative body. Finding the best blend of organizational efficiency and effectiveness balanced with appropriate oversight was an overriding objective of the Committee.

As a result, the Strategic Plan should drive the budget process and the House should have input to and high level approval of strategic plan goals. In addition, a hybrid group of skilled House members and Board trustees led by the treasurer could assume authority delegated from the full House to review and approve the annual operating budget.

Conclusions: While the delegation of budget approval authority by the House of Delegates to the Board might be most efficient, the Committee recognized that the House might wish to retain some oversight over the ADA budget process and the creation of a hybrid group of trustees and delegates as members with the appropriate skills would appear to enable the best compromise solution.

The following outline describes the structure which the 97H Committee recommends:

Summary of the House of Delegates Budget Approval Committee

A. Composition. The Budget Approval Committee shall consist of the Treasurer, along with four (4) current members of the House of Delegates and four (4) members of the Board of Trustees selected in accordance with the following criteria. The selection of committee members shall be made by the President, as noted below, at the same time as other members of the standing committees of the Board of Trustees are named.

a. **House Members.** Two (2) of the House of Delegates members shall have served on the Administrative Review Committee of the Board of Trustees' Budget and Finance Committee that participated in the development of the proposed budget to be considered by the Budget Approval Committee. The remaining two (2) House of Delegates members shall be selected by the President, in consultation with the Treasurer, from among the House members that currently serve on Standing Committees of the Board of Trustees.
b. **Board Members.** The four (4) Board of Trustee members shall have served on the Administrative Review Committee of the Board of Trustees' Budget and Finance Committee that participated in the development of the budget to be considered for approval by the Budget Approval Committee. Any Board of Trustee member whose term expires while the Budget Approval Committee is convened will continue to serve as a member of the Committee until it adjourns.
c. **Committee Chair.** The Treasurer shall serve as chair. In the event there is a vacancy in the position of Chair of the Committee, the senior most Trustee at the time of creation of the vacancy shall assume the position as Chair. If the Treasurer's term expires while the Budget Approval Committee is convened, the former Treasurer will continue to serve as chair of the Committee until it adjourns.
d. **Vacancies.**
    i. **House Members.** A vacancy caused by the inability of a House member to serve on the Committee shall be filled from among the House members that currently serve on Standing Committees of the Board of Trustees, with the selection being made by the President in consultation with the Treasurer sitting on the Budget Approval Committee.
    ii. **Board Members.** A vacancy caused by the inability of a Board member to serve on the Committee shall be filled from among the current and immediate past Trustees, with the selection being made by the President.
e. **Change in Board Committee Structure.** In the event the Board restructures its Committees in a way that would affect the composition of the Committee, the President, acting in consultation with the Treasurer, shall select members of the Committee so that the House of Delegates and the Board of Trustees will be equally represented, with each member having financial and budgeting experience to the extent possible. Current or immediate past board members may serve as Committee members under this provision.

B. Duties. The Budget Approval Committee shall have the following duties:

a. **Receipt of Proposed Budget.** The Committee shall receive the proposed budget developed by the Board of Trustees upon its approval by the Board of Trustees, with the proposed budget being provided to the Committee no later than thirty (30) days prior to the date of the opening of the House of Delegates
b. **Budget Reference Committee.** The Committee shall attend the budget Reference Committee for the purpose of assisting in interpreting the budget and finances of the Association for the membership.
c. **Approval of a Budget.** The Committee shall approve a budget for the ensuing fiscal year by December 31, according to the following procedures:
    i. **Balanced or Surplus Budget.** If at the adjournment of the House of Delegates the budget proposed by the Board of Trustees, together with the financial implications of any resolutions adopted by the House of Delegates, is balanced or has revenues that exceed expenditures, the sole duty of the Committee shall be to approve the proposed budget with the financial implications of any resolutions adopted by the House of Delegates as the annual budget for the ensuing fiscal year.
    ii. **Deficit Budget.** If at the adjournment of the House of Delegates the budget proposed by the Board of Trustees, together with the financial implications of any resolutions adopted by the House of Delegates, results in expenses that exceed revenues, the Committee shall review the Board's proposed budget and the financial implications of any resolutions adopted by the House of Delegates. The

Committee shall then approve or disapprove the proposed budget and financial implications of any resolutions adopted by the House of Delegates. If disapproved, the Committee shall:

1. Return the proposed budget to the Board of Trustees;
2. Forward budgetary recommendations to the Board of Trustees which shall include the recommendation that any financial implications of resolutions passed by the House of Delegates that are offset by an approved increase in the membership dues of the Association be included in any revised budget the Board of Trustees develops.
3. The recommendations of the Committee shall be based upon the Universal Assessment Criteria and Strategic Plan then in effect.

Following the transmittal of such recommendations, the Committee shall receive a revised budget from the Board of Trustees for its approval or disapproval. The process set forth in this section shall repeat until a budget (either balanced or in surplus or deficit) is approved by the Committee.

d. Updated or Additional Data. In fulfilling its enumerated duties, the Committee may consider any additional data and any updates to data used to develop the proposed budget that may be available to the Committee.

e. Report to the House of Delegates. Following approval of the budget, the Committee shall provide a summary report of its activities to the House of Delegates.

f. Adjournment. Following the completion of its duties enumerated above, the Committee shall adjourn.

Resolutions

(Resolution 64:Worksheet:5053)
(Resolution 65:Worksheet:5059)
(Resolution 66:Worksheet:5061)

Resolution No. 64 New

Report: 97H Workgroup Report Date Submitted: August 2013

Submitted By: Workgroup to Study Approval Authority for the ADA Budget

Reference Committee: Legislative, Health, Governance and Related Matters

Total Net Financial Implication: None Net Dues Impact:

Amount One-time Amount On-going FTE 0

ADA Strategic Plan Goal: Financial (Required)

APPROVAL OF THE ADA BUDGET

Background: (See 97H Workgroup Report to the House of Delegates, Worksheet:5047)

Resolution

64. Resolved, that the ADA *Bylaws*, CHAPTER V. HOUSE OF DELEGATES, *Section 50*. DUTIES, Subsection E, be amended as follows (deletions ~~stricken through~~):

E. ~~Adopt an annual budget and e~~Establish the dues of active members for the following year.

and be it further

Resolved, that the ADA *Bylaws*, CHAPTER V. HOUSE OF DELEGATES, *Section 130*. RULES OF ORDER, Subsection A. STANDING RULES AND REPORTS, subsection c. APPROVAL OF THE BUDGET, be amended as follows (additions underscored, deletions ~~stricken through~~):

c. APPROVAL OF ANNUAL BUDGET. The proposed annual budget shall be submitted by the Board of Trustees to the members of the House of Delegates at least thirty (30) days prior to the opening meeting of the annual session, ~~and~~ shall be referred to a ~~special~~ reference committee on budget ~~and assigned to~~ the Budget Approval Committee of the House of Delegates for action ~~for hearings at the annual session and then shall be considered for approval as a special order of business at the second meeting of the House of Delegates~~. The annual budget for the ensuing fiscal year shall be approved by December 31 by the Budget Approval Committee of the House of Delegates pursuant to procedures that, from time to time, are enacted by the House of Delegates. ~~In the event the budget as submitted is not approved, all recommendations for changes shall be referred to the Board of Trustees to prepare and present a revised budget. This procedure shall be repeated until a budget for the ensuing fiscal year shall be adopted.~~

and be it further

Resolved, that the ADA *Bylaws*, CHAPTER V. HOUSE OF DELEGATES, *Section 140*. COMMITTEES, be amended by addition of a new Subsection D to read as follows:

D. BUDGET APPROVAL COMMITTEE

a. Composition. The Budget Approval Committee shall consist of the Treasurer, along with four (4) current members of the House of Delegates and four (4) members of the Board of Trustees selected in accordance with the following criteria.

i. House Members. Two (2) of the House of Delegates members shall have served on the Administrative Review Committee of the Board of Trustees Budget and Finance Committee that participated in the development of the proposed budget to be considered by the Budget Approval Committee. The remaining two (2) House of Delegates members shall be selected by the President, in consultation with the Treasurer, from among the House members that currently serve on standing committees of the Board of Trustees.

ii. Board Members. The four (4) Board of Trustee members shall have served on the Administrative Review Committee of the Board of Trustees' Budget and Finance Committee that participated in the development of the budget to be considered for approval by the Budget Approval Committee. Any Board of Trustee member whose term expires while the Budget Approval Committee is convened will continue to serve as a member of the Committee until it adjourns.

b. Committee Chair. The Treasurer shall serve as chair. In the event there is a vacancy in the position of chair of the committee, the senior-most trustee at the time of creation of the vacancy shall assume the position as chair. If the Treasurer's term expires while the Budget Approval Committee is convened, the former Treasurer will continue to serve as chair of the Committee until it adjourns.

c. Vacancies.

i. House Members. A vacancy caused by the inability of a House member to serve on the committee shall be filled from among the House members that currently serve on standing committees of the Board of Trustees, with the selection being made by the President in consultation with the Treasurer sitting on the Budget Approval Committee.

ii. Board Members. A vacancy caused by the inability of a Board member to serve on the committee shall be filled from among the current and immediate past trustees, with the selection being made by the President.

d. Change in Board Committee Structure. In the event the Board restructures its committees in a way that would affect the composition of the committee, the President, acting in consultation with the Treasurer, shall select members of the committee so that the House of Delegates and the Board of Trustees will be equally represented, with each member having financial and budgeting experience to the extent possible. Current or immediate past Board of Trustees members may serve as committee members under this provision.

e. Duties. The Budget Approval Committee shall have the following duties:

i. Receipt of Proposed Budget. The committee shall receive the proposed budget developed by the Board of Trustees upon its approval by the Board of Trustees, with the proposed budget being provided to the committee no later than thirty (30) days prior to the date of the opening of the House of Delegates

ii. Budget Reference Committee. The committee shall attend the budget reference committee for the purpose of assisting in interpreting the budget and finances of the Association for the membership.

iii. Approval of the Budget. The committee shall approve the budget for the ensuing fiscal year by December 31, according to procedures that, from time to time, are enacted by the House of Delegates.

iv. Adjournment. Following the completion of its duties enumerated above, the committee shall adjourn *sine die*.

Resolved, that the ADA *Bylaws*, CHAPTER V. HOUSE OF DELEGATES, *Section 140*. COMMITTEES, be amended by relettering existing Subsections D and E as Subsections E and F, respectively, and be it further

Resolved, that the ADA *Bylaws*, Chapter VII. BOARD OF TRUSTEES, *Section 100.* DUTIES , be amended by addition of a new Subsection F to read as follows:

F. Prepare a budget for carrying on the activities of the Association for each ensuing fiscal year for submission to the House of Delegates and for action consistent with the *Bylaws*.

and be it further

Resolved, that existing Subsection F. of Chapter VII. BOARD OF TRUSTEES, *Section 100*. DUTIES, of the ADA *Bylaws* be relettered as Subsection G and amended as set forth below (additions underscored, deletions ~~stricken through~~):

~~F.~~ G. Prepare a ~~budget for carrying on the activities of the Association for each ensuing fiscal year, and present for action by each House of Delegates a~~ resolution setting forth the proposed dues of active members for the following year. Notice of such a resolution shall be sent by a certifiable method of delivery to each constituent society, federal dental service and the American Student Dental Association not less than ninety (90) days before such session to permit prompt, adequate notice by each constituent society, federal dental service and the American Student Dental Association to their delegates and alternate delegates to the House of Delegates of this Association, and shall be announced to the general membership in an official publication of the Association at least sixty (60) days in advance of the annual session.

and be it further

Resolved, that existing Subsections G. through S. of Chapter VII. BOARD OF TRUSTEES, *Section 100*. DUTIES, of the ADA *Bylaws* be relettered as Subsections H. through T, respectively, and be it further

Resolved, that the ADA *Bylaws*, Chapter VIII. ELECTIVE OFFICERS, *Section 90*. DUTIES, Subsection F. TREASURER, subsection e, be amended as follows (new language underscored; deletions stricken through):

e. Serve as chair of the Budget Approval Committee of the House of Delegates and as the principal resource person for interpreting the budget ~~reference committee in the House of Delegates~~ and ~~to help interpret~~ the Association's finances for the membership.

and be it further

Resolved, that the *Rules of the House of Delegates* be amended by deleting in its entirety the section titled "Consideration of Budget".

~~**Consideration of Budget**~~

~~The proposed annual budget shall be submitted to the members of the House of Delegates at least 30 days prior to the opening meeting of the annual session. In the event the proposed~~

~~budget as submitted is not approved, all recommendations for changes adopted by the House of Delegates shall be referred to the Board of Trustees to prepare and present a revised, proposed budget.~~

~~Recommendations for changes shall be made in the form of fully debatable motions which shall be individually considered and acted upon by the House of Delegates. To be in order, the proper wording for such a motion must be:~~

~~"I move that the proposed budget be returned to the Board of Trustees for revision with the recommendation that..."~~

~~If any recommendations for changes in the proposed budget receive House approval, they shall be identified as House Budget Recommendation 1, House Budget Recommendation 2, etc.~~

~~House approval of any recommendations for changes automatically returns the proposed budget to the Board of Trustees for revision and subsequent resubmission to the House of Delegates for approval or further recommendations for modification. This procedure will be repeated until a preliminary budget for the ensuing fiscal year is adopted.~~

~~This preliminary budget includes all items that the Board of Trustees and House of Delegates have approved, but it remains a preliminary budget since it does not incorporate any programs that may subsequently be adopted by the House at this session which require additional funding. The final budget is established and adopted by the House of Delegates through its approval of the preliminary budget plus the changes made as a result of actions by the House of Delegates. The Board of Trustees will present this final budget, which will include the preliminary budget plus any additions made as a result of action by the House of Delegates, to the House at the last meeting of the annual session.~~

and be it further

Resolved, that the foregoing amendments to the ADA *Bylaws* and *Rules of the House of Delegates* shall take effect at adjournment *sine die* of the 2013 House of Delegates.

BOARD COMMENT: The Board appreciates the fine work of the Task Force on this complex topic and discussed the benefits and problems associated with the Task Force's proposal at great length. The Board does not agree with the final approach advocated by the Task Force and has moved a Board substitute for both Resolutions 64 and 65 based on the original Resolution 97 proposed by the Board last year. (The worksheet for that 2012 Resolution may be found at (Supplement 2012:7036). That Resolution was based on considerable study and the advice of our expert consultants as detailed in the 2012 Governance Study.

Accordingly, the Board proposes the following Board substitute:

64B. Resolved, that CHAPTER V. HOUSE OF DELEGATES, *Section 50.* DUTIES of the ADA *Bylaws* be amended as follows (additions <u>underscored</u>, deletions ~~stricken through~~):

Section 50. DUTIES: It shall be the duty of the House of Delegates to:

A. Elect the elective officers.

B. Elect the members of the Board of Trustees.

C. Elect the members of the councils and commissions except as otherwise provided by these *Bylaws*.

D. Receive and act upon reports of the committees of the House of Delegates.

E.~~ Adopt an annual budget and~~ <u>E</u>stablish the dues of active members for the following year.

F. Serve as the court of appeal from decisions of the Council on Ethics, Bylaws and Judicial Affairs involving disputes arising between constituent societies or between constituent and component societies, and as provided in Chapter XIII of these *Bylaws*.

and be it further

Resolved, that CHAPTER V. HOUSE OF DELEGATES, *Section 130*. RULES OF ORDER, Subsection A. STANDING RULES AND REPORTS, paragraph c. APPROVAL OF THE ANNUAL BUDGET of the ADA *Bylaws* be deleted in its entirety as follows (deletions ~~stricken through~~):

A. STANDING RULES AND REPORTS.

a. REPORTS. All reports of elective officers, councils and committees, except supplemental reports, shall be sent to each delegate and alternate delegate at least fourteen (14) days in advance of the opening of the annual session. All supplemental reports shall be distributed to each delegate before such report is considered by the House of Delegates.

b. APPROPRIATION OF FUNDS. Any resolution proposing an appropriation of funds, shall be referred to the Board of Trustees for a report at the same session on the availability of funds for the purpose specified.

~~c. APPROVAL OF ANNUAL BUDGET. The proposed annual budget shall be submitted by the Board of Trustees to the members of the House of Delegates at least thirty (30) days prior to the opening meeting of the annual session, shall be referred to a special reference committee on budget for hearings at the annual session and then shall be considered for approval as a special order of business at the second meeting of the House of Delegates. In the event the budget as submitted is not approved, all recommendations for changes shall be referred to the Board of Trustees to prepare and present a revised budget. This procedure shall be repeated until a budget for the ensuing fiscal year shall be adopted.~~

and be it further

Resolved, that the remaining paragraphs d. through f. of CHAPTER V. HOUSE OF DELEGATES, *Section 130*. RULES OF ORDER, Subsection A. STANDING RULES AND REPORTS, be re-lettered as paragraphs c. through e., respectively, and be it further

Resolved, that CHAPTER VII. BOARD OF TRUSTEES, *Section 100*. DUTIES, Subsection F. of the ADA *Bylaws* be amended as shown below (additions underscored, deletions ~~stricken through~~):

F. Develop, prepare and adopt a budget for carrying on the activities of the Association for each ensuing fiscal year, and present for action by each House of Delegates a resolution setting forth the proposed dues of active members for the following year. Notice of such a resolution shall be sent by a certifiable method of delivery to each constituent society not less than ninety (90) days before such session to permit prompt, adequate notice by each constituent society to its delegates and alternate delegates to the House of Delegates of this Association, and shall be announced to the general membership in an official publication of the Association at least sixty (60) days in advance of the annual session.

and be it further

Resolved, that the section entitled “Consideration of Budget” contained in the *Rules of the House of Delegates* be deleted in its entirety.

~~**Consideration of Budget**~~
~~The proposed annual budget shall be submitted to the members of the House of Delegates at least 30 days prior to the opening meeting of the annual session. In the event the proposed budget as submitted is not approved, all recommendations for changes adopted by the House of Delegates shall be referred to the Board of Trustees to prepare and present a revised, proposed budget.~~

~~Recommendations for changes shall be made in the form of fully debatable motions which shall be individually considered and acted upon by the House of Delegates. To be in order, the proper wording for such a motion must be:~~

~~"I move that the proposed budget be returned to the Board of Trustees for revision with the recommendation that..."~~

~~If any recommendations for changes in the proposed budget receive House approval, they shall be identified as House Budget Recommendation 1, House Budget Recommendation 2, etc.~~

~~House approval of any recommendations for changes automatically returns the proposed budget to the Board of Trustees for revision and subsequent resubmission to the House of Delegates for approval or further recommendations for modification. This procedure will be repeated until a preliminary budget for the ensuing fiscal year is adopted.~~

~~This preliminary budget includes all items that the Board of Trustees and House of Delegates have approved, but it remains a preliminary budget since it does not incorporate any programs that may subsequently be adopted by the House at this session which require additional funding. The final budget is established and adopted by the House of Delegates through its approval of the preliminary budget plus the changes made as a result of actions by the House of Delegates. The Board of Trustees will present this final budget, which will include the preliminary budget plus any additions made as a result of action by the House of Delegates, to the House at the last meeting of the annual session.~~

BOARD RECOMMENDATION: Vote Yes on the Substitute.

Board Vote: Resolution 64B

BUCKENHEIMER	No	FEINBERG	Yes	NORMAN	Yes	VERSMAN	Yes
CROWLEY	Yes	GOUNARDES	Yes	ROBERTS	Yes	WEBER	Yes
DOW	Yes	HAGENBRUCH	Yes	SCOTT	Yes	YONEMOTO	Yes
ENGEL	Yes	ISRAELSON	Yes	SEAGO	Yes	ZENK	Yes
FAIR	Yes	KIESLING	Yes	SUMMERHAYS	Yes	ZUST	Yes

Resolution No. 65 New

Report: 97H Workgroup Report Date Submitted: August 2013

Submitted By: Workgroup to Study Approval Authority for the ADA Budget

Reference Committee: Legislative, Health, Governance and Related Matters

Total Net Financial Implication: None Net Dues Impact:

Amount One-time Amount On-going FTE 0

ADA Strategic Plan Goal: Financial (Required)

PROCEDURES GOVERNING THE BUDGET APPROVAL PROCESS

Background: (See 97H Workgroup Report to the House of Delegates, Worksheet:5047)

Resolution

65. Resolved, that the following procedures govern the Budget Approval Committee of the House of Delegates:

A. Appointment of Members. The President is urged to name all members of the Budget Approval Committee at the same time ~~the two (2) members of the House of Delegates who do not sit on the Administrative Review Committee of the Board of Trustees' Budget and Finance Committee at the same time as other members of the standing committees of the Board of Trustees are named~~. The Board of Trustees is urged to direct that the Administrative Review Committee of the Board of Trustees' Budget and Finance Committee invite the two (2) House of Delegates members of the Budget Approval Committee to meetings of the Administrative Review Committee of the Board of Trustees' Budget and Finance Committee as observers to allow those members to become as familiar as possible with the budget process.

B. Balanced or Surplus Budget. If at the adjournment of the House of Delegates the budget proposed by the Board of Trustees, together with the financial implications of any resolutions adopted by the House of Delegates, is balanced or has revenues that exceed expenditures, the sole duty of the committee shall be to approve the proposed budget including the financial implications of any resolutions adopted by the House of Delegates as the annual budget for the ensuing fiscal year.

C. Deficit Budget. If at the adjournment of the House of Delegates the budget proposed by the Board of Trustees, together with the financial implications of any resolutions adopted by the House of Delegates, results in expenses that exceed revenues, the committee shall review the Board's proposed budget and the financial implications of any resolutions adopted by the House of Delegates. In conducting such review, the committee may consider any additional data and any updates to data used to develop the proposed budget that may be available to the committee. The Committee shall then approve or disapprove the proposed budget and financial implications of any resolutions adopted by the House of Delegates. If disapproved, the committee shall:

1. Return the proposed budget to the Board of Trustees;

2. Forward budgetary recommendations to the Board of Trustees which shall include the recommendation that any financial implications of resolutions passed by the House of Delegates that are offset by an approved increase in the membership dues of the Association be included in any revised budget the Board of Trustees develops.

3. The recommendations of the committee shall be based upon the Universal Assessment Criteria and Strategic Plan then in effect.

Following the transmittal of such recommendations, the committee shall receive a revised budget from the Board of Trustees for its approval or disapproval. The process set forth in this section shall repeat until a budget (either balanced or in surplus or deficit) is approved by the committee.

D. Report to the House of Delegates. Following approval of the budget, the committee shall provide a summary report of its activities to the House of Delegates.

E. Adjournment. Following the completion of its duties enumerated above, the committee shall adjourn *sine die*.

BOARD COMMENT: The Board appreciates the fine work of the Task Force on this complex topic and discussed the benefits and problems associated with the Task Force's proposal at great length. The Board does not agree with the final approach advocated by the Task Force and has moved a Board substitute for both Resolutions 64 and 65 based on the original Resolution 97 proposed by the Board last year. (The worksheet for that 2012 Resolution may be found at (Supplement 2012:7036). That Resolution was based on considerable study and the advice of our expert consultants as detailed in the 2012 Governance Study.

BOARD RECOMMENDATION: Vote Yes on the Substitute for Resolution 64B.

Board Vote: Resolution 64B

BUCKENHEIMER	No	FEINBERG	Yes	NORMAN	Yes	VERSMAN	Yes
CROWLEY	Yes	GOUNARDES	Yes	ROBERTS	Yes	WEBER	Yes
DOW	Yes	HAGENBRUCH	Yes	SCOTT	Yes	YONEMOTO	Yes
ENGEL	Yes	ISRAELSON	Yes	SEAGO	Yes	ZENK	Yes
FAIR	Yes	KIESLING	Yes	SUMMERHAYS	Yes	ZUST	Yes

Resolution No. 66 New

Report: 97H Workgroup Report Date Submitted: August 2013

Submitted By: Workgroup to Study Approval Authority for the ADA Budget

Reference Committee: Legislative, Health, Governance and Related Matters

Total Net Financial Implication: None Net Dues Impact:

Amount One-time Amount On-going FTE 0

ADA Strategic Plan Goal: Financial (Required)

APPROVAL OF HIGH LEVEL STRATEGIC GOALS BY THE HOUSE OF DELEGATES

Background: (See 97H Workgroup Report to the House of Delegates, Worksheet:5047)

Resolution

66. Resolved, that upon the initiation of a new strategic plan, the Board shall submit the draft plan to the House for approval of the high level strategic goals.

BOARD COMMENT: The Board did agree with the intent of the Task Force that the House should have a role in the strategic plan, but did not agree with Resolution 66, as proposed by the Task Force. As a strategic plan is a document used to communicate an organization's goals, the actions needed to achieve those goals, and all of the other critical elements developed during the strategic planning process, it is viewed as an organizational management activity that requires a disciplined effort to produce fundamental decisions and actions that shape and guide the organization over the plan's life. The Board passed a resolution calling for the Strategic Planning Steering Committee to host an informational forum at the House in order to allow House members a meaningful opportunity to provide input to the developing plan. The Board believes the informational forum stipulated in the Board's resolution will provide House members with an important opportunity for input into each strategic plan.

BOARD RECOMMENDATION: Vote No.

BOARD VOTE: UNANIMOUS.

Resolution No. N/A N/A

Report: Board Report 7 Date Submitted: August 2013

Submitted By: Board of Trustees

Reference Committee: Legislative, Health, Governance and Related Matters

Total Net Financial Implication: None Net Dues Impact:

Amount One-time Amount On-going FTE 0

ADA Strategic Plan Goal: Members (Required)

REPORT 7 OF THE BOARD OF TRUSTEES TO THE HOUSE OF DELEGATES: FOLLOW UP TO 2012 WESTMAN GOVERNANCE SUGGESTIONS

Background: The Board of Trustees is providing this report to the House of Delegates to address those suggestions from the 2012 Governance study which were not tied to House action and were not, therefore, addressed in the report to the House last year. This report relates to those suggestions from the governance consultants, Westman and Associates, which were more administrative in nature or could be addressed by Board or senior staff action. This is an informational report; there are no resolutions.

The 2012 Board Report 3 on the Governance Study addressed 39 of the 80 suggestions received from the governance consultants and included ten resolutions. These were the suggestions which required House action of some type. In addition to these, the Westman report included 41 other suggestions addressed by the Board and senior staff. This report will review these suggestions and action taken in response to them. The full Westman report is attached as an appendix to the 2012 Board Report 3, which may be found in the archive section of the House ADA Connect site.

2012 Westman Governance Study Suggestions and Board Response:

Suggestion #1: Determine the specific competencies/skills in high-level knowledge and understanding that is needed for all governance positions -- asking "what does the governance entity need in terms of talent and knowledge?" Use these competencies/skills to select candidates for positions in various governance entities. Keep this competency/skills listing in an operations manual for that entity.

Many leadership positions are elected and not necessarily selected based on set criteria. Nevertheless, the Board's Compensation Committee has developed draft role descriptions for key volunteer positions. In addition, at its June 2013 meeting, the Board's Governance Committee reviewed the existing guidelines for selection of council chairs and reaffirmed them.

Suggestion #2: Develop and utilize job descriptions for governance positions (e.g., BOT officers and trustees, council and committee chairs, and delegates) based on competency and skill profiles. Keep these job descriptions in an operations manual for that entity.

The Board's Compensation Committee is currently reviewing draft role descriptions.

Suggestion #3: Develop a database of ADA members who have expressed interest in serving in various leadership capacities – including the skills, competencies, and skills they can offer.

The Board's Governance Committee discussed this recommendation at length and concluded that it should not be pursued. The committee recognized that the constituent societies are the primary conduit for volunteer leaders at the national level. This suggestion was deemed to be both an infringement on the role of the constituent societies and impractical, given the many organizations involved.

Suggestion #4: Reevaluate the volunteer leader orientation program(s) to make sure it covers structure, functions, roles, protocols, parliamentarian process, HOD operations, council operations, etc.

The Board recognizes the importance of volunteer orientation and notes that the Association has been working on this for several years, at both the Board and Council levels. The orientation process addresses each of the items referenced by the consultants and is regularly reviewed and updated.

Suggestion #5: Establish written/recorded committee-specific orientation programs.

The Board directs the House to the previous suggestion and accompanying comment. In addition, in June 2013, the Board adopted a resolution requiring each of its committees to undertake an annual self-assessment and to report the results of that self-assessment, including any proposed changes flowing from it, to the Board's Governance Committee. Further, the Board passed a resolution at its August 2013 meeting requiring each of its committees to provide orientation materials for new members to include, at a minimum, agenda and minutes from the prior year, and reports to the Board during the prior year and a copy of the committee charter.

Suggestion #6: Establish a mentoring program for all appointed and elected positions, similar to what the BOT currently employs. This would involve identifying knowledgeable members who are willing to work with a new council, commission, or committee member, HOD delegate or alternate delegate, and other volunteers. For example, "Senior" leaders could mentor "Freshman" leaders. Create either a written or web based training on how to be a mentor that would be required for each new mentor.

The Board sees some value in this suggestion and uses a mentoring system itself. Councils and state or district delegations to the House currently have the authority to use a similar system if they feel it will be of value. The Board does not wish to impose a new process on these entities when the entities themselves are best positioned to judge the value of it in their particular circumstance.

Suggestion #7: Collaborate with and learn from districts and states that have a strong reputation for leadership development to fine-tune leadership training at the national level.

The Board sees value in this suggestion and notes that such collaboration is being pursued. Best practices in leadership development from around the tripartite are shared in various Membership, Tripartite Relations and Marketing Division forums, teams and communications with component and constituent societies. An advisory team of constituent and component executives will be recruited to work with ADA in developing new leadership education strategies encompassing all levels.

Suggestion #8: Create an operations/procedures manual for councils and their committees that covers all governance issues such as their charters, how meetings are run, how agendas are set, how they address their budgets, how to relate their work to the strategic plan, how they choose their Chairs & Vice Chairs and job descriptions for the Chair and Vice Chair. Seek to have consistency between each entity in these procedures. This can be used as part of the orientation package for each new council or committee member, as well as for daily operational practices.

The Board agrees with this suggestion. Council staff is currently creating such a manual in order to promote a more uniform and positive volunteer experience. Use of ADA Connect is expected to enhance this effort.

Suggestion #9: Establish a short-term task force to enhance communications between various governance entities (i.e., appropriate vehicles, formats, and frequencies).

The Board agrees with this suggestion. The council chairs and vice chairs meet quarterly by conference call specifically to enhance communications and collaboration. In addition, a council chair/vice chair breakfast meeting will be held at the 2013 Annual Session. This group also has its own community on ADA Connect. The Board notes that the group is effectively managed with a volunteer leader(s) selected from among the chairs and vice chairs.

Suggestion #10: Educate ADA leaders and general members on the cost of governance at ADA and how it compares with other associations. This should be a metric ADA monitors, looking at measures like cost of governance per member.

The governance study itself has provided significant education on this issue.

Suggestion #19: Engage a parliamentarian to support the Speaker during HOD meetings.

The ADA currently utilizes one of its senior attorneys to serve in this role. Although the attorney is not a certified parliamentarian, she has extensive parliamentary experience.

Suggestion #22: Take a fresh look at the council committee structure – evaluating the type of committees, short-term task forces or work groups required to meet council charters and goals. Ask questions like "Is this what the members need now?" "Is this what the dental profession needs now and three years from now?" "Is there a better way to accomplish this same goal?" Then implement the structural changes accordingly.

This could result in:

- *Sunsetting certain entities.*
- *Converting selected councils or committees into short-term, specific purpose work groups with a definite timeline.*
- *Determining the expertise and skill base required of each committee.*

The Board agrees that the effectiveness of the Association's council structure needs to be regularly reviewed. The Board notes that the Task Force on Council Issues has forwarded a resolution to the House, supported by the Board, requiring regular self-assessments by each council. Some councils have already started this process and the Association expects others will pursue it as well.

Suggestion #23: Form a task force charged with thoroughly reviewing each council and committee relative to finding ways to reduce the time spent by volunteers in council or committee work by 25%. This can be done by identifying tasks more appropriately handled by staff or which are not contributing to the charter, strategy or goals.

The Board does not believe a centralized task force should undertake this effort. Rather, the Board believes that the councils themselves are best positioned to address this issue. Finally, the Board notes that the resolution proposed by the Task Force on Council Issues addresses this issue through regular self-assessments.

Suggestion #25: Reduce the size of committees and task forces/work groups.

The Task Force on Council Issues has proposed a resolution to the House which would require Council's to address this issue in their self-assessments. Similarly, the Board's standing committees are being asked to address the same issue in their self-assessments. Other work groups and task forces are created by the Board or the House. The Board wishes the House to know that it is mindful of the need to avoid excessive size of such workgroups or task forces and asks the House to be mindful of it as well in any such group created pursuant to House action. Nevertheless, the Board notes that the Association would be best served by avoiding a one-size-fits-all approach and by setting the size of a group based on the specific needs to be addressed by it.

Suggestion #28: Focus on using small short-term, skill-based task forces with narrow foci to address key issues – as opposed to relying on continuing councils or committees.

The Board agrees that the use of short-term task forces is a viable option in many circumstances. The Board does not, however, believe a blanket rule would be useful.

Suggestion #32: Sunset the Information Technology Committee.

The Board considered this suggestion last year and decided not to sunset this committee. The Board notes, however, that the committee did take steps to stream line its activities, reduce the frequency of its meetings and brief the committee and the Board in writing on a regular basis.

Suggestion #33: Sunset the Diversity Committee and instead rely on a short-term (i.e., six months to one year) Diversity Task Force to include members with specific expertise. The Task Force would be charged with:

- *Reviewing data concerning the growth of diversification – women, minorities, new dentists, etc. – in ADA governance and how it can be improved.*
- *Recommending what relationship ADA should have with the Hispanic Dental Association, National Dental Association, and Society of American Indian Dentists.*
- *Evaluating the Diversity Institute (i.e., leadership development training) and its role in enhancing diversity development.*
- *Developing "best practices" recruiting strategies to recommend to states.*

The Board considered and rejected this proposal last year based on the importance of the diversity issue to the Association.

Suggestion #35: Create an Inter-Governance Committee that includes all council chairs, vice chairs, and a BOT representative to share information across all governance entities.

Without resorting to formal creation of a new committee, the Association has already done this through creation of an ADA Connect community and quarterly conference calls (and a breakfast at the House meeting) among this group.

Suggestion #36: Assure each council receives a briefing between October and February regarding the upcoming year's goals and plans for their council by the executive director and/or a board representative. Consideration could be given to combining this meeting with the board's planning meeting.

The Board appreciates this suggestion but notes that it is already implemented. In addition, the Board will meet with council chairs and vice chairs in December as part of the strategic plan development process.

Suggestion #37: Establish a process to examine the agendas associated with all or selected council and committee meetings – identifying possible opportunities for minimizing on-site meeting time. This could be completed by a short-term task force or may be more effectively addressed by staff. This could be coordinated electronically.

This is encompassed in the self-evaluations called for by the task force on councils.

Suggestion #38: Evaluate the feasibility of certain meetings being held on weekend days versus week days.

ADA meetings are currently held throughout the week, including weekends.

Suggestion #40: Provide more formal training to the President prior to assuming his/her duties on meeting agenda development, facilitation, conflict resolutions skills, etc.

This year, the president, president elect and the executive director are expected to attend an AASE training session together. Future budgets will include this sort of program as well.

Suggestion #47: Eliminate the Speaker's participation on the BOT.

The Board disagrees with this suggestion. The presence of the Speaker is very helpful to the Board. In particular, during Board meetings leading up to the Annual Session, the Speaker provides important guidance to the Board on parliamentary issues presented by resolutions or reports being forwarded to the House.

Suggestion #51: Establish an Executive Committee with a defined role and scope – composed of the:

- *President*

- *President-Elect*
- *Vice President (assuming this position remains)*
- *Chairs of the Audit, Budget and Finance, and Governance committees*
- *Treasurer (assuming this position remains)*
- *Executive Director*

The Governance Committee considered this suggestion last year and rejected it as unnecessary. In addition, the Board believes an executive committee would add an additional layer to the governance structure.

Suggestion #52: Decrease the number of BOT meetings, assuming establishment of an Executive Committee.

The Board does not support creation of an executive committee.

Suggestion #53: Clarify the BOT's role and responsibilities with emphasis on the need to focus more on strategic issues and less on day-to-day management. This would include adopting the following guidelines for the BOT:

- *Responsible for governing the association by setting broad policies and objectives, ensuring that the association has adequate resources and guiding the association in the best interests of the association.*
- *Assumes major responsibility for organizational planning by developing, implementing and measuring progress on the strategic plan, including determining the organization's mission and purpose.*
- *Assures that other governance entities align with the mission and goals of the organization.*
- *Approves, monitors, and enhances programs and services.*
- *Ensures legal and ethical integrity and maintains accountability.*
- *Does not inject itself into administrative decisions and management operations.*
- *Allows the Executive Director and staff to be responsible for running the association in a way that meets the objectives established by the BOT.*

The Board appreciates this suggestion and believes it is already being implemented. Because of the ADA's complex governance structure, some level of role confusion is bound to occur from time to time, but the Board believes that the Association has made significant progress in this area over the last several years.

Suggestion #56: Enhance education provided to all members of governance entities regarding the strategic plan (i.e., the mission, vision) through orientation sessions.

The Board agrees that volunteer leaders need to be fully informed about the strategic plan. The issue is addressed through the orientation process and annually with all councils.

Suggestion #57: Facilitate increased education efforts to increase awareness of the strategic plan through opportunities such as a webinar education session with delegates, through ADA Connect or during orientation opportunities.

The Board's Strategic Plan Steering Committee is fully aware of the importance of education and outreach during development and implementation of the next strategic plan. The committee will be developing a communication plan to address this.

Suggestion #60: Continue to enhance ties between the ADA's strategic plan and budget.

The Board agrees with this suggestion and notes that it is being implemented. One example is that the universal assessment criteria against which all programs are evaluated as part of the next budget cycle explicitly includes the strategic plan goals. In addition, in proposing a resolution to the House, the maker is asked to identify the strategic plan goal with which the resolution is aligned. The Board is committed to strengthening the connection between the strategic plan and the budget.

Suggestion #62: Educate the constituents and delegates of the requirement to identify a funding mechanism for all HOD resolutions involving an expenditure of funds.

The resolution worksheets utilized by the House require identification of a financial impact. This is tracked during the House meeting and, at the end of the House, any deficit and dues increase needed to eliminate the deficit are identified.

Suggestion #66: Encourage districts and states to cultivate diversity in volunteers, promote opportunities for women to become involved in organized dentistry, recruit targeted minorities, and target younger dentists and dental schools

The Board agrees with this suggestion. The Membership, Tripartite Relations and Marketing Division have already undertaken significant action in furtherance of it. This includes support for: a) the Board Diversity and Inclusion Committee's 2013 focus on constituent leadership diversity, b) sharing experience from ADA's Institute for Diversity in Leadership and connecting dental societies with class members and alumni, c) the New Dentist Committee network, and d) Office of Student Affairs initiatives. Supporting leadership diversity, efforts to recruit members from diverse segments also continue to be a priority.

Suggestion #68: Develop a tool kit that constituents can utilize to implement diversity training programs.

The Membership, Tripartite Relations and Marketing Division offers diversity consulting and training onsite for constituents and components, and also shares experiences from ADA Board diversity education programs with interested dental societies. Several societies have engaged faculty from the ADA's national programs. In addition, the Membership Program for Growth has provided funding to both constituents and components to conduct activities that attract and retain diverse dentist members and an inventory of successful programs is being created to share among the tripartite via ADA Connect.

Suggestion #69: Feature a diversity program at the President-Elect's conference.

Diversity has been a featured topic at this conference in the past. The agenda is developed each year by the current President elect.

Suggestion #71: Utilize telephonic and/or web-based meetings to a greater extent for all governance entities, with a goal of reducing the number of face-to-face meetings at least 25% by fiscal year 2014 and 50% by fiscal year 2016.

Most volunteer bodies within the ADA already heavily rely on conference calls and, for Councils, the number of in-person meetings has already been significantly reduced over the last several years.

Suggestion #72: Appoint a short term task force with specific expertise and representation from each segment of the governance structure (i.e., HOD, BOT, councils, committees, and constituents) to review and recommend how ADA Connect can be utilized to a great extent to streamline governance activities, reduce governance expense, and increase communication, information sharing, and user-friendliness.

The roll out of ADA Connect has been, and continues to be, a major undertaking with very significant input from volunteer leaders at all levels. The Board does not believe another task force is needed.

Suggestion #73: Develop a better search mechanism for use by governance volunteers on ADA Connect.

ADA Connect has strong search capabilities and, as more document tagging occurs as more documents are moved to ADA Connect, the volunteers will have a greater opportunity to use it.

Suggestion #74: Enhance the training program on use of ADA Connect (e.g., written and video formats or an e-learning course).

Numerous training opportunities were developed last year and continued this year. Training opportunities employ in-person, conference call and video formats.

Suggestion #75: Set up networking sections for each governance entity on ADA Connect.

This has always been a component of ADA Connect and the Association expects this feature to be used with a greater frequency as volunteer leaders become familiar with the tool.

Suggestion #77: Assure that Help Desk staff are available during all meetings of governance entities where ADA Connect is utilized.

ADA Connect site owners already provides support to ADA volunteers on ADA Connect, including at the HOD and are in turn supported by the IT Help Desk.

Suggestion #78: Create a Governance Coordinator position in the staff organization reporting to the Chief of Governance and Strategy Management. Specific responsibilities would include:

- *Assuring all governance entities are involved in and aware of strategic plan development and implementation.*
- *Maintaining a database of all governance entities and coordinating efforts to assure ongoing communications, self-evaluations, updating of operations manuals and job description for governance entity positions, establishing and monitoring charges, etc.*
- *Preparing and updating operations manuals for key governance entities, including job descriptions and committee charges.*
- *Coordinating activity on ADA Connect for governance entities.*

This work is already being addressed by various individuals and entities.

Suggestion #79: Periodically survey council leaders regarding their satisfaction with staff support.

The Board agrees with this suggestion and believes it can best be accomplished through the self-assessment process proposed by the Task Force on Council Issues.

As can be seen, the governance study generated many proposals in addition to those explicitly presented to the 2012 House for action. The Board believes the Association continues to make progress in fostering an effective governance structure.

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)

Resolution No. N/A N/A

Report: Board Report 12 Date Submitted: August 2013

Submitted By: Board of Trustees

Reference Committee: Legislative, Health, Governance and Related Matters

Total Net Financial Implication: None Net Dues Impact:

Amount One-time Amount On-going FTE 0

ADA Strategic Plan Goal: Collaboration (Required)

REPORT 12 OF THE BOARD OF TRUSTEES TO THE HOUSE OF DELEGATES: ANNUAL REPORT OF THE STATE PUBLIC AFFAIRS PROGRAM OVERSIGHT WORKGROUP

Oversight Workgroup History and Status: The State Public Affairs (SPA) Program is completing its sixth year of public affairs program funding in 2013. The ADA Board of Trustees (BOT) created a Volunteer Oversight Workgroup for the program in 2009 with a revised membership and charge made in 2012. Given the size of the annual budget for the project, the Board has directed the Oversight Workgroup to provide an annual report to the House of Delegates.

The Oversight Workgroup regularly received updates on activities in the states and addressed budget issues. The Oversight Workgroup also developed selection criteria and approved the applications of states for participation in the SPA Program. In addition, the Oversight Workgroup assessed the effectiveness of each participating state through mid-year and end-of-year reviews.

Both Council on Government Affairs (CGA) and Council on Communications (CC) members, along with members of the BOT, have been appointed to serve on the Workgroup annually. The members of the 2013 SPA Volunteer Oversight Workgroup are: Dr. Henry Fields (CGA – chair), Dr. Jeffrey Dow (BOT), Dr. Steven Gounardes (BOT), Dr. Carmine LoMonaco (CGA), and Dr. George Shepley (CC).

Financial Summary: The 2012 ADA House of Delegates approved a budget for the program for 2013 in the amount of $3,100,000, a decrease of $400,000 from 2011. Even with this decrease, the Workgroup has been able to allocate funds to support constituent public affairs challenges and capacity building across the country and maintain a small reserve for unanticipated challenges.

- As of this writing, approximately $1.715 million dollars was provided (or allocated) directly to states as grants for their public affairs programs. This reflects a reduction of approximately $85,000 as compared to 2012.

- Another $75,000 was allocated to bring a Community Dental Health Coordinator (CDHC) demonstration project to New Mexico, the first state in the nation to recognize CDHCs. Additionally, the grant was designed to provide support for the development of an on-going CDHC education program in the state.

- An additional $120,000 was provided to the Oregon Dental Association to support a May, 2013 ballot initiative in the City of Portland (one of the largest non-fluoridated water systems in the nation) to uphold a decision made by the City Council in 2012 to provide the benefits of community water fluoridation to subscribers. Unfortunately, that measure was unsuccessful.

- Approximately $100,000 was spent indirectly to assist all state dental associations in the following capacities:
    - Hiring consultants to advise the ADA and state dental societies on the 2010 Patient Protection and Affordable Care Act Health Insurance Exchange issues;
    - Developing print, radio and billboard ad templates to be used in states where workforce is an issue; and,
    - ADA staff and contract consultant travel associated with assisting states in the program.
- Approximately $415,000 was paid to the national State Public Affairs Consultant, Chlopak, Leonard and Schechter (CLS) to assist both the ADA and state dental societies in designing their state public affairs programs and developing strategies regarding their programs for the first seven months of 2013. In June, the Workgroup approved changing the national consultant to FleishmanHillard (FH) for the remainder of the year to move the program forward at a monthly retainer of $43,000, a reduction from the CLS retainer of $50,000.
- Lastly, approximately $375,000 is unspent and available for unanticipated challenges, should they arise this year. At the end of 2013, unspent funds will be returned to uncommitted reserves.

Report of the States: The Workgroup submits the following report of activities in State Public Affairs participating states in 2013.

The ADA SPA project continues to provide strategic direction, support and day-to-day oversight for public affairs activities undertaken by state dental societies in 27 states. Collectively, the project helps guide public affairs programs within the states, assisting the states in identifying their own active solutions for expanding access to oral care, helping states counter efforts to remove fluoride from municipal water supplies and providing resources to tackle these and other emerging issues for the dental profession at the state level. This ongoing engagement has helped to enhance the effectiveness of state public affairs programs and shared learning across states, while allowing each state to pursue campaigns and tackle public affairs challenges in a manner appropriate to its own needs.

Additionally, the SPA program has developed into one of the primary vehicles for coordination and support for the ADA's **Action for Dental Health** (ADH) project, an initiative to effectively reduce barriers to oral health care both locally and nationally by developing workable projects to: provide care now; strengthen the dental safety net; and enhance prevention and education.

Workforce: Advocates for midlevel providers continue to press their case aggressively. The Kellogg Foundation and the Pew Charitable Trusts Children's Dental Campaign have committed millions of dollars over several years to organize oral health coalitions in various states and advance alternative workforce legislation. As a result of these resources and an increased aggressiveness among workforce advocates, there was a significant increase in the number of states considering workforce legislation in 2013. Those included Connecticut, the District of Columbia, Kansas, Maine, New Hampshire, New Mexico, North Dakota, Vermont and Washington.

To counter these threats and demonstrate what states are doing to expand access to care, we continued to work with the states to identify proactive access solutions, provide strategic direction, offer media relations advice, supported local lobbyists and develop a number of communications materials to support the targeted states. As communication around this issue became more salient, we monitored progress, counseled on strategy and shared resources across state lines. For example, SPA developed a workforce toolkit that includes strategies and materials states can use, as well as information developed by adversaries so state dental societies know what to expect from Pew, Kellogg and their allies. The toolkit is available on ADA Connect and is periodically updated.

Additionally, bi-weekly workforce calls with SPA and non-SPA states facing threats continued throughout the year. These calls help the states learn what to expect from Kellogg, Pew and other groups pushing workforce positions – how they buy ads, pitch Op-Eds and organize coalitions. The states have used this knowledge-sharing to draft proactive plans to address access issues and help strengthen their communications. States targeted by Kellogg, Pew and others seeking to establish alternative workforce models are invited to join these calls.

Fluoride: There has been a noticeable uptick in anti-fluoride activity around the country in recent months. Among those states are Montana, Oregon, New Mexico and Wisconsin. In some states ADA and the state associations have worked collaboratively with Pew in an effort to maintain the appropriate levels of fluoride in community water supplies. Other states, meanwhile, have supported local campaigns to add fluoride to water supplies. The largest effort for 2013 was the ballot initiative previously described in Portland, OR in May, 2013 that was unsuccessful. Regardless, the number of individuals with access to community water fluoridation continues to grow across the nation and is discussed in more detail in the CAPIR report.

Corporate Ownership: In the past year we saw continued increased attention and focus paid to corporate dentistry and corporate ownership of dental practices at both the national and state level.

Building on a new law to help bring corporate entities under the regulatory authority of the state Dental Board, North Carolina continued with implementation steps in 2013 after the law passed in 2012

Native American Project: The purpose of the Native American Oral Health Care Project is to identify workable solutions to dental care issues facing tribes in Arizona, New Mexico, North Dakota and South Dakota. The local consultants and state executive directors continue to hold meetings throughout the states with tribal leaders in order to engage Native Americans on access to care issues.

In 2013, expanded efforts to initiate new ways to reach out to Native students to bring them into the dental professions were developed and CDHC discussions among several tribes began in earnest. North Dakota has used these advancements to engage in CDHC discussions and bring a Mission of Mercy to tribal lands in 2013. Further, NDDA has been a leader in discussions to break down some of the credentialing barriers presented within the Indian Health Service system.

Meanwhile, the South Dakota Dental Association, in concert with the Delta Dental Foundation of South Dakota, was awarded a CMS Healthcare Innovation Award to improve Native American oral health in 2012. A portion of this has been used to develop a modular CDHC training to add oral health skills and understanding to existing Community Health Workers.

In 2011, New Mexico became the first state to authorize a CDHC in statute. NMDA is in discussions with a New Mexico Community College to develop a CDHC program and hopes to have a program ready by in 2014. Further, NMDA is considering hosting its first Native American Oral Health summit, to build on the successes these meetings have fostered in other states.

In Arizona, AzDA has conducted regional roundtables with tribal representatives from 18 of the 22 Native American tribes in the state. These meetings have focused on oral health literacy, preventive programs, CDHC, the educational pipeline, and coalition building. Additionally, AzDA has been awarded a DentaQuest Development grant to support the work of the Native Oral Health Alliance they have founded as an outgrowth of this work. One of the most tangible pipeline project possibilities is in discussion with the San Carlos Apache Tribe.

Working with the states, SPA continues to steer the strategic direction of the project and ensure all state associations involved are sharing information. A bi-weekly Native American call is now conducted in order for all four states to have an opportunity to speak with each other. The group plans to discuss, among other things, goals and processes for reporting outcomes with regards to CDHC, the education

pipeline and the translation of work on the ground in the states to the formation of national policy as well as develop specific workgroups for each specific topic.

SPA Resources: SPA has developed a series of documents to help state societies and associations. These resources prevent states from having to "reinvent the wheel" and further encourage states to share information. Working together the ADA staff along with the national SPA consultant, CLS, and later FH, periodically update these resources to include recent initiatives. These resources include:

- **Bank of Legislative Solutions:** lists legislative initiatives various states have undertaken to address access challenges, which dental societies have developed and/or supported;
- **Case Studies:** provides in-depth analysis of different states' legislative accomplishments;
- **Social Media Guide:** offers a step-by-step guide on how to use social media to more successfully engage important audiences;
- **Dentist Salary Talking Points:** lays out appropriate talking points when asked about the economics of the dental profession and dentist earnings in general, especially as the cost of care remains an unfortunate barrier to access during these lean economic times;
- **Dentists as Doctors Handbook:** outlines easily implementable initiatives to strengthen the perception of dentists as highly-skilled medical professionals; and
- **Coalition Guide:** explains how building coalitions can strengthen your position on oral health, and how to build and manage a successful coalition.

State Activities-Details:

STATE	ISSUES
Arizona	• Native American Project as described above.
California	• CDA has taken an active role in defining the California Health Benefits Exchange, a mandate from the national health care legislation. • CDA is focusing on educating the legislature, their staff and other policy makers on how dental is different, and must be treated as so as they craft the Exchanges. • The information gathered in CA has helped to inform other states as to challenges and opportunities in the implementation process when they are at different stages of exchange development.
Colorado	• Work began in 2012 preparing for workforce legislation that did not materialize. • CDA used that development to help pass a partial restoration of adult dental Medicaid benefits and work to develop new ways to bring dentists to more remote areas of the state.
Connecticut	• CSDA faced another effort by workforce proponents to pass an ADHP study bill. The bill failed to move again in 2013, but CT is a state where we anticipate efforts each year.
District of Columbia	• A member of the Washington, DC City Council introduced legislation to expand city sealant and topical fluoride programs and study alternative dental workforce models. With SPA assistance, DCDS has engaged a lobbyist, activated members to lobby and is working to develop a counter legislative proposal.
Florida	• FDA used a grant to attempt to affect change to the state dental Medicaid program and prepare for potential workforce challenges.
Georgia	• Responding to repeated claims of a dental workforce and access shortage in the state, the GDA conducted a dental census across the state. • It was designed to provide a true picture of Georgia's dental workforce and the state's needs, which can be utilized to address the oral health care needs of Georgia's patients. • This project was funded in 2012 and released by GDA in 2013. • Additionally, a supplemental grant was made to GDA to support legal action to defend the state's prompt pay law.
Idaho	• ISDA continues to face a number of challenges including: countering the claims of workforce proponents that the state lacks adequate dental capacity; preventing dental hygienists from expanding their scope of practice or establishing a separate board; restoring adult dental Medicaid; opening the DentaQuest provider panel

	developing the state-based health insurance exchange;. Additionally, the very active hygiene assn. continues to explore ways to advance ADHP. Further, denturists are using these opportunity to attempt to modify their scope and regulatory systems. • ISDA made significant strides in all these areas in large part because of the SPA funding. In particular, ISDA has shown significant progress in demonstrating quantifying the state's dental capacity with credible data. • Also, ISDA has started actively educating legislators on access and workforce issues.
Kansas	• KDA continues to face an aggressive campaign from the Kellogg Foundation, including advertising and support of DHAT-type legislation. • KDA's continued to work on implementation of the legislation they passed in 2012 to provide for volunteer dental licenses for retired dentists to donate care to underserved populations and an expansion of locations where charitable dental care can be provided, as well as other access solutions including the development of a 3rd level of Expanded Function Hygienist.
Kentucky	• KDA was approved for a grant to assist in persuading state administrators to modify their overly aggressive policy of auditing dental Medicaid providers and demanding refunds of payments for procedures the Medicaid office had instructed dentists to submit.
Maine	• Maine has had an extremely busy 2013 legislative session with increase pressure by workforce advocates. As of this writing it appears the dental hygiene therapist legislation which passed in the House and was defeated in the Senate is now stalled. As the measure was sponsored by the Speaker of the House, this was a very serious challenge. • MDA dentists responded to the challenge with a huge grassroots effort, coordinated by the MDA and their new SPA consultants. That effort was essential in stalling the bill for 2013.
Michigan	• MDA continues to confront workforce issues from a professor at the University of Michigan School of Social Work. The professor is working with the dean of the University of Detroit Mercy School of Dentistry on a potential unsupervised hygiene program. The school has applied for a HRSA grant to fund the program and is looking into other funding sources. • MDA has been successful at educating the legislators, media and third party stakeholders on what dentists are doing to address access while pushing solutions forward. The expansion of the widely recognized Healthy Kids Dental program was part of this success. Additionally, MDA has actively embraced the ADH agenda.
Missouri	• MDA was successful in passing its non-covered services bill in 2013. • Separately, MDA continued to hold off workforce advocates from introducing legislation this session. A state

	representative has already articulated plans to introduce an alternative workforce bill in 2014. • It also has a strong focus on prevention as an integral part of the solution. It started a new public education campaign called "Your Mouth is Talking," which has been positively received by legislators, news media and other influencers.
Montana	• Denturists and hygienists attempted to create a separate, non-dentist regulatory board and increase scope. MDA was successful in halting these proposals in 2013, but regulatory wrangling continues and may spill over into the next session.
New Hampshire	• Workforce continues to be a particularly hot issue in the state. NHDS was successful defeating a dental hygiene therapy bill again in 2013. However, the pressure continues to mount. • To counter, NHDS has been a leader in implementing ADH. A supplemental grant was approved for NHDS to hire a dentist as a part-time ADH coordinator who is working to increase access for 0 – 3 year olds, ER interventions and school-based sealant programs.
New Mexico	• Native American Project as described above. • During the 2013 legislative session, NMDA was again successful in defeating a dental hygiene therapy bill. However, Kellogg has made a significant investment in the state and we anticipate continued pressure. • NMDA is in discussions to develop a CDHC program at a community college and hopes to have a program ready by 2014. Currently, a SPA approved CDHC demonstration project is proving the viability of the model in NM and providing exceptionally promising initial results.
North Carolina	• NCDS is working to implement Dental Management Arrangements legislation enacted in 2012 to bring those organizations under the jurisdiction of the dental board would clarify the operating guidelines for dental management corporations (DMCs) doing business in North Carolina and restricting them, for example, from controlling parts of the dental practice that could have a negative impact on patient care. • With the field moving from legislative to regulatory action, the NCDS grant was reduced for the second half of 2013. • Additionally, NCDS is working to reframe an initiative of the administration that would move the dental Medicaid program to a managed care system.
North Dakota	• Native American project as described above. • A bill to introduce dental therapy to ND was introduced in the 2013 legislative session. When NDDA had been successful in halting the progress of the measure the sponsor was granted the ability to change the bill to a study. That was approved, but to date no funding has been provided to facilitate the report.
Oregon	• ODA was a leader in a coalition effort to retain the City Council decision of 2012 to provide community water

	fluoridation within the City of Portland's system. However, that effort was unsuccessful in May, 2013. • ODA is considering adapting the CDHC model to provide for regional dental exchange personnel as required by the guidelines established for the state exchanges in Oregon. • With the end of the fluoridation initiative the ODA grant was not renewed for the second half of 2013.
Pennsylvania	• PDA is a member of the Pennsylvania Coalition for Oral Health, which gives the association an important avenue for building support for its policies and initiatives for improving access to care. However, the risk of other interests becoming involved in the Coalition for Oral Health could lead to the introduction of a workforce proposal if PDA does not maintain a leadership role. • PDA is working for the restoration of funding for the Donated Dental Services Program and enactment of assignment of benefits legislation. • Defluoridation efforts and anti-amalgam efforts continue to pop-up periodically in the state.
Puerto Rico	• The Colegio was approved for a public affairs effort to work on bills amending the Comprehensive Health Insurance system of the Commonwealth, seeking an agreement with the Dental Board to permit the Colegio to expand CE and licensure facilitation and amending a pharmacy bill to not sweep dentists in with physicians.
Rhode Island	• Rhode Island was initially approved in 2013 to work against legislation that would have reconstructed the Dental Board into a dentist minority. They have been successful with that effort. • However, a new challenge arose where the state began to raid dental offices in inspections and shut them down without due process. RIDA has filed suit asking that the raids be stopped and a due process protocol be established. As this may primarily be a legal issue, the grant was not renewed for the second half of the year; however, RIDA is working toward an ADA Legal Grant.
South Dakota	• Native American Project as described above.
Vermont	• VSDS faced several challenges including a workforce measure pushed by a Kellogg-backed coalition. As such, VSDS was more aggressive and proactive in providing access solutions, successfully introducing a comprehensive oral health care package. • VSDS was successful in convincing legislators not to take any workforce actions until a "Dental Landscape Study" commissioned by the Department of Health is completed. • Additionally, VSDS was successful in securing a 3% dental Medicaid increase. • Lastly, to promote tangible oral health solutions, VSDS sponsored a CDHC pilot, additional funds for the "Tooth Tutor" program and expanding loan repayment and loan forgiveness programs for dentists. • With US Senator Bernie Sanders having held hearings and

	introduced legislation on oral health, it simply adds to the volatility of the political environment in VT, but the dentists in Vermont have worked diligently to open up lines of communication with the Senator.
Virginia	• A lump grant was approved for VDA for a project with the Medicaid State Dental Association aimed at quantifying program data and providing for valuable information for program improvement across the nation. • Additionally, VDA is committed to working broadly to enact various ADH initiatives.
Washington	• WSDA's 2012 House of Delegates approved a legislative proposal to potentially seek enactment of legislation to create an "expanded function dental extender" position that would work exclusively within an FQHC and for the limited surgical scope proposed would have required the on-site supervision of the delegating dentist. • When dental workforce advocates introduced their 2013 bills to enact dental hygiene therapists, WSDA did not introduce the proposal and was successful in holding the measures in both legislative chambers again in 2013. • WSDA is also working to expand existing ER intervention projects to other areas of the state.
Wisconsin	• WDA has been aggressive in efforts to expand their reach including maximizing opportunities for increased positive news coverage and expanded legislative and regulatory outreach. • Additionally, WDA is continually working to stem an effort by an Alderman in Milwaukee to defluoridate that water system. In response a "rapid response" fluoride team has been developed.

Resolution

This report is informational and no resolutions are presented.

BOARD RECOMMENDATION: Vote Yes to Transmit.

BOARD VOTE: UNANIMOUS.

Resolution No. 68 New

Report: CEBJA Supplemental Report 1 Date Submitted: October 2013

Submitted By: Council on Ethics, Bylaws and Judicial Affairs

Reference Committee: Legislative, Health, Governance and Related Matters

Total Net Financial Implication: None Net Dues Impact:

Amount One-time Amount On-going FTE 0

ADA Strategic Plan Goal: Members (Required)

COUNCIL ON ETHICS, BYLAWS AND JUDICIAL AFFAIRS SUPPLEMENTAL REPORT 1 TO THE HOUSE OF DELEGATES: RESCISSION OF THE POLICY: "THE DENTIST'S PRAYER"

Background: As part of its established policy review responsibilities, the Council on Ethics, Bylaws and Judicial Affairs (CEBJA) undertook a review of Resolution141H-1991, entitled "The Dentist's Prayer" (*Trans.*1991:643), which states as follows:

> **Resolved,** that the American Dental Association express its belief on quality assurance by accepting this first general Parameter of Care:
>
> The Dentist's Prayer
>
> Thank you, O Lord, for the privilege of being a dentist,
> For letting me serve as your instrument in ministering to the sick and afflicted,
> May I always treat with reverence the human life which you have brought into being and which I serve,
> Deepen my love for people so that I will always give myself gladly and generously to those stricken with illness and pain,
> Help me to listen patiently, diagnose carefully, prescribe conscientiously, and treat gently,
> Teach me to blend gentleness with skill,
> To be a dentist with a heart as well as a mind.
>
> Joseph G. Kalil, D.D.S.

Analysis: In discussions concerning the review of this policy, concerns were expressed that "The Dentist's Prayer" was not the proper subject of an Association Policy and might be viewed as offensive to those members or potential members who are atheists or agnostics or who practice other than Judeo-Christian religions. However, it was also recognized that "The Dentist's Prayer" has historical significance, having been ADA policy for over 20 years. Further, CEBJA noted that the prayer is held in high regard by many members; indeed, during its review, anecdotal reports were received indicating that framed copies of the prayer are placed in members' waiting rooms.

As a result of its review, CEBJA determined that because "The Dentist's Prayer" is not a true policy statement and in view of the fact that the Judeo-Christian expression of the prayer as ADA policy might be viewed as objectionable by segments of membership, a recommendation to rescind the policy was appropriate. Because of its historical significance and the fact that "The Dentist's Prayer" is held in high regard by some members, CEBJA determined that it was also appropriate to recommend that "The Dentist's Prayer" be placed in the ADA archives so that it would continue to be available to interested members.

Because of the potential ramifications that CEBJA's recommendation might have on diverse member segments of the Association, CEBJA also requested that the Diversity and Inclusion Committee of the Board of Trustees review CEJBA's proposed recommendation before finalizing it. The Diversity and Inclusion Committee considered the matter and, in correspondence dated August 8, 2013, indicated that it supported the recommendation.

Resolution

68. Resolved, that Resolution 141H-1991, "The Dentist's Prayer" (*Trans.*1991:643) be rescinded, and be it further

Resolved, that the text of Resolution 141H-1991, "The Dentist's Prayer" (*Trans.*1991:643) be placed in the ADA archives as a matter of historical import to the Association.

BOARD COMMENT: The Dentist's Prayer has been a policy of the Association for many years and is believed to be a generic enough statement so as not to be offensive to the majority of members or potential members of the Association. Consequently, while the Board of Trustees appreciates the sensitivity of the Council on Ethics, Bylaws and Judicial Affairs in its review of this issue, it does not support rescission of this policy.

BOARD RECOMMENDATION: Vote No.

BOARD VOTE: UNANIMOUS.

Resolution No. 69-83 New

Report: CAPIR Supplemental Report 1 Date Submitted: October 2013

Submitted By: Council on Access, Prevention and Interprofessional Relations

Reference Committee: Legislative, Health, Governance and Related Matters

Total Net Financial Implication: None Net Dues Impact:

Amount One-time Amount On-going FTE 0

ADA Strategic Plan Goal: Collaboration (Required)

COUNCIL ON ACCESS, PREVENTION AND INTERPROFESSIONAL RELATIONS SUPPLEMENTAL REPORT 1 TO THE HOUSE OF DELEGATES: ADA POLICY REVIEW

Background: The Council considered a portion of the Association's Access, Prevention, and Interprofessional Relations related polices for review, as directed by Resolutions 111H-2010 and 170H-2012, Regular Comprehensive Policy Review (*Trans.*2010:603; *Trans.*2012:370*).* A total of 24 ADA policies were reviewed by the Council with assistance from its relevant subcommittees.

Recommendations—Policies to be Maintained

The Council concluded that the following ADA policies should be maintained as written:

Definition of Oral Health Literacy (*Trans.*2005:322; *Trans.*2006:316)
Certification or Approval of Dental Care Facilities (*Trans.*1993:689)
Women's Oral Health Research (*Trans.*2001:460)
Physical Examinations by Dentists (*Trans.*1977:924; *Trans.*1991:618)

In addition, during the review, the Council questioned the inclusion of the following resolutions listed in the ADA *Current Policies* which appear to be directives and not policies. The Council consulted with the ADA Speaker of the House of Delegates, Dr. Glen Hall, who concurs that these resolutions are directives which can be archived:

Adequacy of Community Dental Services (*Trans.*1962:289)
National Children's Dental Health Month (*Trans.*1979:625)
Priority Treatment for Combat Veterans (*Trans.*2006:346)
Oral Health Literacy Awareness (*Trans.*2000:456)

Actions taken by the Council on the remaining policies that underwent systematic review are indicated in turn below:

Recommendations—Policies to be Amended

The Council recommends that the policy, "State Dental Programs" be amended to make this policy current and offers the following resolution:

69. Resolved, that the ADA policy on State Dental Programs (*Trans.*1954:278) be amended to read as follows (additions <u>underscored</u>; deletions are ~~stricken~~):

Resolved, that constituent dental societies be urged to ~~take immediate steps to strengthen the~~ support state oral health ~~dental health~~ programs in their respective state by (1) assuming the necessary leadership to secure the appropriation of state funds earmarked for dental health purposes, (2) fostering the appointment of a capable state dental director, and (3) aiding in the establishment of a sound administrative position for the state oral health program ~~dental unit~~.

The Council recommends that the policy, "Dental Care in Institutional Settings" be amended by revising the title to include "Homebound Settings." In addition, it is recommended that the first resolving clause be amended for purposes of consistency with the ADA's existing Policy on the Aged, Blind and Disabled (*Trans.*202:390; *Trans.*2012:440). That policy uses the terms "aged, blind and disabled" in lieu of "special needs" and recommends use of the phrase "people with intellectual disabilities" where appropriate. The proposed amendment in the second resolving clause would simplify the language. The third and fourth resolving clauses are directives and it is recommended that they be deleted as the desired action has been accomplished.

70. Resolved, that the policy on Dental Care in Institutional Settings (*Trans.*1986:518) be amended by revising the title to Dental Care in Institutional and Homebound Settings, and amending the policy to read as follows (additions underscored; deletions are ~~stricken~~).

Dental Care in Institutional and Homebound Settings

Resolved, that appropriate agencies of the American Dental Association work with national organizations involved with care for the ~~disabled, mentally retarded, blind and elderly~~ aged, blind and disabled in homebound or longer term care facilities in formulating policies that will assure delivery of comprehensive dental care, and be it further

Resolved, that constituent and component dental societies be urged to work with health care facility administrators, dental and medical directors and other responsible parties to assure that any underserved populations are receiving comprehensive dental care ~~and that dental auxiliaries functioning in these programs are~~ under ~~direct, indirect or personal~~ the supervision of a licensed dentist., ~~and be it further~~

~~**Resolved,** that the Association, through appropriate councils and agencies, explore and develop new programs that will assist constituent and component societies in responding to the needs of underserved populations, and be it further~~

~~**Resolved,** that the ADA only endorse existing and newly developed programs that meet or follow existing ADA policies.~~

The Council recommends that the policy "Informational Support for Members Providing Oral Care in Long-Term Care Facilities" be amended to add clarifying language in the first resolving clause, which would also eliminate the need for the second resolving clause.

71. Resolved, that the policy on Informational Support for Members Providing Oral Care in Long-Term Care Facilities (*Trans.*1997:671) be amended to read as follows (additions underscored; deletions are ~~stricken~~).

Resolved, that constituent dental societies be encouraged to collect, maintain and distribute to members information about federal and state laws and regulations, including the Incurred Medical Expenses reimbursement mechanism, for provision of dental care in long-term care facilities, assisted living facilities, and private homes., ~~and be it further~~

~~**Resolved,** that such information should include details about: the Post Eligibility Treatment of Income Provision contained within the Social Security Act, the regulations pertaining to the use of~~

~~allied dental personnel in long-term care facilities, assisted living facilities and private homes; the oral health services covered under the Medicare program; and the state regulations pertaining to non-Medicaid and Medicare certified nursing homes.~~

The Council recommends that the policy "Communication and Dental Practice" be amended. It is imperative for professionals to assure that patients understand and can act upon oral health information provided to them.

72. Resolved, that the policy on Communication and Dental Practice (*Trans.*2008:454) be amended to read as follows (additions underscored; deletions are ~~stricken~~).

Resolved, that the ADA affirms that clear, accurate and effective communication is an essential skill for ~~effective~~ patient-centered dental practice.

The Council recommends that the policy "Limited Oral Health Literacy Skills and Understanding in Adults**"** be amended by deletion of the second resolving clause, which is a directive and not a policy statement.

73. Resolved, that the policy on Limited Oral Health Literacy Skills and Understanding in Adults (*Trans.*2006:317) be amended to read as follows (additions underscored; deletions are ~~stricken~~).

Resolved, that the ADA recognizes that limited oral health literacy is a potential barrier to effective prevention, diagnosis and treatment of oral disease. ~~, and be it further~~

~~**Resolved,** that the Council on Access, Prevention and Interprofessional Relations and other appropriate ADA agencies work with constituent and component societies, other dental and non-dental organizations, the health care community and governmental agencies to increase awareness that many adults have limited oral health literacy skills and difficulty understanding oral health information and available services.~~

The Council recommends that the policy "Preventive Dental Procedures" be amended as it was originally worded as a directive.

74. Resolved, that the policy on Preventive Dental Procedures (*Trans.*1967:325) be amended to read as follows (additions underscored; deletions are ~~stricken~~).

Resolved, that constituent dental societies ~~actively promote~~ support the use of preventive procedures in all dental offices, and be it further

Resolved, that constituent and component societies ~~make available to members~~ support continuing education programs in the effective use of preventive procedures.

The Council recommends that the policy "Bottled Water, Home Water Treatment Systems and Fluoride Exposure" remains relevant. It is proposed that the portion of the second and third resolving clauses be deleted as the ADA Health History Form now includes this information.

75. Resolved, that the policy on Bottled Water, Home Water Treatment Systems and Fluoride Exposure (*Trans.*2002:390) be amended to read as follows (additions underscored; deletions are ~~stricken~~).

Resolved, that in order to ensure optimal fluoride intake, the American Dental Association ~~urges its~~ supports actions by its members to educate their patients regarding the level of fluoride in bottled water and the possible removal of fluoride by some home water treatment systems, and be it further

Resolved, that the American Dental Association urges its members to inquire about their patients' primary and secondary water source as part of the health history, ~~and that the appropriate ADA agencies be asked to include a question regarding the primary and secondary water source on the ADA Health History Form,~~ and be it further

Resolved, that the American Dental Association supports the labeling of bottled water with the fluoride concentration of the product and company contact information including address and telephone number, and be it further

Resolved, that the American Dental Association supports the inclusion of information on the system's effect on water fluoride levels with each home water treatment system. ~~, and be it further~~

~~**Resolved,** that the American Dental Association inform other communities of interest of the ADA's policy on bottled water, home water treatment systems and fluoride exposure~~.

The Council recommends that the policy "Pouring Rights Contracts and Marketing of Soft Drinks to Children" be amended as it was originally worded as a directive.

76. Resolved, that the policy on Pouring Rights Contracts and Marketing of Soft Drinks to Children (*Trans.*2003:359) be amended to read as follows (additions underscored; deletions are ~~stricken~~).

~~**Resolved,** that the policy titled "Marketing of Soft Drinks in Schools" (Trans.2000:457) be renamed "Pouring Rights Contracts and Marketing of Soft Drinks to Children" and be amended to read as follows:~~

Resolved, that the American Dental Association~~, through its appropriate agencies, continue to gather the scientific facts and supporting data concerning~~ supports further study of the oral health effects of the increasing consumption of beverages containing sugars, carbonation or acidic components. These products are commonly referred to as "soft drinks," including but not limited to juice drinks, sports drinks and soda pop, and be it further

Resolved, that the Association ~~encourages~~ supports constituent and component dental societies efforts to work with education officials, pediatric and family practice physicians, dietetic professionals, parent groups, and all other interested parties, to increase awareness of the importance of maintaining healthy vending choices in schools, and to encourage the promotion of beverages of high nutritional value, and be it further

Resolved, that the American Dental Association opposes contractual arrangements, including pouring rights contracts that influence consumption patterns that promote increased access to "soft drinks" for children.

The Council recommends that the "Policy on Obesity" be amended as it was originally worded as a directive.

77. Resolved, that the Policy on Obesity (*Trans.*2009:420) be amended to read as follows (additions underscored; deletions are ~~stricken~~).

Resolved, that the ADA supports collaborative efforts with other health professionals (physicians, pediatricians, nurses, dieticians, nutritionists, etc.) to combat the growing problems of overweight and obesity, and be it further

Resolved, that the ADA supports collaborative efforts with other ~~work in collaboration with~~ appropriate stakeholder organizations/agencies to ~~assure that~~ educate professionals and the

public regarding issues specific to nutrition and oral health, as well as the systemic/oral health relationship. ~~, are incorporated into documents and educational materials, and be it further~~

~~**Resolved,** that the ADA investigate opportunities to offer continuing education courses related to nutrition and obesity.~~

The Council recommends that the Policy of "Oral Health Assessment for School Children" be amended as it was originally worded as a directive.

78. Resolved, that the Policy on Oral Health Assessment for School Children (*Trans.*2005:323) be amended to read as follows (additions underscored; deletions are ~~stricken~~).

Resolved, that the ADA ~~policy~~ supports oral health assessments for school children, intended to gather data, detect clinically apparent pathologic conditions and allow for triage and referral to a dentist for a comprehensive dental examination, and be it further

Resolved, that the ADA ~~urges~~ supports state dental associations' efforts to sponsor legislation to provide oral health assessments for school children, and be it further

Resolved, ~~that children and their parents and/or caregivers be informed that an oral assessment is not an examination, and~~ that ADA ~~policy~~ recommends that school children receive a comprehensive examination conducted by a licensed dentist, and be it further

Resolved, that the ADA ~~take steps~~ supports efforts to educate policymakers and the public that oral health is an integral part of overall health, and as such, oral health assessments should be given the same priority as other health assessments for children, and urges state and local dental societies to take similar actions.

The Council recommends that the Policy on "High Blood Pressure Programs" be amended as it was originally worded as a directive.

79. Resolved, that the Policy on High Blood Pressure Programs (*Trans.*1974:643) be amended to read as follows (additions underscored; deletions are ~~stricken~~).

Resolved, that the ~~members of the~~ American Dental Association ~~be urged to participate~~ supports member participation in the National High Blood Pressure Program.

Recommendations—Polices to be Rescinded

The Council reviewed the policy, "Home Health Care" and is recommending rescission because the policy is duplicative of current policy titled Dental Care in Institutional Settings (*Trans.*1986:518).

80. Resolved, that the ADA Policy, Home Health Care (*Trans*.1989:541) be rescinded.

The Council reviewed the policy, "Health Hazards of Air and Water Pollution" recommending rescission because the policy is no longer relevant as written.

81. Resolved, that the ADA Policy, Health Hazards of Air and Water Pollution (*Trans*.1969:325) be rescinded.

The Council reviewed the policy, "Guidelines for Hospital Dental Services" recommending rescission because dentists working within hospitals must follow the guidelines established by the hospital medical staff section.

82. Resolved, that the ADA Policy, Guidelines for Hospital Dental Services (*Trans*.1991:618) be rescinded.

The Council reviewed the policy "Suggestions for Dentists on Participating in the National High Blood Pressure Education and Screening Program" recommending rescission because the language in the guidelines is no longer current and relevant based on National Institutes for Health guidelines, accessed on September 10, 2013 at http://www.nhlbi.nih.gov/about/nhbpep/.

83. Resolved, that the ADA Policy, Suggestions for Dentists on Participating in the National High Blood Pressure Education and Screening Program (*Trans*.1976:114, 849; *Trans*.1995:610) be rescinded.

Resolutions

(Resolution 69:Worksheet:5086)
(Resolution 70:Worksheet:5087)
(Resolution 71:Worksheet:5089)
(Resolution 72:Worksheet:5090)
(Resolution 73:Worksheet:5091)
(Resolution 74:Worksheet:5092)
(Resolution 75:Worksheet:5093)
(Resolution 76:Worksheet:5094)
(Resolution 77:Worksheet:5095)
(Resolution 78:Worksheet:5096)
(Resolution 79:Worksheet:5097)
(Resolution 80:Worksheet:5098)
(Resolution 81:Worksheet:5100)
(Resolution 82:Worksheet:5102)
(Resolution 83:Worksheet:5105)

Resolution No. 69 New

Report: CAPIR Supplemental Report 1 Date Submitted: October 2013

Submitted By: Council on Access, Prevention and Interprofessional Relations

Reference Committee: Legislative, Health, Governance and Related Matters

Total Net Financial Implication: None Net Dues Impact:

Amount One-time Amount On-going FTE 0

ADA Strategic Plan Goal: Collaboration (Required)

AMENDMENT OF POLICY ON STATE DENTAL PROGRAMS

Background: The Council recommends that the policy, "State Dental Programs" be amended to make this policy current and offers the following resolution:

Resolution

69. Resolved, that the ADA policy on State Dental Programs (*Trans.*1954:278) be amended to read as follows (additions underscored; deletions are ~~stricken~~):

> **Resolved,** that constituent dental societies be urged to ~~take immediate steps to strengthen the~~ support state oral health ~~dental health~~ programs in their respective state by (1) assuming the necessary leadership to secure the appropriation of state funds earmarked for dental health purposes, (2) fostering the appointment of a capable state dental director, and (3) aiding in the establishment of a sound administrative position for the state oral health program ~~dental unit~~.

BOARD RECOMMENDATION: Vote Yes.

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

Resolution No. 70 New

Report: CAPIR Supplemental Report 1 Date Submitted: October 2013

Submitted By: Council on Access, Prevention and Interprofessional Relations

Reference Committee: Legislative, Health, Governance and Related Matters

Total Net Financial Implication: None Net Dues Impact:

Amount One-time Amount On-going FTE 0

ADA Strategic Plan Goal: Collaboration (Required)

AMENDMENT OF POLICY ON DENTAL CARE IN INSTITUTIONAL SETTINGS

Background: The Council recommends that the policy, "Dental Care in Institutional Settings" be amended by revising the title to include "Homebound Settings." In addition, it is recommended that the first resolving clause be amended for purposes of consistency with the ADA's existing Policy on the Aged, Blind and Disabled (*Trans.*202:390; *Trans.*2012:440). That policy uses the terms "aged, blind and disabled" in lieu of "special needs" and recommends use of the phrase "people with intellectual disabilities" where appropriate. The proposed amendment in the second resolving clause would simplify the language. The third and fourth resolving clauses are directives and it is recommended that they be deleted as the desired action has been accomplished.

Resolution

70. Resolved, that the policy on Dental Care in Institutional Settings (*Trans.*1986:518) be amended by revising the title to Dental Care in Institutional and Homebound Settings, and amending the policy to read as follows (additions underscored; deletions are ~~stricken~~).

Dental Care in Institutional and Homebound Settings

Resolved, that appropriate agencies of the American Dental Association work with national organizations involved with care for the ~~disabled, mentally retarded, blind and elderly~~ aged, blind and disabled in homebound or longer term care facilities in formulating policies that will assure delivery of comprehensive dental care, and be it further

Resolved, that constituent and component dental societies be urged to work with health care facility administrators, dental and medical directors and other responsible parties to assure that any underserved populations are receiving comprehensive dental care ~~and that dental auxiliaries functioning in these programs are~~ under ~~direct, indirect or personal~~ the supervision of a licensed dentist., ~~and be it further~~

~~**Resolved,** that the Association, through appropriate councils and agencies, explore and develop new programs that will assist constituent and component societies in responding to the needs of underserved populations, and be it further~~

~~**Resolved,** that the ADA only endorse existing and newly developed programs that meet or follow existing ADA policies.~~

BOARD RECOMMENDATION: Vote Yes.

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

Resolution No. 71 New

Report: CAPIR Supplemental Report 1 Date Submitted: October 2013

Submitted By: Council on Access, Prevention and Interprofessional Relations

Reference Committee: Legislative, Health, Governance and Related Matters

Total Net Financial Implication: None Net Dues Impact:

Amount One-time Amount On-going FTE 0

ADA Strategic Plan Goal: Collaboration (Required)

AMENDMENT OF POLICY ON INFORMATIONAL SUPPORT FOR MEMBERS PROVIDING ORAL CARE IN LONG-TERM CARE FACILITIES

Background: The Council recommends that the policy "Informational Support for Members Providing Oral Care in Long-Term Care Facilities" be amended to add clarifying language in the first resolving clause, which would also eliminate the need for the second resolving clause.

Resolution

71. Resolved, that the policy on Informational Support for Members Providing Oral Care in Long-Term Care Facilities (*Trans*.1997:671) be amended to read as follows (additions underscored; deletions are ~~stricken~~).

Resolved, that constituent dental societies be encouraged to collect, maintain and distribute to members information about federal and state laws and regulations, including the Incurred Medical Expenses reimbursement mechanism, for provision of dental care in long-term care facilities, assisted living facilities, and private homes., ~~and be it further~~

~~**Resolved,** that such information should include details about: the Post Eligibility Treatment of Income Provision contained within the Social Security Act, the regulations pertaining to the use of allied dental personnel in long-term care facilities, assisted living facilities and private homes; the oral health services covered under the Medicare program; and the state regulations pertaining to non-Medicaid and Medicare certified nursing homes.~~

BOARD RECOMMENDATION: Vote Yes.

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

Resolution No. 72 New

Report: CAPIR Supplemental Report 1 Date Submitted: October 2013

Submitted By: Council on Access, Prevention and Interprofessional Relations

Reference Committee: Legislative, Health, Governance and Related Matters

Total Net Financial Implication: None Net Dues Impact:

Amount One-time Amount On-going FTE 0

ADA Strategic Plan Goal: Collaboration (Required)

AMENDMENT OF POLICY ON COMMUNICATION AND DENTAL PRACTICE

Background: The Council recommends that the policy "Communication and Dental Practice" be amended. It is imperative for professionals to assure that patients understand and can act upon oral health information provided to them.

Resolution

72. Resolved, that the policy on Communication and Dental Practice (*Trans.*2008:454) be amended to read as follows (additions underscored; deletions are ~~stricken~~).

Resolved, that the ADA affirms that clear, accurate and effective communication is an essential skill for ~~effective~~ patient-centered dental practice.

BOARD RECOMMENDATION: Vote Yes.

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

Resolution No. 73 New

Report: CAPIR Supplemental Report 1 Date Submitted: October 2013

Submitted By: Council on Access, Prevention and Interprofessional Relations

Reference Committee: Legislative, Health, Governance and Related Matters

Total Net Financial Implication: None Net Dues Impact:

Amount One-time Amount On-going FTE 0

ADA Strategic Plan Goal: Collaboration (Required)

AMENDMENT OF POLICY ON LIMITED ORAL HEALTH LITERACY SKILLS AND UNDERSTANDING IN ADULTS

Background: The Council recommends that the policy "Limited Oral Health Literacy Skills and Understanding in Adults**"** be amended by deletion of the second resolving clause, which is a directive and not a policy statement.

Resolution

73. Resolved, that the policy on Limited Oral Health Literacy Skills and Understanding in Adults (*Trans.*2006:317) be amended to read as follows (additions underscored; deletions are ~~stricken~~).

Resolved, that the ADA recognizes that limited oral health literacy is a potential barrier to effective prevention, diagnosis and treatment of oral disease. ~~, and be it further~~

~~**Resolved,** that the Council on Access, Prevention and Interprofessional Relations and other appropriate ADA agencies work with constituent and component societies, other dental and non-dental organizations, the health care community and governmental agencies to increase awareness that many adults have limited oral health literacy skills and difficulty understanding oral health information and available services.~~

BOARD RECOMMENDATION: Vote Yes.

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

Resolution No. 74 New

Report: CAPIR Supplemental Report 1 Date Submitted: October 2013

Submitted By: Council on Access, Prevention and Interprofessional Relations

Reference Committee: Legislative, Health, Governance and Related Matters

Total Net Financial Implication: None Net Dues Impact:

Amount One-time Amount On-going FTE 0

ADA Strategic Plan Goal: Collaboration (Required)

AMENDMENT OF POLICY ON PREVENTIVE DENTAL PROCEDURES

Background: The Council recommends that the policy "Preventive Dental Procedures" be amended as it was originally worded as a directive.

Resolution

74. Resolved, that the policy on Preventive Dental Procedures (*Trans.*1967:325) be amended to read as follows (additions underscored; deletions are ~~stricken~~).

Resolved, that constituent dental societies ~~actively promote~~ support the use of preventive procedures in all dental offices, and be it further

Resolved, that constituent and component societies ~~make available to members~~ support continuing education programs in the effective use of preventive procedures.

BOARD RECOMMENDATION: Vote Yes.

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

Resolution No. 75 New

Report: CAPIR Supplemental Report 1 Date Submitted: October 2013

Submitted By: Council on Access, Prevention and Interprofessional Relations

Reference Committee: Legislative, Health, Governance and Related Matters

Total Net Financial Implication: None Net Dues Impact:

Amount One-time Amount On-going FTE 0

ADA Strategic Plan Goal: Collaboration (Required)

AMENDMENT OF POLICY ON BOTTLED WATER, HOME WATER TREATMENT SYSTEMS AND FLUORIDE EXPOSURE

Background: The Council recommends that the policy "Bottled Water, Home Water Treatment Systems and Fluoride Exposure" remains relevant. It is proposed that the portion of the second and third resolving clauses be deleted as the ADA Health History Form now includes this information.

Resolution

75. Resolved, that the policy on Bottled Water, Home Water Treatment Systems and Fluoride Exposure (*Trans.*2002:390) be amended to read as follows (additions underscored; deletions are ~~stricken~~).

Resolved, that in order to ensure optimal fluoride intake, the American Dental Association ~~urges its~~ supports actions by its members to educate their patients regarding the level of fluoride in bottled water and the possible removal of fluoride by some home water treatment systems, and be it further

Resolved, that the American Dental Association urges its members to inquire about their patients' primary and secondary water source as part of the health history, ~~and that the appropriate ADA agencies be asked to include a question regarding the primary and secondary water source on the ADA Health History Form,~~ and be it further

Resolved, that the American Dental Association supports the labeling of bottled water with the fluoride concentration of the product and company contact information including address and telephone number, and be it further

Resolved, that the American Dental Association supports the inclusion of information on the system's effect on water fluoride levels with each home water treatment system. ~~, and be it further~~

~~**Resolved,** that the American Dental Association inform other communities of interest of the ADA's policy on bottled water, home water treatment systems and fluoride exposure~~.

BOARD RECOMMENDATION: Vote Yes.

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

Resolution No. 76 New

Report: CAPIR Supplemental Report 1 Date Submitted: October 2013

Submitted By: Council on Access, Prevention and Interprofessional Relations

Reference Committee: Legislative, Health, Governance and Related Matters

Total Net Financial Implication: None Net Dues Impact:

Amount One-time Amount On-going FTE 0

ADA Strategic Plan Goal: Collaboration (Required)

AMENDMENT OF POLICY ON POURING RIGHTS CONTRACTS AND MARKETING OF SOFT DRINKS TO CHILDREN

Background: The Council recommends that the policy "Pouring Rights Contracts and Marketing of Soft Drinks to Children" be amended as it was originally worded as a directive.

Resolution

76. Resolved, that the policy on Pouring Rights Contracts and Marketing of Soft Drinks to Children (*Trans.*2003:359) be amended to read as follows (additions underscored; deletions are ~~stricken~~).

~~**Resolved,** that the policy titled "Marketing of Soft Drinks in Schools" (Trans.2000:457) be renamed "Pouring Rights Contracts and Marketing of Soft Drinks to Children" and be amended to read as follows:~~

Resolved, that the American Dental Association~~, through its appropriate agencies, continue to gather the scientific facts and supporting data concerning~~ supports further study of the oral health effects of the increasing consumption of beverages containing sugars, carbonation or acidic components. These products are commonly referred to as "soft drinks," including but not limited to juice drinks, sports drinks and soda pop, and be it further

Resolved, that the Association ~~encourages~~ supports constituent and component dental societies efforts to work with education officials, pediatric and family practice physicians, dietetic professionals, parent groups, and all other interested parties, to increase awareness of the importance of maintaining healthy vending choices in schools, and to encourage the promotion of beverages of high nutritional value, and be it further

Resolved, that the American Dental Association opposes contractual arrangements, including pouring rights contracts that influence consumption patterns that promote increased access to "soft drinks" for children.

BOARD RECOMMENDATION: Vote Yes.

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

Resolution No. 77 New

Report: CAPIR Supplemental Report 1 Date Submitted: October 2013

Submitted By: Council on Access, Prevention and Interprofessional Relations

Reference Committee: Legislative, Health, Governance and Related Matters

Total Net Financial Implication: None Net Dues Impact:

Amount One-time Amount On-going FTE 0

ADA Strategic Plan Goal: Collaboration (Required)

AMENDMENT OF POLICY ON OBESITY

Background: The Council recommends that the "Policy on Obesity" be amended as it was originally worded as a directive.

Resolution

77. Resolved, that the Policy on Obesity (*Trans.*2009:420) be amended to read as follows (additions underscored; deletions are ~~stricken~~).

Resolved, that the ADA supports collaborative efforts with other health professionals (physicians, pediatricians, nurses, dieticians, nutritionists, etc.) to combat the growing problems of overweight and obesity, and be it further

Resolved, that the ADA supports collaborative efforts with other ~~work in collaboration with~~ appropriate stakeholder organizations/agencies to ~~assure that~~ educate professionals and the public regarding issues specific to nutrition and oral health, as well as the systemic/oral health relationship. ~~, are incorporated into documents and educational materials, and be it further~~

~~**Resolved,** that the ADA investigate opportunities to offer continuing education courses related to nutrition and obesity.~~

BOARD RECOMMENDATION: Vote Yes.

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

Resolution No. 78 New

Report: CAPIR Supplemental Report 1 Date Submitted: October 2013

Submitted By: Council on Access, Prevention and Interprofessional Relations

Reference Committee: Legislative, Health, Governance and Related Matters

Total Net Financial Implication: None Net Dues Impact:

Amount One-time Amount On-going FTE 0

ADA Strategic Plan Goal: Collaboration (Required)

AMENDMENT OF POLICY ON ORAL HEALTH ASSESSMENT FOR SCHOOL CHILDREN

Background: The Council recommends that the Policy of "Oral Health Assessment for School Children" be amended as it was originally worded as a directive.

Resolution

78. Resolved, that the Policy on Oral Health Assessment for School Children (*Trans.*2005:323) be amended to read as follows (additions underscored; deletions are ~~stricken~~).

Resolved, that the ADA ~~policy~~ supports oral health assessments for school children, intended to gather data, detect clinically apparent pathologic conditions and allow for triage and referral to a dentist for a comprehensive dental examination, and be it further

Resolved, that the ADA ~~urges~~ supports state dental associations' efforts to sponsor legislation to provide oral health assessments for school children, and be it further

Resolved, ~~that children and their parents and/or caregivers be informed that an oral assessment is not an examination, and~~ that ADA ~~policy~~ recommends that school children receive a comprehensive examination conducted by a licensed dentist, and be it further

Resolved, that the ADA ~~take steps~~ supports efforts to educate policymakers and the public that oral health is an integral part of overall health, and as such, oral health assessments should be given the same priority as other health assessments for children, and urges state and local dental societies to take similar actions.

BOARD RECOMMENDATION: Vote Yes.

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

Resolution No. 79 New

Report: CAPIR Supplemental Report 1 Date Submitted: October 2013

Submitted By: Council on Access, Prevention and Interprofessional Relations

Reference Committee: Legislative, Health, Governance and Related Matters

Total Net Financial Implication: None Net Dues Impact:

Amount One-time Amount On-going FTE 0

ADA Strategic Plan Goal: Collaboration (Required)

AMENDMENT OF POLICY ON HIGH BLOOD PRESSURE PROGRAMS

Background: The Council recommends that the Policy on "High Blood Pressure Programs" be amended as it was originally worded as a directive.

Resolution

79. Resolved, that the Policy on High Blood Pressure Programs (*Trans.*1974:643) be amended to read as follows (additions underscored; deletions are ~~stricken~~).

Resolved, that the ~~members of the~~ American Dental Association ~~be urged to participate~~ supports member participation in the National High Blood Pressure Program.

BOARD RECOMMENDATION: Vote Yes.

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

Resolution No. 80 New

Report: CAPIR Supplemental Report 1 Date Submitted: October 2013

Submitted By: Council on Access, Prevention and Interprofessional Relations

Reference Committee: Legislative, Health, Governance and Related Matters

Total Net Financial Implication: None Net Dues Impact:

Amount One-time Amount On-going FTE 0

ADA Strategic Plan Goal: Collaboration (Required)

RESCISSION OF POLICY ON HOME HEALTH CARE

Background: The Council reviewed the policy, "Home Health Care" and is recommending rescission because the policy is duplicative of current policy titled Dental Care in Institutional Settings (*Trans.*1986:518).

Resolution

80. Resolved, that the ADA Policy, Home Health Care (*Trans*.1989:541) be rescinded.

BOARD RECOMMENDATION: Vote Yes.

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

WORKSHEET ADDENDUM
COUNCIL ON ACCESS, PREVENTION AND INTERPROFESSIONAL RELATIONS
ADA POLICY TO BE RESCINDED

Home Health Care (*Trans*.1989:541)

Resolved, that constituent dental societies meet with licensed home care agencies in their states to stress the need for attention to the oral health needs of home care patients, and be it further

Resolved, that the American Dental Association encourage national accrediting bodies to adopt meaningful oral health care standards within their accrediting standards for home care agencies, and be it further

Resolved, that the Council on Access, Prevention and Interprofessional Relations develop and distribute guidelines to be used as a basis for recommendations to home care agencies and accrediting bodies.

Resolution No. 81 New

Report: CAPIR Supplemental Report 1 Date Submitted: October 2013

Submitted By: Council on Access, Prevention and Interprofessional Relations

Reference Committee: Legislative, Health, Governance and Related Matters

Total Net Financial Implication: None Net Dues Impact:

Amount One-time Amount On-going FTE 0

ADA Strategic Plan Goal: Collaboration (Required)

RESCISSION OF POLICY ON HEALTH HAZARDS OF AIR AND WATER POLLUTION

Background: The Council reviewed the policy, "Health Hazards of Air and Water Pollution" recommending rescission because the policy is no longer relevant as written.

Resolution

81. Resolved, that the ADA Policy, Health Hazards of Air and Water Pollution (*Trans*.1969:325) be rescinded.

BOARD RECOMMENDATION: Vote Yes.

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

WORKSHEET ADDENDUM
COUNCIL ON ACCESS, PREVENTION AND INTERPROFESSIONAL RELATIONS
ADA POLICY TO BE RESCINDED

Health Hazards of Air and Water Pollution (*Trans*.1969:325)

Resolved, that the American Dental Association wishes to express its great concern of the health hazards presented by the pollution of our air and water which seems to be on the increase throughout our country, and be it further

Resolved, that as one of the great health organizations of the world, that we share the responsibility of instituting and supporting effective legislation to control this ravage of mankind, before it is too late, and be it further

Resolved, that we recommend to our members, as concerned citizens, an educational program, both on the national and local level by our participation in civic movements, to curb and control the continued pollution of our air and water so vital to life.

Resolution No. 82 New

Report: CAPIR Supplemental Report 1 Date Submitted: October 2013

Submitted By: Council on Access, Prevention and Interprofessional Relations

Reference Committee: Legislative, Health, Governance and Related Matters

Total Net Financial Implication: None Net Dues Impact:

Amount One-time Amount On-going FTE 0

ADA Strategic Plan Goal: Collaboration (Required)

RESCISSION OF POLICY ON GUIDELINES FOR HOSPITAL DENTAL SERVICES

Background: The Council reviewed the policy, "Guidelines for Hospital Dental Services" recommending rescission because dentists working within hospitals must follow the guidelines established by the hospital medical staff section.

Resolution

82. Resolved, that the ADA Policy, Guidelines for Hospital Dental Services (*Trans*.1991:618) be rescinded.

BOARD COMMENT: The Board believes it important to maintain the Guidelines for Hospital Dental Services (*Trans*.1991:618) although it is acknowledged that the language of the policy needs updating. The Board recommends that Resolution 82 be referred back to the Council on Access, Prevention and Interprofessional Relations for updating of the policy with a report on its work to be given to the 2014 House of Delegates.

BOARD RECOMMENDATION: Vote Yes on Referral.

Vote: Resolution 82

BUCKENHEIMER	Yes	FEINBERG	Yes	NORMAN	Yes	VERSMAN	No
CROWLEY	Yes	GOUNARDES	Yes	ROBERTS	Yes	WEBER	Yes
DOW	Yes	HAGENBRUCH	Yes	SCOTT	Absent	YONEMOTO	Yes
ENGEL	Yes	ISRAELSON	Yes	SEAGO	Yes	ZENK	Yes
FAIR	Yes	KIESLING	Yes	SUMMERHAYS	Yes	ZUST	Yes

WORKSHEET ADDENDUM
COUNCIL ON ACCESS, PREVENTION AND INTERPROFESSIONAL RELATIONS
ADA POLICY TO BE RESCINDED

Guidelines for Hospital Dental Services (*Trans*.1991:618)

Guideline I: Medical Staff Bylaws, Rules and Regulations
There is a single medical staff that includes dentists who are eligible for all categories of medical staff membership.

Guideline II: Clinical Privileges
Dentist members of the medical staff participate in the development of the scope and extent of clinical privileges granted to a dentist.

Guideline III: Admission, Management and Discharge of Patients
Qualified dentist members of the medical staff are granted privileges to admit, manage and discharge their patients.

Guideline IV: Organizational Structure
The medical/dental staff organization provides a framework within which duties and functions of the dental service can be carried out effectively.

Guideline V: Department or Section Meetings
Regularly scheduled meetings of the dental department/section are consistent with the medical/dental staff bylaws.

Guideline VI: Financial, Facility and Personnel Resources
As a department/service involved in the budget process of the hospital, the dental department/service is provided adequate resources to meet the mission of the department/service and to assure efficient delivery of optimal oral health care.

Guideline VII: Infection Control
Sterilization and infection control procedures are in compliance with currently recognized standards.

Guideline VIII: Emergency Dental Care
Oral health care is included in the emergency service of the hospital.

Guideline IX: Pathology Services
All specimens removed during surgical procedures are properly identified and, where appropriate, sent to the pathologist for laboratory examination.

Guideline X: Library Services
The hospital provides library services appropriate for professional needs of the dental service.

Guideline XI: Medical Records
Dental records are part of the patient's medical record in accordance with the standard procedure of the hospital.

Guideline XII: Quality Improvement
The dental service maintains and participates in a quality improvement program consistent with Joint Commission on Accreditation of Healthcare Organizations standards.

Guideline XIII: Continuing Education
The dental service should provide a program of continuing education.

Guideline XIV: Statistical Records
The dental service maintains statistical data for information and educational needs of members of the department and of the hospital.

Resolution No. 83 New

Report: CAPIR Supplemental Report 1 Date Submitted: October 2013

Submitted By: Council on Access, Prevention and Interprofessional Relations

Reference Committee: Legislative, Health, Governance and Related Matters

Total Net Financial Implication: None Net Dues Impact:

Amount One-time Amount On-going FTE 0

ADA Strategic Plan Goal: Collaboration (Required)

RESCISSION OF POLICY ON SUGGESTIONS FOR DENTISTS ON PARTICIPATING IN THE NATIONAL HIGH BLOOD PRESSURE EDUCATION AND SCREENING PROGRAM

Background: The Council reviewed the policy "Suggestions for Dentists on Participating in the National High Blood Pressure Education and Screening Program" recommending rescission because the language in the guidelines is no longer current and relevant based on National Institutes for Health guidelines, accessed on September 10, 2013 at http://www.nhlbi.nih.gov/about/nhbpep/.

Resolution

83. Resolved, that the ADA Policy, Suggestions for Dentists on Participating in the National High Blood Pressure Education and Screening Program (*Trans.*1976:114, 849; *Trans.*1995:610) be rescinded.

BOARD RECOMMENDATION: Vote Yes.

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

WORKSHEET ADDENDUM
COUNCIL ON ACCESS, PREVENTION AND INTERPROFESSIONAL RELATIONS
ADA POLICY TO BE RESCINDED

Suggestions for Dentists on Participating in the National High Blood Pressure Education and Screening Program (*Trans*.1976:114, 849; *Trans*.1995:610)

The National High Blood Pressure Education Program offers dentists an opportunity to provide an additional health benefit to their patients by joining the national multidisciplinary health campaign to identify undetected hypertension. The Association is a participating agency in this national voluntary control, public education and screening program. Practicing dentists may be more likely than physicians to see relatively healthy persons on a regular basis and thus are in a unique position to assist in detecting previously unsuspected cases of hypertension.

For these reasons, the House of Delegates in 1974 approved a directive "that the members of the American Dental Association be urged to participate in the National High Blood Pressure Education Program" (*Trans.*1974:643). Also in 1974, the House of Delegates adopted a directive to "develop guidelines for dentists on hypertension detection and further promote the procedure through continuing education for dentists and their auxiliaries" (*Trans.*1974:644).

Extent of Problem: High blood pressure, frequently an asymptomatic condition, is a major cause of cardiovascular disease in the United States. One in four adults has hypertension, but only half of them are aware of it. Alerting patients to this condition and making appropriate referral to physicians may prevent heart attack, stroke, kidney disease and other consequences of undetected and uncontrolled hypertension. Measuring the patient's blood pressure is consistent with the dental profession's priority for prevention of disease, confirms to patients the dentist's sincere interest in their total health and underlines the dentist's participation with his or her allied dental personnel in the community health team.

Guidelines: In response to the directive of the House of Delegates calling for guidelines on incorporation of hypertension detection in the dental office, the following suggestions are presented, subject to any state law restrictions.

1. Blood pressure measurement for screening purposes may be appropriate on all new patients, including children, and on recall patients. This procedure could be included in the office routine; for instance, as part of taking or updating a health history.

2. Dentists and allied dental personnel desiring in-service training in the technique of taking blood pressure may consult with local chapters of the American Heart Association or other recognized authorities.

3. Blood pressure measurements may be taken and recorded by allied dental personnel.

4. Dentists should inform patients of hypertension and that it may have serious health consequences that may necessitate changes in their dental treatment. Dentists and their allied dental personnel should explain to patients that their measurement of blood pressure does not constitute a diagnosis and that it is a screening procedure to assist in identifying unsuspected cases of high blood pressure.

5. A patient should be referred to a physician when, in the judgment of the dentist, the best interest of the 7patient will be served.

6. Referral to physicians or seeking of physicians' consultation should be based on accepted cutoff points in blood pressure levels as recommended by the American Heart Association and as

indicated by the most current *Report of the Joint National Committee on Detection, Evaluation and Treatment of High Blood Pressure*.

7. Recommended equipment is the standard mercury manometer, available from medical and dental supply houses, to be used with a stethoscope. Automatic devices and aneroid manometers may also be used and should be calibrated initially and annually thereafter.

8. Dentists may seek information on hypertension control medication that may be taken by patients and that may affect the provision of dental treatment or anesthesia.

Resolution No. 87 New

Report: N/A Date Submitted: October 2013

Submitted By: Sixth Trustee District

Reference Committee: Legislative, Health, Governance and Related Matters

Total Net Financial Implication: $160,000 Net Dues Impact:

Amount One-time Amount On-going $160,000 FTE 1.0

ADA Strategic Plan Goal: Public Health (Required)

NATIONAL ORAL HEALTH REPORTS

The following resolution was adopted by the Sixth Trustee District and submitted on October 3, 2013 by Mr. David Horvat, executive director, Tennessee Dental Association.

Background: During the past three years, we have witnessed a national nonprofit organization publicly release three oral health reports grading each of the 50 states according to that organization's self-determined set of benchmarks. It was implied by the organization that the reports were evidence-based scientific reports, however, the conduct and methodology utilized was not based on sound science nor were the sometimes erroneous findings vigorously and publicly challenged by the American Dental Association. This not only misled the public but left each state to defend its ongoing programs.

When a well-known national organization publishes an oral health report purported to be scientific, drawing conclusions and assigning grades to the various states based on incomplete, old or inaccurate data, improper interpretation or application of national oral health objectives along with using invalid indicators, such reports must be rigorously assessed and challenged by the American Dental Association to ensure that the public is not misinformed. If non-scientifically based oral health reports, national in scope and designed to further the organization's policy, are presented without a proper disclaimer, then the American Dental Association should also criticize these reports both publicly and in writing.

Resolution

87. Resolved, that when an oral health report, national in scope, is released to the American public via the media and the report is purported to be based upon sound scientific principles and the American Dental Association (ADA) believes the report's facts, conclusions, or methods, including its claims of using scientific principles or being evidence-based are suspect, and when such report may mislead the public or is harmful to the reputation of the Association or the tripartite, the ADA must challenge the report by written rebuttal, and be it further

Resolved, that the ADA challenge any such nationally publicized report that clearly implies or states that there is an underlying motive or agenda furthering an organization's policies when the report is released without a proper disclaimer, and be it further

Resolved, that in such instances the ADA inform the public through appropriate media outlets including, but not limited to, the same media outlets that released the original report.

BOARD COMMENT: The Board appreciates the serious concern raised by the Sixth Trustee District regarding the issuance of oral health reports by national non-profit organizations which purport to measure the oral health status of populations and the provision of services within individual states and the

ADA's role in evaluating and responding to such reports. The Board notes that the Association has developed significant analytic resources within the Health Policy Resources Center and retained outside public relations experts to specifically assist with reputational challenges nationally and also within individual states through the State Public Affairs program. The Association has also directly addressed reports containing egregious data errors and misstatements with the issuing organizations and in the media when such circumstances have occurred and has counseled states on appropriate responses to such reports as part of on-going public affairs activities. The Association also undertakes and publicizes evidence based reviews and issues policy perspectives and is currently compiling a comprehensive state –based data summary to address the facts of oral health service delivery and access to care based on government reported and vetted information. Additionally, the Association is aggressively implementing the Action for Dental Health to preemptively establish dentistry's leadership in access and care provision to vulnerable populations. The Board believes that the processes and proactive support for public affairs outreach are in place. The requirement to specifically evaluate and react publicly as required by the resolution would limit the Association's options for response, dilute and diminish the Association's current public affairs programs summarized in this response and require additional resources. Therefore, while the Board appreciates the sentiments leading to the proposed resolution, it must urge a vote of No on Resolution 87.

BOARD RECOMMENDATION: Vote No.

Vote: Resolution 87

BUCKENHEIMER	No	FEINBERG	No	NORMAN	No	VERSMAN	No
CROWLEY	No	GOUNARDES	No	ROBERTS	No	WEBER	No
DOW	No	HAGENBRUCH	No	SCOTT	No	YONEMOTO	No
ENGEL	No	ISRAELSON	No	SEAGO	No	ZENK	No
FAIR	No	KIESLING	No	SUMMERHAYS	No	ZUST	Yes

Resolution No. N/A N/A

Report: CAPIR Supplemental Report 2 Date Submitted: October 2013

Submitted By: Council on Access, Prevention and Interprofessional Relations

Reference Committee: Legislative, Health, Governance and Related Matters

Total Net Financial Implication: None Net Dues Impact:

Amount One-time Amount On-going FTE 0

ADA Strategic Plan Goal: Collaboration (Required)

COUNCIL ON ACCESS, PREVENTION AND INTERPROFESSIONAL RELATIONS SUPPLEMENTAL REPORT 2 TO THE HOUSE OF DELEGATES: RECENT COUNCIL ACTIVITIES

Background: The Council met on July 11-13, 2013, at the ADA Headquarters Building in Chicago. There are no action items in this Supplemental Report.

U.S. National Oral Health Alliance: The U.S. National Oral Health Alliance http://www.usalliancefororalhealth.org/) concluded its current series of six colloquia, which highlighted the prioritized areas that impact access identified at the 2009 ADA-convened Access to Dental Care Summit and developed unifying messages for action. The sixth colloquium, held in June 2013 in Washington, D.C., addressed strengthening the dental care delivery system. Private dental practitioners were present at this colloquium, including two ADA trustees and members of CAPIR and the Council on Government Affairs (all of who were attending as individuals and not as official representatives of organized dentistry). Previous colloquia have addressed medical and dental collaboration, prevention and public health infrastructure and oral health literacy, oral health metrics and financing models. Many current ADA activities, including the Action for Dental Health campaign, align with these Alliance priorities and serve as a platform for further collaboration. (Supports ADA Strategic Goals 2 and 3).

Acting upon the recommendations of its Medicaid Provider Advisory Committee, CAPIR is encouraging the convening of pertinent stakeholder representatives (Centers for Medicare & Medicaid Services (CMS), state dental Medicaid programs, third party payers, American Academy of Pediatric Dentistry (AAPD) and Medicaid providers) to collectively begin to address the growing number of fraud and compliance allegations involving dental Medicaid providers, which lessens public confidence in the profession and makes recruitment and retention of dental Medicaid providers increasingly difficult. The anticipated goal of this meeting is to come to agreement on positive steps that can be taken to promote the oral health of the public, while eliminating fraud. CAPIR encourages consideration of uniform compliance training for both providers and compliance officers/auditors and having audited providers be reviewed by peers or auditors who work in conjunction with a dental consultant who represents that provider's peer group. (Supports ADA Strategic Goals 1 and 3).

Centers for Medicare & Medicaid Services (CMS): Invited by CMS Medicaid leadership, ADA leadership participated on the first of several quarterly calls to share information and invite collaboration among oral health stakeholders, including representatives of the American Association of Pediatric Dentistry, the Hispanic Dental Association, the National Dental Association and the Children's Dental Health Project. The ADA raised the question about what CMS leadership and this group could do to alleviate the increasing number of fraud and abuse allegations involving dental Medicaid providers, which are often unsubstantiated. Again, such allegations make recruitment and retention of dental Medicaid

providers increasingly difficult, which is problematic as demand increases via the Affordable Care Act. This first call was largely informational in nature. (Supports Strategic Goals 1 and 3.)

Resolution 18H-2011: Acting upon Resolution 18H-2011, Leading Community Efforts to Improve Oral Health, *(Trans.*2011:3013; 450; 453*)*, a tool kit to support individual dentists being leaders within their communities has been placed with the ADA's Center for Professional Success. This one-page tool kit consists of multiple hyperlinks, which is a practical, usable aid to ADA members. (Supports ADA Strategic Goals 1 and 3).

The 7th National Smokeless and Spit Tobacco Summit: The Summit was held in Missoula, Montana on August 6-8, 2013, addressed "*Empowering Advocates for the Next Frontier in Smokeless Tobacco*." This biennial Summit provides an opportunity for collaboration with various leading medical, dental and other entities to discuss science transfer and policy updates. It is the only national conference designed especially for those working in the field of smokeless tobacco prevention and cessation. The ADA co-sponsored and promoted the event with an article in the *ADA News.* (Supports ADA Strategic Goal 2).

The National Association of Community Health Centers (NACHC) (www.nachc.org): The NACHC held its 2013 Community Health Institute meeting in Chicago with a renewed interest in incorporating oral health as part of primary care. Dr. Ron Yee, new NACHC chief medical officer, is interested in increasing dental capacity due to the recent funding of 300 new health center access points. Considering his familiarity with oral health principles and practice, it is anticipated that oral health will increase its profile in upcoming NACHC meetings, which directly supports increased contracting between private dentists and health centers, which aligns with the ADA policy titled "Community Health Centers" (*Trans.*2002:415*)* in its third resolve. (Supports ADA Strategic Goals 1 and 3).

The United Nations Environment Program: The United Nations Environment Program and its position on dental amalgam continue to be discussed within CAPIR and the ADA. Based on the best scientific evidence available, the ADA maintains that dental amalgam is a safe restorative material, whose loss as a restorative materials option could be devastating to the dental health of vulnerable populations. There is a need for further education, outreach and technical assistance to reduce dental decay, coupled with an increase in prevention efforts, which will result in fewer amalgam restorations placed. (Supports ADA Strategic Goals 2 and 3).

Geriatric and Special Needs: The broad goals of the Long-Term Care Dental Initiative in ADA's Action for Dental Health are: 1) preparing dentists to interact effectively with nursing homes; and 2) assisting state dental associations implement long-term care programs. A plan developed by ADA's National Elder Care Advisory Committee (NECAC) addresses both goals. Preparation of dentists will be accomplished through a multi-module continuing education course, entitled *Dental Practice Management in Long-Term Care Facilities,* and offered through the ADA's Center for Professional Success. Helping state dental associations create and implement a state long-term care initiative will be accomplished through a series of actions including resource development, training, technical assistance and the creation of a multi-state long-term care collaborative. (Supports ADA Strategic Goals 1 and 3).

American Medical Directors Association (AMDA) and the Healthy Aging Committee of the Association of State and Territorial Dental Directors (ASTDD) collaboration with the ADA has resulted in the creation of an Oral Health in the Long Term Care Setting toolkit for use by nursing home staff. Similarly, a *Best Practice Approaches for State and Community Oral Health Programs on Older Adult Oral Health* for use by the dental public health community has been facilitated by provision of content expertise to ASTDD's Healthy Aging Committee. (Supports ADA Strategic Goal 3).

National Roundtable for Dental Collaboration (NRDC): The 24 member organizations met to discuss action steps for 2013. A joint letter was sent to the Deans of dental schools to urge further development of mandatory financial management modules for dental students. The NRDC plans to share the findings of two American Dental Education Association and ADA taskforces that looked at student debt issues,

while reviewing the Commission on Dental Accreditation (CODA) curriculum requirements pertaining to policies on financial knowledge. The theme of the 2014 conference will be: *What does the future of the profession look like?* (Supports ADA Strategic Goal 3).

American Academy of Pediatrics (AAP): The ADA collaborates with the American Academy of Pediatrics through participation on the AAP Section on Oral Health. In June, AAP hosted a webinar entitled *Working Together to Promote Oral Health During Pregnancy*, through a cooperative agreement with the Strategic Partnerships to Advance Maternal and Child Health garnering over 1,000 persons participants. Pertinent AAP Oral Health Section publications include: *The Oral Health for Children with Disabilities Clinical Report* was published in the March issue of *Pediatrics*. Reports in progress include the *Dental Trauma Clinical Report*, the *Preventive Oral Health for Pediatricians Policy Statement* and *The Fluoride Use for Pediatricians Clinical Report.* The AAP encourages dentists to join the Oral Health Section at http://www2.aap.org/oralhealth/SOPDOH.html. (Supports ADA Strategic Goals 1, 2 and 3).

American College of Obstetrics and Gynecology: American College of Obstetrics and Gynecology released a committee opinion on oral health care during pregnancy and through a lifetime, which complements the ADA-supported National Consensus Statement on the Importance of Oral Health during Pregnancy (https://www.ada.org/news/7566.aspx). The opinion advises an oral health assessment during the first prenatal visit (http://www.ada.org/news/8898.aspx). (Supports ADA Strategic Goals 1 and 2).

2013 Prevention Summit: Planning continues for the 2013 Prevention Summit - *Advancing America's Oral Health*, which will be held at ADA Headquarters from November 18-20. Serving as the convener, the ADA facilitated 11 diverse key oral health stakeholder representatives as planners to draft an agenda, develop a participant list, and invite speakers. In September, 121 participants were invited to the Summit. The proceedings of the Summit will be posted on the ADA website. In addition to corporate support from Colgate, CAPIR has secured external funding to support the Summit from multiple foundations and dental specialty groups. (Supports Strategic Goals 2 and 3)

The purpose of the Summit is to develop a framework for action that leverages today's opportunities, represents strategic choices, takes full advantage of multi-stakeholder engagement, and includes plans for sustainability and accountability. The Summit objectives include: to catalyze and revitalize the national inter-professional, multi-stakeholder movement advancing the prevention of oral diseases, the promotion of oral health literacy and the importance of oral health risk management; to focus on actions that take today's evidence based knowledge to a place of broad and effective dissemination and implementation; to ensure a systems approach that represents well-orchestrated and integrated action by multiple stakeholders while building on best practices and leveraging what is already in place; and to establish a culture of primary prevention based on a set of shared values that include new partnerships and decision-makers who will make a difference.

The key stakeholders responsible for Summit planning are: Dr. Robert Weyant (Academia/Research); Dr. Charles H. Norman III (ADA Board and Councils); Mr. Ralph Fuccillo (Foundations); Dr. Gary Davis (General Dentists/Dental Team/Specialties); Dr. Dushanka Kleinman (Health Promotion/Disease Prevention); Mr. Gary Price (Industry); David M. Krol, MD, MPH, FAAP (Non-Dental Health Care Providers); Ms. Beth Truett (Patient Advocates); Ms. Mary Foley, MPH (Policymakers); Dr. Ron Inge (Third Party Payers) and Mr. Peter DuBois (Tripartite).

Fluoridation: CAPIR and Communication staff participates in monthly calls with the Centers for Disease Control and Prevention's Division of Oral Health's Communication team as they work to develop strategies for communication opportunities prior to the release of the final Department of Health and Human Services recommendations on optimal fluoridation levels. This report is expected by the end of 2013. The ADA Fluoridation Toolkit (updated July 2013) is available on ADA Connect for use by all state dental associations and on the Association of State and Territorial Dental Directors (members only)

website for state oral health programs. CAPIR staff will present a fluoridation CE course at the 2013 ADA annual session. CAPIR worked with Global Affairs to investigate how ADA might be of assistance to the dental community in Israel as recently adopted regulations will effectively end fluoridation there in August 2014 unless action is taken. (Supports ADA Strategic Goals 1, 2 and 3)

Response to Assignments from 2012 House of Delegates:

Resolution 105-2012, Amendment of the Policy, Non-Dental Providers Completing Education Programs on Oral Health. This resolution was referred to the appropriate ADA agency for study with a report to the 2013 House of Delegates. Resolution 105-2012 urged the House to amend this policy to encourage primary care providers, such as pediatricians, to provide preventive oral health information across the lifecycle with referral to the dentist.

Resolution 106-2012, Amendment of the Policy, Non-Dental Providers Notification of Preventive Dental Treatment for Infants and Young Children. This resolution was referred to the appropriate ADA agency for study with a report to the 2013 House of Delegates. Resolution 106-2012 urged the House to amend this policy that encouraged risk assessment be performed by appropriately training primary care providers with referral to a dentist for a comprehensive examination and establishment of a dental home.

Resolutions 105-2012 and 106-2012 were reviewed by CAPIR's Interprofessional Relations subcommittee for their input. Dr. Monica Hebl, CAPIR chair, considered their input and requested further review from the subcommittee before bringing these resolutions back to the entire Council. It is expected that the November 2013 ADA-convened Prevention Summit will provide additional insight for the Interprofessional Relations subcommittee to consider in its further deliberations. CAPIR will report back on these resolutions to the 2014 House of Delegates.

Resolutions

This report is informational and no resolutions are presented.

BOARD RECOMMENDATION: Vote Yes to Transmit.

Vote: CAPIR Supplemental Report 2

BUCKENHEIMER	Yes	FEINBERG	Yes	NORMAN	Yes	VERSMAN	Yes
CROWLEY	Yes	GOUNARDES	Yes	ROBERTS	Absent	WEBER	Yes
DOW	Yes	HAGENBRUCH	Yes	SCOTT	Yes	YONEMOTO	Yes
ENGEL	Yes	ISRAELSON	Yes	SEAGO	Yes	ZENK	Yes
FAIR	Yes	KIESLING	Yes	SUMMERHAYS	Yes	ZUST	Yes

Resolution No. N/A N/A

Report: CC Supplemental Report 2 Date Submitted: October 2013

Submitted By: Council on Communications

Reference Committee: Legislative, Health, Governance and Related Matters

Total Net Financial Implication: None Net Dues Impact:

Amount One-time Amount On-going FTE 0

ADA Strategic Plan Goal: Members (Required)

COUNCIL ON COMMUNICATIONS SUPPLEMENTAL REPORT 2 TO THE HOUSE OF DELEGATES: PUBLIC RELATIONS INITIATIVE PROGRESS REPORT

Background: This report provides an update on the ADA's public relations initiative which began after the adoption of Resolution 75H-2012 Initiative to Enhance the Image and Advance the Reputation and Brand of the ADA submitted by the Council on Communications. The report describes the selection of a national public relations firm and immersion of the agency in ADA key issues (Q1); the subsequently developed initiative goals, strategies, tactics and metrics (Q1-2); results achieved as of the end of August 2013 (Q2- Q3 Aug. 2013); and pending national media outreach (Q3-Q4).

Selection of National Public Relations Firm: Upon the adoption of Resolution 75H-2012, a comprehensive request for proposal (RFP) was issued to 12 major, multi-office public relations firms in November 2012. ADA President Dr. Robert Faiella appointed a workgroup composed of two Trustees, the Chair and Vice Chair of the Council on Communications and the Chair of the Council on Government Affairs to provide volunteer input and oversight to the selection process.

From the preliminary identification of 12 firms, the workgroup carefully evaluated the detailed responses of five firms received in December 2012 and reduced the choices to three finalist agencies in January 2013. In early February, the three finalist agencies made in person presentations of their proposals at the ADA headquarters and participated in question and answer sessions with the workgroup. Finalists were ranked by the workgroup based on a number of factors including strategy, creativity, experience in healthcare and not for profits, and case study demonstrations.

FleishmanHillard (FH) achieved clear consensus from the workgroup as the agency of choice. ADA leaders and members were informed of the agency selection in mid-February, and the in-depth on-boarding and team meetings were conducted with the agency February 25. The agency is managed by Communications and Marketing staff with volunteer oversight provided by the Council on Communications.

FH has extensive experience and expertise across many different businesses, as diverse as Visa and the U.S. government to the Missouri Dental Association, as part of the State Public Affairs program. To execute the strategies outlined in their proposal to the ADA, FH assembled a team of communications professionals from their New York, Washington, DC, Chicago, and St. Louis offices.

Initiative Goals: To reaffirm the ADA's position as America's leading advocate for oral health, the public relations initiative has five long-term communications goals:

- Reinforce the dentist's role in achieving oral health
- Take a stronger role in leading conversations on oral health issues with targeted audiences
- Ensure fair and accurate media coverage
- Support advocacy efforts and public awareness of ADA positions
- Extend consumer awareness of oral health

Central to the success of the initiative is the alignment of programs to advance ADA policies and positions among key audiences, therefore comprehensive strategic development was begun immediately along with an evaluation of current attitudes and perceptions, the conduct of original research and specific message development and testing.

Results of the public relations initiative will be measured on an ongoing basis by metrics based on media coverage, attitude, awareness and perception surveys, digital traffic and specifically identified program objectives.

Initial Actions and Results: In the six months (February through August) since FH has been engaged, impressive progress has been achieved in the following areas:

- Opinion leader and consumer opinion research evaluated
- Message testing conducted
- Media and social media audit conducted and ADA's "share of voice" measured
- FleishmanHillard evaluation of ADA's communications' needs conducted
- Communications platform and goals created
- Action for Dental Health: Dentists Making A Difference program developed
- Action for Dental Health brand identity created
- Action for Dental Health campaign launched at National Press Club event
- Media and social media outreach in support of communications platform initiated
- Notable major media placements/coverage tracked
- Metrics "scorecard" created

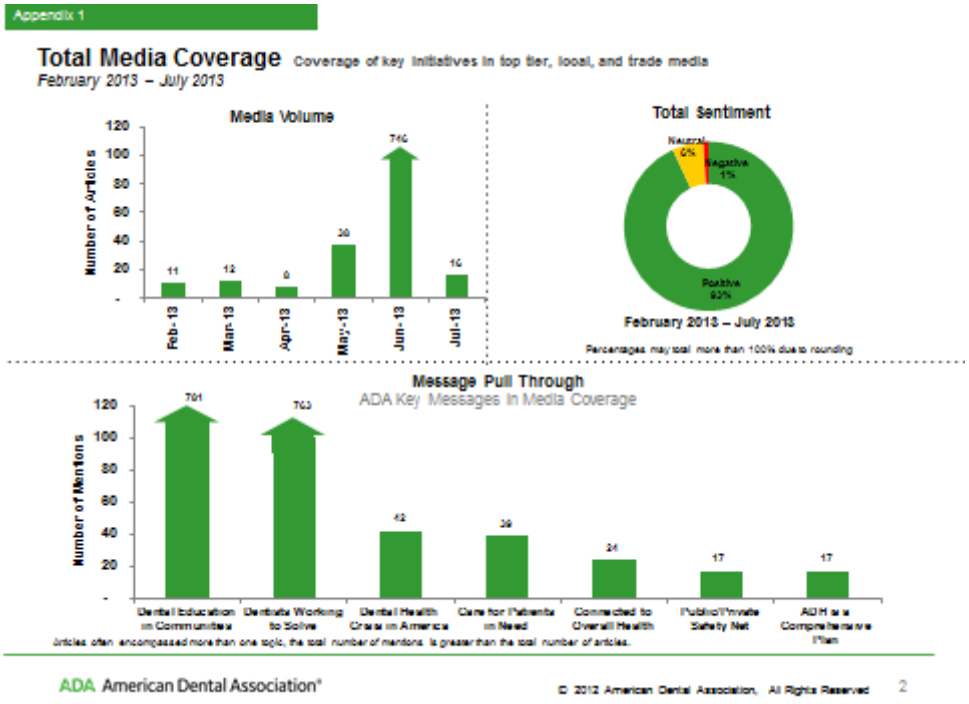
The metrics scorecard developed by FH measures media results and digital/social momentum. The scorecard will track progress of the initiative and highlight areas in which the communications programs might be adjusted.

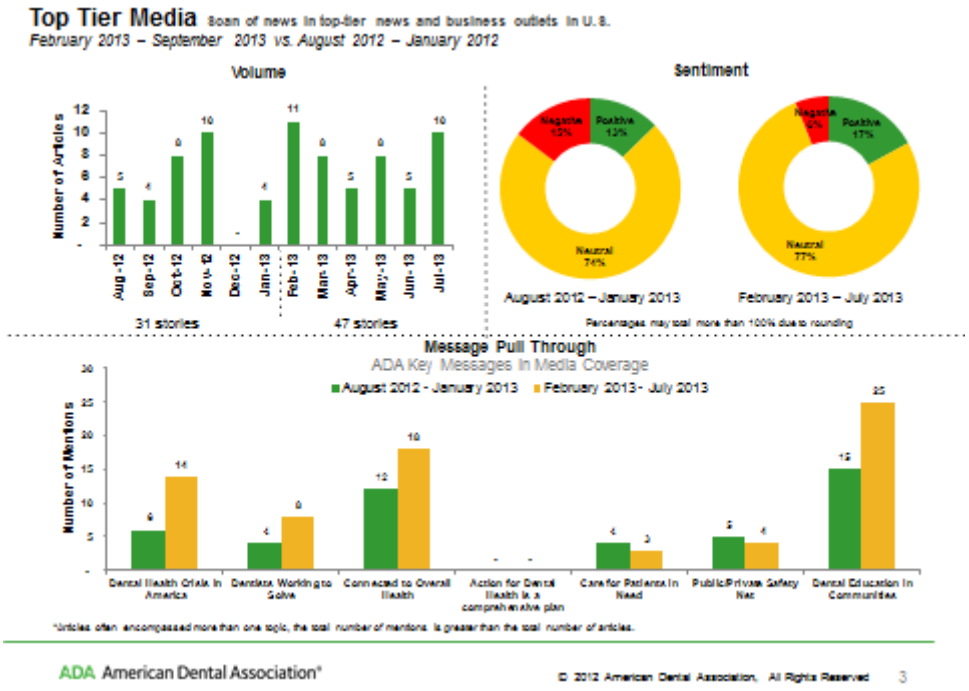
The first scorecard was prepared in September and is included in Appendix 1. There were several key findings from the scorecard:

- The Action for Dental Health launch drove an overall increase in media coverage in May and June.
- A campaign on oral health during pregnancy generated significant local media coverage, leading to a large increase in June media volume. The results demonstrate ADA's ability to promote dental health education messages into local communities.
- The sentiment of top-tier media coverage shifted after the selection of the public relations firm, from 15 percent negative coverage in the prior period to 6 percent negative. Positive and neutral coverage increased. This metric is an early indicator that the revised messaging from the communications program is helping to shift the tone of coverage overall.
- In evaluating how ADA messages are pulled into media coverage, the concept that dentists are working to bring dental health education and disease prevention into communities was most frequently included in articles. The message least frequently included in articles was the concept

that Action for Dental Health is a comprehensive plan. This finding indicates that future media efforts should highlight this message more strongly in order for it to surface in resulting coverage.

- ADA's social channels saw dramatic increases in followers in the last year. On both Twitter and Facebook, ADA's three primary channels attracted new followers.
- MouthHealthy.org saw traffic fluctuate slightly on a month-by-month basis. This measurement will serve as a benchmark for future scorecards that will gauge the effectiveness of programs aimed at driving traffic to the site.





FleishmanHillard Evaluation of ADA's Communications' Needs: At a national level, the Association and our member dentists face continued potential reputational challenges due to an elevation of national media coverage of healthcare issues generally and access to care specifically. Many of these challenges, while directly linked to access to care issues and barriers to oral health, also focus on the association between oral health and overall health, perceived risk of technologies or materials used in dentistry such as radiographs and dental amalgam, patient financing and utilization, and the challenges to community water fluoridation, to name a few.

The ADA utilizes a responsive and proactive issues management approach to protect and promote the reputation of the ADA and dentists. The increase in negative media attention requires a high level of responsive communications geared toward reputation protection. Thus a corresponding and heightened need to promote the reputation of the ADA and dentists through proactive national media outreach became increasingly clear which led to the development of Resolution 75H-2012.

Historically, ADA has been viewed as a leading organization on oral health issues. The ADA and member dentists have strived to continually improve the nation's oral health through advances in dental materials research and public health measures such as water fluoridation and tobacco use cessation.

Yet an evaluation conducted by FH involving opinion leader and consumer opinion research and an audit of media and social media coverage indicated the ADA was marginalized and perceived as largely reactionary to the issue of access to dental care. ADA was often portrayed as opposing dental therapists without articulating ADA's solutions to help improve the oral health of the underserved.

FH's evaluation contends that the environment surrounding dentists and all health professionals today seeks cost reductions, less expensive alternatives and access for all. In this climate, dentists, like many of their medical doctor peers, are being challenged on scope of practice issues.

Thus, despite a long history of successful public education and advocacy that has for many decades helped to improve oral health in this country, FH contends that maintaining a positive reputation and

retaining a leadership position in the eyes of legislators and opinion leaders will depend on the profession's ability to differentiate clear benefits to gain public support.

Based on FH's evaluation, the current environment poses opportunities and challenges for ADA, but among these, one simple reality stands out among the research: the public believes dentists should play a leadership role in oral health, but they don't consistently value the unique expertise of dentists. Consumers appear willing to consider a dental therapist for services as critical to personal health as an oral exam, but still believe dentists are best suited to set oral healthcare policies.

ADA cannot secure its leadership or influence public policy without the public's support. The ADA's positioning campaign must align the public's understanding with their expectations in order for ADA to be successful in its national agenda.

The Communications Platform: A platform that communicates ADA's record of achievements contributes to changing the oral health care conversation from scope of practice to one about progress and prevention – past, present and future. Through these insights, FH identified "Progress Through Prevention" as the foundational platform for all communications efforts.

FH will apply the ADA's commitment to progress and prevention as the underpinning of the positioning campaign. FH captured the concept of "Progress Through Prevention" as follows:

> For well over a century, the ADA has moved America forward by educating the public about oral hygiene and oral disease prevention. Today, preventive practices are firmly rooted in our culture – from an early age, we are taught behaviors for long lasting oral health. As a result, our mouths have never been healthier.
>
> Now the ADA must expand the concept of "prevention" well past an individual's oral care habits to tackle even bigger challenges. This new prevention agenda must bring solutions aimed at solving the nation's most pressing healthcare challenges today to prevent even bigger ones in the future.
>
> Expanding the definition of prevention encompasses new answers, new audiences, and a new call to action. The ADA and member dentists can once again take their place at the forefront by leading "progress through prevention."

Program Framework: The communications program framework supports the Progress Through Prevention platform with three signature communications programs that align with key leadership pillars– the things an organization must do to be a leader. These key leadership pillars are: validate, educate and demonstrate.

For each of these leadership pillars, FH and ADA have identified signature communications programs to implement in this multiyear campaign.

Validate. ADA's rich and unmatched body of knowledge positions it as the most credible leader in oral health. This pillar is meant to promote that knowledge while underlining dentists' roles as doctors and reaffirming dentistry as a science-based profession.

This spawned the **Science of Dentistry** program, which pulls from the ADA's bank of data and research to raise awareness of health connections and outcomes.

Educate. To continue ADA's legacy of educating consumers on the best oral health practices, this pillar includes promotion efforts around MouthHealthy.org, ADA's consumer channel.

This program will use social media tactics as well as online media to point consumers to the wealth of dental health tips at **MouthHealthy.org**.

Demonstrate. This pillar houses the centerpiece program of the public relations initiative – **Action for Dental Health: Dentists Making a Difference**. This is an action oriented approach to positioning ADA as a leader in dental health and overall health in the U.S. – demonstrating that not only does a dental health crisis exists in America but that dentists are best positioned to provide leadership, create, deliver and advocate for solutions.

These three pillars will work in tandem to reinforce ADA's position as America's leading advocate for oral health by elevating the discussion on dental health as an overall health imperative and communicating the ADA's leadership to all stakeholders – from public policymakers to those on the street.

This strategic platform is ongoing and long-term in its approach. The tactics that support each pillar will continue to roll out on an ongoing basis to build into the larger framework of the initiative.

Action for Dental Health: Dentists Making A Difference: When FleishmanHillard (FH) was selected by the ADA in February, their first and foremost priority was the launch and promotion of the national campaign then known as "call to action" during the ADA's Washington Leadership Conference in May. Thus, the ADA and FH focused its Q2 energies almost exclusively on the campaign which became Action for Dental Health: Dentists Making a Difference.

The origin of Action for Dental Health began in September 2012 when the Board of Trustees authorized the development and communication of a "call to action" that asserted ADA leadership on the issue of access to oral health and highlighted an existing suite of solutions to help improve the oral health of underserved populations.

The call to action encompassed the following programs executed at the grassroots level:

- Emergency Room Dental Intercept—the right place for the right care
- Nursing Home, Long Term Care Facilities
- Give Kids A Smile, Mission of Mercy (MOM) events
- Community Dental Health Coordinator expansion
- Water Fluoridation
- Medicaid Reform
- Private contracting with FQHCs
- Collaborations with other health professionals and organizations

In collaboration with Government Affairs, State Government Affairs, Council on Access, Prevention and Interprofessional Relations and Communications staff, descriptions and resources for state dental societies were developed to encourage them to commit to at least one program as part of the campaign.

Goals and Metrics: With input from leaders from the Councils on Access, Prevention and Interprofessional Relations, Government Affairs and Communications, a series of goals for the campaign were developed which are reflective of key oral health goals in Healthy People 2020 (see Appendix 2). The overarching goal of the campaign is to reduce the proportion of adults and children with untreated dental decay via multiple interventions, early diagnosis and risk assessment, disease management and health education and preventing dental disease before it starts.

Progress toward the achievement of these goals will be measured through a variety of data mechanisms such as NHANES, CMS data by state, CDC data on emergency room visits, UDS data from federally qualified health center annual reports, and self-reported metrics from state dental societies.

Communications Goals for the campaign include:

- Assert ADA leadership and change the conversation about access to dental health
- Broaden awareness and boost belief in ADA's approach among influencers, media and policymakers
- Position ADA as the leading advocate for dental health by putting forth a nationally coordinated plan to address the dental health crisis in America
- Generate understanding of campaign programs among state dental societies
- Provide tools and resources to dental societies to successfully build, launch and promote campaign programs

Message Testing. Message testing was conducted to aid in campaign message development, outreach strategy and generally how ADA tells the story of the campaign and positions dental health issues. Messaging research firm, Maslansky, gathered groups in two cities – Bethesda, MD and Chicago, IL – to test emotional reactions to a wide range of messaging. These groups consisted of 43 members of the influential audience ADA seeks to reach with the campaign; beltway insiders whose work focuses on health policy in Bethesda and professionals working in health or community-based roles in Chicago.

To determine the most compelling and credible language articulations, Maslansky employed Instant Response methodology where participants use dial controls to indicate their agreement or disagreement with a message track as it is spoken to them. The method showed us the instant, emotional reactions these influencers had to a wide range of language, detailing what does and doesn't resonate.

From this testing, ADA and FH obtained insights on the language that best connects with target audiences. Chiefly, the testing showed that messaging around ADA's call to action needed to be simplified for lay audiences unfamiliar with dentistry and to be highly action oriented. For example, the participants indicated that they would understand the campaign goals more clearly if the eight individual programs were grouped into a fewer number of categories. The message testing results also indicated that word choice can impact perceptions. For example, the audience connected more with the term "dental health" than "oral health."

This informed the three focus areas used to communicate the national campaign:

- Provide Care Now to Those in Need
- Strengthen the Public/Private Safety Net
- Bring Dental Health Education and Prevention to Communities

As a product of the message testing sessions, Maslansky created a Language Dictionary which gives a detailed report of what language does and doesn't connect with the Action for Dental Health (ADH) audience.

The testing also gauged responses to various campaign name options which led to the selection of "Action for Dental Health: Dentists Making a Difference" (ADH). ADA Marketing staff then created a logo and brand identity for the campaign which is used in all ADH communications.

Materials Development. The Language Dictionary was then used as a tool for developing a suite of materials to bring Action for Dental Health to life and to communicate its goals to media and stakeholders. These include a program factsheet that gives an overview of each of the eight initiatives, the goals that the program intends to address in the coming year, and a media advisory and news release for the national launch to media. These materials were also compiled to form the programs web page, www.ada.org/action, to which media and stakeholders are directed to learn more. In addition a resource toolkit was developed to aid dental societies in promoting the launch of Action for Dental Health to their

respective state legislators and local media. ADA members were informed of the campaign launch via ADA News and other e-communications.

Harris Interactive Survey: To demonstrate the urgent need for action and add exigent news value, the ADA through FH commissioned a study with market research firm Harris Interactive to shine light on the dental divide in America. The study was created to show the glaring differences between the dental health practices of those with lower incomes and those with higher incomes – helping drive media coverage and further interest in the news value of the Action for Dental Health Launch.

The survey sought to better understand parents' attitudes, perceptions and behaviors related to dental care. Harris Interactive fielded the survey between April 24 and 29, 2013 online to 1,221 adults. Respondents were asked questions about how they perceived their current dental health, sources of information on dental health, choices they have made regarding dental health, and their personal dental hygiene habits.

The survey helped confirm the need for Action for Dental Health, with major findings including:

- Nearly half of lower-income adults say they haven't seen a dentist in a year or longer, while the vast majority of middle- and higher-income wage earners (70%) have.
- Lower-income adults 18 and older are more than two times as likely as middle- and higher-income adults to have had all of their teeth removed (7% vs. 3%).
- Nearly one in five (18%) lower-income adults have reported that they or a household member has sought treatment for dental pain in an emergency room at some point in their lives, compared to only seven percent of middle- and higher-income adults.
- Only 6% of those low-income adults who went to the ER reported that the problem was solved in the ER.
- Even though the Affordable Care Act offers little relief for adult Americans who lack dental coverage, 40% of lower-income adults believe that health care reform will help them obtain dental care.

The report was used as the centerpiece of the ADH launch strategy to lend credibility to the campaign and drive media interest and coverage. FH designed an infographic (see Appendix 3) to highlight the survey into a more digestible format for media and influencers.

National Press Club Launch: The Action for Dental Health campaign launched at a May 15 press event at the National Press Club in Washington, D.C. during the ADA's Washington Leadership Conference.

In addition to dentist members leading the charge for action, stakeholders in attendance included representatives from the Catholic Health Association, Center for Public Integrity, Center for Medicaid and CHIP Services, U.S. Senate, Health Resources and Services Administration, Kaiser Family Foundation and the National Association of Community Health Centers.

Also in attendance in person and via phone were a number of media outlets including ABC News, Wall Street Journal, Association of Healthcare Journalists, New York Times, Dr. Bicuspid, and Scripps Howard Foundation Wire. Prior to the press conference FH and ADA Communications staff worked together to brief key media targets – ABC News, New York Times, Los Angeles Times and others – to give a preview of what was to come. These reporters had the chance to talk with ADA President Dr. Robert Faiella and other spokespeople to learn more about Action for Dental Health programs and initiatives.

The press conference was designed to give factual evidence of the dental health crisis, details on how dentist and community members are working to solve it and personal stories from those on the front lines. Speakers at the event included:

- Dr. Faiella: Launched the Action for Dental Health campaign and described its three core elements
- U.S. Congressmen Mike Simpson and Paul Gosar: Spoke of the need for a solution to the dental health crisis in America and their commitment to supporting Action for Dental Health
- Regina Corso (Harris Interactive): Outlined the findings of the national study on the dental divide in America
- Angela Black (CDHC, Chickasaw Nation): Illustrated the importance of the CDHC program and how it can impact communities
- Samantha Pearl (Community Healthcare Connections) and Mark Crawford (Bronson Battle Creek health system): Spoke of their innovative program to direct ER patients to a dentist for the care they need

The event resulted in immediate coverage from the Association of Healthcare Journalists, Scripps Howard Foundation Wire and Dr. Bicuspid – the communications team continued to work with reporters seeking more information after the conference resulting in coverage on the lapse of dental hygiene in nursing homes from the New York Times on August 4.

Media coverage associated with the prompted by launch of Action for Dental Health included (See Appendix 4 for some sample clips):

- Politico Dentists: More low-income people landing in ER for oral care
- Dr. Bicuspid: New ADA campaign targets U.S. 'dental divide'
- Sacramento Bee: America's Dentists Launch Nationwide Campaign to Address U.S. Dental Crisis
- Dentistry IQ: Community Catalyst responds to ADA oral health campaign
- Dental Product Shopper: ADA Statistics Reveal "Dental Divide" for Low-Income US Population
- CBS Atlanta: Survey Shows Dental Care Experience Depends On Income
- Scripps Howard Foundation Wire: American Dental Association Takes Action in Dental Health Crisis
- Infozine - Kansas City: American Dental Association Takes Action in Dental Health Crisis
- Dental Tribune: ADA launches ‘Action’ campaign to address oral health crisis
- Healthjournalism.org: Campaign strives to improve access to care; critics say ADA misses mark
- Spear Education: The ADA Targets the "Dental Divide"
- Healthcanal.com: Targeting the "Dental Divide"
- Idaho State Journal: Dentists Launch Nationwide Campaign to Address Kids' Needs
- Vermont Digger: Vermont dentists pledge support to campaign to address dental crisis
- Medscape: Groups Clash About Approach To Treating Underserved
- Rollcall: Many Solutions Needed to Bridge the Dental Divide
- New York Times: In Nursing Homes, an Epidemic of Poor Dental Hygiene

FH also worked closely with the ADA social media team to live-tweet the press conference for influencers and members who couldn’t attend the live session. At the height of the event, 82 tweets were generated using #DentalAction. Several state and local dental associations picked up the Twitter messaging (the ISDA, Hispanic Dental Association, PA Dental Association, South Carolina Dental Association),

retweeting it on their own accounts as did event speaker, campaign supporter, and fellow dentist Rep. Paul Gosar. @ADANews also retweeted parts of the press conference information. (See Appendix 5)

Constituent dental societies were provided with a toolkit of template media materials to promote the launch of the Action for Dental Health (ADH) campaign and ADH programs taking place in their states to state legislators, opinion leaders and the local media.

State Public Affairs Integration. In 2013, FleishmanHillard was been named as the national public affairs consulting firm for the ADA's State Public Affairs program, which provides greater operational efficiencies as well as alignment of communications strategies and messaging among the Tripartite.

Members of FH's national ADA team also support the agency's work on the ADA's State Public Affairs program. As such, state and national communications surrounding Action for Dental Health is becoming closely aligned. For example, when ADA President Dr. Faiella traveled to Idaho to address the constituent dental society, the Idaho state public affairs program secured an in studio television interview on a popular public affairs program. This media interview provided the opportunity to align messaging at a national and state level on access to dental health, the ADA's Action for dental Health campaign and the impact of the Affordable Care Act on related to dentistry.

Action for Dental Health – Q3-Q4. In the three months following the May press conference, ADA and FH continued to focus on the Action for Dental Health campaign as described below while at the same time planning and executing tactics associated with the Science of Dentistry and MouthHealthy communications program pillars.

Responsive Media Outreach. Using a news bureau approach, FH and ADA work collaboratively to monitor ongoing national media coverage of access to dental health issues; identify stories offering good opportunities for the ADA to demonstrate leadership on the issue; and develop/submit responses in the form of online comments, letters to the editor, or opinion editorials in consultation with the ADA President over his signature. To date responses have been developed for outlets including The New York Times, Dentistry IQ, Washington Post and Huffington Post.

Continued Proactive National Media Outreach. Planning and execution of proactive national media outreach focused on access to dental health issues and the ADA's Action for Dental Health campaign during Q3-Q4 of 2013 include Missions of Mercy, New Orleans

To demonstrate ADA's commitment to improving access to dental health, FH and ADA will promote the ADA's first Missions of Mercy event in New Orleans on November 3 to key wire reporters (AP, Reuters, etc.) in the New Orleans bureau as well as key national health blogs. The ADA communications team will develop and pitch a Missions of Mercy focused op-ed to Times-Picayune as well as pitch key local media outlets including the Times-Picayune and local broadcast television.

In Depth Media Pitches. In late Q3 through Q4, FH and ADA collaborated on the development of in depth pitches to major healthcare reporters, bloggers and national news outlets on several ADH programs via two specific tracks:

1) A feature story placement on specific elements of the ADH in major newspapers and national broadcast news outlets
2) Development and placement of an op-ed(s) from ADA leadership in a major news outlet

Potential media targets include network evening news, New York Times, Washington Post, and Newsweek.

Science of Dentistry: The Science of Dentistry pillar of the public relations initiative is intended to validate dentistry as a science-based profession and underscore that dentists are doctors of oral health.

Two consumer-facing outreach efforts were developed for execution in May/June and November on the importance of oral health care during pregnancy and the association between oral health and diabetes respectively. These outreach efforts feature ADA consumer advisor spokespersons who relay scientific data and tips to the public to underscore the importance of self-care as well as professional dental visits to achieve good oral health and contribute to overall wellness, particularly for pregnant or diabetic patients.

Oral Health During Pregnancy. In collaboration with Mom-it-Forward, an influential website targeted to mothers, a Twitter chat with ADA consumer advisor spokesperson Dr. Ruchi Sahota was held pegged to Mother's Day. Dr. Sahota spent an evening hour answering questions from Mom-it-Forward's Twitter-active community panelists, moms-to-be, and parents with small children from the @AmerDentalAssn Twitter handle. This twitter chat generated an estimated 2,100 tweets by roughly 260 participants garnering more than 12,600 impressions (see Appendix 6).

An ADA mat release, which is an article authored by the ADA and distributed by a vendor to online and print media, was distributed on caring for oral health during pregnancy. The mat release garnered 732 placements with an estimated total readership of 15,099,536. Mat releases are far more economical than purchasing advertising space. Based on the number of placements the ADA mat release achieved, the equivalent ad value if the space were purchased totaled $179,622.

Mom-it-Forward determined that the oral health during pregnancy content from the twitter party was so useful that they used it to craft three additional blog posts for their site– two have been posted and the third is scheduled for September. The Mom-it-Forward site receives over 40,000 unique monthly views.

Oral Health and Diabetes. It is estimated that diabetes affects nearly 26 million Americans and an estimated 79 million people are at risk for developing the disease. On November 1, during National Diabetes Month and with the ADA Annual Session as a backdrop, the ADA will host a television and radio satellite media tour from New Orleans on the association between oral health and diabetes. Consumer Advisor spokesperson Dr. Maria Lopez Howell will be interviewed by English and Spanish speaking media outlets about the association between oral health and diabetes as well as impart oral health tips for diabetic patients. In addition to the satellite media tour, the ADA will distribute a mat release to regional print and online media outlets and is exploring joint social media outreach with a major allied health organization to underscore the importance of oral health to overall health and wellness.

MouthHealthy: The MouthHealthy pillar of the public relations initiative is intended to continue ADAs legacy of educating consumers on the best oral health practices while driving traffic to the ADA's award-winning consumer website MouthHealthy.org. MouthHealthy will primarily leverage social media tactics to directly engage consumers, particularly those who primarily seek health information online yet may not be aware of the ADA's patient education materials.

In mid-September, as part of the MouthHealthy pillar, ADA and FH launched an online retro public service announcement (PSA) campaign entitled "*Throwback Tooth Day*" using ADA public service announcements from the 60s, 70s and 80s. Throwback Tooth Day is a promotion that piggybacks on a widespread practice in social media known as "Throwback Thursday" or #TBT–where people post and comment on old pictures and videos via their social networks on Thursdays. Throwback Tooth Day is intended to help educate the public about taking care of their oral health and showcases the ADA's historical commitment to improving oral health. All of the retro PSAs direct consumers back to the ADA's website MouthHealthy.org for the latest oral health care information from the ADA.

Dental societies and grassroots members will be informed about Throwback Tooth Day via a variety of ADA member communications and provided instructions on how to embed the retro PSAs in their own dental society and practice websites if they so choose.

In addition, the Throwback Tooth Day campaign will be promoted to a variety of media including Buzzfeed, Ad Week, Ad Age, Mashable, USA Today, Washington Post and CBS News.com health boggers, and ABC News digital reporter.

Future Planning, Outreach: In the first year of the public relations initiative, great strides have been made in choosing and onboarding a national, multi-office public relations firm; conducting research to inform development of a communications platform with three signature communications programs intended to educate, validate and demonstrate ADA leadership on oral health issues; conducting message testing to ensure the effectiveness of our messages with our targeted audiences; providing communications resources to dental societies; executing media outreach tactics in support of the three programs—Action for Dental Health, Science of Dentistry and MouthHealthy; and measuring our progress as of August 31, 2013.

The public relations initiative is a multi-year endeavor intended to change the conversation and position the ADA and member dentists as the nation's leading advocates for oral health. Baseline research conducted with opinion elites prior to the launch of the public relations initiative will be repeated in November to measure our progress. Planning for 2014 will take place in January to continue proactive and responsive media outreach in support of the three programs. Progress will be measured and reported in the ADA operating plan on a quarterly basis against the baseline metrics established during this first year of the public relations initiative. The Council on Communications will continue to provide volunteer oversight to the initiative.

Resolutions

This report is informational and no resolutions are presented.

Appendix 1:
Scorecard

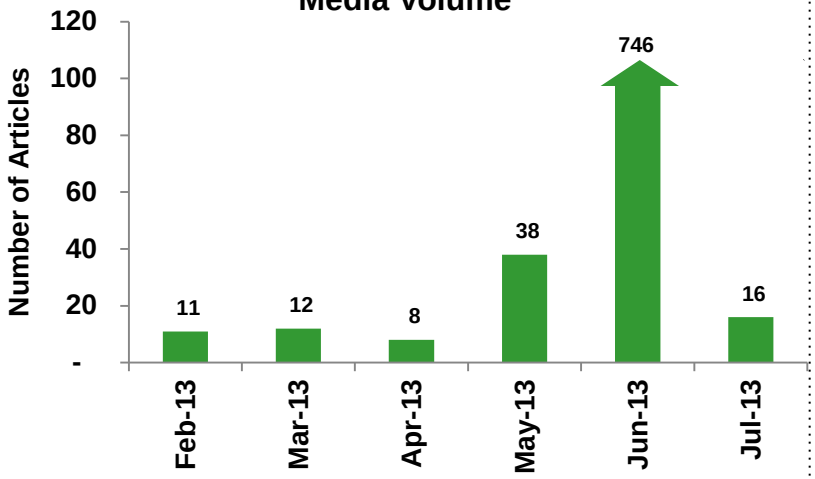
February 2013 – July 2013

Total Media Coverage

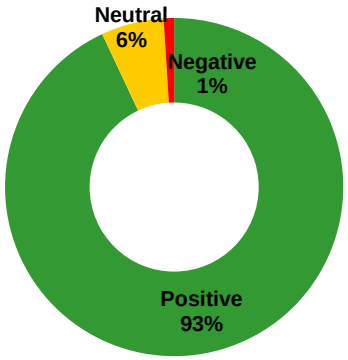
Coverage of key initiatives in top tier, local, and trade media

February 2013 – July 2013

Media Volume



Total Sentiment

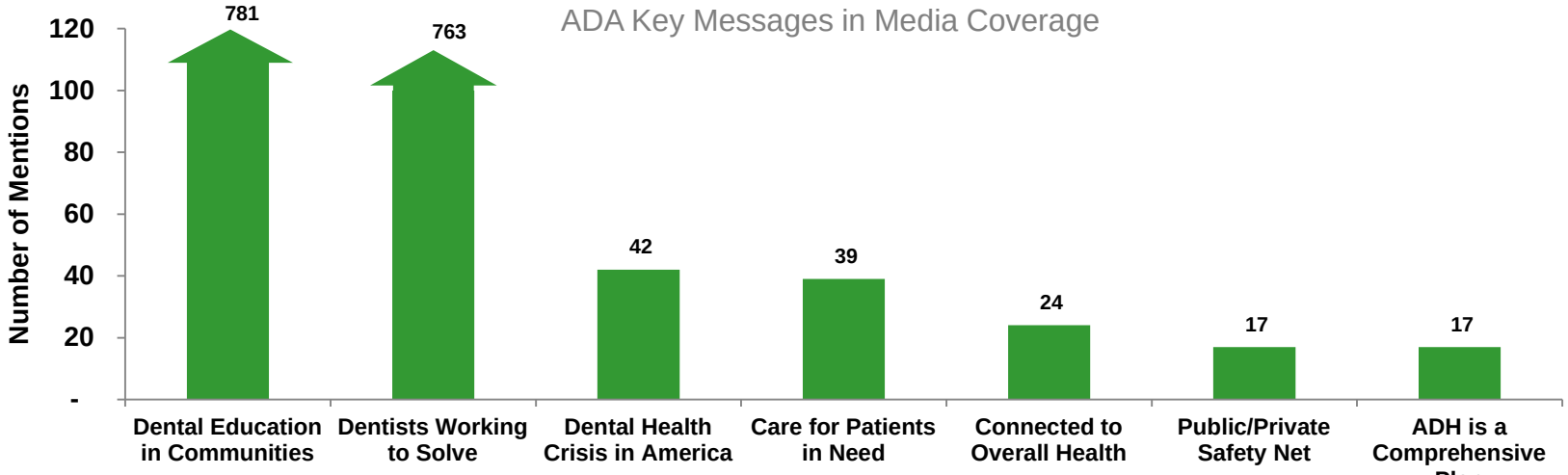


February 2013 – July 2013

Percentages may total more than 100% due to rounding

Message Pull Through

ADA Key Messages in Media Coverage



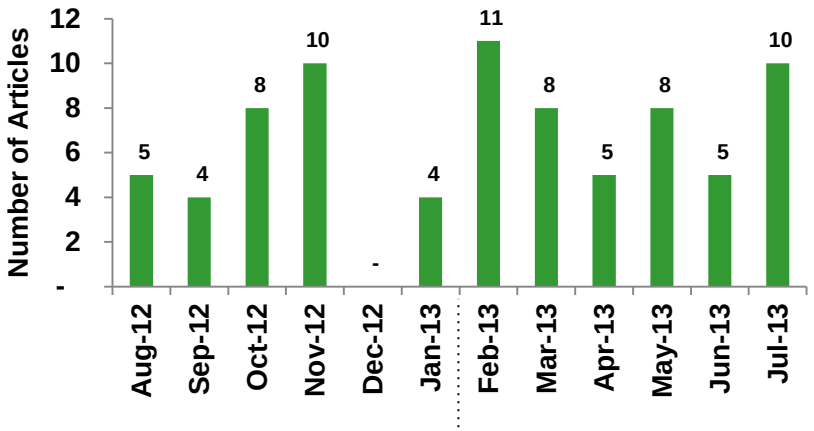
Articles often encompassed more than one topic, the total number of mentions is greater than the total number of articles.

Top Tier Media

Scan of news in top-tier news and business outlets in U.S.

February 2013 – September 2013 vs. August 2012 – January 2012

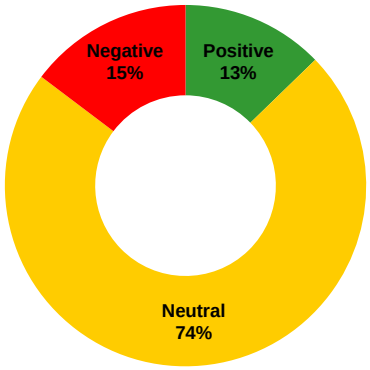
Volume



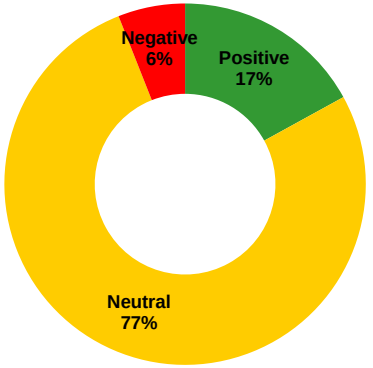
31 stories

47 stories

Sentiment



August 2012 – January 2013

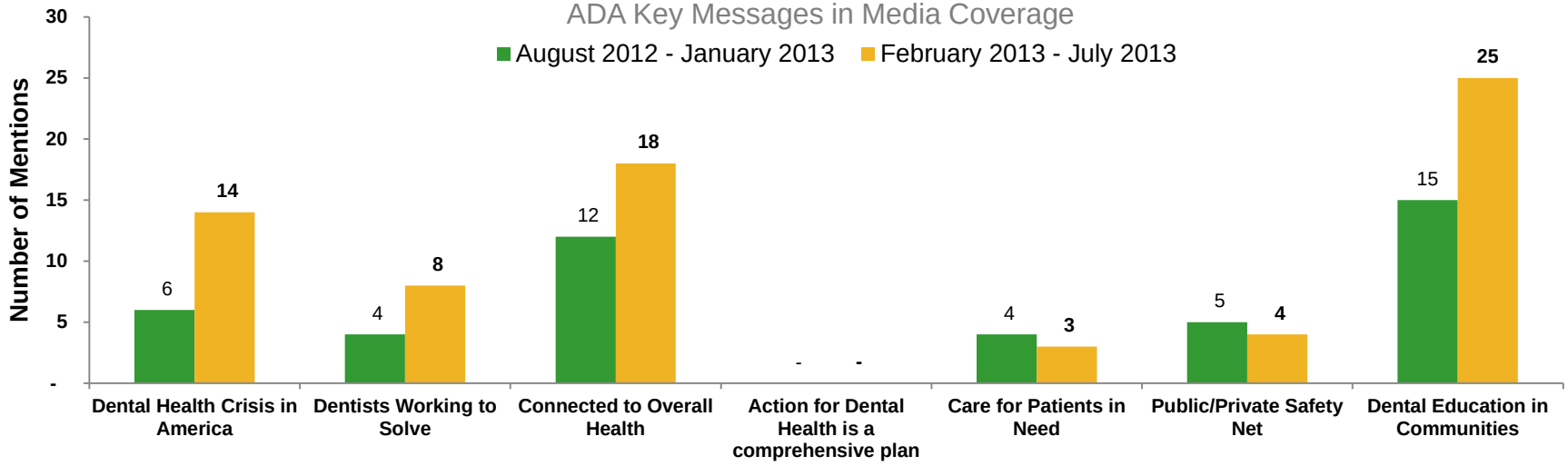


February 2013 – July 2013

Percentages may total more than 100% due to rounding

Message Pull Through

ADA Key Messages in Media Coverage

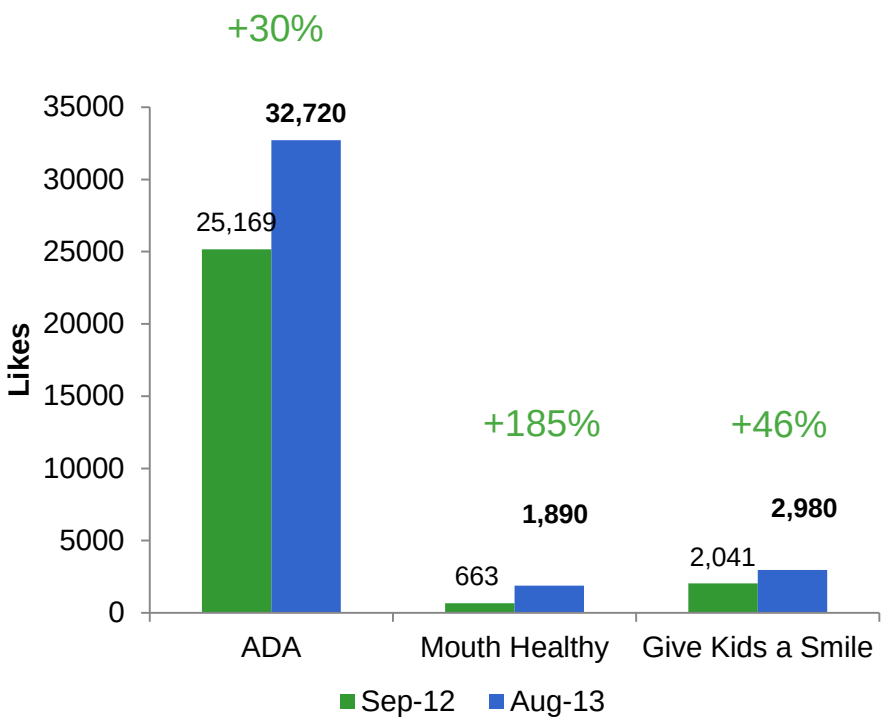


*Articles often encompassed more than one topic, the total number of mentions is greater than the total number of articles.

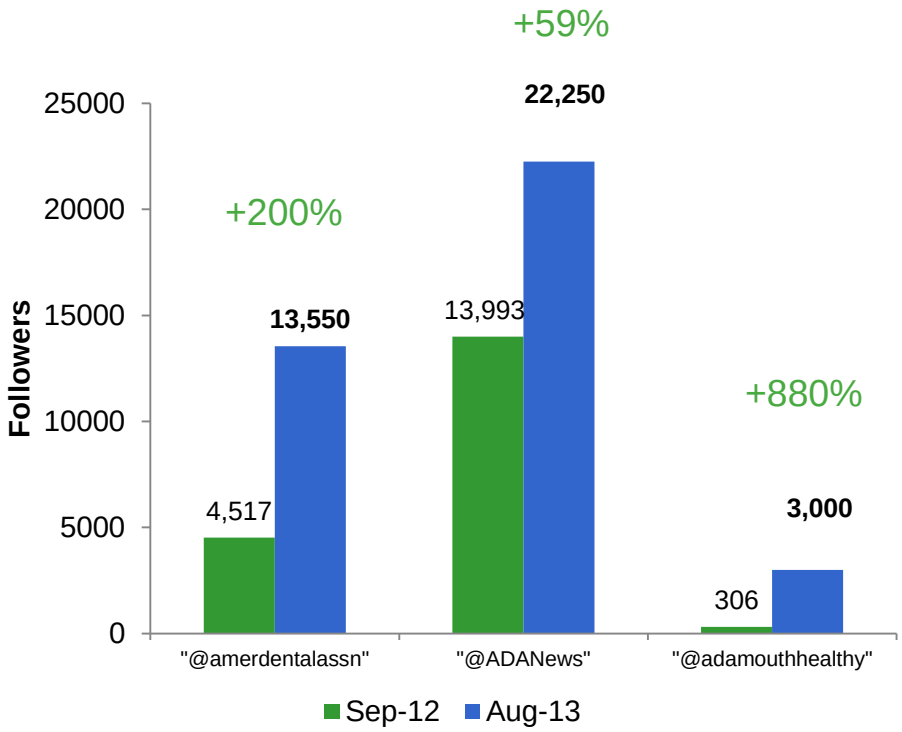
Social Media

Percent Growth in Followers since September 2012

Facebook



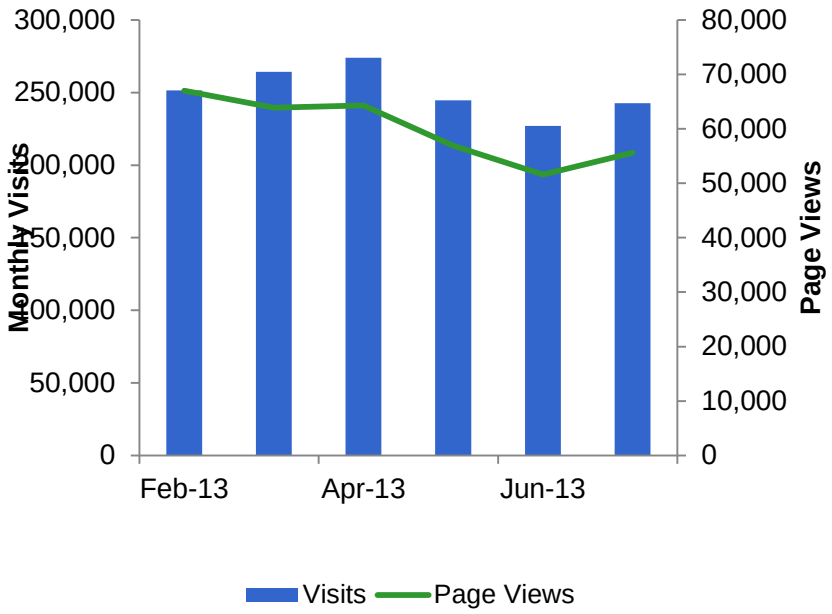
Twitter



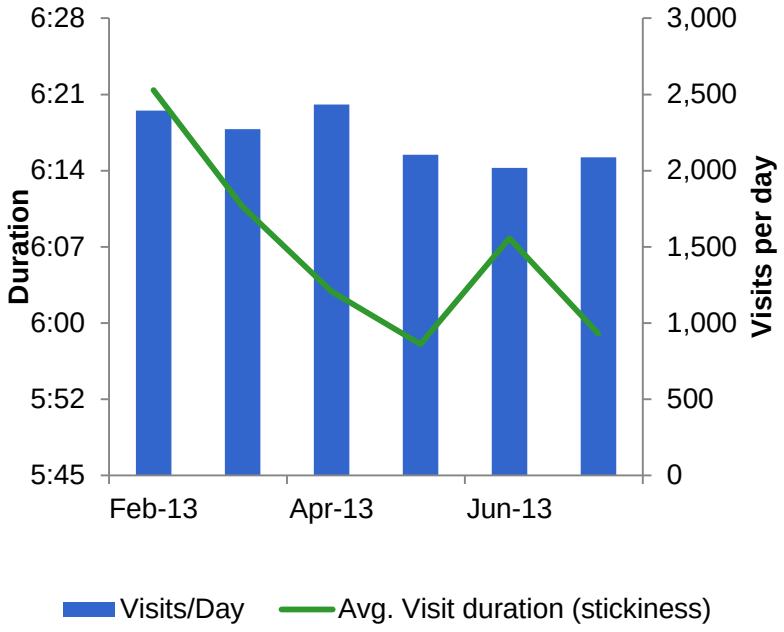
MouthHealthy.org

Web Traffic

Monthly Visits/Page Views



Duration/Visits per day



Methodology

“Total Media Coverage” Methodology

- Total media coverage from multiple sources mentioning the “American Dental Association” and/or the “ADA” were collected and analyzed for sentiment and messaging topics. These sources included:
  - Top-tier media articles acquired from the Factiva database (see Methodology slide)
  - MAT release coverage from Dental Health and Pregnancy campaign
  - Coverage report on Media Monitoring - ADA access issues
- While some coverage in smaller or extremely local media may not have been captured, the coverage included here would be a strong representative sample of ADA coverage.
- A six-month time period encompassing February 2013 – July 2013 was analyzed.
- Many articles included more than one key message; therefore, the total messages in a given period exceeds the total volume of top-tier coverage.

Key Message Measurement

- Seven key message concepts were evaluated:
  - *There is a dental health crisis in America.*
  - *Dentists are working to solve the dental health crisis.*
  - *Dental health is connected to overall health.*
  - *Action for Dental Health is a comprehensive plan.*
  - *Dentists are providing care now for patients in need.*
  - *Dentists are working to strengthen the public/private safety net.*
  - *Dentists are working to bring dental health education and disease prevention into communities.*
- Articles that expressed the idea behind any of these key messages concepts were counted toward they relevant key messages' count.
- Many articles included more than one key message; therefore, the total messages in a given period exceeds the total volume of top-tier coverage.

“Top Tier” Methodology

- Traditional media articles mentioning the “American Dental Association” and/or the “ADA” were collected analyzed for sentiment and topic.
- Analysis covers the “Major News and Business Publications: U.S.” category in the Factiva database. Publications included in this category can be found in the Appendix.
- Two distinct, six-month time periods were analyzed to assess changes facilitated by the communications program.
  - August 2012 – January 2013
  - February 2013 – July 2013
- Coverage not included in the Factiva dataset are represented in separate volume counts but not analyzed for sentiment or message pull-through.

“Top Tier” Media

Factiva database of Major News and Business Publications: U.S.

- Web Site: ABC News
- Web Site: All Things D
- The Atlanta Journal - Constitution
- Web Site: The Atlanta Journal - Constitution
- The Atlantic
- The Baltimore Sun
- Web Site: The Baltimore Sun
- Barron's
- Web Site: Barron's Blogs
- Barron's Online
- Web Site: Bloomberg
- Web Site: Bloomberg Businessweek
- The Boston Globe
- Web Site: Boston Herald
- Web Site: The Business Insider
- Charlotte Observer (N.C.)
- Web Site: Chicago Sun-Times
- Chicago Sun-Times
- Chicago Tribune
- Web Site: Chicago Tribune
- The Christian Science Monitor
- Web Site: The Christian Science Monitor
- Web Site: CNBC
- Web Site: CNN
- Web Site: CNNMoney
- The Dallas Morning News
- Web Site: The Dallas Morning News
- Web Site: Denver Post
- The Denver Post
- Detroit Free Press
- Web Site: Detroit Free Press
- Dow Jones Global News Select
- Dow Jones News Service
- Forbes
- Web Site: Forbes.com
- Web Site: FOXNews.com
- Web Site: The Hartford Courant (Conn.)
- Houston Chronicle
- Web Site: Houston Chronicle
- Web Site: Indianapolis Star
- latimes.com
- Los Angeles Times
- MarketWatch
- Web Site: MarketWatch Blogs
- The Miami Herald
- Web Site: My San Antonio
- Web Site: National Public Radio
- Web Site: NBC News
- New York Daily News
- New York Post
- Web Site: New York Post
- The New York Times
- New Yorker
- The News & Observer (Raleigh, N.C.)
- Newsday (N.Y.)
- Newsweek
- Newsweek - Print and Online
- Web Site: NJ.com
- Web Site: Nola.com
- NYT Blogs
- NYTimes.com Feed
- Web Site: Orlando Sentinel
- Orlando Sentinel (Fla.)
- The Philadelphia Daily News
- The Philadelphia Inquirer
- Web Site: Philly.com (Philadelphia, Pa.)
- Web Site: Pittsburgh Post-Gazette
- Pittsburgh Post-Gazette
- Web Site: Politico
- San Antonio Express-News
- The San Francisco Chronicle
- Web Site: San Jose Mercury News
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- Web Site: SF Gate
- Web Site: South Florida Sun-Sentinel
- South Florida Sun-Sentinel
- St. Louis Post-Dispatch
- St. Paul Pioneer Press
- Tampa Bay Times
- Tampa Bay Times: Blogs (Fla.)
- Web Site: TampaBay.com
- Web Site: Time
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- The Wall Street Journal Online
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- The Washington Post
- Washington Post.com
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- WSJ Guides
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Action for DENTAL HEALTH

ADA American Dental Association®

Action for Dental Health: Dentists Making a Difference

Progress Report Goals

OVERARCHING GOAL:

Reduce the proportion of adults and children with untreated dental decay through multiple interventions, early diagnosis and risk assessment, disease management and health education, and by preventing dental disease before it starts.

Initiative: Lead Collaborations to Achieve and Exceed the Healthy People 2020 goals

Dedicate resources to collaborations, public/private partnerships and community-based interventions defined locally to achieve and exceed the Healthy People 2020 oral health goals adopted by U.S. Department of Health and Human Services.

Goal: Reduce the proportion of adults with untreated dental decay 15% by 2020, exceeding the 10% HP 2020 goal by 50%

Goal: Reduce the number of children under 18 with untreated dental decay 15% by 2020, exceeding the 10% HP 2020 goal by 50%

Goal: Increase the proportion of low income children who received any preventive dental services during the past year by 15% by 2020, exceeding the 10% HP 2020 goal by 50%

Initiative: Get People the Right Care, in the Right Setting – Emergency Department to Dental Chair

The utilization of emergency departments for dental conditions burdens the hospital, drains resources and becomes a cycle of care that does not treat and solve the underlying patient problem.

Baseline: Total dental emergency room visits 2.1 million (2010). Estimated 830,000 visits for preventable dental conditions and 390,000 visits for caries (cavities) as primary diagnosis (2009).

Goal: Institute ER interception programs in 25 states by 2015 and 50 states and District of Columbia by 2020

Goal: Reduce ER dependency for patients with dental caries (cavities) and the pain associated with dental emergencies 50% by 2020

Goal: Reduce the total proportion of ER visits for dental-related issues by 35% by 2020

Action for DENTAL HEALTH

ADA American Dental Association®

Initiative: Community Based Contracting Between Local Dentists and Federally Qualified Health Centers

Help Federally Qualified Health Centers (FQHCs) increase the capacity of their dental programs through the contracting of private practices to accept publicly insured patients in the private practice setting, while the administrative burden of state insurance programs remains with the FQHC, reducing the barrier for private practice participation in public dental programs.

Baseline: 20% of FQHC patients received oral health services (2011)

Goal: Increase patients receiving oral health services 150% by 2020 - target 50% of all FQHC patients to receive oral health services, such as risk assessments, preventive measures, dental referrals and direct treatment

Initiative: Dentists Providing Care to Nursing Home Residents - Establish the Long-term Care Dental Campaign

Dentists are to participate in nursing home care and prevention programs through local community outreach, continuing education and training to work in long-term care.

Baseline: Currently, there is insufficient data at a national level to accurately understand how many nursing home residents are receiving regular dental care. Therefore, one goal of this initiative is to gain a better understanding and measurement of the extent of the problem. Ultimately, our goal is to ensure every nursing home resident who wants and needs dental care is able to get it.

Goal: At least ten state dental associations committed to implementing a long-term care program to improve the oral health of nursing home residents by 2015.

Goal: Through ADA continuing education, train at least 1,000 dentists to provide care in nursing homes by 2020, and increase the number of dentists serving on advisory boards or as dental directors of long-term care facilities.

Initiative: Expansion of Give Kids A Smile Local Community Screening and Treatment Efforts

The Give Kids A Smile mission is that as a public/private partnership, to serve as a catalyst for community-based children's oral health and wellness programs that are expandable, sustainable and innovative. Each year dentists and dental team members in communities around the country conduct free screenings and provide preventive care, such as fluoride varnish and sealant applications, as well as offer treatment to children in need while getting them into continuity of care.

Action for DENTAL HEALTH

ADA American Dental Association®

Baseline: 400,000 children screened and treated in 2012. Fact: National Health and Nutrition Examination Survey reports 23.8% of children aged 3-5 years had untreated dental decay in at least one primary tooth.

Goal: The Vision Statement of Give Kids a Smile calls for the elimination of cavities in U.S. five year olds by 2020.

Goal: ADA supports the Healthy People 2020 objectives that call for a 10% increase in children 3-15 who receive sealants. Sealants have been proven effective in reducing dental decay on the chewing surfaces of children's teeth.

Initiative: Expansion of Community Water Fluoridation – Tap Into Your Health

The Centers for Disease Control and Prevention have proclaimed community water fluoridation as one of the 10 great public health achievements of the 20th Century. Community Water Fluoridation is one public health program that actually saves money. An individual can have a lifetime of fluoridated water for less than the typical cost of one dental filling.

Baseline: As of 2010, 74 percent of people on public water systems enjoy the cavity-prevention benefits of fluoridated water.

Goal: Provide fluoridated water to 80% of Americans on public water systems by 2020

Initiative: Improve Utilization of the Existing Safety Net Through the Use of Community Dental Health Coordinators: Working with Patients in 15 States by 2015

Expand the number of community dental health coordinators (CDHC) working as patient navigators, preventive specialists, and oral health screening workforce within the community health center environment and the private practice environment to reduce barriers to access (socio-economic, cultural, geographic, educational and psychological), while increasing capacity of the community health center dental programs and private practices.

Baseline: As of April 2013, 34 Community Dental Health Coordinators are actively working in 7 states. A CDHC pilot project evaluation found 1 CDHC working just 1 day a week was able to provide services to 114 patients over a 9 month period.

Goal: Increase the number of states with active Community Dental Health Coordinators to 15 states by 2015

Action for DENTAL HEALTH

ADA American Dental Association®

Initiative: Educating all Americans to be Mouth Healthy for Life

Continue to provide public education outreach programs and to improve oral health literacy among the general public though direct investment and collaborations.

Baseline: The ADA's MouthHealthy.org website launched in July 2012. The ADA is a founding and executive member of the Partnership for Healthy Mouths, Healthy Lives and the Ad Council developed Children's Oral Health campaign.

Goal: Establish MouthHealthy.org as the most respected and trusted online resource for oral health information and as one of the top 5 most visited websites for oral health information.

Goal: Support and expand the efforts of the Partnership for Healthy Mouths, Healthy Lives and the Ad Council campaign through ADA member dentists in the local community

Initiative: Reducing the Barriers to Provider Participation in Medicaid/CHIP through Reductions in Administrative Burdens and State Developed Solutions for Sustainable Reimbursement

Many states are cutting adult dental Medicaid. Six states provide no adult dental benefits through Medicaid and 18 states provide benefits for emergency dental care only. There are no states providing full coverage at this time. Each year, only $143 per Medicaid patient is spent on dental treatment. Across the U.S., Medicaid spending for dental care is approximately 1% of total Medicaid spending.

Goal Increase the number of states that have streamlined their credentialing process to less than one month by 10%

Goal: Increase the number of states that have a dental Medicaid advisory committee by 25%

Appendix 3

ACTION FOR DENTAL HEALTH

National Dental Health Survey Infographic:

The Dental Divide in America infographic was used to communicate the results of the Harris Interactive survey in a punchy, visual manner. The infographic was shared across social media channels, highlighted on ADA.org/action, included in the Action for Dental Health press kit and displayed in Times Square and Las Vegas on launch day.

Appendix 3

Dental Divide Infographic on display in Times Square
5:47pm May 15, 2013

Note: PR Newswire displays graphics only during high traffic periods.

Appendix 3

The Dental Divide Infographic on display in Las Vegas
5:02 pm May 15, 2013
Note: PR Newswire displays graphics only during high traffic periods.

Appendix 4

Media Coverage Surrounding Action for Dental Health Launch:

New York Times
In Nursing Homes, an Epidemic of Poor Dental Hygiene
August 4, 2013

The New York Times has a print circulation of over 1.86 million.

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AGING | AUGUST 4, 2013, 2:30 PM | 203 Comments

In Nursing Homes, an Epidemic of Poor Dental Hygiene

By CATHERINE SAINT LOUIS

Jennifer Whitney for The New York Times

Dr. Sarah Dirks, right, a dentist who treats nursing home residents in San Antonio, said she would be "surprised if oral care was even on the radar of the medical directors" at nursing homes.

FACEBOOK
TWITTER

Katherine Ford visited her father, Dean Piercy, a World War II veteran with dementia, at a nursing home in Roanoke, Va., for months before she noticed the dust on his electric toothbrush. His teeth, she found,

WELL HOME PAGE »

PREVIOUS POST
Think Like a Doctor: Not Just the Flu, Solved!

NEXT POST
To Ensure Bone Health, Start Early

ASKWell
Your health questions answered by Times journalists and experts.

Ask a question

Related Questions

What is a good exercise plan for a middle-aged person who is out of shape (assuming good health other than the lack of fitness)?
Answered by GRETCHEN REYNOLDS , 3 months ago

On your "Rare Mutation Ignites Race for Cholesterol Drug" article, did any of the studies mention a decrease in triglycerides? My doctor recently prescribed Vascepa (icosapent ethyl) along with Lipitor – so I'm curious if these studies will lower both cholesterol and triglycerides?

What's the best way to create a habit of exercising? I want to exercise regularly but its hard for me to do things daily (I have a type of ADHD).
Asked by Wood0174 from San Francisco

My LDL levels consistently test extremely low and I have never taken any cholesterol medication. Is there a way for me to be tested to see if this is a result of the genetic mutation discussed herein? And is there a way for me to volunteer to participate in studies addressing this issue, so that we can better understand

Appendix 4

New York Times
Letter to the Editor
August 12, 2013

The New York Times has a print circulation of over 1.86 million.

LETTERS

Dental Care in Nursing Homes (1 Letter)

Published: August 12, 2013

Connect With Us on Social Media
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· Science Reporters and Editors on Twitter

Like the science desk on Facebook.

To the Editor:

"Nursing Homes Neglect Teeth" (Aug. 6) sheds much needed light on a largely hidden population facing a dental health crisis, the 1.3 million seniors living in nursing homes. Dr. Sarah Dirks is one of a handful of heroes, dentists who have carved out practices caring for the institutionalized elderly.

FACEBOOK
TWITTER
GOOGLE+
SAVE
E-MAIL
SHARE
PRINT
REPRINTS

THE WAY WAY BACK
WATCH TRAILER

Fortunately, an increasing number of private practice dentists are devoting part of their caseloads to caring for nursing home residents. The American Dental Association has started a campaign, Action for Dental Health: Dentists Making a Difference, one component of which is to deliver care to such patients through a little-known provision in Medicaid law.

Dr. Robert A. Faiella
Osterville, Mass.
The writer is the president of the American Dental Association.

A version of this letter appeared in print on August 13, 2013, on page D6 of the New York edition with the headline: Dental Care in Nursing Homes.

Appendix 4

CBS Atlanta (WAOK)
Survey Shows Dental Care Experience Depends On Income
May 16, 2013

CBSAtlanta.com receives nearly 160,000 unique visitors per month.

Appendix 4

Politico
Dentists: More low-income people landing in ER for oral care
By Paige Winfield Cunningham
May 15, 2013

PoliticoPro.com receives over 23,000 unique visitors per month.

POLITICO Pro

Home | Defense | Energy | Financial Services | Health Care | Tax | Technology | Transportation

ADA: More adults visiting ER for oral care

Send to me Print

Nearly half of lower-income adults say they haven't visited the dentist in a year or longer. | *REUTERS*

By PAIGE WINFIELD CUNNINGHAM | 5/15/13 9:45 AM EDT

More low-income Americans are visiting the emergency room with dental problems instead of getting care in a dentist's office, according to data released Wednesday by the American Dental Association.

And the health care law won't do much to address the problem, the dentists say, because it only requires dental coverage for children.

Appendix 5

Action for Dental Health—Topline Social Media Results

Twitter:

The launch press event for the Action for Dental Health campaign was covered live via the @AmerDentalAssociation Twitter handle. At the height of the event, 82 tweets were generated using #DentalAction.

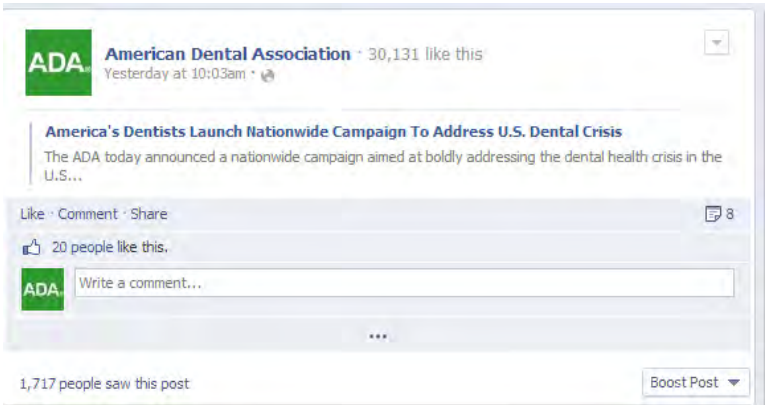
Several state and local dental associations picked up the Twitter messaging (the ISDA, Hispanic Dental Association, PA Dental Association, South Carolina Dental Association), retweeting it on their own accounts as did event speaker, campaign supporter, and fellow dentist Rep. Paul Gosar. @ADANews also retweeted parts of the press conference information.

Appendix 5

Photos tweeted live from the event looked like this:

Facebook

A Facebook post about the campaign went up immediately following the press event. The post has been shared eight times, has 20 likes, and a reach of more than 1,700.



Appendix 6

SCIENCE OF DENTISTRY

Dental Health and Pregnancy Mat Release:

The mat release garnered 732 placements with an estimated total readership of 15,099,536. Based on the number of placements the ADA mat release achieved, the equivalent ad value if the space were purchased totaled $179,622.

HEALTHY LIVING

The Facts about Your Dental Health and Pregnancy

(StatePoint) Many moms-to-be receive advice from well-meaning friends and relatives. Yet there seem to be myths about taking care of teeth and gums -- if dental health is even mentioned at all.

While pregnancy comes with many responsibilities, oral hygiene should be a top priority to ensure both mother and child are set up for healthy habits that will last a lifetime.

What to Expect

Hormonal changes can lead to an increased risk of gum disease (gingivitis) throughout pregnancy. Some women may develop "pregnancy tumors," painless bumps on their gums, most often during their second trimester. In addition to flossing once daily and brushing twice daily, work closely with your dentist throughout pregnancy to flag issues before they become problematic.

"Delaying necessary treatment for dental problems could result in significant risk to you and your baby," said Dr. Maria Lopez Howell, DDS, spokesperson for the American Dental Association (ADA). "It's worth your time to visit the dentist even if you don't think you have dental problems."

According to national experts in women's health, public health and dental health, a new consensus statement based on scientific evidence reaffirms that preventive oral care, including the use of dental X-rays, pain medication and local anesthesia for dental procedures, is safe throughout pregnancy.

"Don't put dental care on the back burner, as the complications could far outweigh potential risks. Make it part of your health and wellness visits during pregnancy," Dr. Howell said.

Post-pregnancy, maintaining good dental health habits are critical for everyone in the family. Evidence suggests that most infants and young children "catch" the germs that cause cavities from their parents or caregivers. Refrain from sharing utensils or attempting to "clean" a pacifier by putting it in your own mouth, as these types of activities may transfer cavity-causing germs.

Take Baby Steps to Better Dental Health

Together with the ADA, the American College of Obstetricians and Gynecologists (ACOG), the National Maternal and Child Oral Health Resource Center at Georgetown University (OHRC) and the Health Resources and Services Administration (HRSA), recommend following a few simple steps to help maintain a healthy mouth during pregnancy:

(c) pressmaster - Fotolia.com

- Get dental health treatment, as recommended by your dentist, before delivery. Schedule an appointment with your dentist if your last dental visit was more than six months ago. The use of dental X-rays, pain medication and local anesthesia for dental procedures is safe throughout pregnancy.
- If you experience "morning sickness," rinse your mouth with a teaspoon of baking soda in a cup of water to prevent stomach acid from harming your teeth.
- Drink water throughout the day that contains the recommended amount of fluoride to help to keep you hydrated and prevent tooth decay.
- Avoid foods that are high in added sugar and drink water or milk instead of juice, fruit-flavored drinks or soda.

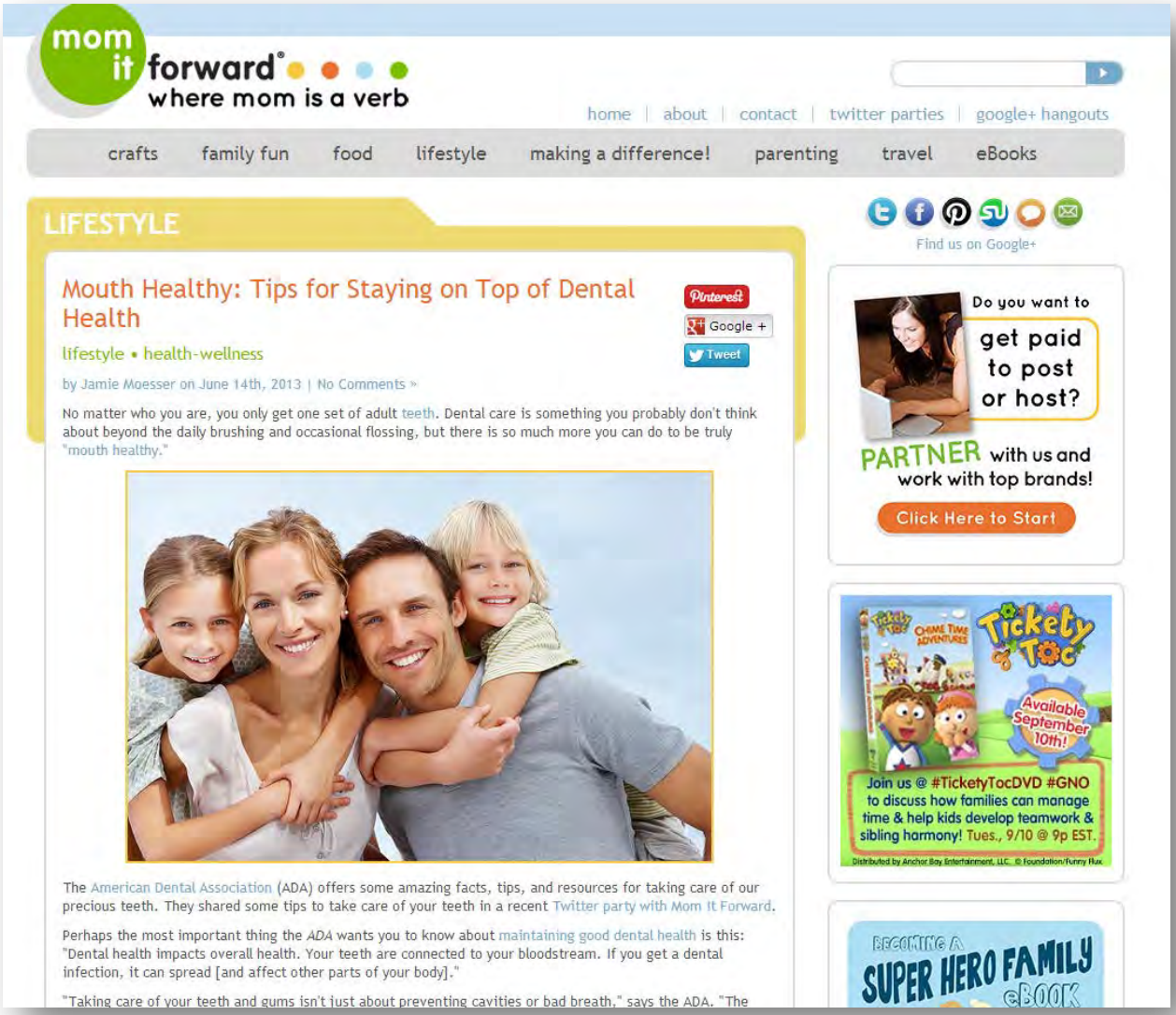
More advice from the American Dental Association about dental health during pregnancy is available at www.MouthHealthy.org.

Appendix 6

Mom it Forward Blog Posts:

Mom it Forward
Mouth Healthy: Tips for Staying on Top of Dental Health
By Jamie Moesser
June 14, 2013

MomItForward.com receives over 40,000 unique viewers each month.



Appendix 6

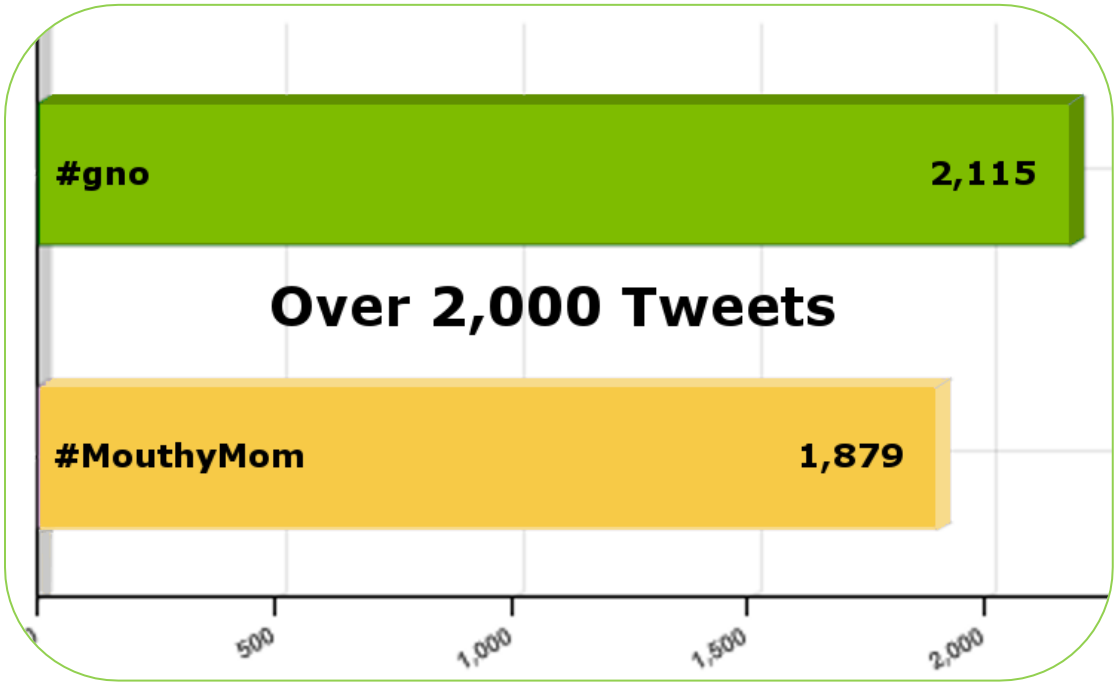
Mom it Forward
Dental Health During Pregnancy: Some Tips From the Experts
By Jamie Moesser
June 26, 2013

MomItForward.com receives over 40,000 unique viewers each month.

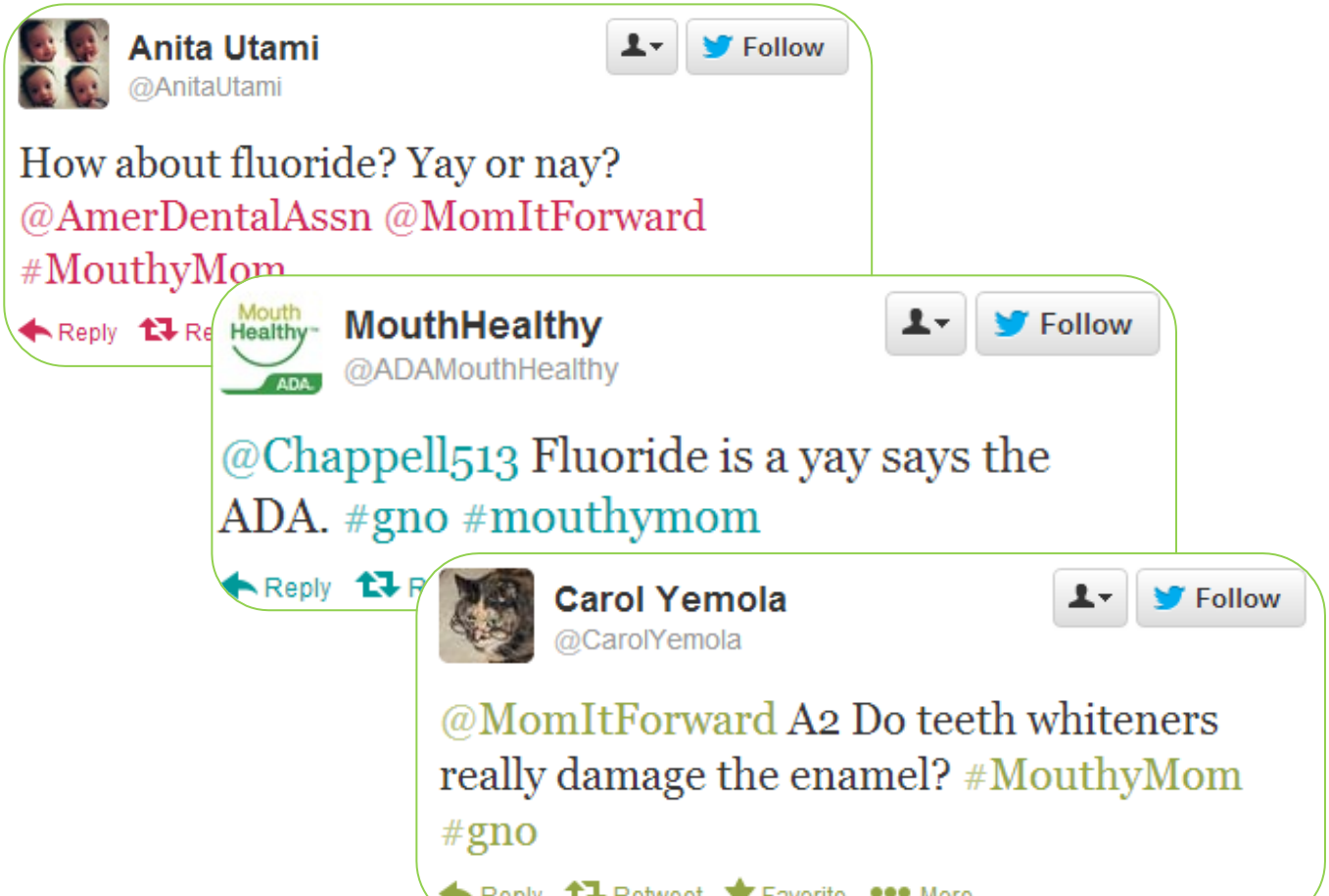
Appendix 6

Mom it Forward Twitter Party Results:

The joint ADA / Mom it Forward Twitter party received over 2,000 tweets from expecting mothers via its dedicated hashtags in just one hour on May 8, 2013.



Sample Discussion:



Appendix 6

Additional Sample Discussion:

Resolution No. N/A N/A

Report: CAPIR Supplemental Report 3 Date Submitted: October 2013

Submitted By: Council on Access, Prevention and Interprofessional Relations

Reference Committee: Legislative, Health, Governance and Related Matters

Total Net Financial Implication: None Net Dues Impact:

Amount One-time Amount On-going FTE 0

ADA Strategic Plan Goal: Public Health (Required)

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

Background: In 2006, the ADA initiated a pilot project to educate, train and deploy a new type of community health worker, one with a focus on patient education, disease prevention and patient navigation. The Community Dental Health Coordinator (CDHC) pilot project graduated 34 students, who are now working in underserved areas such as remote rural communities, inner cities and American Indian communities. The ADA invested thousands of hours and millions of dollars in making the Community Dental Health Coordinator a reality. The trainees invested their hopes for meaningful careers. All have done so with the conviction that the Community Dental Health Coordinator will be a significant element in a larger effort to break down barriers that impede many Americans from achieving good oral health.

The pilot program will be completed at the end of 2013. Education of the trainees and the evaluation of the program have been accomplished. The remainder of 2013 will be spent transitioning the program and curriculum to colleges and universities interested in developing a CDHC program. In addition, work will continue with the State constituent societies to encourage adoption of the CDHC as a viable member of the dental team.

Key Issues:

- 34 CDHC completed the CDHC pilot program in 3 training cohorts and are now employed in 7 States.

- The pilot program is expected to be completed within the $7 million appropriation approved by the House of Delegates. As of June 30, 2013, the project has incurred expenses paid by the ADA totaling $6,024,471.00, with remaining available funds for the project of $940,621.00. Projected expenses for the remainder of the project are approximately $773,190.00, with total expenses projected to be paid by the ADA to be $6,797,661.00.

- The ability to complete the CDHC pilot program has been due, in part, to the support of in-kind donations from Henry Schein valued at approximately $535,000.00 to off-set equipment expenses, and funding from the ADA Foundation in the amount of $200,000 over 4 years.

- To ensure a non-biased evaluation of the CDHC pilot program curriculum and training, a consultant was contracted to gather and analyze information about the education of the students. This part of the evaluation assessed the didactic, clinical, and internship experiences of the

students and faculty within the CDHC pilot. In addition, the ADA contracted with an independent team of evaluators to review the findings and analysis provided by the consultant. The independent evaluation of the training of the CDHCs was positive with the conclusion that the CDHC curriculum is very appropriate for educating this new category of dental health care worker.

- To evaluate the impact to patient access and outcomes, the ADA conducted an evaluation based on a case study model. A total of 46 case studies were completed for the evaluation. The data demonstrate the efforts of the CDHCs impacting over 11,000 patient lives at their respective clinics and generating revenues of approximately 1.85 million dollars. Comparing the geographic locations of the clinics, the data demonstrate the greatest impact to the dental practice was in the American Indian settings. The total value of services provided through school-based outreach events was $ 1,396,106.00. Twenty of the case studies targeted specific populations such as diabetic patients, foster children, perinatal patients or HIV patients. The data support the fact that the CDHC has significant impact in reaching out to those in their communities who lack access to care; key to the work of the CDHC is patient navigation and improving access.

- ADA staff also evaluated the sustainability of the CDHC model by developing a pro forma calculator based upon assumptions made using the case study data available. Results clearly indicate the model is sustainable under defined scenarios. The results emphasize the value of the CDHC in the field with more revenue generated through outreach activities.

- Transition of the curriculum to interested colleges and universities is underway with CDHCs presently employed in 7 states. A CDHC from Pennsylvania completed a four-month sabbatical at the Hidalgo Medical Services clinic, a Federally Qualified Health Center in New Mexico, where she demonstrated the knowledge and skills gained through the CDHC training program. Her time in New Mexico was spent working with the local community health workers and clinical staff to develop outreach programs and improve access to care through patient navigation. In addition, the CDHC was active in promoting oral health through education and delivered preventive services. As a result of that sabbatical, there are currently two colleges that have indicated interest in exploring the possibility of offering the CDHC training in that state.

- Recently two other states (Vermont and Florida) have expressed an interest in short term sabbaticals.

- Communications staff is currently updating all CDHC materials. Communications efforts have been focused on the *Action for Dental Health* that was launched with a media event held in Washington, DC, where a CDHC spoke on her background and her experiences with the program. An article published in the May 20, 2013 edition of *ADA News* illustrated her personal experiences and that of another CDHC also trained in the pilot program. (See http://www.ada.org/news/8635.aspx) Lastly, a CDHC and her former site directors presented on the topic of “Strengthening the Dental Safety Net through Community Coordination: Use of the CDHC” at the 2013 National Oral Health Conference in Huntsville, Alabama.

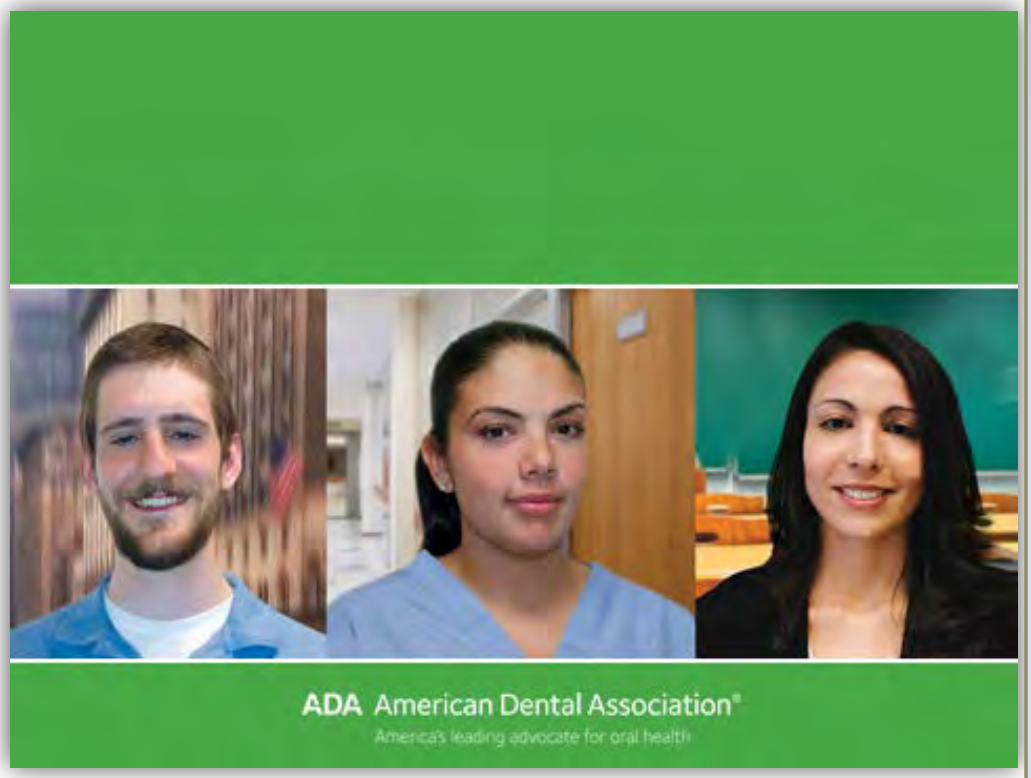
A comprehensive report with details of the pilot program and all of the case studies is available for review in Appendix 1.

Resolutions

This report is informational and no resolutions are presented.

Appendix 1

COMMUNITY DENTAL HEALTH COORDINATOR PILOT PROGRAM



Report to the American Dental Association House of Delegates and Board of Trustees

September 2013

Prepared by the Council on Access, Prevention and Interprofessional Relations

TABLE OF CONTENTS

Acknowledgements

The ADA invested thousands of hours and millions of dollars in making the Community Dental Health Coordinator a reality. Internationally recognized universities have invested faculty time, facilities, and other resources. Henry Schein donated several hundred thousand dollars in equipment. And the students have invested their hopes for meaningful careers. All have done so with the conviction that the Community Dental Health Coordinator will be a significant element in a larger effort to break down barriers that impede many Americans from achieving good oral health. The ADA wishes to acknowledge the volunteers, educators and staff who made this possible.

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Dr. Paul Glassman
Dr. Amid Ismail
Dr. Marshall Kreuter
Dr. JoAnn Allen Nyguist
Dr. Judy Skeleton
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Introduction

In 2006, the ADA initiated a pilot project to educate, train and deploy a new type of community health worker for the dental team, one with a focus on patient education, disease prevention and patient navigation to improve access to dental care. The Community Dental Health Coordinator (CDHC) pilot project graduated 34 students, who are now working in underserved areas such as remote rural communities, inner cities and American Indian communities.

The success of community health workers (CHWs) in managing and improving the health of people in underserved communities is well documented. CHWs live in or are at least familiar with the communities in which they work. They can link health care providers, social and community agencies and underserved populations in ways that promote healthy behaviors, prevent disease and help people get health care when they need it.

The Health Resources and Services Administration estimated that there were roughly 120,000 CHWs in the United States in 2005. The model has continued to gain momentum, as more communities utilize CHWs to improve public health through outreach and education. These workers are widely acknowledged as helping to reduce and eliminate health disparities. A 2002 Institute of Medicine report addressing the racial and ethnic disparities in health care stated that CHWs offer promise as a community-based resource to increase racial and ethnic minorities' access to health care and to serve as a liaison between health care providers and the communities they serve. According to a 2009 American Public Health Association policy statement, "A growing body of research indicates the effectiveness of CHWs in improving the quality of care and individual health outcomes."

The ADA Community Dental Health Coordinator model was developed to build on the CHW's proven success by layering on an oral health component. CDHCs are not midlevel providers; they are not intended to take the place of dentists but, rather, to educate, prevent dental disease and connect patients to dentists who will provide treatment. The design of this position embodies organized dentistry's belief that the nation will never drill, fill and extract its way out of its profound oral health disparities. So rather than focusing on surgical interventions, CDHCs provide the oral health education, prevention and patient navigation skills that are the nation's best hope of stemming the tide of untreated oral disease.

The CDHC role targets underserved populations encountered at WIC centers, Head Start and Early Start Centers, mental health organizations, healthy baby initiatives, hospices, substance abuse clinics, senior citizen centers, cancer societies, Community Health Fairs, Schools, and other community events. In addition, CDHCs target current Federally Qualified Health Centers (FQHCs) and Indian Health Services (IHS) enrollees encountered at medical visits for inclusion in dental services visits and provides the following type of services:

- Provide ***community outreach services*** that: 1) are culturally relevant to the target population served; 2) increase effective interaction through communication with key informants, leaders, and community residents; 3) increase networking and foster external agency partnerships; 4) encourage alliance with dental education and service providers; 5) encourage community acceptance of receiving early oral health treatment; 6) enable the community to mobilize for healthier lifestyles; 7) continuously broaden and deepen the CDHC exposure in the community with regard to boundaries spanned so as to increase the number of people receiving and understanding oral health messages;

and 8) map out the social and health support networks within a community; access to community resources, and insure community members also know how to access resources.

- Provide ***patient advocacy, care coordination, and navigation services*** that encourage continuity of care: 1) Assist patients in obtaining healthcare appointments, transportation, childcare or other support when necessary; 2) advocate and support the development of problem solving skills among community members; 3) make home visits and other contacts with patients, as needed; 4) provide feedback relevant to improving dental service accessibility and acceptability to clinic providers; and 5) accompany clients to scheduled appointments and/or referral sites, as needed.

- Provide ***group and individual dental health education services*** that: 1) assist individuals and groups in identifying and pursuing personal oral health goals; 2) demonstrate effective individual oral health preventive techniques; 3) employ instructional and coaching techniques that can be used in various learning environments, especially peer to peer learning; 4) encourage use of individual behavior change strategies that can be used to improve oral health status; 5) collect information on risk-factors using ADA-approved assessment protocols; 6) present benefits of dental treatments such as sealants; 7) present benefits of community-wide water fluoridation; 8) present individual dietary practices that prevent dental caries; and 9) prioritize relevant topics to deliver educational sessions based on measureable objectives.

- Provide dental services, allowable under the state dental practice act, in various clinic or community settings that include:
    - Data collection (e.g., Medical/Dental History)
    - Facilitate basic legal and regulatory compliance, (e.g., HIPAA, Informed Consent)
    - Manage patient appointments/follow up in collaboration with home clinic
    - Practice infection and hazard control
    - Dental health screening using visual inspection and photographs/radiographs for electronic transmission to supervising dentist who will diagnose and recommend treatment
    - Take, process, and store digital radiographs
    - Assist in patient triage based on emergent, urgent and routine needs
    - Oral hygiene education
    - Fluoride applications
    - Sealant applications
    - Coronal polishing
    - Scaling for periodontal Type I (gingivitis)
    - Temporization of dental cavities in preparation for restorative care by a dentist
    - Maintain, operate and store portable dental equipment safely and ergonomically

The ADA committed substantial resources to developing and evaluating the CDHC as a new member of the dental team. It is the ADA's belief the CDHC will be an ADA legacy program that dentists will be proud of for generations to come.

History and Background

The ADA Board of Trustees, in June 2004, 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 Workforce Models Task Force proposed five classifications of dental assistants and two classifications of dental hygienists in Report 15 of the Board of Trustees to the 2005 House of Delegates: Dental Workforce Models (*Supplement 2* 2005:6002). Included was the "community dental health aide," a proposed allied dental team member with preventive skills who would provide basic restorative procedures under a dentist's supervision in community-based settings. 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. 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.

In April 2006, the Chair of the Resolution 96H-2005 Committee reported to the Board on the Committee's progress towards developing core competencies for the new position and indicated the committee had determined that the term "Community Dental Health Coordinator" was developed to accurately describe the new member of the dental team. In June, 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."

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.

In 2007, 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. In 2008, the initial selection of the pilot sites for the CDHC program had been completed: University of Oklahoma for rural; University of California at Los Angeles (UCLA) for Native American; and University of Michigan for urban.

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 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.

In 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.

CAPIR volunteers and staff developed a project plan to include several divisions of the ADA to complete the project: Education, Communications, Finance, Legal and Health Policy. The pilot CDHC workforce initiative officially launched March 6-7, 2009, with a kickoff meeting at the University of Oklahoma, College of Dentistry (OU). Twelve CDHC students participated. Dr. John Findley and Dr. Wayne Thompson provided opening remarks and reiterated the Association's support for the CDHC project as one of the ADA's proactive initiatives for improving access to oral health. On March 16, 2009, the first 12 CDHC students in pilot training programs at OU and the University of California-Los Angeles (UCLA) School of Dentistry began their 12 months of online coursework through Rio Salado College in Tempe, AZ. The project continued through September, 2013 at which time a transition plan post-project was implemented.

Education and Training

Overview: The CDHC curriculum is founded on four overarching concepts: community outreach, coordination of care, educational and social interventions in the community and oral disease prevention. Interns learn to screen for oral health problems, develop and implement community-based oral health promotion program, provide preventive dental services, temporize dental cavities in preparation for permanent care by a dentist and provide individual and community-wide preventive services. Each of these concepts and skills are the foundation on which the didactic courses and in-person course tasks were developed.

The curriculum is designed so that upon successful completion of the first twelve months of the program, trainees will begin internships in a community agency. This is in keeping with the program philosophy that the trainees should work in communities where residents have no or limited access to dental care. Trainees come from the communities in which they will serve. And as members of the community, trainees understand the culture and language barriers to care. The success of this program will be having the right people, with the right skills, in the right place.

The unique feature of the CDHC Pilot Program is preparing trainees to work in community agency clinics, but also independently in different settings focusing on improving oral health via outreach and education. Prior to the internship component, the trainees learn how to collect data on the oral health status of patients who are in remote areas area. The dentist diagnosis the patients and then, in collaboration with the CDHC, develops a dental care management plan and a preventive plan which can be executed by the CDHC. The CDHC manages and coordinates the patient referrals based on their urgency of care. The CDHC follows-up with those who need care to be sure that they receive the care.

Curriculum: The CDHC curriculum is organized into three domains/learning clusters:
1) Community Health Promotion Skills
2) Dental Skills
3) Community-based Field Experience.

During the first twelve months of the program, the trainees complete courses that prepare them for their role in the community as advocates, leaders, educators and providers of preventive dental services. The community health worker component is a unique aspect of the education. Not only do the trainees become familiar with health care systems and legal issues related to health care, they develop the skills needed to help others navigate the system and become good stewards of their own health.

The CDHC student also learns to provide preventive dental services such as fluoride treatment, sealant application and self-care education. The development of these clinical skills is an important component of the course work. In addition to completing the didactic instruction, the trainees attend in-person sessions and complete a series of performance evaluations with their Pilot Program Directors and/or staff. Upon successful completion of the following courses and in-person evaluations, trainees are ready to continue to develop their skills to competency in an internship.

Community Health Promotion Skills Courses

HCC 130AA Health Care Today
HCC 130AB Workplace Behaviors in Health Care

HCC 130AD Communications and Team Work in Health Care Organizations
HCC 130AE Legal Issues in Health Care
HCC 130AF Decision Making in the Health Care Setting
CDH 115 Interviewing Skills for the Dental Health Advocate
COM 263 Elements of Intercultural Communication
CDH 125 Teaching and Learning Skills
CFS 207 Organization and Community Leadership in Child and Family Organizations

Dental Skills Courses

CDH 205 Introduction to Dentistry
CDH 210 Screening and Classification
CDH 215 Prevention of Dental Caries
CDH 220 Prevention of Periodontal Diseases
CDH 225 Prevention of Oral Cancer
CDH 230 Palliative Care
CDH 240 Dental Care Finance

In-Person Student Performance Evaluations

CDHC trainees' performance on all the tasks must be completed at a satisfactory level before the intern begins the clinical internship. Once trainees have completed the tasks, they have met preclinical competency; that is, they are able to perform each task, but require direct supervision.

A. INFECTION CONTROL TASKS

1. Infection Control: Practice Personal Protection
2. Infection Control: Hand Hygiene Antisepsis
3. Infection Control: Aseptic Technique
4. Infection Control: Disinfection of Surfaces and Equipment
5. Infection Control: Pre-sterilization Instrument Processing
6. Infection Control: Sterilization of Instruments
7. Infection Control: Post Sterilization/Handle Sterile Instruments and Equipment

B. PRINCIPLES OF INSTRUMENTATION

1. Positioning and Ergonomics –Positioning the Clinician and Patient
2. Principles of Instrumentation - Principles of Instrumentation
3. The Dental Mirror – Demonstrate the Use of the Dental Mirror
4. Use of the Explorer – Demonstrate the Use of the Explorer

C. ORAL ANATOMY AND ORAL INSPECTION

1. The TMJ and Salivary Glands – Identification of TMJ and Salivary Glands
2. Structures of the Periodontium – Describe and Recognize Anatomy of the Periodontium
3. General Principals of Observation - Apply General Principals of Observation
4. Oral Pathology: Neoplasia – Perform Self-Inspection for Oral Cancer
5. Vital Signs – Take Vital Signs

D. DENTAL RADIOLOGY

1. Radiation: Demonstrate Radiation Safety Techniques
2. Radiology: Discuss Exposure Factors
3. Radiology: Infection Control - Demonstrate Infection Control for Digital Radiographic Procedure
4. Radiology: Demonstrate Patient Management Techniques
5. Digital Radiography - Take full Mouth Series Using Direct Digital Imaging

E. PREVENTIVE SERVICES

1. Topical Fluorides - Administer Topical Fluorides
2. Fluoride Varnish - Administer Fluoride Varnish
3. Sealants - Apply Pit and Fissure Sealants
4. Oral Hygiene Improvement Plan (OHIP): Teach Oral Biofilm Removal Using a Toothbrush and Floss
5. Oral Hygiene Instructions: Teach the Use of Supplemental Oral Biofilm Removal Aids Oral Hygiene Improvement Plan: Oral Health Instruction for the Child Patient and Parent/Caregiver
6. Dietary Practices - Perform Dietary Counseling

F. SCALING AND POLISHING SKILLS

1. Sickle Scalers - Demonstrate Use of Sickle Scalers
2. Sickle Scalers - Sharpen Sickle Scalers
3. Coronal Polishing: Identify Removable Dental Stains
4. Coronal Polishing: Describe and Choose Equipment and Materials to Selectively Polish Teeth
5. Coronal Polishing: Demonstrate Coronal Polishing Technique

G. INTERIM RESTORATIONS

1. Single Surface Manual Interim Restoration (MIR) Using Glass Ionomer Cement (Hand Mix)
2. Single Surface Manual Interim Restoration (MIR) Using Glass Ionomer Cement (Machine Mix)
3. Multiple Surface Manual Interim Restoration (MIR) Using Glass Ionomer Cement (Hand Mix)
4. Multiple Surface Manual Interim Restoration (MIR) Using Glass Ionomer Cement (Machine Mix)
5. Single Surface Manual Interim Restoration (MIR) Using Intermediate Restorative Cement
6. Multiple Surface Manual Interim Restoration (MIR) Using Intermediate Restorative Cement

Internship/Community-based field work

The goals of the internship are to provide the CDHC trainees with sufficient experiences to become competent and safe clinicians, to promote oral health practices and to assist patients in navigating the oral health care system.

The internship component of the program provides the opportunity for the trainees to gain

competency in delivering preventive services, performing clinical supportive treatments and carrying out administrative procedures. In order to gain competency in completing these tasks, the trainees must work in clinics and complete these services on patients. Because agency dental directors and supervising dentists play a critical role in the ability of the trainees to complete the clinical requirements and continue to develop their clinical skills, they worked with the trainees to develop their work schedule and plan their community activities.

The agency staff members worked daily and closely with the trainees and were able to evaluate the trainees' performance and assist the trainees in developing self-assessment skills. A series of skill evaluation forms were designed to systematically document the procedures completed by the trainees and evaluate their skill in performing the procedures.

CDHC trainees were required to meet the following objectives based on the internship experiences:

1. Perform safe work practices.
2. Perform various clinical and technical digital radiography skills.
3. Perform various clinical and technical procedures utilizing the intraoral camera.
4. Prepare operatory for specific dental procedure.
5. Operate equipment related to CDHC functions.
6. Demonstrate maintenance of all portable equipment according to manufacturer's guidelines.
7. Communicate effectively with patients, supervising dentist, and staff.
8. Dress appropriately and utilize PPE.
9. Display teamwork, professionalism, preparedness, and cooperation.
10. Record and manage procedures in electronic patient chart adhering to HIPPA compliance.
11. Effectively manage patient using techniques appropriate for procedure.
12. Demonstrate standard infection control procedures in line with OSHA regulations.
13. Obtain vital signs.
14. When indicated, place temporary palliative restorations on patients.
15. Demonstrate control of instruments in the oral cavity.
16. Identify anatomical landmarks on patients.
17. Cleanse appropriate teeth with hand scalers and/or perform coronal polishing.
18. Deliver fluoride treatment using various/applicable techniques.
19. Work with supervising dentist who diagnosis and approves treatment or referral.
20. Demonstrate screening for suspicious oral lesions to be presented to supervising dentist for diagnosis and/or referral.
21. Demonstrate ability to effectively place sealants.
22. Identify suspect carious lesions (emergent, urgent, routine) to be evaluated by clinic dentist for diagnosis and treatment recommendation or referral.
23. Develop an employment agreement and/or create a resume and cover letter.
24. Review fire escape plan and MSDS Manual at home clinic.
25. Summarize the technical skills developed during your internship.
26. Summarize the communication skills developed during your internship.
27. Summarize the interpersonal relationship skills developed during your internship.
28. Record findings in the form of a journal.

The program was designed to have approximately half of the 1,040 internship hours (520 hours) spent in direct patient encounters. This included providing preventive services such as applying dental sealants, providing fluoride treatments, taking dental radiographs and placing interim restorations (as dictated by the state dental practice act). This also included time that trainees

spent one-on-one with patients providing oral health instruction, admission/intake interviewing and assistance in navigating the oral health care system.

Trainees also worked in remote sites providing oral health programming and preventive dental services. The agency, supervising dentist and staff along with the student established a work schedule and a plan to meet the requirements of the internship and the needs of the community agency.

The overall skill evaluation of the student was conducted four times during the internship at six week intervals or at the completion of each 260 hours. It was recommended that the staff members who worked most closely with the student conduct the evaluation. Trainees who were not progressing were referred to the Pilot Program Directors for remediation.

The trainees were also responsible for consistently elevating and monitoring their own performance during the clinical internship. They completed the same Performance Evaluation Check Sheet as the agency staff at the same intervals to develop their self-assessment skills. Below are key areas that were focused on during the evaluation:

1. Performance screenings
2. Application of fluoride
3. Provision of oral health instruction
4. Tobacco cessation
5. Dietary counseling
6. Placement of sealants
7. Coronal Polishing
8. Periodontal Type 1 Scaling
9. Placement of provisional restorations
10. Exposing radiographs
11. Taking intraoral photographs
12. Motivational Interviewing

Internship Assignments:

There were several assignments which supported the assessment of clinical skills and community-based service aspects of the internship. The assignments were aimed at assisting the trainees in reflecting on their roles as CDHCs and the impact of their services on patients and the community. They also assisted trainees in accounting for their clinical experiences and level of performance. The assignments are listed below.

1. Operating Portable Equipment:

The purpose of this assignment is to become more familiar with the operation of portable equipment and to develop the ability to explain the steps involved in operating the equipment to others. The assignment required each student to list the steps involved in operating the following pieces of equipment in dental practice and included cleaning and storage of the equipment.

- Patient light - including information on controlling intensity of beam
- Patient chair
- CDHC chair
- Portable dental unit - include water spray control to handpiece

- Curing light
- Laptop computer
- Digital X-ray unit
- Intraoral camera
- Slow speed handpiece
- Hazardous waste management
- Autoclave
- Ultrasonic

2. OSHA Mandates:

The purpose of this assignment was to deepen the understanding of the trainees regarding the application of Federal OSHA mandates in the dental practice. The trainees were required to provide evidence of the following:

- List the date of your OSHA training during your time at the dental practice
- Make a copy of the 29 CFR 1910.1030 Medical Record and complete it for the dental practice to keep in your permanent records.
- Know where the MSDS manual is located in the dental office.
- Know where the Exposure Control Plan (or the infection control manual) is located in the dental office.
- Know who to report to if you receive a needle stick or any other exposure incident.
- Understand the report provided in your training manual entitled "Report of Significant Work Exposure to Bodily Fluids"
- Understand how to complete an "Exposure Incident Evaluation Form".
- List the infection control procedures that you find to be effective in your dental practice.
- List which infection control procedures can be improved in the dental practice and how you would improve them.
- List the hazardous materials procedures you find effective in your dental practice.
- Document which hazardous materials procedures can be improved in the dental practice and how would you improve them.
- Locate the Cleaning Schedule form.
- Complete the Cleaning Schedule form using information from the office manual or by other means. It must reflect the cleaning protocol for the dental practice and the following:
    _ Waste baskets
    _ X-ray machines
    _ Operatory equipment
    _ Horizontal surfaces (counters)
    _ Vertical surfaces (walls and doors)
    _ Ultrasonic cleaner solution
    _ Evacuation lines
    _ Evacuation traps in the dental unit

- List the types of protective eyewear available at your dental practice.
- List the types of gloves available at your dental practice.
- List the types of gloves available at your dental practice.

3. Developing a Job Description for a CDHC

The purpose of this exercise was to create a job description for a CDHC in the facility in which the student was completing the internship.

4. Summary Paper:

The CDHC trainees completed a summary paper describing his/her experience during the internship. Required elements of the document included, but were not limited to, type of services provided, community members served, activities in which the CDHC participated, and lessons learned about serving as a CDHC. The trainees were asked to evaluate what aspects of their education and training assisted them during the internship. In addition, trainees were asked to comment on the benefits of a field experience. Lastly, trainees were asked to answer the question, "What makes one more qualified to provide CDHC services to people than someone who is hired without the educational/certificate component?"

5. Journal Entries:

Trainees were required to record one journal entry for every 40 hours of Internship time – for a total of 26 journal entries. Journal entries were to be made several times a week and reflect the outreach work conducted in their respective communities. Trainees were to record their experiences in the field, observations and interactions with the people attending the events. In additions, trainees were asked to document any patient concerns and/or challenges in accessing care. An evaluation of the effectiveness of the different programs was part of this exercise.

Core Competencies:

There are the seven CDHC core competencies:

1. The CDHC must be competent in the development and implementation of community-based oral health prevention and promotion programs.

a. Support water fluoridation programs
b. Collaborate and develop community oral health initiatives
c. Collaborate and develop oral health programs with other health and social services organizations and providers to promote oral health (e.g., Women, Infants and Children Programs, Head Start, mental health organizations, healthy baby initiatives, long-term care providers, hospices, senior citizen centers, substance abuse clinics, cancer societies, chambers of commerce, local businesses, school boards)

2. The CDHC must be competent in the knowledge and skill required to collect diagnostic data.

a. Medical and dental histories
b. Dental health screening/assessment (data collection) via:
   - Visual inspection of the oral cavity for carious lesions and other hard tissue anomalies

- Visual soft tissue inspection
- Take radiographs, when appropriate

c. Vital Signs
d. Dental Charting

3. The CDHC must be competent in the knowledge and skill required to perform a variety of supportive treatments:

a. Practice infection and hazard control protocol consistent with published professional guidelines
b. Prepare tray set-ups
c. Prepare and dismiss patients
d. Apply topical anesthetics
e. Assist with or apply fluoride agents
f. Process and store digital radiographs
g. Provide oral health instruction
h. Maintain accurate patient treatment records
i. Maintain operatory area and dental equipment in a community setting.
j. Assist in the management of medical and dental emergencies
k. Administer basic life support
l. Clean removable oral appliances and prostheses in community settings

4. The CDHC must be competent in the knowledge and skill required for administrative procedures:

a. Collaborate with community partners including telephone management and communication skills
b. Maintain supply inventory
c. Control appointments and manage recall systems
d. Operate business equipment, including computers
e. Complete and process appropriate reimbursement papers and online forms
f. Facilitate basic legal and regulatory compliance, (e.g., HIPAA, Informed Consent)

5. The CDHC must be competent in the knowledge and skill required to prioritize population/patient groups:

a. Identify potential emergent dental care needs
b. Communicate findings to the supervising dentist using electronic or paper transmissions
c. Revise the screening/assessment based upon dentist directive
d. Develop a referral recommendation and submit it to the dentist for approval
e. Develop an oral preventive recommendation and submit it to the dentist for approval

6. The CDHC must be competent in the knowledge and skill required to provide individual preventive services based upon plans, including:

a. Oral hygiene education

b. Tobacco cessation
c. Dietary counseling
d. Fluoride applications
e. Sealant applications
f. Coronal polishing
g. Scaling for periodontal Type I (gingivitis) patients in community settings

7. The CDHC has the knowledge and skill required to temporize dental cavities in preparation for restorative care by a dentist:

a. Hand instrumentation only
b. Only open cavities that are accessible to hand instruments
c. Manual removal of debris from cavities
d. Placement of temporary materials such glass ionomer materials

Cost of Training and Equipment:

The cost per student for the didactic training was approximately $14,000. Each CDHC student in the Pilot Program used portable equipment to provide screenings and direct preventive services in community settings such as schools, churches and nursing homes. The equipment, e.g., digital portable x-ray machine, digital intraoral camera, computer with appropriate software, portable dental chair, portable dental unit with accessories, sterilization unit and appropriate dental instruments, (valued at approximately $45,000.00) was loaned to the student during the internship and subsequently donated to each of the participating community agencies at the end of the pilot program.

Role of Participating Institutions

The primary role of participating institutions was to provide facilities and personnel to conduct and supervise the clinical instruction of CDHC trainees. Faculty members provided the skills-related training. The academic project directors also assisted with student activities at clinics or other selected sites.

Rio Salado College was the academic sponsor and provided the online didactic courses for the CDHC training program. The Pilot Program Sites coordinated in-person clinical practice & assessment sessions during the 12-month didactic training which was hosted by four dental schools:

- Temple University's Kornberg School of Dentistry, where trainees were educated to work in inner city settings
- The University of Oklahoma, College of Dentistry, where trainees were educated to work in remote rural areas
- AT Still University's Arizona School of Dentistry and Oral Health (ASDOH), where trainees were educated to work in American Indian communities. In 2011, the ADA and ASDOH reached an agreement to instruct the final cohort of American Indian trainees at that institution, in large part because of the dental school's longstanding ties to the American Indian Community.
- The UCLA School of Dentistry hosted the American Indian track for the first two cohorts of trainees.

Trainee Participants

The CDHC pilot program educated 3 cohorts of trainees through an on-line curriculum and hands-on coursework at four Universities.

Over a period of 3 years, fifty trainees matriculated into the program. Thirty-four trainees completed the program. The 16 that were dismissed from the program had either academic performance issues or personal circumstances that precluded their ability to continue with the training.

The trainees represented rural, urban, and Native American Indian communities. Prior to the start of the program, the trainees had various degrees of dental knowledge from no prior dental experience, to dental assisting/EFDA training experience and also dental hygiene programs. A few trainees were also credentialed as dental therapists working in American Indian clinics. In addition, all trainees instructed at Temple University (apart from hygienists) were required to have, or obtain, EFDA certification in accordance with the temporary statute provided for the pilot program in the State of Pennsylvania.

Testimonials from the trainees demonstrate the enthusiasm of these men and women who completed the pilot program:

> "I got involved in the program because I believe in its potential to increase dental health care access to the community.
>
> "I am a resource to my community and local dentists."
>
> "I wanted to work in a nonprofit setting. I liked the CDHC program because it gave me an understanding of the social issues in dentistry, including navigating the system for access to care and enhancing patients' oral health literacy. It's important when you act as a translator to make sure patients understand their oral health status, the instructions the dentist or team members is giving them and the importance of having good oral health."
>
> "This is my dream job," ……."I loved my old job, but I really wanted more. The CDHC program really prepared me for it. It's rewarding at the end of each day to know that I guided someone and provided hope."

Program Evaluation: Structure & Process Evaluation

The goal of the evaluation of the CDHC training process was to examine the pilot program through a process approach by reviewing two broad dimensions of the program: structure, and process. The intent was to provide a comprehensive and meaningful evaluation of the program.

Structure evaluation involved 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 was available. Of critical importance was the accessibility of the program to students who participated.

The process evaluation measured 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.

As with other types of research, a structure and process evaluation begins with a set of objectives from which a research design is developed. The research design then governs the types of data that will be collected and how it will be analyzed. A structure and process evaluation results in a collection of data and facts. In this case, information gathered about the CDHC training process provided both a qualitative and quantitative analysis.

Data about structure can consist of inventories of those items necessary to implement CDHC training, such as course materials, clinical training equipment, and classroom space for training activities. Data about process can include metrics to assess the number of hours spent in training, results of testing, and can be combined with measures of perception collected from students, instructors, and supervisors.

The structure and process evaluation examined the success of the following CDHC training components: 1.) Recruitment; 2.) Curriculum, both didactic and clinical; 4.) Employment; 3.) Internships; and 4.) Clinic management of the new CDHC.

To ensure a non-biased evaluation of the CDHC pilot program education curriculum and training, a consultant was retained to gather and analyze the data as required in the RFP (Request for Proposal) – See Appendices to review the RFP and full report of the curriculum evaluation.

In addition, an independent team of evaluators reviewed the findings and analysis provided by the consultant. Their report provides a review of training program. Overall, the independent evaluation was positive with the conclusion that the CDHC curriculum is very appropriate for educating this new category of dental health care worker. The evaluators reported the curriculum is well-founded and has the potential to be incorporated into programs of other educational institutions. See Independent evaluation to review the full report.

Structure & Process Evaluation of the CDHC Pilot Program: RFP

American Dental Association – May 2012

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Background:

The American Dental Association (ADA) is soliciting proposals to evaluate the training of a new dental team member, the Community Dental Health Coordinator (CDHC). The evaluation is intended to analyze the comprehensiveness and effectiveness of the training provided during the pilot program that was conducted beginning in March, 2009 with the last cohort of students graduating in the fall of 2012.

The Community Dental Health Coordinator pilot program was designed to train and assess a new member of the dental team to expand access to populations in rural, urban and tribal communities.

The study will be conducted under contract with the ADA. The standard request for proposals (RFP) legal terms can be found in the annex. This RFP outlines the background, study objectives, contract deliverables, and guidelines for proposal preparation and proposal evaluation criteria.

The study is anticipated to take 3 months to complete. Deadline for submission is October 30, 2012.

Any questions regarding the RFP and preparation of the proposal should be directed to:

Dr. Luciana Sweis
CDHC Project Manager
Council on Access, Prevention and Interprofessional Relations
American Dental Association
211 East Chicago Avenue
Chicago, Illinois 60611-2678
Phone: 312-440-2741
Email: sweisl@ada.org

Proposals should be submitted by email by 6pm CDT October 30, 2012 to:
Dr. Luciana Sweis
sweisl@ada.org

Scope of the Evaluation: Overview

The goal of an 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.

As with other types of research, the structure and process evaluation will begin with a set of objectives from which a research design is developed. The research design then governs the types of data that will be collected and how it will be analyzed. The structure and process evaluation will result in a collection of data and facts. In this case, information gathered about the CDHC training process will provide both a qualitative and quantitative analysis. The results of the analysis will be summarized in reports, presentations and other publications.

Data about structure will consist of inventories of those items necessary to implement CDHC training, such as course materials, portable dental chairs, and location of training activities. Data about process will consist of metrics including, but not necessarily limited to, hours spent in training, results of testing, and measures of perception collected from students, instructors, and supervisors during the training through the use of survey tools. The metrics may need to be developed specific to each site. Therefore, other parameters will need to be considered.

Specific to this evaluation the investigator will review the curriculum and the capacity of Rio Salado College to provide on-line learning, and four Universities contracted to provide on-site training: The University of Oklahoma, Temple University, University of California at Los Angeles, and Arizona School of Dentistry and Oral Health. For the university sites the availability of both onsite and offsite training locations, instructional equipment, and qualified faculty will be assessed. Due to the virtual curriculum used for CDHC training at Rio Salado college, the evaluation will include examination of the availability of course materials on-line, ability to conduct on-line testing, access to technical support for students and other types of support. The interface of the university sites and Rio Salado's virtual community college will also need to be evaluated.

The evaluation of the training process for the CDHC pilot program will assess the didactic, clinical, and internship experiences of the students and faculty. Other involved parties that may also be evaluated include, but are not limited to: support staff, clinic administrators, patients, and clinic employees who have contact with the CDHC during training. Metrics will include utilization or attendance measurements, such as the number of hours trained and live classroom attendance. Feedback surveys from students, faculty, and others will also be collected and analyzed. Other sources of process information include correspondence between the parties during the training via helpdesk logs, requests for instructor assistance, etc. Interviews with clinic leadership about how well prepared they feel the CDHC is for the job will be the endpoint measurement of the entire training process.

Contract Deliverables

The consultant will assess didactic instruction (lectures, demonstrations or other instruction without active participation by students), laboratory or preclinical instruction (students receive supervised instruction in performing functions using models, manikins or other simulation methods), and clinical instruction (supervised clinical experience with patients), and will provide reports and metrics with analysis that will answer the following:

Assessment of Pilot Program Design:

- The program demonstrated its effectiveness using a formal and ongoing planning and assessment process that included program goals, assessment of student achievement through defined methodology and metrics
- Results obtained during the pilot program were used to improve the program

Educational Program:

- Admission of students was based upon defined criteria, procedures and policies which may include, but not limited to, evidence of completion of high school or its equivalence, class ranking, cumulative grade point averages, if applicable, and evidence of writing skills.
- The number of students was proportionate to the resources available.
- Student recruitment activities provided an adequate number of qualified applicants to ensure that standards of instruction and achievement can be maintained.
- Applicants were informed of the criteria and procedures for selection, goals of the program, curricular content and employment opportunities.
- There was an established admissions committee for each program site.
- There was an established process for adjudication of academic and disciplinary complaints
- Student satisfaction and retention.

Curriculum:

- The curriculum was of sufficient depth to ensure defined competencies are achieved
- Written documentation of each course in the curriculum included the course description, course outline, instructional objectives and criteria for course grading.
- Appropriate time was allocated for didactic, pre-clinical (laboratory) and clinical experiences
- Curriculum was reviewed and revised, as needed, to reflect new concepts and to enhance the learning experience.

Instruction:

- There was evidence of objective evaluation criteria utilized by faculty and clinical personnel to evaluate students' competence in performing specified procedures during clinical experiences.
- There was evidence of objective student evaluation methods utilized to measure laboratory, preclinical and clinical course objectives.
- Clinical experience demonstrated students were able to perfect their competencies in the field under supervision.
- Faculty supervised and evaluated the student's clinical experience.

Administration, Faculty and Staff:

- Faculty have background in and current knowledge of dental assisting and community health work, the specific subjects they are teaching and educational theory and methodology e.g., curriculum development, educational psychology, test construction, measurement and evaluation.
- There is evidence of a defined evaluation process that ensures objective measurement of the performance of each faculty member.

Facilities/Equipment:

- Adequate facilities are available to support the purpose of the program; the physical facilities and equipment accommodate the schedule, number of students, faculty and staff
- Facilities at each University site and Rio Salado are evaluated and meet the above criteria
- Off-site facilities are evaluated and must comply with the same criteria
- Facilities demonstrate evidence of compliance with applicable local, state and federal regulations pertaining to, but not limited to, radiation hygiene, hazardous materials, bloodborne pathogens, infection control and HIPAA.

Data

Pursuant to completion of the contracted deliverables, the ADA consultant or research organization will be provided with data collected pertaining to the implementation of the pilot program for the training of the CDHC. Data elements may include, but are not limited to, the following data elements, if available (source column). Data will not be released until confidentiality and/or other appropriate agreements are signed.

Topic	Value	Metrics	Source of Data
Recruitment	Recruiting strategies Student selection criteria	• Recruitment criteria • Academic success of students • Student ratio appropriate for program	Application data GPA Highest degree Interview scores
Didactic	Content and value of didactic curriculum: Curriculum is comprehensive and provides sufficient depth of instruction to ensure achievement of competencies as a CDHC.	• Test scores • In-person assessments/competencies • Time to complete coursework • Curriculum review • Course/Faculty evaluations • Review of course sequence • Coordination of distance learning with on-site assessments • Accessibility of on-line courses • Administrative oversight of faculty • Academic and disciplinary complaints	Rio Learn test results Assignments Academic Performance GPA Student Evaluation
Clinical	Content and value of clinical training	• Clinical competencies • # hours in clinical training • Review of supervision • Student records • Student Evaluation	Rio Learn clinical evaluation records
Program Completion	Successful completion of program	# of graduates/#matriculated	Pilot Program Sites
Employment	Job placement rates	# graduates employed as CDHCs	Site directors records
Internship	Information about internship length, structure, and experience	• Qualitative descriptions or case studies of internships. • Quantitative reports describing types of experiences	Rio Learn weekly reports Clinic reports Internship manual
Clinic Experience	Successful deployment at the clinic post-training.	• Clinic profile • Assessment of the value of the site director manual. • Feedback from end-users.	Clinic goal sheets Interview reports from clinics and CDHCs Internship manual Site director manual
Budget	Cost of training CDHC	• Tuition cost • Equipment and supplies • Faculty • Travel Expenses	ADA financial data

RFP Submission Guidelines:

The ADA requires that the proposals for this study contain the following information:

 A cover letter containing the name and contact information of the principal investigator, and the overall budget amount of the proposal.

 A clear description of the overall study design and the analytic methods to be used for the analysis.

 A description of the qualifications, expected time commitments, and payment rates of the individuals to be involved in the review. Areas of expertise should include dental education, curriculum development, clinical dentistry, population demographics and public health. Proposals should include the CVs (with references listed) of all individuals on the research team as well as a short description of their proposed roles.

 A detailed work plan, including completion dates for all deliverables and a detailed budget, including proposed payment schedule.

 A statement disclosing any existing relationships with the ADA, firms or organizations that sponsor or promote alternative provider models, or firms that are directly involved in current research on alternative provider models.

ANNEX

Standard RFP Legal Terms

• Neither this RFP nor any responses hereto shall be considered a binding offer or agreement. If ADA and any responding Respondent decide to pursue a business relationship for any or all of the services or equipment specified in this RFP, the parties will negotiate the terms and conditions of a definitive, binding written agreement which shall be executed by the parties. Until and unless a definitive written agreement is executed, ADA shall have no obligation with respect to any Respondent in connection with this RFP.

• This RFP is not an offer to contract, but rather an invitation to a Respondent to submit a bid. Submission of a proposal or bid in response to this RFP does not obligate ADA to award a contract to a Respondent or to any Respondent, even if all requirements stated in this RFP are met. ADA reserves the right to contract with a Respondent for reasons other than lowest price. Any final agreement between ADA and Respondent will contain additional terms and conditions regarding the provision of services or equipment described in this RFP. Any final agreement shall be a written instrument executed by duly authorized representatives of the parties.

• Respondent's RFP response shall be an offer by Respondent which may be accepted by ADA. The pricing, terms, and conditions stated in Respondent's response must remain valid for a period of one hundred twenty (120) days after submission of the RFP to ADA.

• This RFP and Respondent's response shall be deemed confidential ADA information. Any discussions that the Respondent may wish to initiate regarding this RFP should be undertaken only between the Respondent and ADA. Respondents are not to share any information gathered either in conversation or in proposals with any third parties, including but not limited to other business organizations, subsidiaries, partners or competitive companies without prior written permission from ADA.

• ADA reserves the right to accept or reject a Respondent's bid or proposal to this RFP for any reason and to enter into discussions and/or negotiations with one or more qualified Respondents at the same time, if such action is in the best interest of ADA.

• ADA reserves the right to select a limited number of Respondents to make a "Best and Final Offer" for the services or equipment which are the subject of this RFP. Respondents selected to provide a "Best and Final Offer" shall be based on Respondent qualifications and responsiveness as determined solely by ADA.

• All Respondent's costs and expenses incurred in the preparation and delivery of any bids or proposals (response) in response to this RFP are Respondent's sole responsibility.

• ADA reserves the right to award contracts to more than one Respondent for each of the services identified in this RFP. If Respondent's bid or proposal is based on a group 14 purchase, Respondents must specifically identify this in their response.

• All submissions by Respondents shall become the sole and exclusive property of ADA and will not be returned by ADA to Respondents.

Executive Summary of the Self-Study Report

Assessment of Pilot Program Design

It was determined that the planning and assessment process implemented to guide the Community Dental Health Coordinator Pilot Program contributed to the overall program improvement and attainment of program goals. The systematic, ongoing review and assessment of a variety of information sources improved the program's ability to objectively and critically evaluate program success as well as identify areas needing improvement. For example, prior to the matriculation of cohort 1 students, the ADA appointed the CDHC Education committee comprised of key individuals from each of the pilot program sites, faculty from Rio Salado College, and ADA staff. The education committee continuously met throughout most the pilot program to assess the educational attainment of students, and to evaluate the effectiveness of the curriculum as well as the pilot program design. At the culmination of each course, the committee recommended and subsequently approved curricular changes and/or improvements as warranted during review. At the culmination of each cohort, the committee reviewed the curriculum as a whole to ensure it was meeting the program objectives.

The program's outcome assessment mechanisms assisted with identifying necessary modifications to the curriculum. Examples of this include creating ADA sponsored Community Health Worker courses to replace courses taught to cohort 1 and 2 students designed by Rio Salado College. Additionally, content was updated as applicable throughout the entire Pilot program as prescribed by the ADA Education Committee. Data was used on a continuous basis to inform the modifications to both the curriculum and program operation(s). Program outcome measures reveal that, although minor adjustments in the curriculum were needed and have been implemented, the overall instruction and curriculum as designed - support attainment of ADA prescribed CDHC program goals.

Educational Program

The program demonstrates that its policies and procedures related to the admission criteria ultimately identified students with the greatest potential for success. The decision to coordinate efforts amongst the Pilot Program Sites, ADA and RSC Staff demonstrated that the retention, persistence, and overall success rates increased over the 3 cohorts. The CDHC pilot program utilized a combination of application processes. For the first cohort, pilot sites recruited and selected students utilizing an individualized process. Rio Salado College subsequently admitted students to the college via its typical application process once students had been approved by each individual pilot site. For the second cohort, each pilot site continued to recruit prospective students individually, however after discussion at the education committee, it was determined that prior to students gaining admission to the ADA CDHC Pilot Program, their applications needed to be reviewed and approved by both the ADA staff and Rio Salado College prior to Pilot Program Admission. A rubric was developed and a cross-collaborative approach to reviewing admissions applications was implemented. Each applicant was evaluated according to various factors which included: credentials and skills, educational background and history, work experience, a written essay, and an interview. Those candidates meeting the minimum requirements were evaluated and selected based on their ranking. This practice continued on as Cohort 3 students were recruited, selected, and admitted to the CDHC pilot program.

It was determined that the number of students was proportionate to the resources available; however in several cohorts, not all of the seats were allocated during the entire cohort program due to mitigating student circumstances. The pilot program sites, ADA, and RSC worked relentlessly to ensure high-quality individuals were recruited to the program. Recruitment activities were site-specific and outlined the criteria and procedures for selection, goals of the program, and curricular content. One shortcoming of the recruitment process was that employment opportunity data was not readily available. This is due to the fact the CDHC is not a federally recognized TOP Code profession. It is noteworthy, that as each cohort completed the program, the sites continued to collaborate with program graduates and cohort students to build a sense of profession and community. Data was also collected by the ADA demonstrating the impact of the CDHC, and as the profession evolves, the researcher is confident that data sources will reveal that CDHC employment opportunities exist.

The Community Dental Health Coordinator program strictly adhered to college policies concerning ethical standards and the protections of students as consumers. In addition to the college policies, the Community Dental Health Coordinator program requested that each new faculty member complete the Maricopa Community College District online FERPA tutorial. Each course instructor was charged with tracking student academic and/or clinic performance. When academic/clinical difficulties were noted, the instructor notified the student via a "Letter of Concern." This letter was given to the student and the program administrator, site director, and ADA staff. Once this process was initiated, per the program policies, the student was obligated to contact and work with the faculty to outline appropriate methods of remediation. This practice assured that students met the objectives of the program competencies and demonstrated the support services of the pilot program were effective in aiding students with academic concerns.

Curriculum and Instruction

The Community Dental Health Coordinator program goals are broad in scope and allow the program the ability to easily implement ongoing scientific advancements and innovations in the field of Community Dental Health Coordinator. The goals target the ideals of a multifaceted health care practitioner in today's rapidly changing world. The program developed a curriculum management plan designed to assure appropriate sequencing, elimination of duplication and the attainment of student competence. The plan is predicated on and contributes to the program goals and program competencies. Per the plan, the ADA CDHC Education Committee created mechanisms to review and evaluate the curriculum on an ongoing basis throughout each of the cohorts. Multiple sources of feedback were used to make modifications and improve teaching and learning. Examples of the sources of feedback include CDHC Education Committee meeting course feedback forms, course competency evaluations, internship site surveys, student surveys.

The course descriptions and objectives provide consistent delineation of course topics. The descriptions and objectives align with the topical outlines and insure continuity and clarity of the particular course offering. The course descriptions, objectives, and topical outlines were reviewed by the Community Dental Health Coordinator faculty, Maricopa Community Colleges Allied Health Instructional Council, Maricopa Community Colleges District Curriculum Council, Rio Salado College Faculty and Administration, and by the ADA CDHC Education Committee.

The Community Dental Health Coordinator curriculum is sequenced so that:

a. It provides a logical progression of skill and knowledge, building upon previously learned content.

b. It facilitates overall integration of the basic sciences, dental sciences, and community health worker focused courses into the Community Dental Health Coordinator curriculua.

c. The pacing of the courses are appropriate and consistent.

d. The number of credit hours per semester is manageable.

Each cohort of students was co-supported by their Pilot Program Site (OU, Temple, UCLA, ASDOH) and Rio Salado College. Rio Salado College was the academic sponsor and provided the online didactic courses which required the student to log into the college Learning Management System – RioLearn. While students engaged with their online course in RioLearn, they accessed their reading materials, viewed recorded PowerPoint lectures, completed didactic assessments including exams, and had access to directions for completing at home practice distance-lab competencies as well as the requirements for their in-person clinical practice & assessment sessions. Rio Salado College faculty monitored student progress daily in RioLearn. For example, the faculty reviewed student log-in patterns, the number of minutes students spent interacting with the online content, the number of minutes students took to complete online assessments and exams, cumulative scores etc… The faculty also posted messages to students regarding their academic progress and commented on assessment results as needed.

For each of the courses/modules, the Pilot Program Sites coordinated in-person clinical practice & assessment sessions. The sessions were typically held at the Pilot Program Site campus and the sessions included an introduction to the clinical competency, competency attainment practice sessions, self and peer evaluations, and ultimately a competency evaluation by a Pilot Program Site Proctor (Licensed Dentist and/or Hygienist). The Pilot Program Sites, identified Proctors to conduct the sessions and Rio Salado College validated the Proctor and also periodically sent staff to conduct evaluations to ensure academic rigor was maintained. Results of each session were forwarded to Rio Salado and scores were entered into the students' grade book. Students' cumulative course grades were based on a combination of online and in-person assessments. The Pilot Program policies required that students score a minimum of 75% on each assessment (both didactic and clinical). If at any time during a course/module a student did not attain the minimum score, a remediation plan was set in place via a Letter of Concern. This practice was set in place as a means to ensure students met minimum competency standards prior to entering the internship portion of the Pilot Program.

Administration, Faculty, and Staff

In accordance with Rio Salado College philosophy, the Community Dental Health Coordinator program has one full-time faculty member who is designated as the program director. The college employs more than adequate and highly qualified adjunct faculty, clinic lab associates, and supervising dentists to increase scheduling flexibility and achieve program goals. The

faculty evaluation system is very effective in providing a formal mechanism of performance feedback to the adjunct faculty member. The system allows for both supervisor evaluation and adjunct faculty self-assessment. The evaluation is written and shared with the adjunct faculty member and may include recommendations or plans for performance enhancement. Student feedback is considered a critical element in adjunct faculty evaluation. Therefore, the program director places all clinical and adjunct faculty on an annual rotating schedule for student evaluation. The results of this evaluation are shared with the faculty member several weeks after course conclusion.

A review of faculty files and Rio Salado College records indicated that the CDHC pilot program faculty demonstrated the requisite background in and current knowledge of the dental profession and community health work when applicable. Each instructor held the credentials outlined by the Maricopa Community College District in the specific subjects they taught, and required training at Rio Salado College assured that each faculty member was exposed to continuing education coursework focused on: educational theory and methodology e.g., curriculum development, educational psychology, test construction, measurement and evaluation.

Facilities and Equipment

The Community Dental Health Coordinator program adequately supported student learning opportunities at a variety of locations. Each of the locations afforded the Pilot Program sites the flexibility and access to schedule learning opportunities consistently during the Pilot Program ensuring program goals and objectives were met. Each student was supplied with the appropriate auxiliary equipment necessary to gain the competencies and skills necessary throughout the training program. Policies and practices in place at Rio Salado College, under the auspices of the Maricopa Community College District demonstrated evidence of compliance with applicable local, state, and federal regulations pertaining to, but limited to: radiation hygiene, hazardous materials, bloodborne pathogens, infection control and HIPAA.

INDEPENDENT EVALUATION
OF
THE STRUCTURE AND PROCESS EVALUATION
FOR THE
COMMUNITY DENTAL HEALTH COORDINATOR TRAINING PROGRAM
AMERICAN DENTAL ASSOCIATION

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August 27, 2013

Executive Summary

The following is a synopsis of an Independent Evaluation of the Community Dental Health Coordinator (CDHC) Structure and Process Evaluation which includes both the CDHC one year didactic curriculum and associated six month internships conducted at four clinical sites. The Structure and Process Evaluation provided a report on elements of the CDHC curriculum and clinical training including selection of students, the training and education program, faculty/staff and facilities.

The curriculum appears to be well-founded and has the potential to be incorporated into the programs of other educational institutions. The RioLearn program at Rio Salado College has been in place for over ten years and is very efficient in providing an on-line mechanism for teaching CDHC students. In assessing the Structure and Process Evaluation it was evident that the CDHC curriculum addresses the seven core competencies developed by the American Dental Association as well as the twelve dentally related elements listed for inclusion in the program. The six month internships were more difficult for the Structure and Process evaluation to analyze because of limitations in collecting data from the student surveys due to low return rates. Accordingly, statistical analysis for this aspect of data collection was necessarily quite limited. However, those returned by the students presented positive feedback and were very supportive of the program.

Another strength of the training program was Rio Salado's evaluation system for students and faculty. A significant number of faculty evaluations by the CDHC students were collected during the Structure and Process Evaluation however, the great majority of these were for faculty involved with the on-line didactic curriculum. As with the internship program evaluations, student evaluations for faculty associated with the internships were sparse and did not reflect the numbers of students located at the four internship sites. The facilities and equipment at both Rio Salado and the internship sites appeared to be satisfactory, as reported in the Structure and Process Evaluation.

From the Structure and Process Evaluation and our assessment of that process, it can be concluded that the CDHC curriculum is very appropriate for educating this new category of dental health care worker.

Independent Evaluation
of the
CDHC Structure and Process Evaluation

1) CDHC Pilot Program Design

- The pilot program appears to be well designed and comprehensive in scope, leading us to believe it should be well suited to accomplish its intended goals. Reasonable goal driven tools are provided to support evaluation of the program.
- Student achievement appears to have been measured with defined metrics. However, little evidence for effectiveness (in the form of results) was made available.
- There is clear evidence that formative evaluation results were used to make recommendations to improve the program. However, it is recommended that a more rigorous formal ongoing evaluation parallel the program.
- Student achievement appears to have been measured with defined metrics. However the actual results were not provided to the external evaluation team.
- There is evidence that formative evaluation results were used to make recommendations to improve the program. However, it is unclear as to whether this feedback was utilized from all courses as we only received data from CDH230 (module 12), CDH205 (module 7), and CDH210 (module 8).

2) CDHC Educational Program

- A program application was provided along with a form for evaluating candidates for admission.
- Applicants were all approved by Rio Salado as well as by the pilot program site. As this was a pilot program with limited participants, it appears that there were an adequate number of applicants for the four sites.
- A special application pamphlet was designed specifically for CDHC applicants. Additionally, a web site was available for the CDHC program.
- An admissions committee from Rio Salado collaborated with faculty at the individual sites to make decisions on admissions.
- Criteria for admission were discussed but a list of admission criteria was not provided in the exhibit/results.
- There was no evidence provided to assure that resources were sufficient for the number of students planned for the pilot program.
- Academic performance policies are provided but not the policy for due process for students.

3) CDHC Curriculum

- In examining the goals and objectives of the CDHC curriculum and in reviewing the elements of the curriculum we find it to be very well-suited to address the learning objectives of the CDHC program. The information provided in the Structure and Process Evaluation regarding the RioLearn program, which now has ten years of application, gave us a good idea of how the CDHC curriculum was made available to the students and why the ADA chose this application for the CDHC pilot program.
- Examples of coursework being presented in the various phases of the program were provided in the exhibits through curriculum review documents, education committee meeting minutes, course grading documents, competency surveys and faculty evaluation samples.
- Evidence that time given to students to learn the material is provided in the form of examples of pass/dropout rates for courses. We would assume that this indicates adequate time is provided so that the majority of students can complete the requirements of the program in a reasonable period of time.
- Evidence of curriculum review was presented as samples for review and improvement of program goals; education committee meetings discussing the curriculum and formal curriculum/course review forms. There were examples of corrective action taken when problems in the curriculum were identified. These documents included both the on-line curriculum and the internship.
- Although a form was provided for "course competency student surveys" this did not adequately demonstrate student evaluation of the curriculum. Examples of student evaluation of their courses were not evident in the documentation provided and would be needed for a comprehensive evaluation of the curriculum.

4) CDHC Instruction

- There is a student academic performance policy that must be signed by each student. Also submitted are skill assessment forms to assure competence, a feedback form for a "letter of concern" as well as other examples of assessment of CDHC students.
- Can dental school programs assure that all of their grading is "objective"? There is no CODA standard that requires evidence of objectivity in grading. We feel that the mechanisms for evaluating student competence are reasonable and appropriate.
- Faculty are based at Rio Salado and at the internship sites. Their evaluation of didactic and clinical competencies are guided by well thought out and appropriate guidelines for assessing academic and clinical performance. The criteria for course and rotation completion and for student advancement are clearly stated in the available documentation. As will be discussed in the next section, faculty are evaluated by students, peers and the administration. It appears that there was an appropriate number of faculty for the program
- A determination could not be made regarding whether evaluation criteria were objective and successfully applied as no documentation in the form of examples of formal faculty grading calibration exercises were evident in the report.
- Individual faculty qualifications were not available in the documentation due to privacy issues, however, sample faculty resumes with names removed would have been helpful.

5) CDHC Administration, Faculty and Staff

- It appears that both the didactic and clinical sections of the CDHC curriculum fall under the purview of Rio Salado. As the administration of the programs is also their responsibility they oversee the selection and evaluation of faculty. The credentials for full-time faculty are described and are quite demanding for teaching in a dental auxiliary program. Adjunct faculty appear to be quite varied in educational background ranging from certified dental auxiliaries to licensed dentists, along with individuals with pure education backgrounds.
- Due to the ten year history of the RioLearn program at Rio Salado we are comfortable assuming that the full-time faculty there are properly credentialed.
- The faculty evaluation system from Rio Salado for full-time faculty is described as a self-evaluation and a move away from "traditional" faculty evaluation mechanisms. This appears to be more of a formative rather than a summative evaluation. However, this is what Rio Salado uses and we would assume that it has been working. The description of this system is well documented.
- We could not evaluate the range of faculty as a roster of faculty and their credentials was not included in the documentation.
- A listing and qualifications of faculty at the pilot internship sites would be necessary to make a definitive assessment of faculty qualifications.
- There are numerous examples of instructor evaluations by students for the internet courses although the limited return rate makes qualitative assessment difficult.
- There are no student evaluations of full-time faculty from the pilot internship sites. The evaluation system for adjunct (part-time) faculty is explained very well in the Structure and Process Evaluation but no examples of evaluations from the pilot programs are displayed.

6) CDHC Facilities and Equipment

- The "facilities" to support the curriculum provided by internet are housed at Rio Salado College and support all of their educational programs. We therefore assume that they are more than adequate to support the CDHC curriculum through the RioLearn program which provides over one thousand on-line courses each year.
- This program appears to be an innovative and well-regarded entity in the education community.
- There was a list of equipment donated by the Henry Schein Company for one of the sites and we assume that all of the four pilot internship sites were provided with this array of equipment as the total grant from Schein was more than $800,000.
- Regarding the pilot sites, there is an extensive checklist for the responsibilities of each site in addition to a checklist for equipment (routine patient treatment, infection control, emergencies, laboratory and etc.). These checklists are appropriate and complete.
- There was no documentation of examples of completed checklists included in the exhibit so it was not possible to determine the effectiveness of the checklists.

7) CDHC Data collection and feedback surveys

- Surveying appears to have been adequate in that all participants were included in the survey effort (sent surveys). Those returned are very supportive of the program. However, while surveys were sent to all participants, return rates were low, casting into doubt the ability to assume conclusions are accurate assessments of the courses. That said, the course feedback received was typically very positive.
- While the conclusions of the analysis are supported by the survey results, return rates were low. Given that the present data is drawn from a pilot sample, this low return rate makes it difficult to assign significance and assume generalizability from this sample. It is recommended that assessments are continued on future, larger samples and that efforts are made to increase future sample sizes.
- The evaluation effort does not appear to have had to deal with any contaminating factors of substance, other than low return rates and the dual role of Ms. Albo-Lopez serving as faculty and evaluator.
- Statistical analysis was limited or non-existent making analysis of success from quantitative surveying difficult to determine.

8) CDHC Data analysis of feedback surveys

- Qualitative summary was provided and while there is not a discussion of methodology or technique utilized to assess the qualitative data, the results are supported by the overwhelmingly positive feedback from the students.
- Statistical analysis were limited or non-existent making analysis of success from quantitative surveying difficult to determine. While student feedback surveys were included, there was not a summary table with descriptive statistics, or any other statistical analysis present. It is also unclear as to whether all surveys were included, and often the “N” or number returned for a given course is not in agreement with the number included in the report document. However, again it should be pointed out that the student’s perceptions of the courses are typically very high. Of course a more complete assessment would have included exit interview data from individuals who dropped out or were forced out of the program due to grade failure.
- Qualitative analysis of feedback from each course following a methodology such as content or thematic coding would be preferred for over all programmatic assessment.
- Descriptive statistics indicate that the program had a very high pass rate and a very low drop out and fail rate. However, there is no validation data to support whether successful completion of the didactic courses properly prepared the students to succeed in the practice based internships. A thorough assessment of internship performance would add much to the validation of the overall programmatic success.

Evaluation: Patient Access & Outcomes

Overview: The goal of the CDHC patient access and outcomes evaluation was to assess the impact of the CDHC on addressing barriers to access to care for patients in the geographic area in which the clinic provides service. One of the most important inputs into the decision to introduce a new dental provider into the workforce was to objectively evaluate the role of the dental team member with defined metrics and data analysis. For the CDHC pilot program, the evaluation gathered 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 was a process of identifying the goals of the clinic, determining a set of indicators that could be used to measure clinic goals, and performing the measurements involved.

The objectives of this part of the evaluation included: 1. determining how best to deploy CDHCs to improve patient access across a range of settings and problems; and 2. determining if solutions implemented using the CDHC provided the desired outcomes.

Evaluation Project Plan: The patient access and outcomes evaluation used a multiple case study design. A case study approach was appropriate given the great variation between the clinics in how the CDHC was used both prior to and, after training. Each case study was developed based on specific clinic and community access needs the clinic leadership wished to address. The clinic worked with ADA staff to define the metrics to analyze the improvement in access during the time period when the CDHC was working with his/her new skills as compared to the time period before. Once the outreach initiative was developed, each clinic worked with their CDHCs to implement the workflow solutions to determine if an outcome of improved patient access had been achieved. Once data analysis was completed, the results were initially shared with the clinic leadership and the CDHC. As needed, site visits were arranged to meet with the clinic leadership and staff to facilitate the evaluation process. For several of the smaller, rural sites, obtaining the evaluation data was accomplished via conference calls and using the FTP site for secure electronic transfer of the data.

Site Visit Process & Protocol: ADA staff developed protocol to work with the clinics to establish a process for the on-site data extraction and on-going data transmission during the time of the evaluation. Staff visited 13 of 20 clinics where the CDHCs had been employed (See Appendix – Site Visit Manual).

In conformity with applicable HIPAA laws, the CDHC evaluation team took appropriate steps to protect the privacy and security of the patient information the team accessed at each clinic. Business Associate Agreements and ADA Internal Review Board (IRB) approvals were obtained for all participating clinics. There were several Indian Health Service (IHS) clinics for which IHS IRBs were not executed in time for the evaluation phase of the project.

Data were collected from the clinic patient management systems or from patient records scanned and sent to the ADA electronically via a secure FTP connection. All of the data collected for the case studies was stored in an ADA database repository specifically created for the project. Access to the system was restricted with security passwords to only designated staff.

Data collection began in February, 2012 and concluded in August, 2013. Based upon preliminary discussions with the clinics, more than 80 case studies were envisioned. Not all of the outreach initiatives were implemented by the clinics. In addition, in several instances, data was either not available or not amenable to analysis. A total of 46 case studies were completed; 2 of these were CDHC patient satisfaction surveys. All case studies were reviewed by the individual clinics, the ADA staff evaluation team, CAPIR leadership, ADA legal staff, and the ADA volunteer workgroup on the project.

Methodology: There were three basic types of research methodologies used for the case studies in the CDHC evaluation: 1.) Quasi-experiments; 2.) Survey methods; and 3.) Narrative descriptions. For quasi-experiments, most case studies were post-test only where activities directed at increasing access were observed. A smaller number used pre and post-test observations to look at changes in access between time periods; for example, the number of services provided to patients before and after the CDHC began their outreach work in the community. Survey methods were used to collect and analyze patient satisfaction data. Surveys were made available to all CDHC patients during a specific time period of data collection. Narratives were used to describe the qualitative aspects of CDHC implementation, i.e., what the CDHCs did to organize community outreach events or their work flow.

Data limitations included small sample sizes for some case studies. Sample sizes for case studies ranged from as few as six to as many as 583 patients. There were a few case studies with missing or lost observations due to inconsistent definitions of the target population and the enforcement of clinic specific HIPAA requirements that de-identified the data to the researcher. Also, as surveys relied on volunteer respondents, it is possible that non-respondents felt differently about their experiences with the CDHCs.

Case studies primarily reported descriptive statistics. Based on the type of case study, several statistical tools were reported as applicable.

- Descriptive statistics
  - Means, medians, distributions, and plots
- Inferential statistics
  - T-test, chi-square
- Formal statement of hypotheses
  - Table of null hypotheses statements to be tested
- Statistical assumptions

Data from all case studies was also summarized to provide aggregate analysis of the impact of the pilot program trainees in the field. Comparative analyses were conducted across several variables and are presented in this report (see Case Study Findings).

AMERICAN DENTAL ASSOCIATION

CDHC Evaluation:
Site Visit Process & Protocol

2012

211 E. CHICAGO, ILLINOIS 60611

TABLE OF CONTENTS

Introduction

One of the most important inputs into the decision to introduce a new dental provider into the workforce is objectively evaluate 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.

Goal: The goal of the CDHC Evaluation is to assess the impact of the CDHC on addressing barriers to access to care for patients in the geographic area the clinic serves.

Objectives:

1. To determine how best to deploy CDHCs to improve patient access across a range of settings and problems.
2. To determine if solutions implemented using the CDHC provide the desired outcomes.

Process:

Step 1: The clinic will describe an access concern they wish to address utilizing the CDHC
Step 2: The clinic will define metrics to analyze the improvement in access during the time period when the CDHC is working compared to the time period before.
Step 3: Gather data
Step 4: Analyze data (ADA support)

Key points to consider:

- Each clinic will have its own specific concerns they would like to address
- Each clinic will respond to access problems by identifying realistic solutions and by setting goals
- Each clinic will utilize the CDHC to implement their solutions
    - Goal setting process involves the CDHC as part of the team
    - Goals selected will take into consideration clinic priorities, and the core competencies of the CDHC
    - Goals selected will be realistic and feasible.

Role of the ADA/evaluation team: To collect and analyze measureable impacts on patient access to care resulting from the CDHC's actions in pursuit of the clinic's goals

- Collect data from the period before the CDHC started to work
- Collect data for the period the CDHC is working
- Analyze the difference in access between the two time periods
- Report findings to the clinic and later other stakeholders
- Determine if the CDHC's actions in pursuit of the clinic's goals do or do not generate a measureable impact on patient access to care

Agenda

CDHC Evaluation Site Visit

Attendees: Clinic Leadership and Staff, ADA Evaluation Team Staff

8:00 a.m. – 8:30 a.m.	**Introduction**	Clinic Staff ADA Staff
8:30 a.m. – 9:00 a.m.	**Review Case Study Goals & Objectives**	Clinic Leadership ADA Staff
9:00 a.m. – 10:00 a.m.	**Clinic Tour** Review HIPAA Business Associate Agreement Overview of Practice Management System Introduction to key personnel for data extraction	Clinic Leadership ADA Staff
10:00 a.m. – Noon	**Preliminary Data Extraction** Practice Management System data Surveys	Office Manager/IT ADA Staff
Noon – 1:00 p.m.	**Lunch**	All
1:00 p.m. – 4 p.m.	**Continue with Data Extraction & Surveys**	ADA Staff
4:00 p.m. – 5:00 p.m.	**Wrap-up**	Clinic Leadership ADA Staff

Clinic Case study

Report Outline

Case Study Abstract

- Brief description of the case study patterned after a research abstract

Case Study description

- Statement of the problem
    - What is the problem?
    - Define the targeted population
    - What is the current situation? And, what is the desired outcome?
        - Define current system with metrics (e.g. # patient visits)
        - Change in patient access outcome
        - Change in clinic economic outcome

- Description of intervention implemented:
        - Who participates?
        - Who is the target population?
        - What process is implemented? (e.g. school-based assessments)

- Internal or external barriers to success
    - What factors internal to the clinic might influence the success or failure of the intervention planned
    - What factors in the external environment might influence the success or failure of the intervention planned

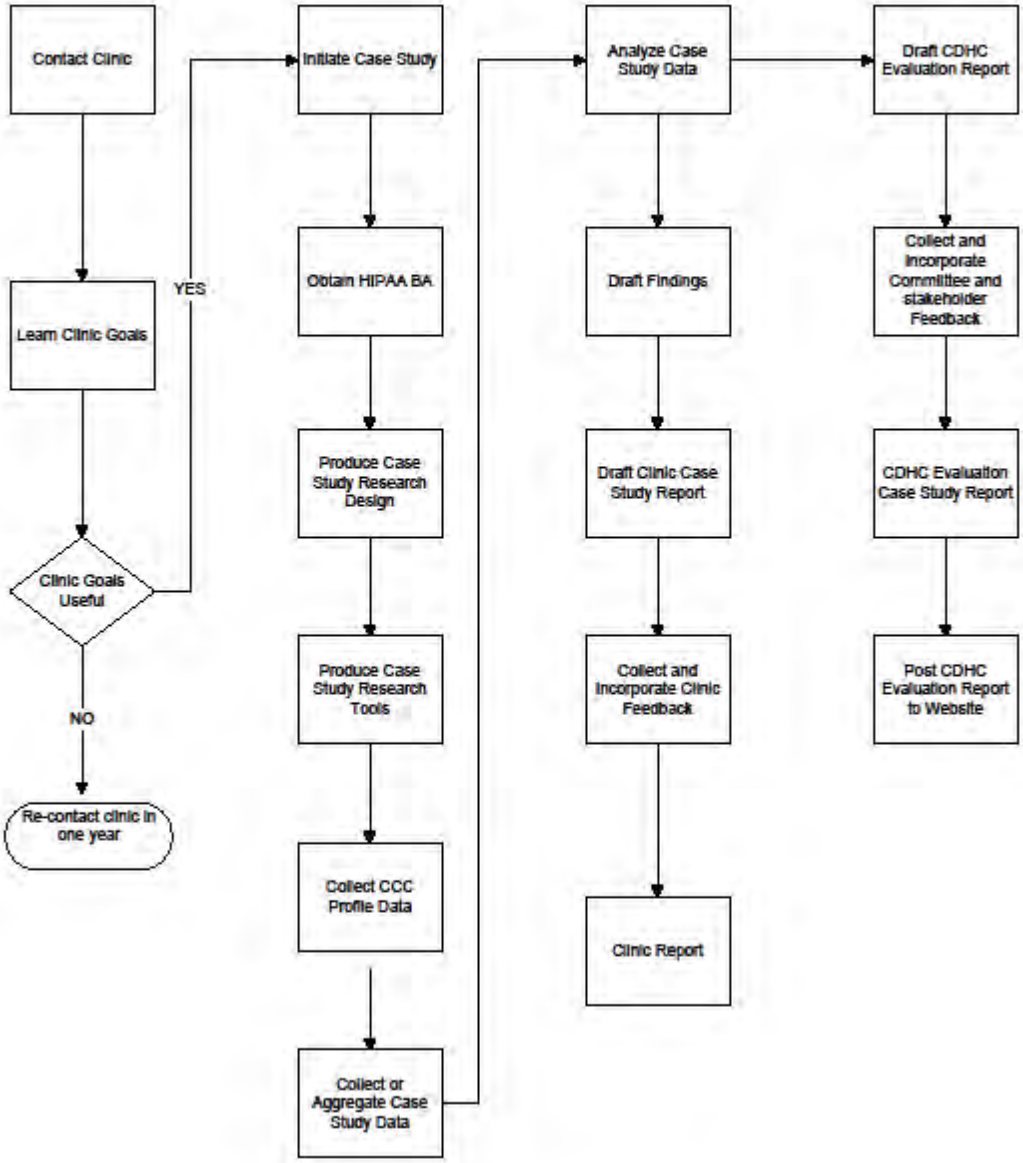
Methods

- Data collection
    - Inventory of data needed to evaluate the case study
    - Description of methods used to collect data
        - Computer record extract
        - Survey or forms
        - Record abstraction
        - Sampling or randomization

- Data limitations
    - Sample sizes
    - Consistency of definition
    - Missing or lost observations
    - HIPAA requirements

- Statistics used
    - Descriptive statistics
        - Means, medians, distributions, and plots
    - Inferential statistic
        - T-test, chi-square, or p-charts
    - Formal statement of hypotheses
        - Table of null hypotheses statements to be tested
    - Statistical assumptions

General CDHC Case Study Enrollment and Implementation Task Flow



Surveys

CDHC Data Instruments

The following surveys have been developed to provide additional data regarding the CDHC in the workplace. See the Appendix for a template for each of the surveys described.

Instrument	Description
Patient satisfaction survey	One page survey measures patient satisfaction with CDHC services and experiences. Distributed to patients seen by the CDHC for both dental services and oral health education and promotion.
CDHC self-assessment and work satisfaction survey	Two page survey measuring CDHC satisfaction with work and job.
Community stakeholder opinion survey	Two page survey consisting of both closed and open-ended questions that measure a community stakeholder's opinion of the value and impact of the CDHC on dental health problems in the community.
Clinic leadership opinion interview	Two page survey consisting of both closed and open-ended questions that measure clinic leaderships' (CEO, Dental directors) opinion of the value and impact of the CDHC on clinic operations, and improving access to dental care at the clinic.
Dental team acceptance of CDHC survey	One page survey measures co-worker's opinion of the CDHC's role and impact on clinic operations.
CDHC time by task allocation	One page grid that is used to log time spent on clinic and CDHC activities for pre-determined time period. To be used in a workflow and productivity analysis of the CDHC. Data collection is done over a time period and will consist of multiple pages of the same grid.
Clinic Profile	Provides information about the size of the clinic, number of providers, types of providers (e.g. dental assistants, front desk, EFDAs, Dental Hygienists, etc.), hours of operation

HIPAA

The HIPAA Security Rule requires:

- protection of the confidentiality, integrity, and availability of electronic protected health information ("ePHI") created, received, maintained, or transmitted
- protection against reasonably anticipated threats or hazards to the security or integrity of ePHI
- protection against reasonably anticipated uses or disclosures of ePHI that are not permitted under the HIPAA Privacy Rule
- assurance that the workforce complies with HIPAA Security

The ADA is committed to maintaining the confidentiality, integrity, and availability of the PHI used to evaluate the CDHC pilot program and in accordance with the Business Associate Agreement signed by the ADA and the clinic.

All ePHI will be stored in the Data Repository housed at the ADA Headquarters in Chicago. The preferred transmission of data is via FTP. If a hard copy of data is required, the document containing PHI should be scanned by the clinic. The scanned documents need to be encrypted. Please do not send PHI by e-mail or Fax. Any PHI on removable media must also be encrypted. FTP and encryption instructions will be provided to the clinic.

During the site visit items below will be discussed.

Activity	Purpose
HIPAA discussion	Discuss the HIPAA business agreement and clarify any of management's questions.
Data Collection	• Identify staff involved in case study data collection • Determine data elements to be extracted
Clinic IT staff	Meet with IT staff regarding how to obtain access to case study data in the patient management system or review hard copy documents that will be scanned and encrypted
Data collection work	Work done to extract or report out case study data from the patient management system or abstract patient records.
HIPAA transport work	• Work done to encrypt or de-identify case study data for transportation. • May include scanning of documents. • Instructions provided as needed (FTP/encryption)
Exit discussion	Discuss outcomes of site visit (data extraction; issues; concerns) Discuss on-going data collection process, if applicable Answer any questions

Data Extraction

The evaluation team has developed a set of case studies unique to each clinic to gather data and analyze specific goals. The data that will be collected will allow for a comparative analysis regarding the impact of the CDHC in the workplace. Data to be gathered will describe the workflow of the CDHC; i.e. time the CDHC has spent in the field vs. the clinic. Analysis will also provide information regarding the number of services provided vs. outreach and health education. There will be several common indicators applied across all clinics. The data elements noted below will be extracted from the patient management system or through a survey document and will be deidentified for the CDHC evaluation summary report.

ADA staff will work with the clinic staff to establish a process for the on-site data extraction and on-going data transmission during the time of the evaluation. ADA staff will comply with HIPAA to protect the security and confidentiality of the data. In clinics with practice management software systems, data will be exported directly to the ADA via an FTP established specifically for the CDHC project. As is necessary, alternative methodology will be utilized including removable media and scanned, encrypted hard copies of reports.

Column	Usage
Patient ID	Identifies patient and links their data
DOB	Age
Gender	Gender
Medical condition(s)	Creates subgroups of patients by underlying medical conditions (eg. Diabetes). There can be several captured.
Risk factors	Creates subgroups of patients by underlying risk factors. Risk factors may include, but are not limited to: Non-English language, substance abuse, homelessness, and chronic unemployment. There can be several captured.
Procedure	Service provided
Procedure date	Date service provided
Procedure charge	Charge for service provided
Service provider number	Identifies who provided service
Clinic site	Location where the service is provided
Patient address	Locator
City	Locator
State	Locator
Zip	Locator
Payer type	Proxy for ability to pay

Other data elements that will be captured include, but are not limited to, number of patient visits

Data Analysis

Data analysis will be conducted by the project staff at ADA headquarters. The case study model will allow the ADA to provide clinic specific data analysis to each clinic. Upon completion of the analysis, it is expected to be able to describe the following:

1. Understand the external and internal environments of the clinics
    - Characteristics of the clinic
    - Demographics of the community
    - Prevalence of dental disease in the population
2. Understand the goals of the clinic
    - Translate goals into indicator statements/metrics
    - Measure the impact of the unique goals of each clinic to improve access to care and patient outcomes
3. Measure the impact of the CDHC
    - CDHC workflow for each clinic
    - Utilize Dentrix system or cross-walk with other patient management systems

Report

A report will be prepared for each clinic to provide results and analysis on the case study. Examples of case studies include school outreach programs from pre-school through high school, improved patient access achieved through a mobile dental service coordinated by a CDHC, and establishment a program for dental screening and patient care coordination for diabetic patients.

A summary report will include descriptive statistics of the various scenarios in which a CDHC was evaluated as well as comparative analysis. CDHC activities will be reviewed and analyzed for rural, urban and tribal clinic settings.

CASE STUDY SUMMARIES: CDHC PILOT PROGRAM EVALUATION
September 2013

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 2: Elementary School Outreach

- During two outreach events, 63 children received dental screenings.
- Screenings indicated:
  - 47.6% of children had visible decay
  - 55.6% of children needed to improve oral hygiene
  - One child showed early signs of gingivitis
  - Two children reported dental pain

Case Study 5: Elementary School Outreach

- During 6 screening events, 139 children received dental screenings.
- Screenings included:
  - Oral health education
  - Oral hygiene instruction
  - Dietary recommendations
  - Oral health assessment
  - Triage for follow-up restorative and preventive care
- Recommendations for follow-up care were sent to parents/guardians.
- Due to the rural geographic area in which the clinic is located, it is evident that a barrier to access remains the inability to transport the children to the clinic.

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 9: Elementary School Outreach

- Over a seven-month period, 201 children received care in the elementary school.
- 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 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 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 14: Including HIV Patients in the Dental Service

- Starting December 2011, the CDHC educated clinic staff serving HIV patients in the medical clinic about oral health and dental referrals, and coordinated dental care for HIV patients.
- This analysis compares the pre-CDHC period (May 31, 2011 - May 31, 2012) to the post-CDHC period (June 1, 2012 - May 31, 2013).
  - Compared to the pre-CDHC period, the post-CDHC period saw the same number of HIV patients and delivered less care, but documented fewer missed appointments.
  - Care value per procedure and total care value per patient were no different.
  - Procedure mix was similar.
- Of the 32 HIV patients who had a visit at the clinic after May 2012, five (15.6%) were new to the clinic system.

Case Study 15: Outreach to the Local HIV Community

- Starting in April, 2012, the CDHC provided oral health education at local HIV support group meetings and assisted in identifying dental needs, scheduling care, and arranging transportation to and from dental appointments.
- The CDHC has participated as an outside speaker presenting HIV-specific information including:
  - education about the importance of oral health, how to maintain oral health, and how HIV affects oral health
  - distribution of free toothbrushes and dental floss
  - A question and answer session
  - Information about the dental clinic
- About one-third to one-half of the support group participants has seen a dentist in the past 6 months. The remaining participants have not received regular dental care.
- The CDHC has had the opportunity to discuss barriers to care with participants, including:
  - Recognizing the importance of regular oral health care
  - Lack of dental coverage/affording dental care
  - Lack of or difficulty with transportation
- The CDHC's collaboration with the HIV/AIDS program's support group has brought eight new patients to the dental clinic. A first visit includes:
  - Comprehensive exam
  - Routine x-rays
  - Dental cleaning (if hygienist is available)
- The CDHC helps participants with registration and medical history paperwork, scheduling future appointments, and explains payment options.

Case Study 16: Including Established Perinatal Patients in the Dental Service

- Starting December 2011, the CDHC educated staff in the perinatal clinic about oral health and dental referrals, and coordinated dental care for perinatal patients.
- This analysis compares the pre-CDHC period (May 31, 2011 - May 31, 2012) to the post-CDHC period (June 1, 2012 - May 31, 2013).
  - Compared to the pre-CDHC period, the post-CDHC period saw the same number of perinatal patients and documented the same number of missed appointments, but delivered more care.
  - Care value per procedure and total care value per patient were no different.
  - Procedure mix was similar.
- Of the 80 perinatal patients who had a visit at the clinic after May 2012, 34 (42.5%) were new to the clinic system.
- The post-CDHC period delivered more care and saw a larger total care value of $16,942, an increase of $2,041.
- The post-CDHC period saw a 29% increase[i] in number of perinatal patients, a 12% increase[i] in number of visits, and a 19% increase in number of procedures.

Case Study 17: Including Established Diabetes Patients in the Dental Service

- Starting December 2011, the CDHC educated staff in the diabetes clinic about oral health and dental referrals, and coordinated dental care for diabetes patients.
- This analysis compares the pre-CDHC period (May 31, 2011 - May 31, 2012) to the post-CDHC period (June 1, 2012 - May 31, 2013).
  - Compared to the pre-CDHC period, the post-CDHC period saw more diabetes patients and documented fewer missed appointments.
  - Care value per procedure and total care value per patient were no different.
  - Procedure mix was similar.
- Of the 179 diabetes patients who had a visit at the clinic after May 2012, 41 (22.9%) were new to the clinic system.
- The post-CDHC period saw a larger total care value of $57,063, an increase of $5,026.
- The post-CDHC period saw a 26% increase in number of diabetes patients, a 3% increase[ii] in number of visits, and a 5% increase[i] in number of procedures.

Case Study 18: Including Established Pediatric Patients in the Dental Service

- Starting December 2011, the CDHC educated staff in the pediatric clinic about oral health and dental referrals, and coordinated dental care for pediatric patients.
- This analysis compares the pre-CDHC period (May 31, 2011 - May 31, 2012) to the post-CDHC period (June 1, 2012 - May 31, 2013).
  - Compared to the pre-CDHC period, the post-CDHC period more pediatric patients, delivered more care, and documented fewer missed.
  - Care value per procedure was slightly higher during the pre-CDHC period, but total care value per patient was no different.
  - Procedure mix was similar.
- Of the 707 pediatric patients who had a visit at the clinic after May 2012, 195 (27.6%) were new to the clinic system.
- The post-CDHC period did see a larger total care value overall ($148,947) compared to the pre-CDHC period ($131,841), an increase of $17,106.
- The post-CDHC period saw a 19% increase in number of pediatric patients, a 14% increase in number of visits, and a 17% increase in number of procedures.

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%.

Case Study 24: Outreach to Rural Low-Wage Workers

- During 1 screening event, 9 adults received dental screenings.
  - Two adults received fluoride varnish, an estimated care value of $52.
- Three adults sought additional dental care at the dental clinic amounting to a care value of $740. Services included:
  - Oral evaluations
  - Oral hygiene instruction
  - Radiographs
  - Fluoride varnish
  - Prophylaxis
  - Restorative treatments

Case Study 25: Elementary School Outreach

- During eight days between January, 2011 and February 2012, 234 children received dental screenings. Fluoride varnish was provided for an estimated care value of $4,575.
- Sixty-six children sought additional dental care at the dental clinic amounting to a care value of $25,335. Services included oral evaluations, oral hygiene instruction, radiographs, fluoride varnish, sealants, prophylaxes, restorative procedures and oral surgical services

Case Study 26: Foster Children Outreach

- During two days at the dental clinic, 43 children received dental screenings. Fluoride varnish was provided for an estimated care value of $1,075.
- Sixteen children sought additional dental care at the dental clinic amounting to a care value of $5,176. Services included:
  - Oral evaluations
  - Oral hygiene instruction
  - Radiographs
  - Fluoride varnish
  - Sealants
  - Prophylaxis
  - Restorative procedures

Case Study 27: Early Childhood Outreach

- During one screening event at the local Head Start, special day school, and preschool, 28 children received dental screenings.
- Four children sought additional dental care at the dental clinic amounting to a care value of $1,335. Services included:
  - Oral evaluations
  - Oral hygiene instruction
  - Radiographs
  - Fluoride varnish
  - Prophylaxis
  - Restorative services
  - Oral surgical services

Case Study 28: Juvenile Detention Center Outreach

- During one screening event at the local juvenile detention center, 14 children received dental screenings.
- Five children sought additional dental care at the dental clinic amounting to a care value of $495. Services included:
  - Oral evaluations
  - Oral hygiene instruction
  - Radiographs
  - Fluoride varnish
  - Prophylaxis
  - Oral surgical services

Case Study 30: Pediatric Dental Outreach

- In May 2012, 40 children received dental screenings.
  - An estimated care value of $7,709 included:
    -Oral evaluations
    -Prophylaxis
    -Fluoride varnish
    -Dental sealants
    -Nutritional counseling
    -Oral health instruction
- Six children sought additional dental care at the dental clinic
  - A care value of $1,890 included:
    -Oral evaluations
    -Prophylaxis
    -Fluoride varnish
    -Dental sealants
    -Nutritional counseling
    -Oral health instruction
    -Restorative procedures

Case Study 31: Head Start Program Dental Screening Compliance

- In August and September 2012, 16 children received dental screenings.
  - An estimated care value of $3,584 included:
    -Oral evaluations
    -Fluoride varnish
    -Nutritional counseling
    -Oral health instruction
- Two children sought additional dental care at the dental clinic
  - A care value of $557 included:
    -Oral evaluations
    -Radiographs/imaging
    -Fluoride varnish
    -Prophylaxis
    -Nutritional counseling
    -Oral health instruction

Case Study 32: Dental Service at High School Medical Clinics

- Over 64 days the CDHC screened 206 members of the community at dental clinics set up in three local high schools.
- Twenty of those screened sought additional dental care at the dental clinic amounting to a care value of $7,469. Services included:
  - Oral evaluations
  - Radiographs and diagnostic imaging
  - Fluoride varnish
  - Prophylaxis
  - Restorative procedures
  - Oral surgical services

Case Study 41: Senior Center Outreach

- During three events at the local senior center, 27 senior citizens received dental screenings and preventive services. Estimated value of services provided = $1,222
- CDHC services included:
  - Denture cleanings
  - Consultation services
- A dental resident provided denture adjustments.

Case Study 49: Community Outreach to Low-Income Housing Residents

- During one day in January and two days in April, 2013, the CDHC conducted screenings for 19 low-income residents.
- A Medicaid worker assisted the CDHC in arranging screenings.

Case Study 50: Elementary School Outreach

- In February 2013 the CDHC gave two oral health presentations for 246 pre-K and first grade students and met with 22 adults from the school's resource and nursing committees to prepare.
- During one screening date in November 2012, the CDHC conducted screenings for 36 children, an estimated care value of $360. Services provided included:
  - Oral evaluations (provided by a dentist)
  - Prophylaxes

Case Study 53: Early Childhood (Ages 0 – 5) Outreach Program

- Between January and May 2013, 28 children who were referred by their pediatrician visited the dental clinic for care.
  - An estimated care value of $10,196 included:
    -Oral evaluations
    -Radiographs/diagnostic imaging
    -Prophylaxis
    -Fluoride varnish
    -Dental sealants
    -Nutritional counseling
    -Oral health instruction
    -Restorative services
    -Oral surgical services

Case Study 57: Outreach to Head Start Programs, Public Schools, and Emergency Departments

- The CDHC conducted screenings for 2,489 children during 17 events:
  - 5 at Head Start programs
  - 12 at public schools
- The CDHC and a dentist met with emergency department staff at 3 local hospital emergency rooms to:
  - explain services the dental clinic could provide for emergency room patients
  - explain the dental clinic's sliding fee schedule
  - provide brochures and contact sheets advertising the dental clinic

Case Study 64: Tweens (5^{th} – 8^{th} grades) Outreach

- During events at local dental centers, 57 children received dental screenings and preventive services. Estimated value of services provided = $1,086
- CDHC services included:
  - Fluoride varnish
  - Dental sealants
  - Consultation services
- Dentist services included:
  - Oral evaluations
  - Palliative treatment of dental pain

Case Study 65: Pre-School and Early Elementary Outreach

- During events at local pre-schools and elementary schools, 98 young children received dental screenings and preventive services. Estimated value of services provided = $3,397
- CDHC services included:
  - Prophylaxis
  - Fluoride varnish
  - Consultation services
- Dentist services included:
  - Oral evaluations
  - Palliative treatment of dental pain

Case Study 66: Senior Citizen Outreach

- 18 senior citizens received dental screenings and preventive services. Estimated value of services provided = $610
- CDHC services included:
  - Prophylaxis
  - Consultation services
- Dentist services included:
  - Oral evaluations
  - Palliative treatment of dental pain

Case Study 67: CDHC Coordinated Mobile Dental Service in Local Schools

- The CDHC conducted screenings for 86 children and parents over 6 days at five Head Start programs and one elementary school. The estimated value of care provided was $6,320.
- Services included:
  - Oral evaluations
  - Radiographs/diagnostic imaging
  - Prophylaxes
  - Fluoride varnish
  - Oral health instruction
- Of those screened, 68 had received services at the clinic, a care value of $9,277. Two of those patients had not been seen at the clinic prior to screening.
- In addition to preventive services, the clinic provided:
  - Restorative procedures
  - Maxillofacial prosthetic procedures
  - Oral surgery services

Case Study 68: Educational Community Service Events

- The CDHC organized 28 oral health education events, delivered 62 hours of oral health education, and traveled 740 miles between May 2012 and April 2013. Events included:
  - Radio spot about oral health
  - Week-long oral health information booth in the hospital lobby
  - Presentations/booths at health fairs
  - Educating future health care providers
- Events targeted various age groups, most commonly, preschool age children.
- Topics addressed included:
  - Health diet
  - Healthy brushing habits
  - Maxillofacial prosthetic procedures
  - Oral diseases/problems

Case Study 72: Patient Satisfaction Survey

- 94 patients were surveyed about satisfaction with services.
- Feedback from patients about the CDHC was positive overall.
- Two-thirds (68.3%) were “extremely satisfied,” while one-third (31.7%) were “satisfied.”

Case Study 76: Veteran and Rehabilitation Centers Outreach

- During two outreach events, 23 adults received dental screenings.
- Screenings indicated:
  - Eleven adults needed extractions
  - One adult requested extractions
  - Eight adults had decay
  - Six adults received prophylaxes
  - One adult reported dental pain

Case Study 77: Women, Infants and Children (WIC) Screening Program

- During four screening events at the for the local Women, Infants and Children (WIC) program, 46 mothers and 45 children received dental screenings.
- Services provided at screening were estimated at $6,150 and included:
  - Fluoride varnish
  - Dental Sealants
  - Radiographs
  - Prophylaxis
  - Oral evaluation (by dentist)
  - Restorative services (by dentist)
  - Hypertension screenings (during one event)
- Two mothers went to the dental clinic for comprehensive care totaling $428. Services included:
  - Oral evaluation
  - Radiographs
  - Oral surgical services

Case Study 78: Patient Satisfaction Survey

- 128 patients were surveyed about satisfaction with services.
- Feedback from patients about the CDHC was positive overall.
- Almost half (48.0%) were “extremely satisfied,” while the other half (49.6%) were “satisfied.” Three patients indicated that they were “neither satisfied nor dissatisfied.”

Case Study 79: High School Outreach

- During a presentation at the local high school, 37 students received oral health education. Estimated value of services provided = $999
- A dental resident accompanied the CDHC.

Case Study 80: Men’s Outreach

- During a one event, 6 participants of a local men’s program received dental services and preventive care. Estimated value of services provided = $256
- CDHC services included:
  - Prophylaxis
  - Consultation services
- A dental resident provided oral evaluations.

Case Study 81: High School Outreach

- During events at local dental centers, 28 students received dental screenings and preventive services. Estimated value of services provided = $900
- CDHC services included:
  - Prophylaxis
  - Consultation services
- Dentist services included:
  - Oral evaluations
  - Palliative treatment of dental pain

Case Study 82: Adult Outreach

- During events at local dental centers, 148 adults received dental screenings and preventive services. Estimated value of services provided = $4,680
- CDHC services included:
  - Consultation services
- Dentist services included:
  - Oral evaluations
  - Palliative treatment of dental pain

Case Study 83: Tom Joyner Outreach

- 15 patients between ages 16 and 72 received dental screenings and preventive services. Estimated value of services provided = $7,201
- CDHC services included:
  - Prophylaxis
  - Radiographs
  - Consultation services
- Dentist services included:
  - Oral evaluations
  - Restorative services
  - Oral surgery services
  - Palliative treatment of dental pain

Case Study 84: Infant/Toddler Outreach

- 91 infants and toddlers received dental screenings and preventive services. Estimated value of services provided = $4,779
- CDHC services included:
  - Fluoride varnish
- Dentist services included:
  - Oral evaluations
  - Palliative treatment of dental pain

Case Study 85: High School Outreach

- 253 high school students received screenings and other dental services. Estimated value of services provided at outreach = $116,463
- 103 students received dental services at the clinic, a care value of $116,027.
- Services at outreach and clinic included:
  - Oral evaluations
  - Prophylaxis
  - Radiographs
  - Fluoride application
  - Dental sealants
  - Restorative services
  - Endodontic services
  - Periodontic services
  - Oral surgery services

Case Study 86: Middle School Outreach

- 250 middle school students received screenings and other dental services. Estimated value of services provided at outreach = $90,499
- 101 students received dental services at the clinic, a care value of $95,188.
- Services at outreach and clinic included:
  - Oral evaluations
  - Prophylaxis
  - Radiographs
  - Fluoride application
  - Dental sealants
  - Restorative services
  - Endodontic services
  - Periodontic services
  - Oral surgery services

Case Study 87: Foster Children Outreach

- During two days in October 2012, the CDHC conducted screenings for twelve children at a local orphanage.
- The estimated value of care provided was $770. Services provided included:
  - Oral evaluations (provided by a dentist)
  - Prophylaxes
  - Fluoride varnish

Case Study 88: CDHC Activity Summary

- Overall the CDHC participated in 20 events between October 1, 2012 and May 12, 2013.
- The CDHC spent most of her time (81.5%) working in the dental clinic. Clinic activities included:
  - Clinic management
  - Dental assisting.
- The remainder of her time (18.5%) was spent on CDHC outreach-related activities in the field:
  - Community education (8 days)
  - Screenings (3 days)
  - Care delivery (3 days)
    -Oral exams
    -Prophylaxes
    -Fluoride varnish
    -Dental sealants
  - Other activities, i.e., trick-or-treat events, community festivals, health fairs (10 days)

[i] This increase was not statistically significant.
[ii] This increase was not statistically significant.

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 goal of the CDHC was to provide preventive services, promote oral health and, through patient navigation and care coordination, increase access to dental care. The CDHC worked on-site at the clinic providing a limited set of procedures to patients to support the diagnosis of dental disease by a dentist and providing 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

The case study measured the clinic utilization pre- and post-CDHC implementation; during the time periods 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.

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 ($p < .01$)[1].

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	Restorative procedures	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.

[1] 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 that they cannot be explained solely by the change in fees.

CDHC Case Study 2 Report: Elementary School Outreach

Introduction

The focus of this case study is a community health center which serves the surrounding American Indian rural community. 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 overall health. The CDHC arranged for screenings to occur at local elementary schools during the fall of 2010 and spring of 2011.

To measure the success of this goal, the current case study was conducted to answer the following questions. However, due to limitations of the collected data, not all questions could be answered reliably.

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 school?
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 school?
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 were collected from paper forms completed by the CDHC during elementary school screenings and were not entered into the clinic's patient management system. The current analysis reflects data from the time period during which children were screened by the CDHC. Data available for analysis were limited. Paper forms included only the minimal data needed to document screening for each child. No data about any post-screening care provided to these children was made available by the clinic.

Results

Findings demonstrate that the addition of the CDHC has aided in improving access to dental care among elementary school children in the community. During two outreach events in September and October 2010, the CDHC conducted screenings for 63 children. Decay was present in 47.6% of children screened. Oral hygiene was noted as good for 44.4% of children, while 55.6% were told they needed to improve their home care. One child showed early signs of gingivitis and two indicated dental pain during screening. Referrals were made for orthodontic care, sealants, fluoride varnish application and prophylaxis.

	Services Rendered[i]
Screenings	63
Oral Hygiene Instruction	35
Radiographs	27
Sealants	13
Prophylaxis	12
Restorations*	6

*Completed by dentist.

Summary:

Implementation of the CDHC for outreach led to providing dental services to children who may not have otherwise received them.

[i] NOTE: Interpret any frequencies of less than 30 with caution as they may not be statistically reliable.

CDHC Case Study 5 Report: Elementary School Outreach

Introduction

The focus of this case study is a community health center which serves the surrounding American Indian rural community.

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 overall health. The CDHC provided oral health instructions and screenings at local elementary schools during the fall of 2010 and spring of 2011 and made referrals for children needing comprehensive care (i.e., consultations, restorations, prophylaxis, and fluoride treatments).

To measure the success of this goal, the current case study was conducted to answer the following questions. However, due to limitations of the collected data, not all questions could be answered reliably.

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 school?
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 school?
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 were collected from paper forms completed by the CDHC during screenings and encounter data extracted from the clinic patient management system. The current analysis reflects data from the time period during which children were screened by the CDHC. Data available for analysis was limited. Paper forms included only the minimal data needed to document screening for each child. No clinical detail was provided in the data extracted from the clinic patient management system. Extracted encounter data was limited to comprehensive oral evaluation (D0150) visits.

Results

Findings demonstrate that the addition of the CDHC aided in improving access to dental care among elementary school children in the community. During six screening events between May 2010 and May 2011, the CDHC and a dentist from the clinic conducted screenings for 139 children. Eight of those children were screened twice. The screenings included an oral health assessment and triaged the children for follow-up restorative and preventive services (such as fluoride varnish and sealants). Oral health education was also provided including oral hygiene instruction and dietary recommendations. One child screened at school in May 2011 visited the clinic in May 2012.

Letters indicating services provided and recommendations for future treatment were sent to parents/guardians of each child screened. The letters sent also included contact and payment information for the clinic as well as a stated recommendation that cleanings should occur every six months to one year.

Summary:
Due to the limited data available for the case study, the only conclusion that can be made is the CDHC implemented an outreach program for elementary school children that resulted in screening for 139 children previously not seen at the clinic. Although recommendations were sent to the parents/guardians of the children for follow-up care, due to the rural geographic area in which the clinic is located, it is evident that a barrier to access remains in transporting children to the clinic. The clinic may wish to review means to overcome the transportation barrier and any others that prevent the children from receiving care.

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, a dentist would go from the dental clinic to the CDHC and patient in the diabetes clinic. Patients were referred to the dental clinic within the community health center for comprehensive dental care; 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 diabetic 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. Over a nine-month period, providing dental services *only one day per week*, the CDHC served 114 patients in the diabetic clinic at 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 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. These patients received about half as many comprehensive services (14.8%) as dental patients who were seen only at the dental clinic (28.9%).

	Diabetes Patients		Other Dental Patients	
	Frequency (number of procedures)	*Percent*	*Frequency* (number of procedures)	*Percent*
Screening and preventive	588	85.2%	35,584	71.1%
Comprehensive care	102	14.8	14,434	28.9

On average, a dental service provided to a diabetes patient was less expensive than one provided to a patient seen only in the dental clinic.

	Mean	*Median*[1]	*S.D.*	*Minimum*	*Maximum*	*N (procedures)*
Diabetes Clinic	$66	$39	$ 44	$0	$ 207	690
Dental Clinic	94	50	192	0	5,200	50,018

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.

	Mean	*Median*[1]	*S.D.*	*Minimum*	*Maximum*	*N (patients)*
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.

	Mean	*Median*[1]	*S.D.*	*Minimum*	*Maximum*	*N (patients)*
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. Among patients who were seen only at the dental clinic, more comprehensive care services were provided compared to patients who were seen at the diabetes clinic.

	Patients seen at Diabetes Clinic		Patients seen at Dental Clinic	
	Frequency	*Percent*	*Frequency*	*Percent*
Preventive procedures	465	67.4%	20,037	40.1%
Screening	123	17.8	15,547	31.1
Periodontic procedures	94	13.6	1,359	2.7
Restorative procedures	5	0.7	4967	9.9
Adjunctive general services	2	0.3	4824	9.6
Maxillofacial prosthetics	1	0.1	623	1.2
Endodontic procedures	0	0.0	265	0.5
Implant services	0	0.0	60	0.1
Oral and maxillofacial surgery	0	0.0	1365	2.7
Prosthodontic procedures	0	0.0	70	0.1
Orthodontic	0	0.0	901	1.8

Of the total number of dental procedures provided in the diabetes clinic by the CDHC, 175 procedures (dental services) were billable and provided to 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	
	Frequency	*Percent*
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
Temporization	0	0.0

[1] Please note that median is the most representative statistic throughout this report. Means are highly influenced by extreme values, and thus do not provide the best picture for what is "typical" of a given patient or visit.

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 practice 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 children 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 children to receive comprehensive care and followed up with screened children 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 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 school?
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 school?
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 – 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 children 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 children in the community. Over a seven-month period, the CDHC served 201[1] 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 children came to the clinic 56[2] 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

Patients:	**201**
Visits:	**436**
Procedures:	**1,818**

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, children had 2 visits, 4 dental procedures (dental services) per visit, and received $442 of total care, or $204 of care per visit.

	Mean	*Median*[3]	*S.D.*	*Minimum*	*Maximum*	*N (children)*
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

		Frequency[4]	*Percent*
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
	TOTAL	1,818	100.0

Dental Care in the Dental Clinic

Patients:	**74**
Visits:	**137**
Procedures:	**546**
New Patients:	**61**

On average, children had 2 visits, 4 dental procedures (dental services) per visit, and received $562 of total care, or $304 of care per visit.

	Mean	*Median*[3]	*S.D.*	*Minimum*	*Maximum*	*N (children)*
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

		Frequency[4]	*Percent*	*Fee (per procedure)*
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	Restorative procedures	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 children 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[5]*.* Sixty-one of the elementary 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 75 days after screening at the school (mean=74.9,). Over half (50.9%) of these children visited the clinic within two months of their screening at school (median=56.0).

Time between screening and clinic visit	*Frequency*[4]	*Percent*
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

[1] This is the number of children at outreach who received care designated by ADA CDT service codes. Children who refused care or did not receive care for other reasons are not included in this analysis.
[2] 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.
[3] The median value is the most representative statistic throughout this report given the influence of extreme outliers.
[4] NOTE: Interpret any frequencies of less than 30 with caution as they may not be statistically reliable.
[5] 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 December 2010 to September 2011 for which appointment data was collected.

CDHC Case Study 11 Report: Pre-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 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[1] 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[2] 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

Patients:	**240**
Visits:	**390**
Procedures:	**2,141**

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.

	Mean	*Median*[3]	*S.D.*	*Minimum*	*Maximum*	*N (children)*
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	
		Frequency[4]	*Percent*
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	Restorative procedures	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.

	Mean	*Median*[3]	*S.D.*	*Minimum*	*Maximum*	*N* (children)
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

		Frequency[4]	*Percent*	*Fee (per procedure)*
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	Restorative procedures	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
	TOTAL	806	100.0	--

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[5]. 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 139 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).

Time between screening and clinic visit	*Frequency*[4]	*Percent*
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

[1] 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.
[2] 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.
[3] The median value is the most representative statistic throughout this report given the influence of extreme outliers.
[4] NOTE: Interpret any frequencies of less than 30 with caution as they may not be statistically reliable.
[5] 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.

CDHC Case Study 12 Report: Elementary 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 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[1] 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[2] 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

Patients:	**583**
Visits:	**1,023**
Procedures:	**7,711**

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.

	Mean	*Median*[3]	*S.D.*	*Minimum*	*Maximum*	*N (children)*
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

		Frequency[4]	*Percent*
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	Restorative procedures	577	7.5
D4000-D4999	Periodontics	5	0.1
	TOTAL	7,711	100.0

Dental Care in the Dental Clinic

Patients:	**397**
Visits:	**896**
Procedures:	**3,618**
New Patients:	**234**

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.

	Mean	*Median*[3]	*S.D.*	*Minimum*	*Maximum*	*N (children)*
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

		Frequency[4]	*Percent*	*Fee (per procedure)*
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	Restorative procedures	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[5]*.* 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 93 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).

Time between screening and clinic visit	*Frequency*[4]	*Percent*
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

[1] 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.
[2] 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.
[3] The median value is the most representative statistic throughout this report given the influence of extreme outliers.
[4] NOTE: Interpret any frequencies of less than 30 with caution as they may not be statistically reliable.
[5] 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.

CDHC Case Study 14 Report: Including Clinic HIV Patients in the Dental Service

Introduction

The focus for this case study is a dental clinic housed within an urban community health center. Prior to entering the CDHC pilot training program, the CDHC practiced as a dental assistant expanded function dental assistant. Post-training, the CDHC has focused on disease-specific outreach initiatives which target staff and patients from four areas in the health center: medical, perinatal, diabetes, and pediatric.

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 the clinic's HIV patients in order to help them maintain their overall health. Starting December 2011, the CDHC educated clinic staff serving HIV patients in the medical clinic about oral health and dental referrals, and coordinated dental care for HIV patients.

To measure the success of this goal, the current case study answers the following questions:

1. Did outreach to other departments result in HIV patients visiting the dental clinic?
2. How many HIV patients resulted from the CDHC's work?
3. How many HIV patients were new to the dental clinic?
4. What types of dental services were provided to HIV patients at the dental clinic?
5. What was the value of the dental care provided to HIV patients at the dental clinic?
6. What was the missed appointment rate for HIV patients who had appointments at the dental clinic?

Data Collection and Analysis

Dental and medical data were extracted from the health center's patient management system. The current analysis focuses on dental patient encounters with HIV patients (ages 29 to 69) occurring between May 31, 2011 and May 31, 2013. The CDHC began HIV clinic intervention in June 2012. The current analysis compares the pre-CDHC period (May 31, 2011 - May 31, 2012) to the post-CDHC period (June 1, 2012 - May 31, 2013). Chi-square tests (x^2) and t-tests (*t)* were conducted to compare the differences between the pre-CDHC and post-CDHC periods.

Results

Overall Change after CDHC Implementation

Pre-CDHC and post-CDHC, not all differences were statistically significant. Compared to the pre-CDHC period, the post-CDHC period saw the same number of HIV patients and delivered less care, but documented fewer missed appointments (see Table 1). Care value per procedure and total care value per patient were no different between the pre-CDHC and post-CDHC periods (see Table 2). Procedure mix was similar for both periods (see Table 3).

Table 1. Pre-CDHC versus Post-CDHC Summary

	Pre-CDHC	*Post-CDHC*	X^2	*p*
Patients[i]	41	32	1.1096	> .05
Procedures	219	149	13.3152	< .01 *
Visits	101	68	6.4438	< .05 *
Missed appointments	83	40	15.0325	< .01 *
Total care value	$15,753	$11,346	--	--

* indicates a significant difference between pre-CDHC and post-CDHC periods.

Table 2. Pre-CDHC versus Post-CDHC Care Value

	Mean	*Median*	*S.D.*	*Minimum*	*Maximum*	*N*
Total care value per patient						
Pre-CDHC	$384	241	402	82	1,999	41
Post-CDHC	$366	246	316	123	1,522	31
NS						
Care value per procedure						
Pre-CDHC	$ 73	53	82	10	698	217
Post-CDHC	$ 77	53	84	10	726	147
NS						

Table 3. CDHC Services Provided Pre- and Post-CDHC Implementation

		Pre-CDHC *Number of Procedures*	*Post-CDHC* *Number of Procedures*
D0120 - D0150	Oral evaluations	39	31
D0220 - D0330	Radiographs/diagnostic imaging	60	34
D1120	Prophylaxis	28	22
D2140 - D2751	Restorative procedures	44	37
D4341	Periodontal procedures	2	0
D5211 – D5422	Maxillofacial prosthetic procedures	6	12
D7140	Oral surgical services	35	10
D9110	Palliative treatment of dental pain	4	3
D9430	Observation	1	0
	Total	**219**	**149**

New Patients

New HIV patients were defined as those who did not have a visit between March 2010 and May 2012. Of the 32 HIV patients who had a visit at the clinic after May 2012, five (15.6%) were new.

Summary

Despite decreases from pre-CDHC to post-CDHC, the post-CDHC period documented fewer missed appointments. The total care value was less ($11,346) during the post-CDHC period, a decrease of $4,407. Additionally, the post-CDHC period saw a 22% decrease[ii] in number of HIV patients, a 33% decrease in number of visits, and a 32% decrease in number of procedures.

[i] Some patients are represented in each time period.
[ii] This decrease was not statistically significant.

CDHC Case Study 15 Report: Outreach to the Local HIV Community

Introduction

The focus for this case study is a dental clinic housed within an urban community health center. Prior to entering the CDHC pilot training program, the CDHC practiced an expanded function dental assistant. Post-training, the CDHC has focused on disease-specific outreach initiatives which target staff and patients from four areas in the health center: medical, perinatal, diabetes, and pediatric.

For this initiative, the goals of the CDHC were to provide preventive services, promote oral health and, through patient navigation and care coordination, increase access to dental care for the local HIV community in order to help them maintain oral and overall health. Starting in April, 2012, the CDHC provided oral health education at local HIV support group meetings and assisted in identifying dental needs, scheduling care, and arranging transportation to and from dental appointments.

To measure the success of these goals, this case study answers the following questions:

1. How many patients resulted from the outreach to the HIV support group program?
2. How does the support group function and what is the role of the CDHC?
3. Which specific barriers to care have these patients experienced?
4. What is the process for helping these patients get into the dental clinic?
5. What types of services did these patients receive at the dental clinic?

Data Collection

This case study was purely qualitative. Information about outreach to the HIV community was gathered from a narrative prepared by the CDHC, based on the questions below. The narrative described the support group and the CDHC's role there, support group participants and their dental needs, and services provided and logistics of dental appointments for these patients.

1. What happens at a support group meeting?
2. What are the dental needs of support group participants?
3. What types of difficulties do participants face in getting dental care?
4. How many patients have come to the clinic, or have made plans to come to the clinic as a result of CDHC attendance at support group meetings?
5. What types of services are provided to support group participants at the dental clinic?

Results

The Support Group and the CDHC's Role

A local ethnic community organization runs an HIV/AIDS care services program. This HIV/AIDS support group is one of many other services available to HIV/AIDS patients through the program. The group meets 4 days per week from 11:00 AM to 12:30 PM and is facilitated by a case manager.

Support group participants typically learn about the group through street education and HIV testing; referrals are made when a patient tests positive for HIV. Attendance is usually between 10 and 30 participants, all HIV positive.

External speakers visit the group occasionally, always on a Wednesday. The CDHC has participated as an outside speaker at the support group as part of the clinic's outreach plan. He presented HIV-specific information to educate participants about the importance of oral health, how to maintain oral health, and how HIV affects oral health, and distributed free toothbrushes and dental floss. Time was also set aside for questions, and the CDHC provided information about the dental clinic where he works as well as information about two free HIV dental clinics in the area. After the CDHC's presentation, the case manager made plans with 4 to 6 participants to visit the clinic in the following two weeks.

The Participants and Barriers to Care
The CDHC estimated that typically one-third to one-half of the support group participants have seen a dentist in the past 6 months. The remaining participants have not received regular dental care. The case manager worked with the CDHC to organize dental visits for participants in need of dental care; typically these needs were significant. Dental visits were scheduled to occur at the same time as the support group meetings each week. The CDHC blocked the dentists' schedules to accommodate participants.

The CDHC has had the opportunity to discuss barriers to care with participants. Many do not recognize the importance of regular oral health care. Others do not have dental coverage and cannot afford the costs of regular dental care.

Because transportation can be problematic for support group participants, the HIV/AIDS program provided transportation to and from the dental clinic and support group location for the first dental visit. The program has additional resources to help participants pay for transportation to and from follow-up dental visits.

Dental Services Provided
The CDHC's collaboration with the HIV/AIDS program's support group has brought in eight participants who had not previously received care at the dental clinic.

As new patients, each program participant who visits the clinic receives a comprehensive exam and routine x-rays. If the hygienist is available at the time of the appointment, she provides a cleaning. For patients without dental coverage, first visit services are provided pro bono; follow-up visits must be paid out-of-pocket.

The CDHC helps participants with registration and medical history paperwork. He greets them upon arrival at the clinic and assists in checking insurance, registration, walks them to the dental chair, and helps schedule follow-up visits. He also explains payment for services; for example, the first visit is free but additional visits must be paid out-of-pocket if a patient has no dental coverage.

CDHC Assessment
The CDHC has felt well-received by support group participants. Additionally he noted that the case management for this program is particularly comprehensive, which he believes may increase the potential for access to oral health resources for these participants compared to participants of other programs.

Summary
Implementation of the CDHC has helped provide access to care for HIV patients. This has helped patients address their dental needs and has assisted in the HIV/AIDS program meeting the dental needs of participants.

CDHC Case Study 16 Report

Introduction

The focus for this case study is a dental clinic housed within an urban community health center. Prior to entering the CDHC pilot training program, the CDHC practiced an expanded function dental assistant. Post-training, the CDHC has focused on disease-specific outreach initiatives which target staff and patients from four areas in the health center: medical, perinatal, diabetes, and pediatric.

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 the clinic's perinatal patients in order to help them maintain their oral and overall health. Starting December 2011, the CDHC educated staff in the perinatal clinic about oral health and dental referrals, and coordinated dental care for perinatal patients.

To measure the success of this goal, the current case study answers the following questions:

1. Did outreach to other departments result in perinatal patients visiting the dental clinic?
2. How many perinatal patients resulted from the CDHC's work?
3. How many perinatal patients were new to the dental clinic?
4. What types of dental services were provided to perinatal patients at the dental clinic?
5. What was the value of the dental care provided to perinatal patients at the dental clinic?
6. What was the missed appointment rate for perinatal patients who had appointments at the dental clinic?

Data Collection and Analysis

Dental and medical data were extracted from the health center's patient management system. The current analysis focuses on dental patient encounters with perinatal patients (ages 13 to 56) occurring between May 31, 2011 and May 31, 2013. The CDHC began perinatal intervention in June 2012. The current analysis compares the pre-CDHC period (May 31, 2011 - May 31, 2012) to the post-CDHC period (June 1, 2012 - May 31, 2013). Chi-square tests (x^2) and t-tests (*t)* were conducted to compare the differences between the pre-CDHC and post-CDHC periods.

Results

Overall Change after CDHC Implementation

Pre-CDHC and post-CDHC, not all differences were statistically significant. Compared to the pre-CDHC period, the post-CDHC period saw the same number of perinatal patients and documented the same number of missed appointments, but delivered more care (see Table 1). Care value per procedure and total care value per patient were no different between the pre-CDHC and post-CDHC periods (see Table 2). Procedure mix was similar for both periods (see Table 3).

Table 1. Pre-CDHC versus Post-CDHC Summary

	Pre-CDHC	*Post-CDHC*	X^2	*p*
Patients[i]	62	80	2.2817	> .05
Procedures	238	284	4.0536	< .05 *
Visits	116	130	0.7967	> .05
Missed appointments	97	102	0.1256	> .05
Total care value	$14,901	$16,942	--	--

* indicates a significant difference between pre and post groups.

Table 2. Pre-CDHC versus Post-CDHC Care Value

	Mean	*Median*	*S.D.*	*Minimum*	*Maximum*	*Number patients/ procedures*
Total care value per patient						
Pre-CDHC	240	153	192	45	811	62
Post-CDHC	212	148	190	45	1098	80
Difference not significant						
Care value per procedure						
Pre-CDHC	63	53	49	10	651	238
Post-CDHC	60	45	35	10	180	283
Difference not significant						

Table 3. CDHC Services Provided Pre- and Post-CDHC Implementation

		Pre-CDHC *Number of Procedures*	*Post-CDHC* *Number of Procedures*
D0120 - D0150	Oral evaluations	58	76
D0220 - D0330	Radiographs/diagnostic imaging	51	79
D1110, D1120	Prophylaxis	52	53
D1203	Fluoride varnish	2	1
D1351	Dental sealants	1	0
D2140 - D2751	Restorative procedures	57	50
D7140, D7999	Oral surgical services	11	17
D9110	Palliative treatment of dental pain	6	8
	Total	**238**	**284**

New Patients

New perinatal patients were defined as those who did not have a visit between March 2010 and May 2012. Of the 80 perinatal patients who had a visit at the clinic after May 2012, 34 (42.5%) were new.

Summary

Despite the similarities between the pre-CDHC and post-CDHC periods, the post-CDHC period delivered more care and saw a larger total care value of $16,942, an increase of $2,041. Overall, the post-CDHC period saw a 29% increase[ii] in number of perinatal patients, a 12% increase[ii] in number of visits, and a 19% increase in number of procedures.

[i] Some patients visited the clinic during both time periods, so they are counted in the pre-CDHC group and in the post-CDHC group.
[ii] This increase was not statistically significant.

CDHC Case Study 17 Report: Including Established Diabetes Patients in the Dental Service

Introduction

The focus for this case study is a dental clinic housed within an urban community health center. Prior to entering the CDHC pilot training program, the CDHC practiced as a dental assistant expanded function dental assistant. Post-training, the CDHC has focused on disease-specific outreach initiatives which target staff and patients from four areas in the health center: medical, perinatal, diabetes, and pediatric.

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 the clinic's diabetes patients in order to help them maintain their oral and overall health. Starting December 2011, the CDHC educated staff in the diabetes clinic about oral health and dental referrals, and coordinated dental care for diabetes patients.

To measure the success of this goal, the current case study answers the following questions:

1. Did outreach to other departments result in diabetes patients visiting the dental clinic?
2. How many diabetes patients resulted from the CDHC's work?
3. How many diabetes patients were new to the dental clinic?
4. What types of dental services were provided to diabetes patients at the dental clinic?
5. What was the value of the dental care provided to diabetes patients at the dental clinic?
6. What was the missed appointment rate for diabetes patients who had appointments at the dental clinic?

Data Collection and Analysis

Dental and medical data were extracted from the health center's patient management system. The current analysis focuses on dental patient encounters with diabetes patients (ages 8 to 90) occurring between May 31, 2011 and May 31, 2013. The CDHC began diabetes intervention in June 2012. The current analysis compares the pre-CDHC period (May 31, 2011 - May 31, 2012) to the post-CDHC period (June 1, 2012 - May 31, 2013). Chi-square tests (x^2) and t-tests (*t)* were conducted to compare the differences between the pre-CDHC and post-CDHC periods.

Results

Overall Change after CDHC Implementation

Pre-CDHC and post-CDHC, not all differences were statistically significant. Compared to the pre-CDHC period, the post-CDHC period saw more diabetes patients and documented fewer missed appointments (see Table 1). Care value per procedure and total care value per patient were no different between the pre-CDHC and post-CDHC periods (see Table 2). Procedure mix was similar for both periods (see Table 3).

Table 1. Pre-CDHC versus Post-CDHC Summary

	Pre-CDHC	*Post-CDHC*	X^2	*P*
Patients[i]	142	179	4.2648	< .05 *
Procedures	751	792	1.0894	> .05
Visits	366	376	0.1348	> .05
Missed appointments	203	157	5.8778	< .05 *
Total care value	52,037	57,063	--	--

* indicates a significant difference between pre and post groups.

Table 2. Pre-CDHC versus Post-CDHC Care Value

	Mean	*Median*	*S.D.*	*Minimum*	*Maximum*	*Number patients/ procedures*
Total care value per patient						
Pre-CDHC	366	228	372	45	2288	142
Post-CDHC	328	198	369	45	2285	174
Difference not significant						
Care value per procedure						
Pre-CDHC	70	53	78	10	726	740
Post-CDHC	74	53	88	10	726	776
Difference not significant						

Table 3. CDHC Services Provided Pre- and Post-CDHC Implementation

		Pre-CDHC *Number of Procedures*	*Post-CDHC* *Number of Procedures*
D0120 - D0150	Oral evaluations	144	194
D0220 - D0330	Radiographs/diagnostic imaging	206	203
D1110, D1120	Prophylaxis	121	115
D1203	Fluoride varnish	0	1
D2140 - D2751	Restorative procedures	157	125
D3310, D3320	Endodontic procedures	5	1
D4341, D4910	Periodontal procedures	29	10
D5110, D5731	Maxillofacial prosthetic procedures	19	40
D7111, D7140	Oral surgical services	58	87
D9110	Palliative treatment of dental pain	12	16
	Total	**759**	**792**

New Patients

New diabetes patients were defined as those who did not have a visit between March 2010 and May 2012. Of the 179 diabetes patients who had a visit at the clinic after May 2012, 41 (22.9%) were new.

Summary

Compared to the pre-CDHC period, the post-CDHC period saw more diabetes patients and documented fewer missed appointments. Additionally, the post-CDHC period saw a larger total care value of $57,063, an increase of $5,026. Overall, the post-CDHC period saw a 26% increase in number of diabetes patients, a 3% increase[ii] in number of visits, and a 5% increase[ii] in number of procedures.

[i] Some patients visited the clinic during both time periods, so they are counted in the pre-CDHC group and in the post-CDHC group.
[ii] This increase was not statistically significant.

CDHC Case Study 18 Report: Including Established Pediatric Patients in the Dental Service

Introduction

The focus for this case study is a dental clinic housed within an urban community health center. Prior to entering the CDHC pilot training program, the CDHC practiced as a dental assistant expanded function dental assistant. Post-training, the CDHC has focused on disease-specific outreach initiatives which target staff and patients from four areas in the health center: medical, perinatal, diabetes, and pediatric.

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 the clinic's pediatric patients in order to help them maintain their oral and overall health. Starting December 2011, the CDHC educated staff in the pediatric clinic about oral health and dental referrals, and coordinated dental care for pediatric patients.

To measure the success of this goal, the current case study answers the following questions:

1. Did outreach to other departments result in pediatric patients visiting the dental clinic?
2. How many pediatric patients resulted from the CDHC's work?
3. How many pediatric patients were new to the dental clinic?
4. What types of dental services were provided to pediatric patients at the dental clinic?
5. What was the value of the dental care provided to pediatric patients at the dental clinic?
6. What was the missed appointment rate for pediatric patients who had appointments at the dental clinic?

Data Collection and Analysis

Dental and medical data were extracted from the health center's patient management system. The current analysis focuses on dental patient encounters with pediatric patients (ages 1 to 17) occurring between May 31, 2011 and May 31, 2013. The CDHC began pediatric intervention in June 2012. The current analysis compares the pre-CDHC period (May 31, 2011 - May 31, 2012) to the post-CDHC period (June 1, 2012 - May 31, 2013). Chi-square tests (x^2) and t-tests (*t)* were conducted to compare the differences between the pre-CDHC and post-CDHC periods.

Results

Overall Change after CDHC Implementation

Pre-CDHC and post-CDHC, all differences were statistically significant. Compared to the pre-CDHC period, the post-CDHC period saw more pediatric patients, delivered more care, and documented fewer missed appointments (see Table 1 below). Care value per procedure was slightly higher during the pre-CDHC period, but total care value per patient was no different between the pre-CDHC and post-CDHC periods (see Table 2). Procedure mix was similar for both periods (see Table 3).

Table 1. Pre-CDHC versus Post-CDHC Summary

	Pre-CDHC	*Post-CDHC*	X^2	*P*
Patients[i]	593	707	9.9969	< .01 *
Procedures	3,012	3,526	40.4093	< .01 *
Visits	944	1,077	8.7526	< .01 *
Missed appointments	876	782	5.3293	< .05 *
Total care value	$131,841	$148,947	--	--

* indicates a significant difference between pre and post groups.

Table 2. Pre-CDHC versus Post-CDHC Care Value

	Mean	*Median*	*S.D.*	*Minimum*	*Maximum*	*Number patients/ procedures*
Total care value per patient						
Pre-CDHC	222	165	169	45	1,734	593
Post-CDHC	211	144	160	45	1,852	707
Difference not significant						
Care value per procedure*						
Pre-CDHC	44	43	30	10	698	3,012
Post-CDHC	42	43	24	10	180	3,526
t = -2.26, p < .05						

* indicates a significant difference between pre and post groups.

Table 3. CDHC Services Provided Pre- and Post-CDHC Implementation

		Pre-CDHC *Number of Procedures*	*Post-CDHC* *Number of Procedures*
D0120 - D0150	Oral evaluations	647	795
D0220 - D0330	Radiographs/diagnostic imaging	658	828
D1110, D1120	Prophylaxis	637	738
D1203 - D1208	Topical fluoride	545	642
D1351	Dental sealants	157	157
D2140 - D2751	Restorative procedures	290	279
D3220 - D3320	Endodontic procedures	14	8
D5211	Maxillofacial prosthetic procedures	1	0
D7111, D7140	Oral surgical services	58	69
D9110	Palliative treatment of dental pain	5	10
	Total	**3,012**	**3,526**

New Patients

New pediatric patients were defined as those who did not have a visit between March 2010 and May 2012. Of the 707 pediatric patients who had a visit at the clinic after May 2012, 195 (27.6%) were new.

Summary

Despite the lower care value per procedure, the post-CDHC period did see a larger total care value overall ($148,947) compared to the pre-CDHC period ($131,841), an increase of $17,106. Overall, the post-CDHC period saw a 19% increase in number of pediatric patients, a 14% increase in number of visits, and a 17% increase in number of procedures.

[i] Some patients visited the clinic during both time periods, so they are counted in the pre-CDHC group and in the post-CDHC group.

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 children 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 of 2011. The high school was not open during summer months. The CDHC also scheduled appointments at the dental clinic for children to receive comprehensive care and followed up with screened children 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 children came to the dental clinic through the CDHC's high school outreach program?
2. Did the high school outreach activities result in the screened children visiting the clinic?
3. What types of dental services were provided to children at the dental clinic?
4. What was the value of the dental care provided to children at the dental clinic?
5. What was the missed appointment rate for children 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 children 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 children 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 children in the community. Over a seven-month period, the CDHC served 30[1] children in the high school for a total of 50 school visits over 21 days. Sixteen of those 30 children 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 children 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 children at the dental clinic during that seven month period.

High School Outreach Events

Patients:	**30**
Visits:	**50**
Procedures:	**211**

Overall, there were differences in the types of services provided to the 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, children had 2 visits, 4 dental procedures (dental services) per visit, and received $387 of total care, or $232 of care per visit.

	Mean	*Median*[2]	*S.D.*	*Minimum*	*Maximum*	*N (children)*
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	
		Frequency[3]	*Percent*
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, children had 2 visits, 3 dental procedures (dental services) per visit, and received $450 of total care, or $240 of care per visit.

	Mean	*Median*[2]	*S.D.*	*Minimum*	*Maximum*	*N (children)*
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[3]	*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	Restorative procedures	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 children 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[4]*.* Five of the high school 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. Two of five of these children visited the clinic within one month of their screening at school, one within two to three months, and two over four months after screening.

[1] This is the number of children at outreach who received care designated by ADA CDT service codes. Children who refused care or did not receive care for other reasons are not included in this analysis.
[2] The median value is the most representative statistic throughout this report given the influence of extreme outliers for variables reported.
[3] NOTE: Interpret any frequencies of less than 30 with caution as they may not be statistically reliable.
[4] 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 high school; this definition is based on the time period from December 2010 to September 2011 for which appointment data was collected.

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 senior citizens to receive comprehensive care and followed up with screened senior citizens 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 senior citizens 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 citizens?
4. What was the value of the dental care provided to senior citizens?
5. What was the missed appointment rate for senior citizens who received dental care in the elder care center compared to the missed appointment rate for all senior citizens 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 senior citizens 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 ten-month period, providing dental services one day per week (for a total of 35 days), the CDHC served 119[1] 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 senior citizens came to the clinic 56[2] 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

Patients:	**119**
Visits:	**178**
Procedures:	**611**

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, senior citizens 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.

	Mean	*Median*[3]	*S.D.*	*Minimum*	*Maximum*	*N (senior citizens)*
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

		Frequency[4]	*Percent*
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	Restorative procedures	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, senior citizens had 3 visits, 3 dental procedures (dental services) per visit, and received $1,020 of total care, or $360 of care per visit.

	Mean	*Median*[3]	*S.D.*	*Minimum*	*Maximum*	*N (senior citizens)*
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

		Frequency[4]	*Percent*	*Fee (per procedure)*
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	Restorative procedures	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
	TOTAL	869	100.0	--

For senior citizen senior citizens 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[5]. 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 senior citizens 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).

Time between screening and clinic visit	*Frequency*[3]	*Percent*
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

[1] This is the number of senior citizens at outreach who received care designated by ADA CDT service codes. Those who refused care or did not receive care for other reasons are not included in this analysis.
[2] Median is reported here due to the skewed distribution of number of days between school visit and dental clinic visit. The mean was about 65 days.
[3] The median value is the most representative statistic throughout this report given the influence of extreme outliers for variables reported.
[4] NOTE: Interpret any frequencies of less than 30 with caution as they may not be statistically reliable.
[5] For the purposes of this report, a "new patient" is defined as a senior citizen 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.

CDHC Case Study 24 Report: Outreach to Rural Low-Wage Workers

Case Study Description

The focus for this case study is an outreach program designed to provide dental services for working adults from the local rural community who otherwise would not receive care. 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 these adults in order to help them maintain overall health. The CDHC arranged for a screening event. Patients in need of comprehensive care were referred to the dental clinic.

To measure the success of this goal, the current case study answers the following questions.

1. How many adults received dental services through the screening event?
2. What types of dental services were provided to adults at the screening event?
3. What types of dental services were provided to adults at the dental clinic?
4. What was the value of the dental care provided to adults at the screening event?

Data Collection

Data were extracted from the clinic's patient management system, patient records from outreach, and additional documentation of outreach events. The current analysis focuses on the time period from January 2011 through June 2012. Data reflect services provided at outreach events as well as comprehensive care provided in the dental clinic.

Results

Findings demonstrate that the addition of the CDHC at this clinic aided in improving access to dental care among adults in a rural community. During one event in July 2011, the CDHC conducted screenings for 9 adults and provided fluoride varnish treatments for two of those adults. Based on the dental clinic's fee schedule, the estimated value of the care provided at this event was $52.

Three adults went to the clinic for additional care. One adult came to the clinic a day later, another two months later, and the third over eight months later. This third patient had received fluoride varnish treatment at the time of screening. Dental services provided at the clinic for all 3 adults amounted to a care value of $740 and included oral evaluations, oral hygiene instruction, radiographs, fluoride varnish, prophylaxis, and restorative treatments.

Summary:

Implementation of the CDHC for outreach led to providing dental services to adults who may not have otherwise received them.

CDHC Case Study 25 Report: Elementary School Outreach

Introduction

The focus for this case study is an outreach program designed to provide dental services for elementary school children who otherwise would not receive care. For this initiative, the goals of the CDHC were 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 overall health. Outreach work has been a collaborative effort with the local public health service and dental task force composed of representatives from the county's public health department, commission on children and families, child care council, office of education, migrant education, local Head Start and Early Head Start programs, community health plan, as well as local pediatricians and dental professionals.

Two CDHCs coordinated the use of the county's mobile dental van service and arranged for screenings at nine rural elementary schools across two rural communities during fall 2011 and spring 2012. One dentist from the clinic assisted the CDHC in offering dental screenings and fluoride varnish treatments. Children in need of comprehensive care were referred to the dental clinic.

To measure the success of these goals, the current case study answers the following questions.

1. How many children received dental services through elementary school outreach?
2. What types of dental services were provided to children at the elementary school outreach?
3. What types of dental services were provided to children at the dental clinic?
4. What was the value of the dental care provided to children at the dental clinic?
5. How much time elapsed between screening and care delivery at the dental clinic?

Data Collection

Data were extracted from the clinic's patient management system, patient records from outreach, and additional documentation of outreach events. The current analysis focuses on the time period of January 2011 through June 2012. Data reflect services provided at outreach events as well as comprehensive care provided in the dental clinic.

Results

Findings demonstrate that the addition of the CDHC aided in improving access to dental care among children at nine rural elementary schools. One school was within one mile of the closest dental clinic with a CDHC. The other schools were 15 miles or farther from the nearest dental clinic with a CDHC.

During eight days of outreach between January, 2011 and February 2012, the CDHC conducted a total of 282 screenings for 234 children. Forty-eight of the 234 children had two screenings; they were screened once in 2011 and again in 2012. During events, children received screenings and fluoride varnish treatments. Based on the dental clinic's fee schedule, the estimated value of the care provided at these events was about $4,575.

Of the 282 screenings, 86.2% indicated poor oral hygiene, and 16% indicated a need for immediate dental care. Recommendations were made for prophylaxis, dental sealants, and radiographs.

Screening Data

	Percentage of screenings	*Number of screenings*
Signs of decay	34.8%	98
Signs of periodontal disease	36.2%	102
Dental sealants recommended	55.3%	156
Dental prophylaxis recommended	19.5%	55
Radiographs recommended	87.6%	247
Fluoride varnish provided	64.9%	183

Sixty-six children went to the dental clinic for additional care after screening; 75% were seen in the clinic within six months of screening. Dental services provided at the clinic post-screening amounted to a care value of $25,335 and are listed below.

Services Rendered in Clinic Post-Screening

Service Rendered		*Number of procedures*
D0114-D0190	Oral evaluation	196
D0210-D0350	Radiographs/diagnostic imaging	189
D1110-D1120	Dental prophylaxis	56
D1203-D1206	Fluoride varnish treatment	76
D1330	Oral hygiene instruction	95
D1555	Space maintenance	1
D2000-D2999	Restorative procedures	22
D1351	Dental sealants	128
D3220	Pulpotomy	1
D7140-D7210	Oral surgical services	19
Total		**783**

Summary:

Implementation of the CDHC for outreach led to providing dental services to children from rural areas who may not have otherwise received them.

CDHC Case Study 26 Report: Foster Children Outreach

Case Study Description

The focus for this case study is an outreach program designed to provide dental services for children who otherwise would not receive care. For this initiative, the goals of the CDHC were to provide preventive services, promote oral health and, through patient navigation and care coordination, increase access to dental care for foster children in order to help them maintain overall health. The CDHC worked with a CPS nurse to arrange provision of dental services for children and educate their caregivers over two days in the clinic. Children in need of comprehensive care were referred to the dental clinic.

To measure the success of these goals, the current case study answers the following questions.

1. How many children received dental services through the outreach events at the clinic?
2. What types of dental services were provided to children at the outreach events?
3. What types of dental services were provided to children at the dental clinic?
4. What was the value of the dental care provided to children at the dental clinic?
5. How much time elapsed between screening and care delivery at the dental clinic?

Data Collection

Data were extracted from the clinic's patient management system and outreach records. The current analysis focuses on the time period from January 2011 through June 2012. Data reflect services provided at outreach events as well as comprehensive care provided in the dental clinic.

Results

Findings demonstrate that the addition of the CDHC aided in improving access to dental care among local foster care children. During two days at the clinic in August 2011, the CDHC conducted screenings for 43 children. Nineteen children showed signs of decay, three showed signs of periodontal disease, and nine had poor oral hygiene. Fluoride varnish treatments were provided for all 43 children, and reapplication of fluoride varnish every three months was recommended for 37 of them. Dental sealants were recommended for 16 children, and radiographs were recommended for 19. Twelve children were in need of prophylaxis. Of the screened children, two needed immediate dental care, and two (only one who needed immediate dental care) were given referrals. Based on the clinic's fee schedule, the estimated value of the care provided for children at these events was $1,075.

Sixteen children went to the clinic after screening; fourteen of them had not been to the dental clinic before screening. 75% of the children were seen in the dental clinic within three months of screening. Dental services provided at the clinic for the 16 children amounted to a care value of $5,176 and included oral evaluations, oral hygiene instruction, radiographs, fluoride varnish, dental sealants, prophylaxis, and restorative treatments.

Summary:

Implementation of the CDHC for outreach led to providing dental services to children who may not have otherwise received them. Opening the clinic to foster children made dental care accessible to those who had not been able to go to the dental clinic previously.

CDHC Case Study 27 Report: Early Childhood Outreach

Introduction

The focus for this case study is an outreach program designed to provide dental services for young children who otherwise would not receive care. 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 children ages 0 to 6 in order to help them maintain overall health. Outreach work has been a collaborative effort with the local public health service and dental task force composed of representatives from the county's public health department, commission on children and families, child care council, office of education, migrant education, local Head Start and Early Head Start programs, community health plan, as well as local pediatricians and dental professionals.

The CDHC coordinated the use of the county's mobile dental van service and arranged for events at the local Head Start, special day school, and preschool, to provide screenings, prophylaxis, and fluoride varnish treatments with the help of a dental hygienist. Parents who brought their children received oral hygiene education and nutritional counseling, and children without parents present were sent home with a list of local providers. Children in need of comprehensive care were referred to the dental clinic.

To measure the success of this goal, the current case study answers the following questions.

1. How many children received dental services through the early childhood outreach event?
2. What types of dental services were provided to children at the early childhood outreach event?
3. What types of dental services were provided to children at the dental clinic?
4. What was the value of the dental care provided to children at the dental clinic?
5. How much time elapsed between screening and care delivery at the dental clinic?

Data Collection

Data were extracted from the clinic's patient management system, patient records from outreach, and additional documentation of outreach events. The current analysis focuses on the time period of January 2011 through June 2012. Data reflect services provided at outreach events as well as comprehensive care provided in the dental clinic.

Results

Findings demonstrate that the addition of the CDHC aided in improving access to dental care among children at the local Head Start, special day school, and preschool. During one event in April 2011, the CDHC conducted screenings for 28 children. Twenty-six children received prophylaxis, and 24 received fluoride varnish treatments. Six children showed signs of decay, four children had poor oral hygiene, and four (one who needed immediate dental care) were referred for care at the dental clinic or the county's mobile dental van service. Based on the dental clinic's fee schedule, the estimated value of the care provided to children at these events was $1,978.

Four children (one who had been referred) went to the dental clinic for additional care. One of the four came to the clinic about one month after screening, while the other three came to the clinic nearly a year later. Dental services provided at the dental clinic for all four children amounted to a care value of $1,335 and included oral evaluations, oral hygiene instruction, radiographs, fluoride varnish, prophylaxis, restorative services, and oral surgical services.

Summary:

Implementation of the CDHC for outreach led to providing dental services to children and some parents who may not have otherwise received them. Provision of the mobile dental service made dental care accessible to children who had not been able to go to the dental clinic previously.

CDHC Case Study 28 Report: Juvenile Detention Center Outreach Program

Introduction

The focus for this case study is an outreach program designed to provide dental services for youths in the local juvenile detention center who otherwise would not receive care. 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 youths in juvenile detention in order to help them maintain overall health. The CDHC worked with the school nurse at the juvenile detention center to plan the screening event. During the event, the CDHC offered screenings, oral health education, and fluoride varnish treatments, and referred youths in need of comprehensive care to the county's mobile dental van service, the dental clinic, or other local providers.

To measure the success of this goal, the current case study answers the following questions.

1. How many youths received dental services at the juvenile detention center?
2. What types of dental services were provided to youths at the juvenile detention center?
3. What types of dental services were provided to youths at the dental clinic?
4. What was the value of the dental care provided to youths at the dental clinic?
5. What is the juvenile detention center administrator's assessment of the value of the special clinics?

Data Collection

Data were extracted from the clinic's patient management system, patient records from outreach, and additional documentation of outreach events. The current analysis focuses on the time period from January 2011 through June 2012. Data reflect services provided at outreach events as well as comprehensive care provided in the dental clinic.

Results

Findings demonstrate that the addition of the CDHC aided in improving access to dental care among youths at the local juvenile detention center. During one screening event in May 2011, the CDHC conducted screenings for 14 youths in juvenile detention. Ten showed signs of periodontal disease, four showed signs of decay, and three had poor oral hygiene. Orthodontic consultation was recommended for five youths, prophylaxis was recommended for four, and dental sealants were recommended for two. The four youths in need of prophylaxis were referred for immediate dental care to the county's mobile dental van service.

Of the 14 screened youths, five were referred to the dental clinic and five were referred to other local providers. Two of the referred youths went to the dental clinic for additional care, one of whom had been instructed to seek immediate dental care. That youth visited the clinic on 4 occasions after screening. Dental services provided at the clinic for both referred youths amounted to a care value of $495 and included oral evaluations, oral hygiene instruction, radiographs, fluoride varnish, prophylaxis, and oral surgical services.

Unmet needs were evident among youths at the juvenile detention center. Several of them were referred for additional treatment. The nurse at the juvenile detention center indicated that referred youths received comprehensive care and expressed interest in arranging a screening event for next year.

Summary:
Implementation of the CDHC for outreach led to providing dental services to youths who may not have otherwise received them and has influenced plans for regular dental screening for this group.

CDHC Case Study 30 Report: Pediatric Dental Outreach

Introduction

The focus for this case study is a dental clinic which serves the surrounding American Indian rural community. Prior to entering the CDHC pilot training program, the CDHC practiced as a dental therapist (an Oklahoma certification) and an expanded function dental assistant certified for radiographs and coronal polishing. Post-training, the CDHC has focused on outreach initiatives for children in the community.

For this initiative, the goals of the CDHC were to provide preventive services, promote oral health and, through patient navigation and care coordination, increase access to dental care for local children in order to help them maintain their oral and overall health. The CDHC arranged an outreach event at the local school in May, 2012. Dental screenings and preventive services were provided, and patients in need of comprehensive care were referred to the dental clinic.

To measure the success of these goals, the current case study answers the following questions:

1. How many patients were brought into the clinic through contact with the CDHC at outreach?
2. What types of dental services were provided to children the outreach event?
3. What types of dental services were provided to children at the dental clinic?
4. What was the value of the dental care provided to children at the outreach event?
5. What was the value of the dental care provided to children at the dental clinic?
6. What was the missed appointment rate for all children who received comprehensive care in the dental clinic?

Data Collection

Data was extracted from the clinic's Dentrix Enterprise patient management system. The current case study focuses on the time period during which children had contact with the CDHC at outreach and received comprehensive care: May, 2012 through April, 2013.

Results

Services at Outreach

The CDHC scheduled screenings for 63 children in May, 2012. Of those, 40 children received screenings. Each child screened also received oral evaluations, fluoride treatment, oral health instruction, nutritional counseling. Some children received prophylaxes and dental sealants. The screening at outreach was the first dental visit in 2012 for six children. Based on the clinic's fee schedule, the estimated value of care provided at outreach was $7,709.

Services provided during outreach included:

		Number of Procedures
D0140	Clinical oral evaluation	40
D1110	Dental prophylaxis	2
D1206	Topical fluoride	40
D1310	Nutritional counseling	40
D1330	Oral health instruction	40
D1351	Dental sealants	3
	Total	**165**

Services after Outreach
Almost one year after the outreach event, six patients who had been screened had a dental visit at the clinic; two of these six patients had two visits. One of the six broke an appointment but rescheduled and kept that appointment. Based on the clinic's fee schedule, the value of care provided at the clinic was $1,890.

Services provided in the clinic after outreach included:

		Number of Procedures
D0140	Clinical oral evaluation	5
D0190	Revisit	3
D1120	Dental prophylaxis	2
D1206	Topical fluoride	7
D1310	Nutritional counseling	7
D1330	Oral health instruction	7
D2391	Restorative procedures	2
	Total	**33**

Summary
Implementation of the CDHC for outreach led to providing dental services for children who may not have otherwise received them.

CDHC Case Study 31 Report: Head Start Program Dental Screening Compliance

Introduction

The focus for this case study is a dental clinic which serves the surrounding American Indian rural community. Prior to entering the CDHC pilot training program, the CDHC practiced as a dental therapist (an Oklahoma certification) and an expanded function dental assistant certified for radiographs and coronal polishing. Post-training, the CDHC has focused on outreach initiatives for children in the community.

For this initiative, the goals of the CDHC were to provide preventive services, promote oral health and, through patient navigation and care coordination, increase access to dental care for local children in order to help them maintain their oral and overall health. Dental screenings are required for participation in the Head Start program. The CDHC arranged screening events for Head Start program participants at the clinic in August and September, 2012. Dental screenings and preventive services were provided, and patients in need of comprehensive care were referred to the dental clinic.

To measure the success of these goals, the current case answers the following questions:

1. How many children were screened at the Head Start event in the clinic?
2. What types of dental services were provided to children the outreach event?
3. What types of dental services were provided to children at the dental clinic?
4. What was the value of the dental care provided to children at the outreach event?
5. What was the value of the dental care provided to children at the dental clinic?
6. What was the missed appointment rate for children who received comprehensive care in the dental clinic?

Data Collection

Data was extracted from the clinic's Dentrix Enterprise patient management system. The current case study focuses on the time period during which children had contact with the CDHC at outreach and received comprehensive care: August, 2012 through May, 2013.

Results

Services at Outreach

In August and September, 2012, the CDHC provided screenings for 16 Head Start children. Screening was the first dental visit in 2012 for all 16 children. Each child received an oral evaluation, fluoride varnish, nutritional counseling, and oral health instruction. Based on the clinic's fee schedule, the estimated value of care provided at outreach was $3,584.

Dental services provided included:

		Number of Procedures
D0140	Clinical oral evaluation	16
D1206	Topical fluoride	16
D1310	Nutritional counseling	16
D1330	Oral health instruction	16
	Total	**64**

Services after Outreach

Almost one year after the outreach event, two patients who had been screened had a dental visit at the clinic; one of them had two visits. Two other patients who had been screened made appointments, but one broke an appointment and one cancelled; neither was seen again within the time frame for this analysis. Based on the clinic's fee schedule, the value of care provided was $557.

Services provided in the clinic after outreach included:

		Number of Procedures
D0120	Clinical oral evaluation	1
D0191	Assessment of patient	2
D0330	Radiographs/imaging	1
D1120	Dental prophylaxis	1
D1206	Topical fluoride	2
D1310	Nutritional counseling	2
D1330	Oral health instruction	3
	Total	**12**

Summary

Implementation of the CDHC for outreach led to providing dental services for children who may not have otherwise received them and helped children comply with requirements for participating in the Head Start program.

CDHC Case Study 32 Report: Dental Service at High School Medical Clinics

Introduction

The focus for this case study is a clinic system with three medical clinics attached to local high schools. For this initiative, the goals of the CDHC were to provide preventive services, promote oral health and, through patient navigation and care coordination, increase access to dental care for community members of all ages in order to help them maintain overall health. The CDHC provided dental screenings at three local high school clinics during the fall of 2011 and spring of 2012. The CDHC also scheduled appointments at the main dental clinic for patients in need of comprehensive care and followed-up with screened patients about their appointments.

To measure the success of these goals, this case study answers the following questions;

1. How many people came to the dental clinic through the CDHC's school outreach program?
2. Did the high school clinic outreach activities result in the screened people visiting the clinic?
3. What types of dental services were provided to people at the dental clinic?
4. What was the value of the dental care provided to people at the dental clinic?

Data Collection

Data were extracted from the Dentrix Enterprise patient management system. The current analysis focuses on the time period during and after screenings in the high school clinics (Summer/Fall 2011 through May 2012). Data reflect services provided at outreach events as well as comprehensive care provided in the main dental clinic.

Results

Summary

Findings demonstrate that the addition of the CDHC has aided in improving access to dental care in the community. Over 64 days during 2011-12, the CDHC conducted screenings for 206 members of the community at dental clinics set up in three local high schools. One patient was in need of emergency care at the time of screening. Twenty of these patients were also seen at the main dental clinic for comprehensive care (one of whom was already a dental patient at the main clinic at the time of screenings).

Services Provided in the Main Dental Clinic

Twenty patients seen at the high school clinics received dental services across 32 visits at the main dental clinic. On average, each of these patients had 1 visit, underwent 2 dental procedures per visit, and received $373 of total care, or $233 of care per visit.

	Mean	*Median*[i]	*S.D.*	*Minimum*	*Maximum*	*N (patients)*[ii]
Number of visits	1.6	1.0	0.9	1.0	4.0	20
Care value per visit	$233	$187	$124	79.0	$735	20
Number of services per visit	2.5	2.0	1.2	1.0	6.0	20
Total care value	$373	$227	$318	$129	$1,202	20

Overall, 82 dental procedures were provided for these patients. Radiographs/diagnostic imaging (35.4%) was the most common type of service provided. Another 25.7% of procedures were restorations, and 20.7% were oral evaluations. Based on the clinic's fee schedule, $7,469 of care was provided.

		Frequency[ii]	*Percent*
D0120-D0180	Clinical oral evaluation	17	20.7
D0210-D0350	Radiographs/diagnostic imaging	29	35.4
D1110-D1120	Dental prophylaxis	8	9.8
D1201-D1205	Topical fluoride	1	1.2
D2000-D2999	Restorative procedures	21	25.7
D7000-D7999	Oral surgery services	3	3.7
D9000-D9999	Adjunctive services	3	3.7

Summary

Implementation of the CDHC for outreach led to providing dental services to community members who may not have otherwise received them.

[i] The median value is the most representative statistic throughout this report given the influence of extreme outliers.
[ii] NOTE: Interpret any frequencies of less than 30 with caution as they may not be statistically reliable.

CDHC Case Study 41 Report: Senior Center Outreach

Introduction

The focus for this case study is an outreach program designed to provide dental services for local senior citizens who otherwise would not receive care. Due to the state dental practice act limitations, CDHC activities were restricted to events on the reservation only.

For this initiative, the goals of the CDHC were 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 overall health. The CDHC organized screenings and delivery of dental services at an elder care center on the reservation. A dental resident accompanied the CDHC. During three events in January, March, and April 2013, the CDHC provided dental screenings and preventive care. The CDHC referred patients in need of comprehensive care to the dental clinic at the community health center.

To measure the success of these goals, the current case study answers the following questions:

1. What types of dental services were provided for senior citizen patients?
2. What was the value of the dental care provided to senior citizen patients?

Data Collection

Data was collected from the clinic's electronic records of services provided at outreach events. The current analysis focuses on those services provided at outreach events beginning in January 2013 through April 2013.

Results

Findings demonstrate that the addition of the CDHC aided in improving access to dental care among senior citizens at the local senior center. During three screening events, the CDHC conducted screenings for 27 senior citizens; 23 women and 4 men. Services provided included denture adjustments (provided by a dental resident), denture cleanings, and consultation services. Based on the dental clinic's fee schedule, the estimated value of the care provided at these events was $1,222.

		Services Rendered at Outreach
		Number of Procedures
D5410, D5421, D5422	Denture adjustments	11
D9310	Consultation services	16

Summary:
Implementation of the CDHC for outreach led to providing dental services to senior citizens who may not have otherwise received them.

CDHC Case Study 49 Report: Community Outreach to Low-Income Housing Residents

Introduction

The focus of this case study is a community health center which serves the surrounding urban and rural communities. Prior to training, the CDHC worked as a dental office manager who is responsible for three dental clinics. Post-training, the CDHC has focused on several outreach initiatives and continues to manage the three dental clinics.

For this initiative, the goals of the CDHC were to provide preventive services, promote oral health and, through patient navigation and care coordination, increase access to dental care low-income residents in order to help them maintain oral and overall health. The CDHC arranged screenings at three local low-income housing communities in January and April, 2013. A Medicaid worker helped enroll residents for screening.

To measure the success of these goals, this case study answers the following questions:

1. How many residents received screenings?
2. What types of dental services were provided to residents in low-income housing?
3. What was the value of the dental care provided to residents in low-income housing?

Data Collection

Data were collected from paper forms completed by the CDHC during screenings and were not entered into the clinic's patient management system. The current analysis reflects data from the time period during which the CDHC performed screenings. Data available for analysis were limited. Paper forms included only the minimal data needed to document screening for each patient. No data about any post-screening care provided was made available by the clinic.

Results

Findings demonstrate that the addition of the CDHC aided in improving access to dental care among low-income residents. During one day in January and two days in April, 2013, the CDHC conducted screenings for 19 low-income residents between the ages of 54 and 73.

Summary

Implementation of the CDHC for outreach led to providing dental services to residents in low-income housing communities who may not have otherwise received them.

CDHC Case Study 50 Report: Elementary School Outreach

Introduction

The focus of this case study is a community health center which serves the surrounding urban and rural communities. Prior to training, the CDHC worked as a dental office manager who is responsible for three dental clinics. Post-training, the CDHC has focused on several outreach initiatives and continues to manage the three dental clinics.

For this initiative, the goals of the CDHC were 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 oral and overall health. The CDHC arranged oral health education and screenings at a local elementary school during the 2012-13 school year. A dentist accompanied the CDHC.

To measure the success of these goals, this case study answers the following questions:

1. How many children received screenings?
2. What types of dental services were provided to children at the elementary school?
3. What was the value of the dental care provided to children at the elementary school?

Data Collection

Data were collected from paper forms completed by the CDHC during screenings and were not entered into the clinic's patient management system. The current analysis reflects data from the time period during which the CDHC performed screenings and delivered oral health education at the elementary school. Data available for analysis were limited. Paper forms included only the minimal data needed to document screening for each child. No data about any post-screening care provided was made available by the clinic.

Results

Oral Health Education

The CDHC provided oral health education for students and staff at the elementary school. In February 2013 she gave two oral health presentations for 246 pre-K and first grade students. The CDHC also met with 22 adults from the school's resource and nursing committees to prepare for the event.

Screening

Findings demonstrate that the addition of the CDHC has aided in improving access to dental care among children in the community. During one screening date in November 2012, the CDHC conducted screenings for 36 children. The CDHC provided prophylaxis for three of those children, and the dentist provided oral evaluations for five of those children. Based on the clinic's fee schedule, the estimated value of the care provided was $360.

Summary

Implementation of the CDHC for outreach led to providing dental services and oral health education to children who may not have otherwise received them.

CDHC Case Study 53 Report: Early Childhood (Ages 0-5) Outreach Program

Introduction

The focus of this case study is a large dental clinic (with sixteen operatories) housed within a community health center that serves the surrounding American Indian rural community. Post-training, the CDHC has focused on various outreach initiatives.

For this initiative, the goals of the CDHC were to provide preventive services, promote oral health and, through patient navigation and care coordination, increase access to dental care for children age 5 and younger in order to help them maintain their oral and overall health. The CDHC educated doctors and nurses in the pediatric department at the health center about referring children to the dental clinic for care. The pediatric physician referred patients with dental issues to the clinic.

To measure the success of this goal, the current case study answers the following questions:

1. Did the education program result in children age 5 and younger visiting the dental clinic?
2. What types of dental services were provided to children at the dental clinic?
3. What was the value of the dental care provided to children at the dental clinic?

Data Collection

Data was extracted from the clinic's NextGen patient management system. The current analysis focuses on appointments that took place during the time period that referred patients received care at the dental clinic.

Results

Between January and May, 2013, 28 children who were referred by the pediatric physician later visited the dental clinic. Each child had one visit. Based on the clinic's fee schedule, the value of care provided was $10,196.

Services provided at the dental clinic included:

		Number of Procedures	*Percentage of Procedures*
D0140-D150	Clinical oral evaluation	26	15.1%
D0220-D0330	Radiographs/diagnostic imaging	33	19.2
D1120	Dental prophylaxis	16	9.3
D1203,D1206	Topical fluoride	17	9.9
D1310	Nutritional counseling	20	11.6
D1330	Oral health instruction	36	20.9
D1351	Dental sealants	8	4.7
D2391,D2930	Restorative services	9	5.2
D7140	Oral surgical services	2	1.2
D9230	Analgesic services	5	2.9
	Total	**172**	**100.0**

Summary

Implementation of the CDHC to educate other providers led to the clinic providing dental services for children who may not have otherwise received them.

CDHC Case Study 57 Report: Outreach to Head Start Programs, Public Schools, and Emergency Departments

Introduction

The focus of this case study is a dental clinic which serves the surrounding rural community. The CDHC is EFDA certified and post-training has focused on various outreach initiatives at public schools, Head Start programs, health fairs, emergency room departments, and public health clinics.

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 patients of all ages in order to help them maintain their oral and overall health. The CDHC arranged for screenings in recognition of Children's Dental Awareness Month at local public schools and Head Start programs. A dentist assisted with the screenings. Children in need of comprehensive care were referred to the dental clinic.

Additionally, the CDHC and a dentist educated emergency department (ER) providers (i.e., doctors, nurses) from three local hospitals about providing oral health education to patients who present with dental issues in the ER and recommended referring these patients to the dental clinic for definitive care.

To measure the success of this goal, this case study answers the following questions:

1. How many children were screened as part of this program?
2. How many ER providers did the CDHC educate about providing access to dental care for their patients?
3. What types of oral health education materials were given to ER providers for distribution to patients?
4. How often were these materials distributed to the ER providers?
5. What are the ER providers' opinions of the CDHC presenting this information for more effective coordination of care?

Data Collection

Data was collected from the clinic's electronic records of number of children screened at outreach events at Head Start programs and public schools. No data was available for tracking screened patients to comprehensive care received at the clinic.

Results

Head Start Programs and Public Schools

Findings demonstrate that the addition of the CDHC has aided in improving access to dental care for children in the community. The CDHC conducted screenings for 2,489 children during 17 events.

	Number of Events	*Number of children*
Head Start programs	5	207
Public schools	12	2,282
Total	17	2,489

Emergency Departments

The CDHC and a dentist from the clinic met with management at three area hospital emergency rooms. During these meetings, the CDHC and the dentist explained services the dental clinic could provide for emergency room patients as well as the dental clinic's sliding fee schedule. They provided brochures and contact sheets advertising the dental clinic for the hospital management to post in patient waiting areas. The CDHC plans to return in fall of 2013 to reinforce the message.

Summary

Implementation of the CDHC for outreach led to providing dental services for children who may not have otherwise received them, and educated local emergency room staff about the dental clinic.

CDHC Case Study 64 Report: Tweens (5th - 8th grade) Outreach Program

Introduction

The focus of this case study is a clinic system with dental clinics at six different sites which serve the surrounding urban community. Post-training, three CDHCs have focused on various outreach initiatives. One of the CDHCs is also a registered dental hygienist.

For this initiative, the goals of the CDHCs were to provide preventive services, promote oral health and, through patient navigation and care coordination, increase access to dental care for 5th through 8th graders in order to help them maintain their overall health. Two CDHCs arranged for screenings and delivery of dental services to occur during the 2012-13 school year at local dental centers. Children in need of comprehensive care were referred to the dental clinic.

To measure the success of these goals, the current case study answers the following questions:

1. What types of dental services were provided to children at the screening program?
2. What was the value of the dental care provided to children at the screening program?

Data Collection

Data was collected from the clinic's electronic records of services provided at outreach events. The current analysis focuses on those services provided at outreach events beginning in June 2012 through April 2013.

Results

Findings demonstrate that the addition of the CDHCs at this clinic aided in improving access to dental care among children (ages 9 through 14 years) from the local elementary and middle schools. Between June 2012 and April 2013, two CDHCs provided screenings and preventive services for 57 children in 5th through 8th grade. CDHCs provided fluoride varnish treatments, dental sealants, and consultation services. A dentist provided oral evaluations and palliative treatment of dental pain. Based on the dental clinic's fee schedule, the estimated value of the services provided at this event was $1,086.

		Services Rendered at Outreach
		Number of Procedures
D0150	Comprehensive oral evaluation	14
D1203	Topical fluoride	1
D1351	Dental sealant	1
D9110	Palliative treatment of dental pain	6
D9310	Consultation services	5

Summary:
Implementation of the CDHC for outreach led to providing dental services for children who may not have otherwise received them.

CDHC Case Study 65 Report: Pre-School and Early Elementary Outreach Program

Introduction

The focus of this case study is a clinic system with dental clinics at six different sites which serve the surrounding urban community. Post-training, three CDHCs have focused on various outreach initiatives. One of the CDHCs is also a registered dental hygienist.

For this initiative, the goals of the CDHCs were to provide preventive services, promote oral health and, through patient navigation and care coordination, increase access to dental care for pre-school and early elementary school age children in order to help them maintain their overall health. Two CDHCs arranged for screenings and delivery of dental services to occur during the 2012-13 school year at local pre-school programs and elementary schools. Children in need of comprehensive care were referred to the dental clinic.

To measure the success of these goals, the current case study answers the following questions:

1. What types of dental services were provided to children at pre-school the screening program?
2. What was the value of the dental care provided to children at pre-school the screening program?

Data Collection

Data was collected from the clinic's electronic records of services provided at outreach events. The current analysis focuses on those services provided at outreach events beginning in June 2012 through April 2013.

Results

Findings demonstrate that the addition of the CDHCs at this clinic aided in improving access to dental care among children (ages 3 through 8 years) from the local preschool and elementary schools. Between June 2012 and April 2013, two CDHCs provided screenings and preventive services for 98 younger children. CDHCs provided fluoride varnish treatments, prophylaxis, and consultation services. A dentist provided oral evaluations and palliative treatment of dental pain. Based on the dental clinic's fee schedule, the estimated value of the services provided at this event was $3,397.

Services Rendered at Outreach

		Number of Procedures
D0120, D0150	Oral evaluations	49
D1120	Prophylaxis	5
D1206	Topical fluoride	3
D9110	Palliative treatment of dental pain	2
D9310	Consultation services	15

Summary:
Implementation of the CDHC for outreach led to providing dental services for young children who may not have otherwise received them.

CDHC Case Study 66 Description: Senior Citizen Outreach Program

Introduction

The focus of this case study is a clinic system with dental clinics at six different sites which serve the surrounding urban community. Post-training, three CDHCs have focused on various outreach initiatives. One of the CDHCs is also a registered dental hygienist.

For this initiative, the goals of the CDHCs were 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. Two CDHCs arranged for screenings and delivery of dental services. Senior citizens in need of comprehensive care were referred to the dental clinic.

To measure the success of these goals, the current case answers the following questions:

1. What types of dental services were provided to senior citizens at the screening program?
2. What was the value of the dental care provided to senior citizens at the screening program?

Data Collection

Data was collected from the clinic's electronic records of services provided at outreach events. The current analysis focuses on those services provided at outreach events beginning in June 2012 through April 2013.

Results

Findings demonstrate that the addition of the CDHCs at this clinic aided in improving access to dental care among senior citizens (age 65 and older) from the local community. Between June 2012 and April 2013, two CDHCs provided screenings and preventive services for 18 senior citizens. CDHCs provided prophylaxis and consultation services. A dentist provided oral evaluations and palliative treatment of dental pain. Based on the dental clinic's fee schedule, the estimated value of the services provided at this event was $610.

		Services Rendered at Outreach
		Number of Procedures
D0150	Comprehensive oral evaluation	7
D1110	Prophylaxis	2
D9110	Palliative treatment of dental pain	1
D9310	Consultation services	1

Summary:
Implementation of the CDHC for outreach led to providing dental services for senior citizens who may not have otherwise received them.

CDHC Case Study 67 Report: CDHC Coordinated Mobile Dental Service in Local Schools

Introduction

The focus of this case study is a dental clinic with satellite facilities serving the surrounding rural community. Prior to entering the CDHC pilot training program, the CDHC practiced as a dental hygienist. Post-training, the CDHC has focused on mobile outreach initiatives since transportation is a problem for members of this community.

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 local children in order to help them maintain their oral and overall health. The CDHC arranged for screenings and delivery of preventive dental services at Head Start programs and elementary schools during the 2012-13 school year. Although children were the focus, some parents received services as well. Children and parents in need of comprehensive care were referred to the dental clinic or to a previously established dental home.

To measure the success of this goal, the current case answers the following questions:

1. Did the mobile dental service result in patients visiting the dental clinic?
2. What types of dental services were provided to patients at the mobile dental service at schools?
3. What types of dental services were provided to patients at the dental clinic?
4. What was the value of the dental care provided to patients at the mobile dental service at schools?
5. What was the value of the dental care provided to patients at the dental clinic?
6. What was the missed appointment rate for patients who had appointments for comprehensive care at the dental clinic?
7. Did the mobile dental service increase the total number of patients seen by the clinic?
8. Did the CDHC mobile dental service bring new patients to the clinic?

Data Collection

Data was extracted from clinic's EagleSoft patient management system. Analysis focused on outreach events and appointments that took place during the time period in which children had contact with the CDHC and received comprehensive care starting Fall 2012 through Spring 2013.

Results

Findings demonstrate that the addition of the CDHC has aided in improving access to dental care among children and parents in the community. In six days, the CDHC provided services for 86 children and parents at five local Head Start programs and one elementary school.

Services provided for these 86 patients included:

		Services Rendered at Outreach	**Services Rendered at Clinic**
		Number of Procedures	*Number of Procedures*
D0120-D0180	Clinical oral evaluation	21	53
D0210-D0350	Radiographs/diagnostic imaging	28	19
D1110	Dental prophylaxis (adult)	6	13
D1120	Dental prophylaxis (child)	57	4
D1203	Topical fluoride	60	5
D1330	Oral health instruction	64	16
D1351	Dental sealants	--	4
D1555	Removal of spacer	--	1
D2000-D2999	Restorative procedures	--	22
D5110-D5214	Maxillofacial prosthodontics	--	3
D7140	Oral surgery services	--	14
	Total	236	139

Services Provided at Outreach
All of the 86 patients received preventive dental services at screening. On average, each patient underwent 3 dental procedures during their visit. On average, patients received an estimated $74 of care during a screening. Based on the clinic's fee schedule, the total estimated value of care provided at outreach was $6,320.

	Mean	*Median*[i]	*S.D.*	*Minimum*	*Maximum*
Care value per screening	$74	$73	$28	$15	$144
Number of services per screening	2.7	3.0	1.0	1.0	5.0

Services Provided at the Clinic
Of the 86 patients who received a screening, 68 of them received dental services at the clinic. On average, each of these patients underwent 4 dental procedures during a visit. On average, patients received $115 of care during a clinic visit and $136 total. The total estimated value of care provided at the clinic for these 68 patients was $9,277.

	Mean	*Median*[i]	*S.D.*	*Minimum*	*Maximum*
Number of visits	1.2	1.0	0.5	1.0	3.0
Care value per visit	$115	$48	$253	$30	$2,050
Number of services per visit	1.7	1.0	1.2	1.0	6.0
Total care value per patient	$136	$48	$296	$30	$2,139

New Patients[ii]
Of the 68 patients who received care at outreach events and the clinic, two were new to the clinic system. One patient was seen at the clinic three days later, and the other was seen eight days after screening. Services provided for these patients amounted to $111.

Missed Appointments
Four patients who had been screened broke later appointments in the clinic. Two rescheduled and kept the appointment. The other two were not seen again within the time frame for this analysis.

Summary
Implementation of the CDHC for outreach led to providing dental services for parents and children. The mobile clinic provided another option for patients who had previously received care at the dental clinic and provided care for those who had not previously received care at the dental clinic.

[i] The median value is the most representative statistic throughout this report given the influence of extreme outliers.
[ii] A new patient is defined as a patient who was seen in the clinic only after outreach, based on the data from this time frame.

CDHC Case Study 68 Report: Educational Community Service Events

Introduction

The focus of this case study is a dental clinic with satellite facilities serving the surrounding rural community. Prior to entering the CDHC pilot training program, the CDHC practiced as a dental hygienist. Post-training, the CDHC has focused on mobile outreach initiatives since transportation is a problem for members of this community.

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 members of the local community in order to help them maintain their overall health. The CDHC arranged for oral health education events to occur at various community locations.

To measure the success of this goal, the current case study answers the following questions:

1. Who was targeted for outreach events?
2. What types of services were provided at outreach events?

Data Collection Plan

Data was collected from the CDHCs records of outreach events conducted in the surrounding rural community. The current analysis focuses on outreach events that took place between May 2012 and April 2013.

Results

Findings demonstrate that the addition of the CDHC at this clinic aided in improving access to oral health education throughout the community. Total, the CDHC organized 28 oral health education events, delivered 62 hours of oral health education, and traveled 740 miles between May 2012 and April 2013. The average event lasted 2.4 hours and was 26.7 miles away from the dental clinic.

Event Details

The CDHC did not have direct contact with participants for 2 of these 28 events. One was a radio show which included discussion about the CDHC program and a question and answer session about the recommended frequency for dental visits, age to start dental visits, advice for bleeding gums, dry mouth, sensitive teeth, and dental visits for denture patients.

The CDHC also set up an information booth in the hospital lobby for one week to display tips for a healthy diet, brushing and flossing information, and pictures of sealants, fillings, orthodontics, and tooth decay. A model of teeth and a large toothbrush were also displayed for interactive brushing practice.

For 26 of the 28 events, the CDHC made contact with 1,057 children and 1,719 adults. Events were most often aimed at preschool age children, but other age groups were targeted as well.

Age Group	*Number of events including this age group*
Pre-school	18
Elementary	7
Middle school	6
High school	4
College	3
Adult	7
Senior	4

Topics in Oral Health Education

The CDHC provided the following types oral health information during presentations and health fairs:

- tips for healthy diet
- brushing and flossing
- effects of sugary drinks on teeth
- sealants, fillings, tooth decay
- gingivitis, periodontal disease, effects of tobacco use, and oral cancer
- sport injuries and the importance of wearing a mouthguard
- reasons to visit the dentist; age to start dental visits
- information about the clinic's dental and medical center locations and available services
- applications for the clinic's sliding fee program

Additional topics were specific to age groups. For example, young adults and their parents learned about oral health concerns they may have as they transition to the adult world and different fields of study in the dental profession that students may be interested in pursuing. Medical college students learned about oral health assessment, dental professionals, and the benefits of fluoride. They also practiced applying fluoride varnish on each other.

Preschool age children learned a song to sing while brushing, read a story about healthy teeth, worked on an oral health related craft, and practiced brushing on a dental puppet. The CDHC also provided some basic information about oral health and hygiene:

- importance of teeth in eating, speaking, smiling
- tips for a healthy diet
- how to brush, how often to brush, and to never share a toothbrush
- frequency for dental visits

Senior citizens learned about oral health issues specific to aging:

- dry mouth, diabetes, periodontal disease, root decay, denture care, and tobacco use.
- dry mouth as a side effect of medication
- importance of dental visits for denture patients
- applications for the clinic's sliding fee program and assistance filling them out

Summary

Implementation of the CDHC for outreach led to providing oral health education for people of all ages who may not have otherwise have had an opportunity to access this information. In addition to educating the public about oral health, the CDHC educated future health care providers about helping their patients access dental care. Employee health fairs and radio coverage made this CDHC's outreach effort unique.

CDHC Case Study 72 Report: Patient Satisfaction with CDHC

Introduction

The focus of this case study is a community health center which serves the surrounding rural community. Dental services were 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.

Overall, 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 members of their community in order to help them maintain their overall health. In addition to increasing access, as a dental provider, another goal of the CDHC is to ensure patient satisfaction.

To measure patient satisfaction, a patient satisfaction survey was developed. The following items were included.

1. Did the community dental health coordinator spend enough time with you?
2. Did the community dental health coordinator listen to you?
3. Were things explained in a way that was easy to understand?
4. Did the community dental health coordinator treat you with care and concern?
5. Was the office staff friendly?
6. Was it easy to make an appointment?
7. Were you seen on time for your appointment?
8. Would you recommend this clinic to family and friends who need dental care?
9. Do you plan to come back to this clinic for dental care?
10. Was it easy to get to the clinic for your appointment?
11. Did anyone give you advice for payment options?
12. Please rate your overall satisfaction with the care you received.

Data Collection

Data was collected through distribution of the patient satisfaction survey to patients who had contact with the CDHC. Respondents were asked to respond “yes” or “no” to items 1 through 11. For item twelve, respondents were asked to respond on a five-point scale ranging from “not at all satisfied” to “extremely satisfied.”

Results

In total, 94 patients from this clinic completed the patient satisfaction survey. Feedback from patients about the CDHC was positive overall. About two-thirds (68.3%) of respondents indicated that they were "extremely satisfied," while the remaining one-third (31.7%) indicated that they were "satisfied."

A summary of the responses to individual items is presented below. Compared to other items, fewer respondents (90.7%) indicated that they were seen on time for their appointments.

In regards to discussion of payment options, only half (50.7%) of respondents indicated that they were given advice about their payment options. This percentage looks low because most of the time patients are not billed directly for routine services like fillings and check-ups. The local tribe covers cost of services for its tribal members, and other non-tribal patients have dental insurance which covers cost of services. Thus, discussion of payment options is often not applicable at this clinic. When discussion of payment options is applicable, for example when a patient has lab work done, the office manager typically handles the discussion.

Survey Item	***% Yes***	***N***
Did the community dental health coordinator spend enough time with you?	100.0	90
Did the community dental health coordinator listen to you?	100.0	92
Were things explained in a way that was easy to understand?	100.0	93
Did the community dental health coordinator treat you with care and concern?	100.0	92
Was the office staff friendly?	100.0	90
Was it easy to make an appointment?	98.9	89
Were you seen on time for your appointment?	90.7	86
Would you recommend this clinic to family and friends who need dental care?	100.0	89
Do you plan to come back to this clinic for dental care?	100.0	88
Was it easy to get to the clinic for your appointment?	100.0	86
Did anyone give you advice for payment options?	50.7	67

Respondents to the patient satisfaction survey were also provided with the opportunity to make additional comments. (See the table below.) All comments were positive, indicating an appreciation for services received at the clinic. Respondents said things like:

- *Thank you and God bless you for your service to this community.*
- *[They] took great care of my kids.*
- *I love this place.*
- *Thank you for wonderful care.*
- *The dentist was very nice.*
- *Best Program ever! Thanks for what [you] guys do.*
- *It was a very good experience! The staff was extremely helpful, kind, and explained everything so nicely! Thank you so much for your service.*
- *Keep up the good work.*

Additionally, one respondent indicated concerns about not being allowed in the operatory with her child, but was still generally satisfied with the care her son received:

> *Not extremely satisfied due to the fact that my child had to go inside by himself and being [that he is] mentally challenged it scared me a bit. But overall very good service.*

Summary:
Overall, patients were satisfied with their CDHC experiences at the clinic.

CDHC Case Study 76 Report: Veteran and Rehabilitation Centers Outreach

Introduction

The focus of this case study is a community health center which serves the surrounding American Indian rural community.

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 underserved adults in order to help them maintain overall health. The CDHC arranged for screenings to occur at the local veterans and rehabilitation centers in June and September 2011.

To measure the success of this goal, the current case study was conducted to answer the following questions. However, due to limitations of the collected data, not all questions could be answered reliably.

1. Did the veterans and rehabilitation outreach program result in screened adults visiting the dental clinic?
2. How many adults came to the dental clinic through the CDHC's veterans and rehabilitation outreach program?
3. What types of dental services were provided to adults at the veterans and rehabilitation centers?
4. What types of dental services were provided to adults at the dental clinic?
5. What was the value of the dental care provided to adults at the veterans and rehabilitation centers?
6. What was the value of the dental care provided to adults at the dental clinic?
7. What was the missed appointment rate for adults who had appointments for comprehensive care at the dental clinic?

Data Collection

Data were collected from paper forms completed by the CDHC during screenings and were not entered into the clinic's patient management system. The current analysis reflects data from the time period during which the CDHC performed screenings at the veteran's and rehabilitation centers. Data available for analysis were limited. Paper forms included only the minimal data needed to document screening for each adult. No data about any post-screening care provided was made available by the clinic.

Results

Findings demonstrate that the addition of the CDHC has aided in improving access to dental care among underserved adults in the community. During two screening dates in June and September 2011, the CDHC conducted screenings for 23 adults. Eleven adults were in need of extractions, while one adult requested that service. Decay was present in eight adults screened, and six received a dental cleaning. Dental pain was indicated by one adult.

Summary:
Implementation of the CDHC for outreach led to providing dental services to adults who may not have otherwise received them.

CDHC Case Study 77 Report: Women, Infants and Children (WIC) Screening Program

Introduction

The focus for this case study is an outreach program designed to provide dental services for women, infants, and children who otherwise would not receive care. 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 women, infants, and children in order to help them maintain overall health.

WIC outreach events were a coordinated effort between several local health authorities. The local county dental taskforce is composed of representatives from the county's public health department, commission on children and families, child care council, office of education, migrant education, local Head Start and Early Head Start programs, community health plan, as well as local pediatricians and dental professionals. Two CHDCs worked with this dental task force, the local WIC clinic, the community resource center, and the dental clinic, to organize and carry out screening events advertised by flyers around the community.

At the first event, the CDHC provided screenings, fluoride varnish, and oral health education to infants, children, and mothers/caregivers at a local community resource center by appointment. Based on needs identified at the first WIC event, the CDHCs organized three additional events specifically for mothers. WIC staff assisted in arranging appointments. Services offered to mothers included screenings, prophylaxis, dental sealants, and oral health education. Patients in need of comprehensive care were referred to the county's mobile dental van service, the dental clinic, or other local providers that offer urgent dental care.

To measure the success of this goal, the current case study answers the following questions.

1. How many WIC participants received dental services at the WIC screening event?
2. What types of dental services were provided to WIC participants at the WIC screening event?
3. What types of dental services were provided to WIC participants at the dental clinic?
4. What was the value of the dental care provided to WIC participants at screening events and at the dental clinic?
5. What is the CDHC's assessment of the value of the WIC screening event?

Data Collection

Data were extracted from the clinic's patient management system, patient records from outreach, and additional documentation of outreach events. The current analysis focuses on the time period from January 2011 through June 2011. Data reflect services provided at outreach events as well as comprehensive care provided in the dental clinic.

Results

Findings demonstrate that the addition of the CDHC aided in improving access to dental care among participants of the Women, Infants, and Children (WIC) program. During the first event in May 2011, 35 mothers and 45 children were seen. All received screenings, nutritional counseling, and oral health education. The CDHC noted that all mothers showed signs of decay and periodontal disease. Some of the children showed signs of decay. All children received fluoride varnish treatments, an estimated care value of $1,125.

Twenty-one of the 35 mothers and two children screened in May returned for screening in August 2011, and one new mother attended. Two additional screening events were held for mothers in February 2012, and ten mothers attended. CDHCs provided services including fluoride varnish treatments, dental sealants, radiographs, prophylaxis, dental screenings, and hypertension screenings (during the August event). A dentist provided oral exams for three mothers and restorative services for one mother. One mother was instructed to seek immediate dental care. Based on the dental clinic's fee schedule, the estimated value of the care provided to mothers at these events was $4,975. The two children who returned in August received fluoride varnish treatments, an estimated care value of $50.

In total, 91 WIC participants were screened. Two mothers went to the dental clinic for comprehensive care after screening. Dental services provided for them amounted to a care value of $428 and included oral evaluations, radiographs, and oral surgical services.

Mothers who attended screening events with their children had significant unmet dental needs. The CDHC plans to continue outreach to WIC mothers in the future to help meet the needs discovered during initial outreach events.

Summary:
Implementation of the CDHC for outreach led to providing dental services to women, infants and children who may not have otherwise received them and helped to identify and address unmet needs among women in this population.

CDHC Case Study 78 Report: Patient Satisfaction with CDHC

Introduction

The focus of this case study is a community health center which serves the surrounding urban community.

Overall, 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 members of the community in order to help them maintain their overall health. In addition to increasing access, as a dental provider, another goal of the CDHC is to ensure patient satisfaction.

To measure patient satisfaction, a patient satisfaction survey was developed. The following items were included.

1. Did the community dental health coordinator spend enough time with you?
2. Did the community dental health coordinator listen to you?
3. Were things explained in a way that was easy to understand?
4. Did the community dental health coordinator treat you with care and concern?
5. Was the office staff friendly?
6. Was it easy to make an appointment?
7. Were you seen on time for your appointment?
8. Would you recommend this clinic to family and friends who need dental care?
9. Do you plan to come back to this clinic for dental care?
10. Was it easy to get to the clinic for your appointment?
11. Did anyone give you advice for payment options?
12. Please rate your overall satisfaction with the care you received.

Data Collection

Data was collected through distribution of the patient satisfaction survey to patients who had contact with the CDHC. Respondents were asked to respond “yes” or “no” to items 1 through 11. For item twelve, respondents were asked to respond on a five-point scale ranging from “not at all satisfied” to “extremely satisfied.”

Results

In total, 128 patients from this clinic completed the patient satisfaction survey. Feedback from patients about the CDHC was positive overall. Almost half (48.0%) of respondents indicated that they were "extremely satisfied," while the other half (49.6%) indicated that they were "satisfied." Three patients indicated that they were "neither satisfied nor dissatisfied."

A summary of the responses to individual items is presented below. Compared to other items, fewer respondents (84.8%) indicated that they were seen on time for their appointments.

Survey Item	***% Yes***	***Number of respondents***
Did the community dental health coordinator spend enough time with you?	100.0	127
Did the community dental health coordinator listen to you?	100.0	128
Were things explained in a way that was easy to understand?	99.2	126
Did the community dental health coordinator treat you with care and concern?	100.0	128
Was the office staff friendly?	98.0	97
Was it easy to make an appointment?	92.9	91
Were you seen on time for your appointment?	84.8	84
Would you recommend this clinic to family and friends who need dental care?	100.0	98
Do you plan to come back to this clinic for dental care?	100.0	98
Was it easy to get to the clinic for your appointment?	99.0	96
Did anyone give you advice for payment options?	92.9	91

Respondents to the patient satisfaction survey were also provided with the opportunity to make additional comments. One respondent addressed the issue of being seen on time:

> *Appointment was a little late because the girl had to wait for a doctor to help her.*

Another respondent indicated appreciation for the education provided during his/her appointment:

> *I think the knowledge about my teeth help me very much. I will be back so I can keep my teeth.*

Summary

Overall, patients were satisfied with their CDHC experiences at the clinic. Satisfaction was lowest for in regards to being seen on time for appointments. Notably, the education provided during one appointment helped one patient realize the importance of routine visits for maintaining oral health.

CDHC Case Study 79 Report: High School Outreach

Introduction

The focus for this case study is an outreach program designed to provide dental services for local high school students who otherwise would not receive care. Due to the state dental practice act limitations, CDHC activities were restricted to events on the reservation only.

For this initiative, the goals of the CDHC were 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 overall health. During one event in February 2013, the CDHC and a dental resident provided oral hygiene education.

To measure the success of these goals, the current case study answers the following questions:

1. What types of dental services were provided for students?
2. What was the value of the dental care provided to students?

Data Collection

Data was collected from the clinic's electronic records of services provided at outreach events. The current analysis focuses on those services provided at an outreach event in February 2013.

Results

Findings demonstrate that the addition of the CDHC aided in improving access to oral hygiene education among students at the local high school. During one event, the CDHC and a dental resident presented oral hygiene instruction (D1330) for 37 high school students; 17 young women and 20 young men. Based on the dental clinic's fee schedule, the estimated value of this educational service was $999.

Summary:
Implementation of the CDHC for outreach led to educating high school students about oral hygiene.

CDHC Case Study 80 Report: Men's Program Outreach

Introduction

The focus for this case study is an outreach program designed to provide dental services for participants of a local men's program who otherwise would not receive care. Due to the state dental practice act limitations, CDHC activities were restricted to events on the reservation only.

For this initiative, the goals of the CDHC were to provide preventive services, promote oral health and, through patient navigation and care coordination, increase access to dental care for men in order to help them maintain overall health. The CDHC organized screenings and delivery of dental services at a local men's program on the reservation. A dental resident accompanied the CDHC. During one event in April 2013, the CDHC provided dental screenings and preventive care. The CDHC referred patients in need of comprehensive care to the dental clinic at the community health center.

To measure the success of these goals, the current case study answers the following questions:

1. What types of dental services were provided for men?
2. What was the value of the dental care provided to men?

Data Collection

Data was collected from the clinic's electronic records of services provided at outreach events. The current analysis focuses on those services provided at an outreach event in April 2013.

Results

Findings demonstrate that the addition of the CDHC aided in improving access to dental care among men in the community. During one event, six men were screened. The CDHC provided prophylaxis and consultation services, and the dental resident provided oral evaluations. Based on the dental clinic's fee schedule, the estimated value of the services provided at this event was $256.

Summary:
Implementation of the CDHC for outreach led to providing dental services to local men who may not have otherwise received them.

CDHC Case Study 81 Report: High School Outreach Program

Introduction

The focus of this case study is a clinic system with dental clinics at six different sites which serve the surrounding urban community. Post-training, three CDHCs have focused on various outreach initiatives. One of the CDHCs is also a registered dental hygienist.

For this initiative, the goals of the CDHCs were 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. Two CDHCs arranged for screenings and delivery of dental services to occur during the 2012-13 school year at local dental centers. Students in need of comprehensive care were referred to the dental clinic.

To measure the success of these goals, the current case study answers the following questions:

1. What types of dental services were provided to children at the screening program?
2. What was the value of the dental care provided to children at the screening program?

Data Collection

Data was collected from the clinic's electronic records of services provided at outreach events. The current analysis focuses on those services provided at outreach events beginning in June 2012 through April 2013.

Results

Findings demonstrate that the addition of the CDHCs at this clinic aided in improving access to dental care among students (ages 15 through 18 years) from the local high schools. Between June 2012 and April 2013, two CDHCs provided screenings and preventive services for 28 high school students. CDHCs provided prophylaxis and consultation services. A dentist provided oral evaluations and palliative treatment of dental pain. Based on the dental clinic's fee schedule, the estimated value of the services provided at this event was $900.

Services Rendered at Outreach

		Number of Procedures
D0120, D0150	Oral evaluations	13
D1110	Prophylaxis	1
D9110	Palliative treatment of dental pain	2
D9310	Consultation services	5

Summary:
Implementation of the CDHC for outreach led to providing dental services for students who may not have otherwise received them.

CDHC Case Study 82 Report: Adult Outreach Program

Introduction

The focus of this case study is a clinic system with dental clinics at six different sites which serve the surrounding urban community. Post-training, three CDHCs have focused on various outreach initiatives. One of the CDHCs is also a registered dental hygienist.

For this initiative, the goals of the CDHCs were to provide preventive services, promote oral health and, through patient navigation and care coordination, increase access to dental care for adults in order to help them maintain their overall health. Two CDHCs arranged for screenings and delivery of dental services to occur in 2012 and 2013 at local dental centers. Adults in need of comprehensive care were referred to the dental clinic.

To measure the success of these goals, the current case study answers the following questions:

1. What types of dental services were provided to adults at the screening program?
2. What was the value of the dental care provided to adults at the screening program?

Data Collection

Data was collected from the clinic's electronic records of services provided at outreach events. The current analysis focuses on those services provided at outreach events beginning in June 2012 through April 2013.

Results

Findings demonstrate that the addition of the CDHCs at this clinic aided in improving access to dental care among adults (ages 19 through 64 years) from the local community. Between June 2012 and April 2013, two CDHCs provided screenings and consultation services for 148 adults. CDHCs provided consultation services, and a dentist provided oral evaluations. Based on the dental clinic's fee schedule, the estimated value of the services provided at this event was $4,680.

Services Rendered at Outreach

		Number of Procedures
D0120, D0150	Oral evaluations	57
D9110	Palliative treatment of dental pain	48
D9310	Consultation services	9

Summary:
Implementation of the CDHC for outreach led to providing dental services for adults who may not have otherwise received them.

CDHC Case Study 83 Report: Tom Joyner Outreach Event

Introduction

The focus of this case study is a clinic system with dental clinics at six different sites which serve the surrounding urban community. Post-training, three CDHCs have focused on various outreach initiatives. One of the CDHCs is also a registered dental hygienist.

For this initiative, the goals of the CDHC were to provide preventive services, promote oral health and, through patient navigation and care coordination, increase access to dental care for patients of all ages in order to help them maintain their overall health. One CDHC arranged for screenings and delivery of dental services to occur during 2012 and 2013 at local dental centers. Patients in need of comprehensive care were referred to the dental clinic. Several dental professionals provided preventive and other dental services.

To measure the success of these goals, the current case study answers the following questions;

1. What types of dental services were provided to children at the screening program?
2. What was the value of the dental care provided to children at the screening program?

Data Collection

Data was collected from the clinic's electronic records of services provided at outreach events. The current analysis focuses on those services provided at outreach events beginning in October 2012 through April 2013.

Results

Findings demonstrate that the addition of CDHCs at this clinic aided in improving access to dental care among patients of all ages. Between June 2012 and April 2013, one CDHC and several other dental professionals provided screenings, preventive and other dental services for 15 patients (ages 16 through 72). In total, dental professionals provided 96 procedures for these 15 patients. CDHC services provided included prophylaxis, radiographs, and consultation services. Dentists provided oral evaluations, restorative services, oral surgery services, and palliative treatment of dental pain. Based on the dental clinic's fee schedule, the estimated value of the services provided was $7,201.

		Services Rendered at Outreach
		Number of Procedures
D0021	Time out	16
D0120, D0140, D0150	Oral evaluations	16
D0200-D0299, D0330	Radiographs/diagnostic imaging	23
D1110	Prophylaxis	7
D2000-D2999	Restorative procedures	25
D7140, D7210	Oral surgery services	3
D9110	Palliative treatment of dental pain	2
D9310	Consultation services	4

Summary:

Implementation of the CDHC for outreach led to providing dental services for patients who may not have otherwise received them.

CDHC Case Study 84 Description: Infant/Toddler Outreach Program

Introduction

The focus of this case study is a clinic system with dental clinics at six different sites which serve the surrounding urban community. Post-training, three CDHCs have focused on various outreach initiatives. One of the CDHCs is also a registered dental hygienist.

For this initiative, the goals of the CDHCs were to provide preventive services, promote oral health and, through patient navigation and care coordination, increase access to dental care for infants and toddlers in order to help them maintain their overall health. Two CDHCs arranged for screenings and delivery of dental services. Infants and toddlers in need of comprehensive care were referred to the dental clinic.

To measure the success of these goals, the current case answers the following questions:

1. What types of dental services were provided to infants and toddlers at the screening program?
2. What was the value of the dental care provided to infants and toddlers at the screening program?

Data Collection

Data was collected from the clinic's electronic records of services provided at outreach events. The current analysis focuses on those services provided at outreach events beginning in June 2012 through April 2013.

Results

Findings demonstrate that the addition of the CDHCs at this clinic aided in improving access to dental care among infants and toddlers (age 0 to 2) from the local community. Between June 2012 and April 2013, two CDHCs provided screenings and preventive services for 91 infants and toddlers. CDHCs provided screenings and fluoride treatment. A dentist provided oral evaluations and palliative treatment of dental pain. Based on the dental clinic's fee schedule, the estimated value of the services provided at this event was $4,779.

		Services Rendered at Outreach
		Number of Procedures
D0150	Comprehensive oral evaluation	81
D1206	Topical fluoride	1
D9310	Consultation services	4

Summary:
Implementation of the CDHC for outreach led to providing dental services for infants and toddlers who may not have otherwise received them.

CDHC Case Study 85 Report: High School Outreach

Introduction

The focus of this case study is a dental clinic that serves the surrounding urban community. Prior to entering the CDHC pilot training program, the CDHC practiced as a dental hygienist. Post-training, the CDHC clinic worked at the dental clinic to fulfill outreach initiatives aimed at middle and high school students.

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 local high school students in order to help them maintain their oral and overall health. The CDHC arranged for screenings and delivery of dental services to occur during the 2012-13 school year and was accompanied by other dental team members. Comprehensive care was provided at the time of screening when a dentist was present. Otherwise, patients in need of comprehensive care were referred to the clinic.

To measure the success of this goal, the current case answers the following questions:

1. Did high school outreach result in students visiting the dental clinic?
2. What types of dental services were provided to students at high school outreach?
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 high school outreach?
5. What was the value of the dental care provided to students 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 – August 2012 through July 2013. 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.

Results

Findings demonstrate that the addition of the CDHC has aided in improving access to dental care among local high school students. Over 19 days, the CDHC provided services for 253 students from four local high schools.

Services provided for these 253 students included:

		Services Provided at Outreach *Number of Procedures*	**Services Provided at Clinic (Post-Outreach)** *Number of Procedures*
D0120-D0180	Clinical oral evaluation	167	95
D0210-D0350	Radiographs/diagnostic imaging	197	123
D0460,D0999	Other diagnostic procedures	17	1
D1110	Dental prophylaxis (adult)	164	74
D1120	Dental prophylaxis (child)	6	5
D1203-D1208	Topical fluoride	298	230
D1330	Oral hygiene instruction	170	136
D1351	Dental sealants	388	276
D2000-D2999	Restorative procedures	308	403
D3000-D3999	Endodontic procedures	11	35
D4000-D4999	Periodontic procedures	6	9
D5421	Maxillofacial prosthodontics	--	1
D7000-D7999	Oral surgery services	16	29
D8999	Orthodontic procedures	--	1
D9000-D9999	Adjunctive services	4	9
	Total	1,752	1,427

Services Provided at Outreach

At high school outreach events, 253 students received services; some had more than one visit at outreach. During an average visit, a student underwent 5 dental procedures and received an estimated $357 of care. Based on the clinic's fee schedule, the total estimated value of care provided at outreach was $116,463.

	Mean	*Median*[i]	*S.D.*	*Minimum*	*Maximum*
Number of visits per student	1.3	1.0	0.6	1	4
Care value of services provided per visit	$357	$281	$248	$32	$1,414
Number of services provided per visit	5.3	5.0	3.3	1	22
Total care value of services provided	$462	$312	$370	$30	$2,214

Services Provided at the Clinic

Of the 253 high school students at outreach, 103 received services in the clinic after outreach. During an average visit, a student underwent 5 dental procedures and received an estimated $411 of care. Based on the clinic's fee schedule, the total value of care provided to these students in the clinic was $116,027.

	Mean	*Median*[i]	*S.D.*	*Minimum*	*Maximum*
Number of visits per student	2.8	2.0	1.9	1	10
Care value of services provided per visit	$411	$352	$252	$25	$1,458
Number of services provided per visit	5.0	5.0	2.7	1	19
Total care value of services provided	$1,126	$798	$919	$104	$4,254

New Patients

Of the 253 students, 102 had not been seen in the clinic prior to outreach, within the time frame for this analysis.

Summary

Implementation of the CDHC for outreach led to providing dental services for high school students who may not have otherwise received them.

[i] The median value is the most representative statistic throughout this report given the influence of extreme outliers.

CDHC Case Study 86 Report: Middle School Outreach

Introduction

The focus of this case study is a dental clinic that serves the surrounding urban community. Prior to entering the CDHC pilot training program, the CDHC practiced as a dental hygienist. Post-training, the CDHC clinic worked at the dental clinic to fulfill outreach initiatives aimed at middle and high school students.

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 local middle school students in order to help them maintain their oral and overall health. The CDHC arranged for screenings and delivery of dental services to occur during the 2012-13 school year and was accompanied by other dental team members. Comprehensive care was provided at the time of screening when a dentist was present. Otherwise, patients in need of comprehensive care were referred to the clinic.

To measure the success of this goal, the current case answers the following questions:

1. Did middle school outreach result in students visiting the dental clinic?
2. What types of dental services were provided to students at middle school outreach?
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 middle school outreach?
5. What was the value of the dental care provided to students 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 – August 2012 through July 2013. 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.

Results

Findings demonstrate that the addition of the CDHC has aided in improving access to dental care among local middle school students. Over 27 days, the CDHC provided services for 250 students from five local middle schools.

Services provided for these 250 students included:

		Services Provided at Outreach *Number of Procedures*	**Services Provided at Clinic (Post-Outreach)** *Number of Procedures*
D0120-D0180	Clinical oral evaluation	147	106
D0210-D0350	Radiographs/diagnostic imaging	153	104
D0460,D0999	Other diagnostic procedures	19	5
D1110	Dental prophylaxis (adult)	62	39
D1120	Dental prophylaxis (child)	97	60
D1203-D1208	Topical fluoride	277	227
D1330	Oral hygiene instruction	151	167
D1351	Dental sealants	522	377
D2000-D2999	Restorative procedures	182	320
D3000-D3999	Endodontic procedures	9	10
D4000-D4999	Periodontic procedures	4	1
D7000-D7999	Oral surgery services	10	18
D9000-D9999	Adjunctive services	4	11
	Total	1,637	1,442

Services Provided at Outreach

At middle school outreach events, 250 students received services; some had more than one visit at outreach. During an average visit, a student underwent 5 dental procedures and received an estimated $315 of care. Based on the clinic's fee schedule, the total estimated value of care provided at outreach was $90,499.

	Mean	*Median*[i]	*S.D.*	*Minimum*	*Maximum*
Number of visits per student	1.1	1.0	0.4	1	3
Care value of services provided per visit	$315	$255	$213	$32	$1,613
Number of services provided per visit	5.7	5.0	3.6	1	26
Total care value of services provided	$363	$281	$269	$32	$1,636

Services Provided at the Clinic

Of the 250 middle school students at outreach, 101 received services in the clinic after outreach. During an average visit, a student underwent 6 dental procedures and received an estimated $390 of care. Based on the clinic's fee schedule, the total value of care provided to these students in the clinic was $95,188.

	Mean	*Median*[i]	*S.D.*	*Minimum*	*Maximum*
Number of visits per student	2.4	2.0	1.2	1	6
Care value of services provided per visit	$390	$353	$237	$32	$1,653
Number of services provided per visit	5.9	6.0	3.0	1	20
Total care value of services provided	$942	$873	$506	$157	$2,472

New Patients

Of the 250 students, 88 had not been seen in the clinic prior to outreach, within the time frame for this analysis.

Summary

Implementation of the CDHC for outreach led to providing dental services for middle school students who may not have otherwise received them.

[i] The median value is the most representative statistic throughout this report given the influence of extreme outliers.

CDHC Case Study 87 Report: Foster Children Outreach

Introduction

The focus of this case study is a community health center which serves the surrounding urban and rural communities. Prior to training, the CDHC worked as a dental office manager who is responsible for three dental clinics. Post-training, the CDHC has focused on several outreach initiatives and continues to manage the three dental clinics.

For this initiative, the goals of the CDHC were to provide preventive services, promote oral health and, through patient navigation and care coordination, increase access to dental care for foster children in order to help them maintain oral and overall health. The CDHC arranged screenings at the local orphanage during October 2012 and was accompanied by a dentist.

To measure the success of these goals, this case study answers the following questions:

1. How many children received screenings?
2. What types of dental services were provided to children at the orphanage?
3. What was the value of the dental care provided to children at the orphanage?

Data Collection

Data were collected from paper forms completed by the CDHC during screenings and were not entered into the clinic's patient management system. The current analysis reflects data from the time period during which the CDHC performed screenings at the orphanage. Data available for analysis were limited. Paper forms included only the minimal data needed to document screening for each child. No data about any post-screening care provided was made available by the clinic.

Results

Findings demonstrate that the addition of the CDHC aided in improving access to dental care among local foster care children. During two days in October 2012, the CDHC conducted screenings for twelve children, ages 1 to 15. The CDHC provided prophylaxis for eight children and fluoride varnish for seven children. The dentist provided oral evaluations for nine children. Based on the clinic's fee schedule, the estimated value of the care provided for children at was $770.

Summary

Implementation of the CDHC for outreach led to providing dental services to children who may not have otherwise received them.

CDHC Case Study 88 Report: CDHC Activity Summary

Introduction

The focus of this case study is a community health center which serves the surrounding urban and rural communities. Prior to training, the CDHC worked as a dental office manager who was responsible for three dental clinics. Post-training, the CDHC has focused on several outreach initiatives and continues to manage the three dental clinics.

For this initiative, the goals of the CDHC were to provide preventive services, promote oral health and, through patient navigation and care coordination, increase access to dental care in order to help people maintain oral and overall health. In order to reach these goals, the CDHC split time in the dental clinic with time in the community delivering various types of services.

To measure the success of these goals, this case study answers the following questions:

1. How did the CDHC divide her time between the clinic and outreach?
2. What types of services did the CDHC provide?

Data Collection

Summary data were collected from the CDHC. The current analysis reflects CDHC activities that occurred between October 1, 2012 and May 12, 2013, a time span of 224 days.

Results

Clinic versus Field Time

Of the CDHC's 157 work days, most of her time (81.5%) was spent in her primary role working in the dental clinic. Clinic activities included clinic management and dental assisting.

The remainder of her time (18.5%) was spent on CDHC outreach-related activities in the field. The CDHC spent a total of 5 days preparing for outreach events; part of this time included meetings with nurses, Medicaid workers, and other who assisted in organizing events. Outreach activities included community education (8 days), screenings (3 days), and care delivery (3 days). The CDHC spent 10 days participating in other outreach activities such as trick-or-treat events and several community festivals or health fairs.

Outreach in the Field

The CDHC participated in 20 events; four of these occurred over multiple days. The largest event educated 1,667 children for each of three days as part of community event. Preventive care provided at two events included exams and cleanings, fluoride varnish and dental sealants.

Event Type	*Number of People*	*Number of Events*
Booth at community festivals, health fairs	5,834	7
Dental presentations	350	8
Dental screenings	49	3
Preventive care	24	2

Summary

Implementation of the CDHC for outreach led to providing dental services in the community in addition to time spent in the clinic.

Program Evaluation: Case Study Findings

Overview: A total of 46 case studies were completed for the evaluation. An executive summary of the case studies and each detailed case study are available for review in the appendices of the section on Evaluation – Patient Access and Outcomes.

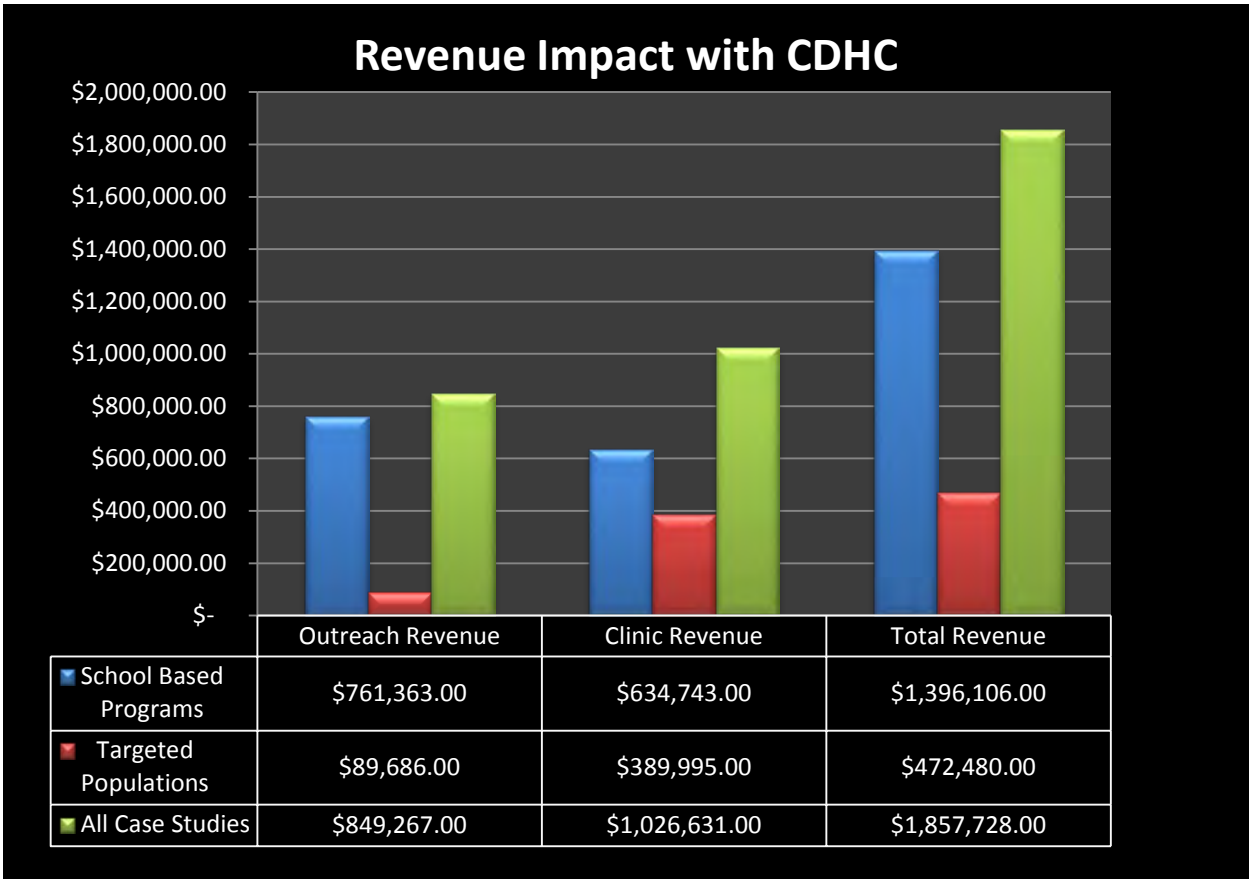
The case studies represent the outreach efforts of the CDHCs in 14 clinics located in urban, rural or American Indian settings. Several clinics were not evaluated due to lack of data available, IRB agreements that could not be executed in time for the evaluation analysis to be completed due to Indian Health Service restrictions or, other mitigating circumstances beyond the control of the evaluation team. Of the 46 case studies, 16 were school-based outreach programs, 20 targeted specific populations such as diabetic patients, foster children or HIV patients, and 2 were patient satisfaction surveys. The remaining case studies provided descriptive data in a narrative summary or included descriptive data not amenable to comparative analysis.

There were 22 case studies that were completed in American Indian clinics, 13 in urban clinics, and 11 in non-American Indian rural settings. The CDHCs impacted over 11,000 patient lives and contributed to approximately1.85 million dollars of total revenues. The revenue generated was from both outreach events and comprehensive dental treatment delivered at the clinic due to the patient navigation, education and screenings performed by the CDHCs.

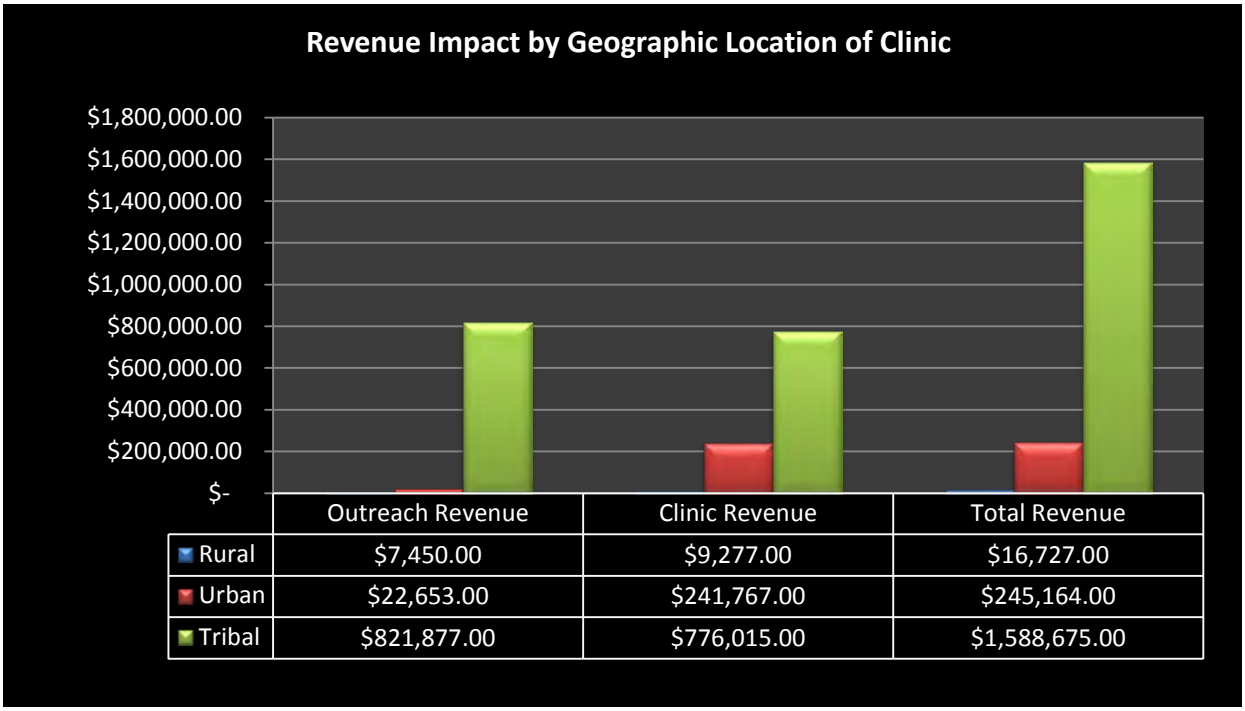
Comparing the geographic locations of the clinics, the data demonstrate the greatest impact to the dental practice was in the American Indian settings. All of these were located in rural areas of the country. However, two case studies from a tribal clinic impacted the urban community of the adjacent city. It is important to note that any dental practice act restrictions do not apply in the American Indian clinics because of the sovereignty of the tribe. Rural clinics saw fewer patients but impacted the lives of community members through unique outreach efforts such as foster care children and low-wage workers. One clinic provided oral health education to almost 2500 persons through outreach events at public schools, Head Start programs, health fairs, emergency room departments, and public health clinics.

Comparative Analysis by Type of Program			
	Outreach Revenue	**Clinic Revenue**	**Total Revenue**
School-based programs	$ 761,363.00	$ 634,743.00	$ 1,396,106.00
Targeted Populations	$ 89,686.00	$ 389,995.00	$ 472,480.00
All Case Studies	$ 849,267.00	$ 1,026,631.00	$ 1,857,728.00

Geographic Location Comparison			
	Outreach Revenue	**Clinic Revenue**	**Total Revenue**
Rural	$ 7,450.00	$ 9,277.00	$ 16,727.00
Urban	$ 22,653.00	$ 241,767.00	$ 245,164.00
Tribal	$ 821,877.00	$ 776,015.00	$ 1,588,675.00



	Outreach Revenue	Clinic Revenue	Total Revenue
School Based Programs	$761,363.00	$634,743.00	$1,396,106.00
Targeted Populations	$89,686.00	$389,995.00	$472,480.00
All Case Studies	$849,267.00	$1,026,631.00	$1,857,728.00

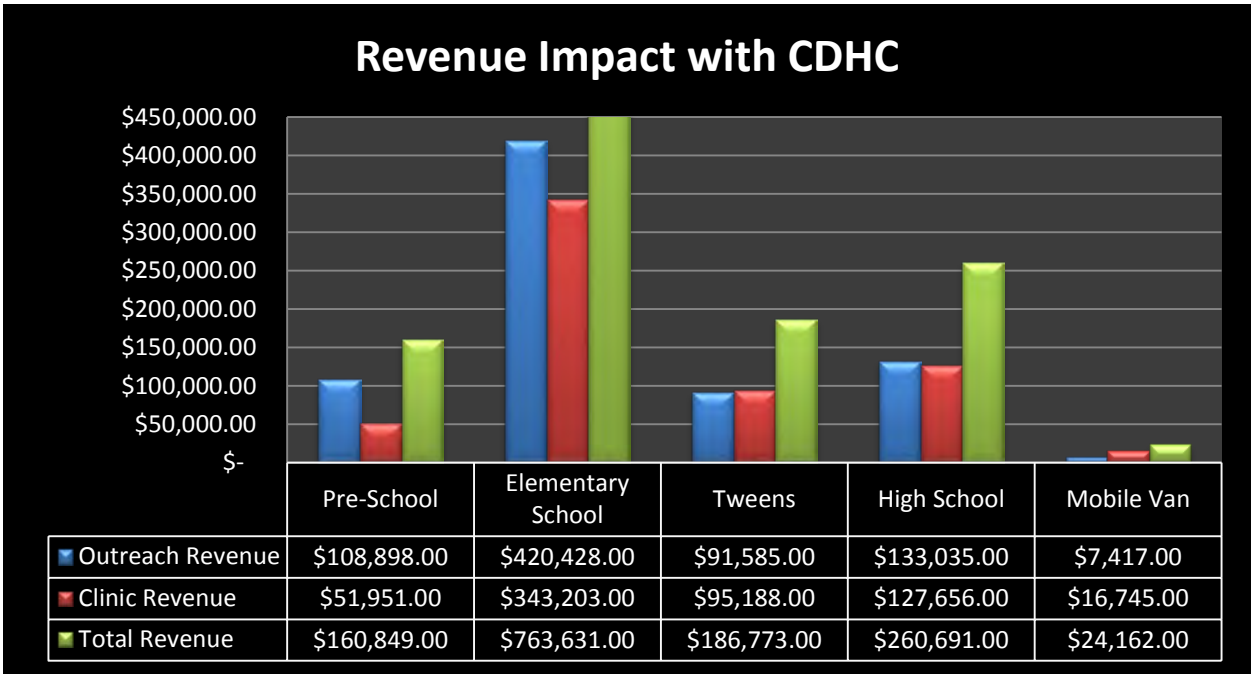


	Outreach Revenue	Clinic Revenue	Total Revenue
Rural	$7,450.00	$9,277.00	$16,727.00
Urban	$22,653.00	$241,767.00	$245,164.00
Tribal	$821,877.00	$776,015.00	$1,588,675.00

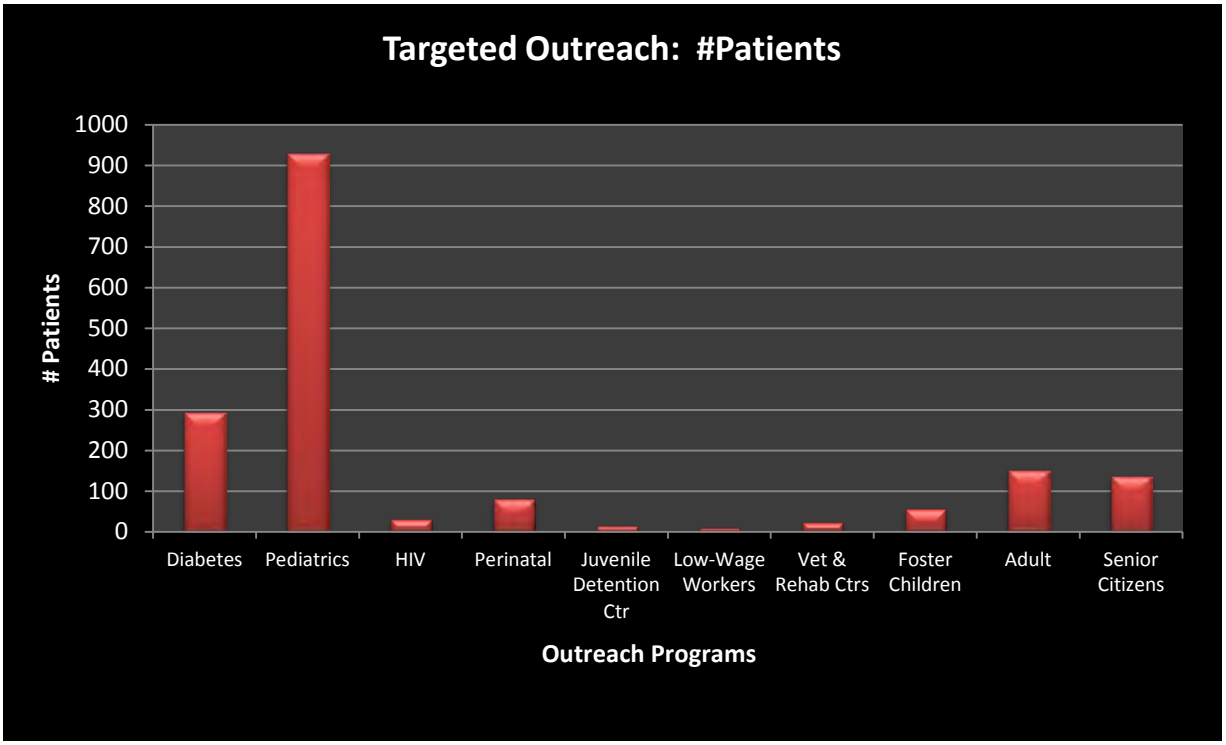
School-based Outreach Events: School-based outreach events spanned the age spectrum for students from pre-school through high school. Events ranged from educational programs only to screening events and mobile units providing more comprehensive care. The number of patients encountered was 2808. The total value of services provided at outreach events and in the clinic was $ 1,396,106.00.

The greatest impact was through outreach events at elementary schools. One American Indian clinic and one Indian Health Service clinic, in separate outreach activities, were able to reach out to a total of over 1500 students with services valued at more than $1.2 million. Both of these clinics were larger group practices and able to utilize the CDHC in numerous outreach events. Rural clinics had a more limited population for outreach events as evidenced by the data and the number of students who were able to be seen by the CDHC in their respective communities. In the urban settings, again outreach was limited with the exception of an outreach event at a high school medical clinic that provided over $7000 in services to 260 students.

	Outreach Revenue	Clinic Revenue	Total Revenue
Pre-School	$ 108,898.00	$ 51,951.00	$ 160,849.00
Elementary School	$ 420,428.00	$ 343,203.00	$ 763,631.00
Tweens	$ 91,585.00	$ 95,188.00	$ 186,773.00
High School	$ 133,035.00	$ 127,656.00	$ 260,691.00
Mobile Van	$ 7,417.00	$ 16,745.00	$ 24,162.00
Total	**$ 761,363.00**	**$ 634,743.00**	**$ 1,396,106.00**



Targeted Populations: Several of the CDHCs developed outreach initiatives specific to targeted populations. These included diabetic patients, HIV patients, pediatric patients and perinatal patients. In addition, the CDHCs provided screenings and preventive services to foster care children, young persons in a juvenile detention center, and senior citizens. Each outreach event was designed to access a community group that previously was not being seen at the dental clinic for a variety of reasons. Over 1700 persons were seen in outreach events and 1140 persons were seen for definitive treatment in the clinics (this number is larger due to the fact that some of the outreach was within the medical department of multi-disciplinary facilities). The value of care provided was approximately $470,000 in total.



Revenue by Targeted Outreach Event:

Diabetes	$	102,863.00
Pediatrics	$	180,099.00
HIV	$	11,346.00
Perinatal	$	16,942.00
Juvenile Detention Ctr	$	495.00
Low-Wage Workers	$	792.00
Foster Children	$	7,021.00
Adult	$	4,936.00
Senior Citizens	$	147,986.00
Total	**$**	**472,480.00**

American Indian Clinics: CDHC trainees in the pilot program came from a number of Native American Indian communities. The clinics were both Indian Health Service facilities and American Indian clinics. Due to the rigorous requirements by the IHS for obtaining data from some of the sites, the evaluation was primarily limited to the American Indian clinics and one IHS site. There are 22 case studies from American Indian clinics that contributed to this evaluation.

CDHCs provided outreach services to over 2400 persons during the time of the evaluation. There were 1127 patients seen at the clinics; 661 as new patients. The total value of the services rendered during outreach events was $821,877.00; the value of clinic services provided was $776,015.00 and the total care value was over $1.5 million. Programs varied and included school outreach and targeted populations such as diabetic and HIV patients.

Rural Clinics: 11 Case studies provided the data for analysis of the impact of the CDHC in non-American Indian rural communities. These case studies demonstrate the work of the CDHC primarily in oral health education activities reaching out to over 6000 persons. Most of these clinics are located in very remote areas with geographic access a barrier for outreach initiatives. One mobile dental van program did reach almost 100 persons and enabled 68 patients to receive more comprehensive services at the clinic. The total care value for the mobile unit initiative was $15,597.00.

Urban Clinics: The CDHCs trained from urban sites were affiliated with Temple University. The CDHCs in these sites encountered very different barriers to access as compared to the rural sites. There are 14 case studies that demonstrate the work of the CDHCs and include school programs, targeted populations and an event similar to a *Give Kids a Smile*® event. The number of persons encountered during outreach events was 724. However, much of the work was done through patient encounters in a medical clinic reaching over 900 patients. The total value of care provided through urban outreach initiatives was $245,164.00.

Patient Satisfaction Surveys: Patient satisfaction surveys were conducted at a American Indian clinic and an urban clinic (case studies #72 and #78).

To measure patient satisfaction, the following items were included on the survey:

1. Did the community dental health coordinator spend enough time with you?
2. Did the community dental health coordinator listen to you?
3. Were things explained in a way that was easy to understand?
4. Did the community dental health coordinator treat you with care and concern?
5. Was the office staff friendly?
6. Was it easy to make an appointment?
7. Were you seen on time for your appointment?
8. Would you recommend this clinic to family and friends who need dental care?
9. Do you plan to come back to this clinic for dental care?
10. Was it easy to get to the clinic for your appointment?
11. Did anyone give you advice for payment options?
12. Please rate your overall satisfaction with the care you received.

Results indicated a high level of satisfaction from approximately 222 respondents in 2 clinics.

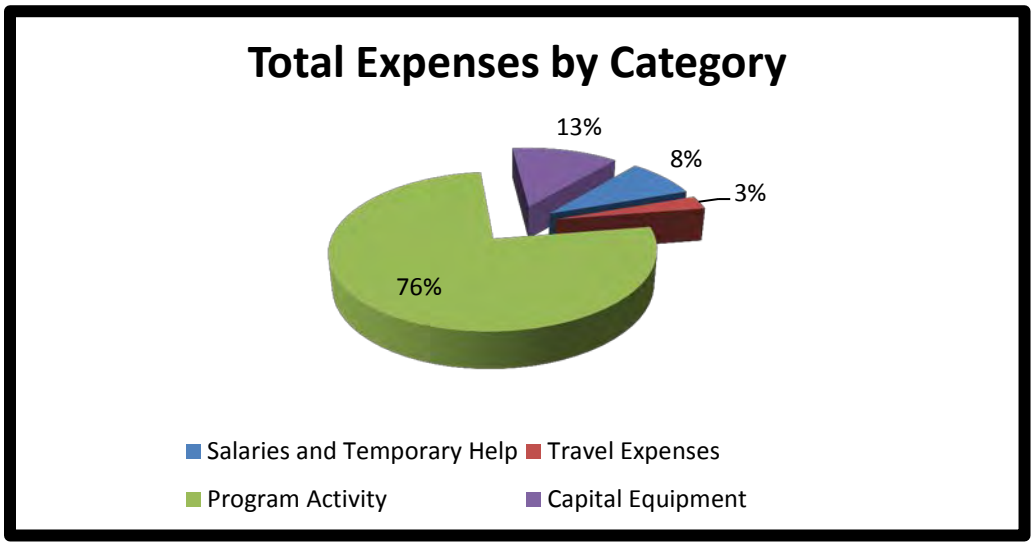
Financial Analysis

In 2006, the House of Delegates adopted Resolution 25H-2006 to create the Community Dental Health Coordinator model training program, including a complete curriculum with implementation and evaluation guidelines. Based on a projected cost of $8.5 million dollars, the House of Delegates authorized a total of $7 million dollars for the pilot program.

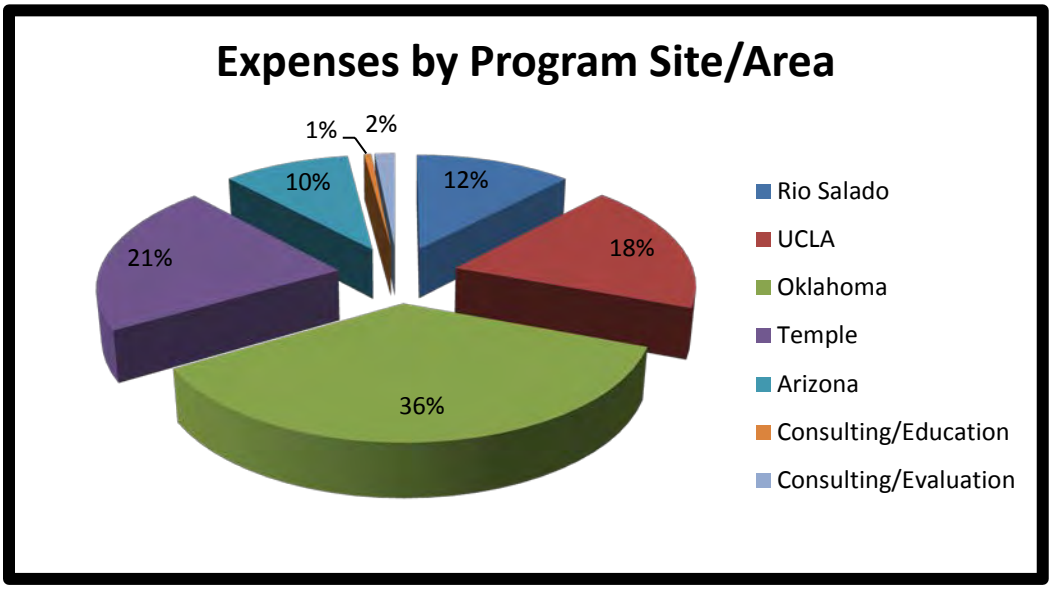
As of June 30, 2013, the project has incurred expenses totaling $6,024,471.00, with remaining available funds for the project of $940,621.00. Projected expenses for the remainder of the project are approximately $773,190.00, with a projected total program cost of $6,797,661.00.

Total expense summaries are graphed according to the specific ADA accounts used by the financial 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.

Total Expenses - Summary by Category	
Salaries and Temporary Help	$ 497,432.09
Travel Expenses	$ 166,083.70
Program Activity	$ 4,421,799.33
Capital Equipment	$ 755,042.99
Total	**$ 5,840,358.11**



Total Expenses - Summary by Program Sites		
Rio Salado	**$**	**518,257.01**
UCLA	**$**	**783,225.47**
Oklahoma	**$**	**1,530,940.32**
Temple	**$**	**912,151.27**
Arizona	**$**	**418,227.00**
Consulting/Education	**$**	**24,000.00**
Consulting/Evaluation	**$**	**66,922.73**
Total	**$**	**4,253,723.80**



The majority of the expenses were directly related to the program activity. This included payments to each of the colleges and universities sponsoring the education and training of the students. Additional expenses included salaries and temporary help, travel expenses (for site visits, evaluation site visits and media opportunities), and capital equipment. Each pilot program site had a unique contract that stipulated how the program would be funded at their respective sites. The University of Oklahoma had students in all 3 cohorts and, therefore, received the largest funding amount. Temple University sponsored 2 cohorts of students; the University of California, Los Angeles – 2 cohorts of students; and the Arizona School of Dentistry and Oral Health – 1 cohort.

Throughout the pilot program, authorized funds were requested to be allocated to the CDHC budget as needed.

- The Commitment for the CDHC Workforce Models was initially established for $2,000,000 via House Resolution 54H-2007.

- September 2009 meeting: the Board approved a motion to make available an additional $2,365,092 to fund the 2010 commitment to the program.

- June 2011 meeting: the Board approved Resolution B74-2011 to provide $1,000,000 of additional funding from reserves.

- The Board approved Resolution B10-2012 to provide $800,000 of funding for CDHC.

- The Board approved Resolution B58-2013 to provide $800,000 of funding for CDHC.

A significant portion of the program expenses was off-set by a donation from the Henry Schein company to pay for equipment for some of the students in cohorts 2 and 3.

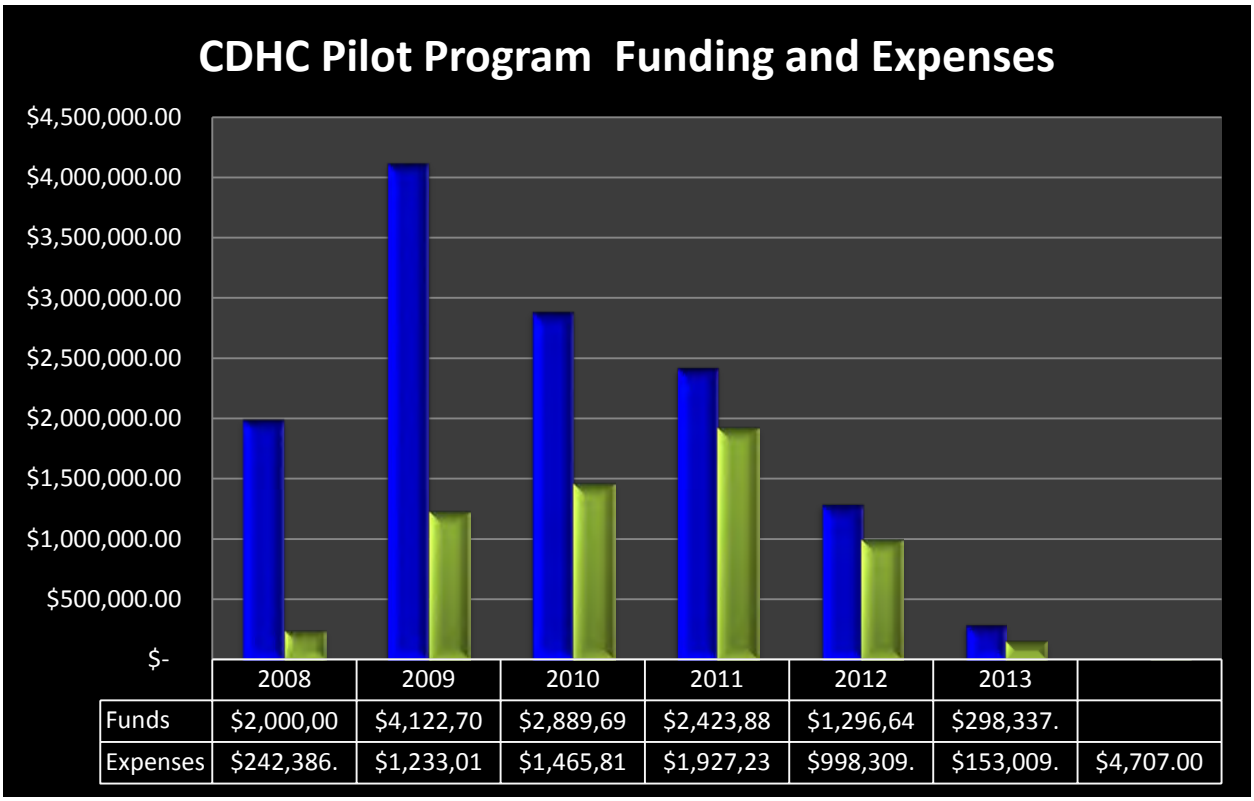
In 2008, the American Dental Association Foundation (ADAF) Board of Directors pledged programmatic support for the program as outlined below in Resolution ADAF37 B-32-2008:

> **Resolved,** that the ADA Foundation Board of Directors approves a $250,000 pledge, with minimum annual payments of $50,000 each year over a five year period beginning in 2009, in support of the on-going development of the ADA Community Dental Health Coordinator (CDHC) program, and be it further
>
> **Resolved,** that the ADA Foundation's Finance Committee, beginning in 2009, conduct yearly assessments of the Foundation's financial ability to meet, or exceed, its $50,000 annual pledge payment for the program as well as its aggregate pledge amount.

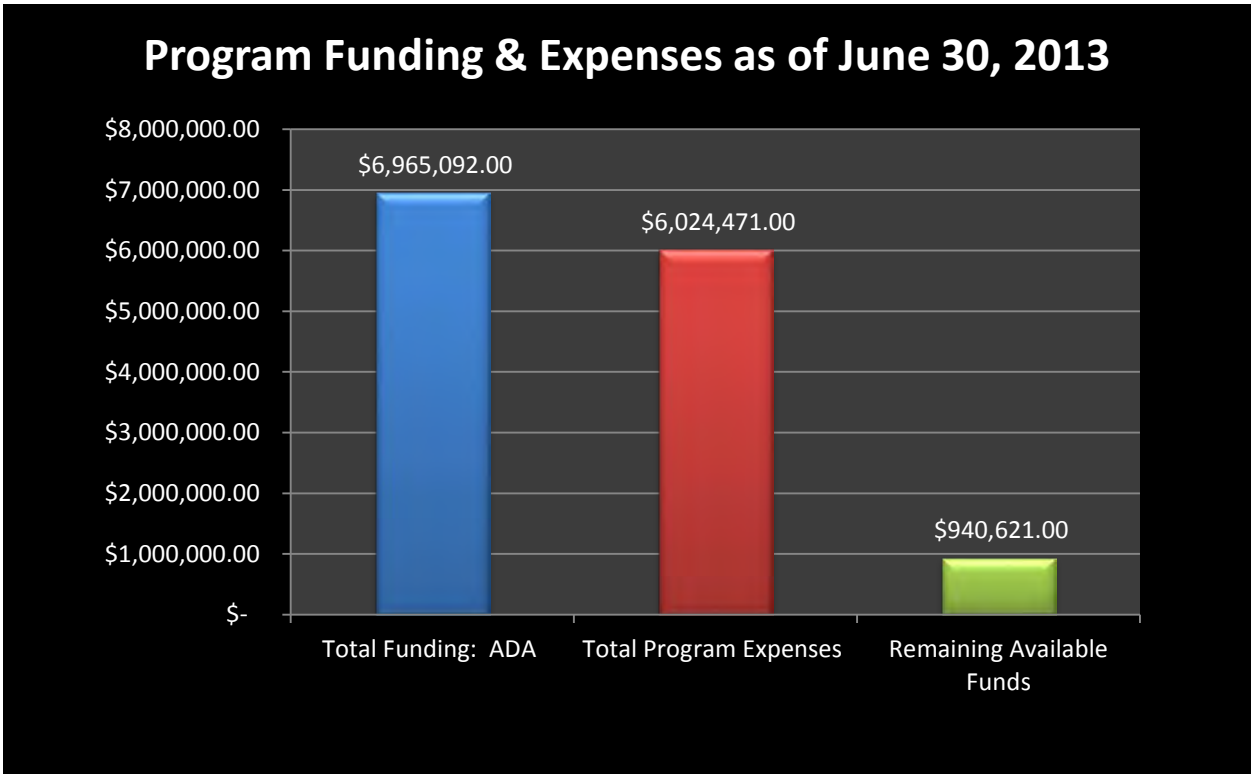
Due to a reorganization of the Foundation, funding was placed on hold in 2010. A grant request was submitted in 2011 and approved. Total funding received by ADAF was $200,000.

Funding for the Pilot Program by Year:

	Total Available Funds	Expenses
2008	$ 2,000,000.00	$ 242,386.00
2009		$ 1,233,014.00
2010	$ 2,889,692.00	$ 1,465,811.00
2011	$ 2,444,788.00	$ 1,927,235.00
2012	$ 1,258,386.69	$ 998,309.00
2013	$ 210,074.69	$ 153,009.00
	reconciling items 2013	$ 4,707.00
Total		**$ 6,024,471.00**



	2008	2009	2010	2011	2012	2013	
Funds	$2,000,00	$4,122,70	$2,889,69	$2,423,88	$1,296,64	$298,337.	
Expenses	$242,386.	$1,233,01	$1,465,81	$1,927,23	$998,309.	$153,009.	$4,707.00



The CDHC pilot program is scheduled for completion no later than December 31, 2013. Projected expenses for the remainder of 2013 to transition the pilot program are $773,190.00.

2013 Projected Expenses		
3 Pilot Sites: Temple, UCLA, OK, Arizona (2011)	$	50,200.00
Management of Online Curriculum: Rio Salado	$	300,000.00
Evaluation of Program	$	163,500.00
CHW curriculum revisions	$	-
Project Support: ADA staff and volunteer expenses	$	180,490.00
Media	$	74,000.00
Equipment and Supplies	$	5,000.00
Total	$	773,190.00

Expenses to date	$	6,024,471.00
Total Project Expense Estimated	**$**	**6,797,661.00**

Any remaining funds allocated for the program will be returned to ADA reserves upon final reconciliation of the program expenses early in 2014.

Sustainability of the CDHC Model

The access problem cannot be solved with one solution. The CDHC pilot program was created to explore one way the profession can address unmet oral health care needs among underserved populations. The CDHC is a community health worker (CHW), who is a potential new member of the dental team, though existing dental team members could be and, have been, trained in this regard.

It is expected the CDHC will be paid a salary in the range of $27,504-$30,772. The cost of tuition is approximately $13,000 for an 18 month program. Additional training expenses include portable equipment for field work ($40,000) and a laptop computer (for data entry, triage and patient assessment-$1,800). The training equipment was specific to the pilot program but could be an operational expense for clinics utilizing CDHCs. The evaluation demonstrated the CDHC can target underserved populations encountered at WIC centers, Head Start and Early Head Start centers, mental health organizations, healthy baby initiatives, foster home children, senior citizen centers, community health fairs, schools and other community events in providing preventive services. Clearly there are numerous other opportunities for outreach. In addition, CDHCs were active in working with patients in the FQHCs and Indian Health Services (IHS) at medical visits for inclusion in dental services visits.

CHW skills included competency in community-based advocacy for health, helping community members enroll and maintain eligibility within state and federally funded dental programs, motivational interviewing and counseling, nutritional counseling and navigating social services. Clinical skills were limited to collection of information to assist dentists in triage, preventive services (cleanings, fluoride applications and sealants), and placement of temporary fillings (limited to non-surgical intervention). State dental practice acts determined whether or not these skills could be provided post-training.

Depending on the state dental practice act where the CDHC is employed, there are procedures that are reimbursable under Medicaid including bite-wing and periapical radiographs, oral hygiene instruction, sealants, prophylaxis and fluoride applications. It was expected that the recruitment of Medicaid recipients from the community to the clinic would qualitatively increase revenue through additional patient visits and services on-site. The evaluation of the work of the CDHCs in the field validated this premise.

The evaluation also validated the inherent value of the efficiencies of a community-based health worker model with a focus on patient education, preventive services and patient navigation. The evaluation demonstrated the value of the CDHC conducting outreach events and bringing new patients into the clinic for comprehensive care and the establishment of a dental home. Data indicated increases in clinic revenues in many of the clinics.

The value of the CDHC breaking down cultural and structural barriers to improve access for targeted populations is truly immeasurable. The data does provide evidence of improved access to countless patients in the communities where the CDHCs have been working. More importantly, the stories of their work clearly underscore their value in reaching out to vulnerable and underserved populations.

Using data obtained from the field evaluation, ADA staff developed a pro forma model to demonstrate the sustainability of the CDHC in a variety of practice settings. Numerous variables were considered in developing the calculator including clinic revenue, number of outreach days, CDHC pre-training credentials, CDHC salary, fixed costs, and payer mix. Several assumptions were made to create the model that calculates the financial impact of adding a CDHC to the dental team.

The CDHC pro forma is a one year financial model that permits a decision-maker to describe a scenario of how their clinic would use a CDHC in the practice and determine potential financial impact. The CDHC pro forma uses input provided by the user, values obtained from real CDHC case studies, and simple revenue and expense calculations to create a pro forma of what a clinic can expect to gain or lose by utilizing a CDHC.

The pro forma model uses two types of days in its calculations: 1.) A clinic day described as the CDHC working in the clinic; 2.) An outreach day described as a day the CDHC works in the community at outreach events providing preventive services and assisting patients in navigating the healthcare system to gain access to care. In addition, the model assesses the revenue derived from patients seen during

outreach events, and, separately, patients receiving more comprehensive care in the clinic. Revenues and expenses are calculated in terms of number of days, or per patient in the financial model.

The financial model makes the following assumptions:

- One person works as a CDHC
- Any past role the CDHC had does not impact revenue generated. (the exception is a dental hygienist who provided billable services pre- and post-CDHC training)
- The clinic can bill for procedures CDHCs provide on outreach days such as sealants and fluoride varnish applications.
- A CDHC may be accompanied by a dentist or a hygienist at outreach events.
- The average work year is 220 days
- Outreach is done for populations who have unmet demand for dental care (low utilization)

The model uses three types of data: Variables that are entered by the person using the calculator; fixed variables (constants) derived from averages through analysis of the CDHC case studies for specific variables; and, calculated values.

Variable data points that can be entered into the model to calculate the impact of the CDHC were developed to answer the following questions:

- Is the CDHC a dental assistant, EFDA, or hygienist?
- What is the CDHC's salary?
- What is the total number of outreach days worked?
- What percentage of outreach days is the CDHC accompanied by a dentist?
- What is payer mix for the clinic? i.e., sliding fee for service to Medicaid?
- What percentage of patients seen during outreach events later receive services in the clinic?
- Over how many years is the CDHC equipment amortized?

Taken collectively all these entered values are called the scenario parameters. If the user varies the scenario parameters, the model will recalculate and the pro forma results will change.

The second data type is a set of constants that are internal to the model and cannot be changed by the user. Constants are derived from averages obtained through analysis of the CDHC case studies for the value in question. There are eight constants embedded in the pro forma model:

- CDHC outreach patients per day
- CDHC equipment cost
- A CDHC who is a dental hygienist and the clinic revenue generated per day
- Revenue per outreach patient referred to, and seen in the clinic
- Benefit percent of the CDHC salary
- CDHC outreach patient revenue (for billable services)
- Lost clinic revenue per day for the dentist when attending outreach events
- Outreach supply costs per patient

Constants are expressed in days or patients and are used as multipliers in the revenue and expense formulas used by the model. Alternatively, a constant can be a fixed value.

The final type of data are values calculated by the model using the first and second types of data. The formulas are simple products of revenue or expenses per day multiplied by the number of days or, per patient by the number of patients.

The model considers both revenue and expenses associated with the CDHC. The model uses three revenue inputs:

- Revenue produced by the CDHC performing billable procedures on community outreach days.
- Revenue from outreach patients seen on outreach days that are appointed to, and later seen in the clinic for more comprehensive care.
- Revenue generated in the clinic by CDHCs who are also dental hygienists.

There are five expense inputs used in the model:

- The cost of the CDHC durable medical equipment used in the community on outreach days (mobile equipment).
- CDHC salary and benefits.
- Lost dentist revenue from the clinic on outreach days when the CDHC is accompanied by a dentist.
- Lost clinic revenue on CDHC outreach days when CDHC is a hygienist.
- The cost of dental supplies utilized on outreach days.

All service based revenues or expenses are adjusted for the mix of sliding fee for service and Medicaid patients seen by the clinic. The model subtracts the sum of all expenses from the sum of all revenues and produces a net income to the clinic with a CDHC as a member of the dental team. A net income from CDHC outreach activities is calculated as well. The CDHC salary and benefit expense and the hygienist CDHC revenue on clinic days are omitted from the CDHC net income from outreach events calculation.

Calculations were run to demonstrate 12 scenarios for a CDHC in the field. Using case study data to determine average salaries, the model was run for a dental assistant and a dental hygienist with CDHC training and outreach field work. The results clearly emphasize the value of the CDHC in the field with more revenue generated through outreach activities. In all cases, the dental hygienist CDHC was able to provide net income to the clinic. A dental assistant with limited outreach activities would not be expected to provide a positive net income to the clinic for several years. As the payer mix changes to more Medicaid patients the expected revenue impact also decreases.

Pro Forma Calculations

CDHC credentials	CDHC salary	#Outreach Days per year	% Outreach with Dentist	Payer Mix	CDHC contribution margin	Cost/Benefit Impact Net Positive
Dental Asst.	$27,648	5	15%	50/50	-$18,334.20	Year 4
				75/25	-$12,920.75	Year 3
		15	15%	50/50	$43,366.46	Year 1
				75/25	$59,606.83	Year 1
		30	15%	50/50	$135,917.45	Year 1
				75/25	$168,398.20	Year 1
Dental Hygienist	$58,560	5	15%	50/50	$72,448.80	Year 1
				75/25	$98,693.59	Year 1
		15	15%	50/50	$121,749.86	Year 1
				75/25	$156,837.63	Year 1
		30	15%	50/50	$195,701.47	Year 1
				75/25	$244,053.69	Year 1

Refer to the appendices to see a demonstration of the model and a more detailed description of the pro forma assumptions: Appendix – CDHC Pro Forma definitions; Appendix - Pro Forma Scenarios.

CDHC Pro Forma Calculator Definitions

CDHC Model Spread Sheet Parameter	Definition and Model Usage	Valid Values
CDHC existing occupation	The dental occupation of the person prior to being trained as a CDHC. If the person has no dental occupation they are treated as a dental assistant. Only the hygienist role is considered to be revenue generating in the model. The parameter is user supplied.	Three values are permitted. • Dental assistant • Expanded function dental auxiliary • Hygienist
CDHC Salary	The annual wages or salary paid to the CDHC by the employing clinic. The parameter is user supplied.	Use prevailing local salary or $30,772
Total outreach days per year	The number of days in the year that the CDHC is in the community screening and providing preventative services to patients. A work day spent in this manner is referred to as an outreach day. The parameter is user supplied.	Zero to 36 days have been observed in case study data.
Percent outreach days with dentist	The number of outreach days that the CDHC is accompanied by a dentist who is providing comprehensive diagnostic and restorative services to patients. This number is expressed as a percent of total outreach days. The parameter is user supplied.	Can range from 0 to 100%
Percent outreach days CDHC only	The number of outreach days that the CDHC is not accompanied by a dentist. This number is expressed as a percent of total outreach days. The parameter is user supplied.	Can range from 0 to 100%
Clinic payment mix level (FFS to MC)	The approximate mix of patients who pay for care via fee for service or Medicaid. The model expresses this as a percent where fee for service is a list price and Medicaid is assumed to be a 50% discount to the fee for service price. For example, a procedure with a list of $100 is discounted to $50 for Medicaid. Accordingly, when the mix is 75% fee for service and 25% Medicaid and 100 patients received the $100 procedure the revenue to the clinic is only $8,750 and not $10,000 because 75 patients paid the $100 price and 25 patients paid the discounted Medicaid price of $50. The parameter is user supplied.	Two values are permitted. • 50% 50% • 75% 25%
Percent outreach patients seen in the clinic	The number of patients seen at the clinic who were seen earlier on an outreach day. Number of outreach day patients seen in clinic divided by the number of outreach day patients. The parameter is user supplied.	This value ranged from 5 to 85% with an average of 32% in case studies.

CDHC Model Spread Sheet Parameter	Definition and Model Usage	Valid Values
Amortization period for CDHC equipment	The number of years over which the dental equipment needed to deploy a CDHC in the community for one or more outreach days per year is depreciated. An approximate amortization of the cost of the dental equipment is performed by the model. The formula used is purchase price divided by years amortized. The parameter is user supplied.	Five values are permitted. • One year • Two years • Three years • Four years • Five years
CDHC outreach patients per day	The number of patients seen on an outreach day by the CDHC.	23.87
Outreach supply costs per patient	The cost of disposable medical supplies used in providing preventative dental care during a CDHC outreach day. The model uses a per patient value to calculate the cost.	$25
CDHC equipment cost	The total dollars paid to purchase durable dental equipment needed to deploy a CDHC in the community for one or more outreach days per year. The model divides this by the number of amortization years when calculating expenses.	$41,800
Hygienist CDHC in clinic revenue per day	The revenue per day produced by the CDHC working in a dental hygienist role in the clinic. The model only considers this revenue for a CDHC whose past occupation is a hygienist where it is treated as a revenue gain for those days spent in the clinic and as an expense for those days that the CDHC is in the community.	$826.64
Clinic revenue per outreach patient	The clinic revenue derived from a patient first seen on an outreach day who is later seen in the clinic for comprehensive dental care.	$577.69
Benefit percentage of salary	Percent of the CDHC salary that is paid for insurance and other benefits. The model calculates the benefits dollars incurred as expenses.	0.275
CDHC Outreach revenue per patient	The revenue derived from a patient who is treated on an outreach day when the CDHC is alone and only providing preventative dental care.	$305.47
Outreach day dentist lost clinic revenue	The dentist generated revenue that is lost to the clinic on outreach days that the CDHC is accompanied by a dentist in the community.	$1687.83
Payer mix multiplier	The percent calculated by the model from the clinic payment mix level (FFS to MC) for the clinic. The percent is used to adjust revenue and expenses from dental procedures provided in the clinic or on an outreach day. Computed from the clinic payment mix level.	The model permits two values. • 0.875 when 75% 25% • 0.75 when 50% 50%
Outreach CDHC patients	The calculated annual number of patients seen on an outreach day when the CDHC is working without a dentist. Outreach days with a dentist X the number of patient seen on outreach days when the CDHC is alone.	The value is calculated by the model.
CDHC days in clinic	The calculated number of days when the CDHC is working in the clinic. If the CDHC is a hygienist these days are revenue generating.	The value is calculated by the model.

CDHC Model Spread Sheet Parameter	Definition and Model Usage	Valid Values
Outreach patients seen in clinic	The calculated annual number of patients first seen on an outreach day who are later seen in the clinic for comprehensive care.	The value is calculated by the model.
Total outreach with dentist patient revenue	The calculated annual revenue from patients seen on those outreach days when the CDHC is accompanied by a dentist who is providing comprehensive services by the model. Annual outreach day dentist patients X outreach dentist patient revenue	The value is calculated by the model.
Total outreach CDHC patient revenue	The calculated annual number of patients seen on those outreach days when the CDHC is working without a dentist. Outreach CDHC patients X Outreach patient revenue CDHC only	The value is calculated by the model.
Annual clinic revenue gain from OR patients	The calculated annual revenue from patients first seen on an outreach day who are later seen in the clinic for comprehensive care Outreach patients seen in clinic X Clinic revenue per OR patient	The value is calculated by the model.
Clinic revenue gains from CDHC services	The annual revenue produced by the CDHC working in a dental hygienist role on those days when the CDHC is in the clinic. Only applies to a dental hygienist. CDHC days in clinic X CDHC in clinic revenue per day	The value is calculated by the model.
Total CDHC salary and benefit costs	Total dollars paid out in salary and benefits for the CDHC. CDHC Salary + CDHC Salary X Benefit percent of salary	The value is calculated by the model.
Total outreach supply costs	Outreach dentist patients + Outreach CDHC patients X $25	The value is calculated by the model.
Clinic DDS revenue loss	This is the annual revenue lost to the clinic by having the CDHC accompanied by a dentist on outreach days.	The value is calculated by the model.
Clinic CDHC revenue loss	This is the annual revenue lost to the clinic by having a CDHC who is a hygienist out of the clinic on outreach days.	The value is calculated by the model.
Net Income due to CDHC	This is the annual revenue less expenses from all CDHC derived by the clinic from the addition of a CDHC.	The value is calculated by the model.
Net Income due to CDHC OR activities	This is the annual revenue less expenses from CDHC outreach days derived by the clinic from the addition of a CDHC.	The value is calculated by the model.

Proforma Scenarios for a CDHC

Proforma Scenarios for a CDHC

Dental Assistant – CDHC (15 Outreach Days with 50/50 Payment Mix) (created 09/03/2013)

Scenario Parameters	Input Values
CDHC existing occupation	Dental assistant
CDHC salary	$27,648
Total outreach days per year	5
Percent outreach days with dentist	20%
Percent outreach days CDHC only	80%
Total	0%
Clinic payment mix (FFS to MC)	50% 50%
Percent of outreach patients seen in clinic	15%
Period of amortization for CDHC outreach equipment	Three year

Revenue Statistics

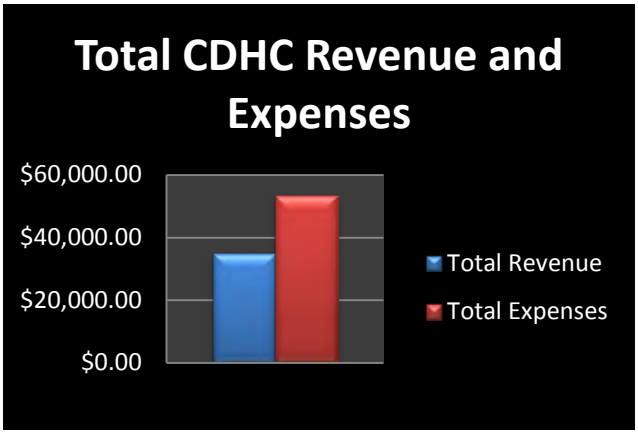
Outreach Revenue with Dentist	$5,468.68
Outreach Revenue CDHC only	$21,874.71
Clinic Revenue Gain From New Outreach Patients	$7,756.57
CDHC Clinic Revenue	$0.00
Total Revenue	$35,099.96

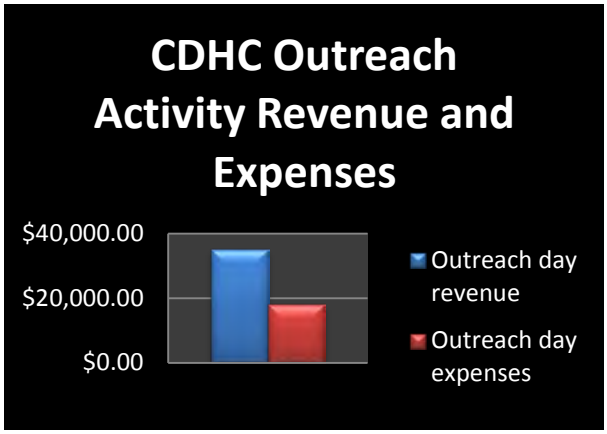
Expense Statistics

CDHC Salary and Benefits	$35,251.20
Equipment	$13,933.33
Supplies	$2,983.75
Clinic Dentist Revenue Lost	$1,265.87
Clinic Hygienist CDHC Revenue Lost	$0.00
Total Expenses	$53,434.15

Net Income

Net Income to Clinic with CDHC	-$18,334.20
Net Income From CDHC Outreach Activities	$16,917.00





Dental Assistant – CDHC (15 Outreach Days with 75/25 Payment Mix) (created 09/03/2013)

Scenario Parameters	Input Values
CDHC existing occupation	Dental assistant
CDHC salary	$27,648
Total outreach days per year	5
Percent outreach days with dentist	20%
Percent outreach days CDHC only	80%
Total	0%
Clinic payment mix (FFS to MC)	75% 25%
Percent of outreach patients seen in clinic	15%
Period of amortization for CDHC outreach equipment	Three year

Revenue Statistics

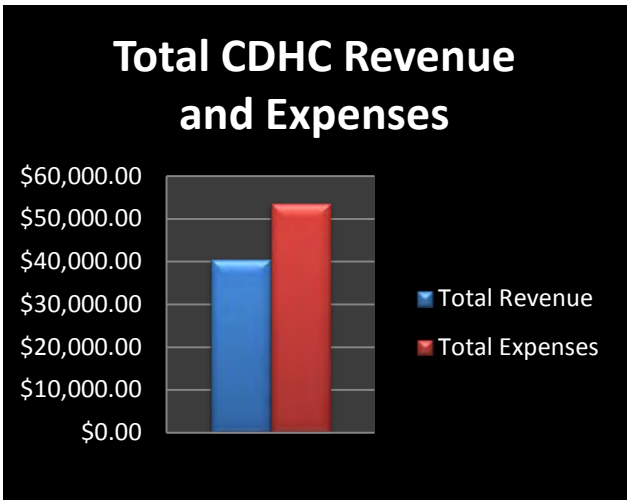
Outreach Revenue with Dentist	$6,343.67
Outreach Revenue CDHC only	$25,374.66
Clinic Revenue Gain From New Outreach Patients	$8,997.62
CDHC Clinic Revenue	$0.00
Total Revenue	$40,715.95

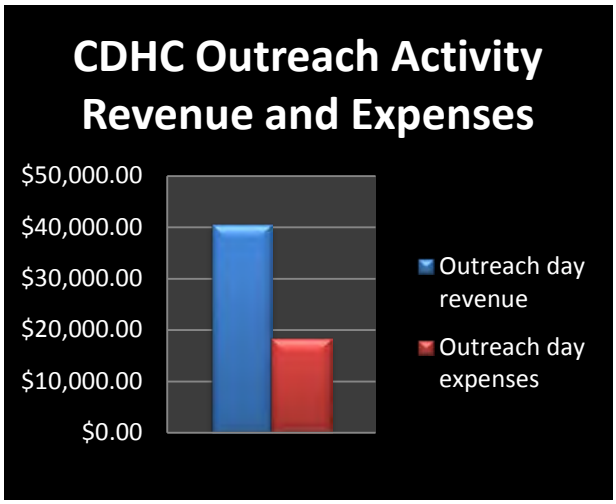
Expense Statistics

CDHC Salary and Benefits	$35,251.20
Equipment	$13,933.33
Supplies	$2,983.75
Clinic Dentist Revenue Lost	$1,468.41
Clinic Hygienist CDHC Revenue Lost	$0.00
Total Expenses	$53,636.69

Net Income

Net Income to Clinic with CDHC	-$12,920.75
Net Income From CDHC Outreach Activities	$22,330.45





Dental Assistant – CDHC (15 Outreach Days with 50/50 Payment Mix) (created 09/03/2013)

Scenario Parameters	Input Values
CDHC existing occupation	Dental assistant
CDHC salary	$27,648
Total outreach days per year	15
Percent outreach days with dentist	20%
Percent outreach days CDHC only	80%
Total	0%
Clinic payment mix (FFS to MC)	50% 50%
Percent of outreach patients seen in clinic	15%
Period of amortization for CDHC outreach equipment	Three year

Revenue Statistics

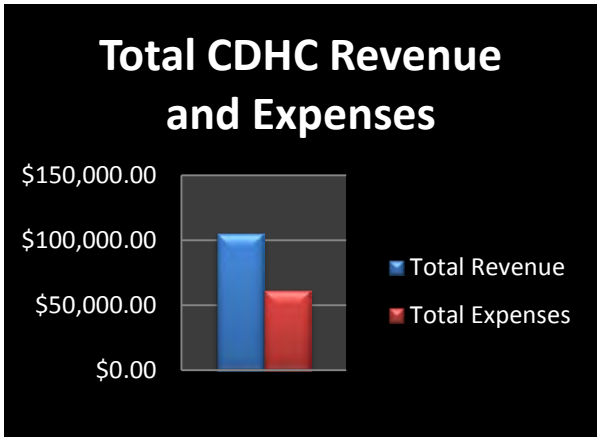
Outreach Revenue with Dentist	$16,406.03
Outreach Revenue CDHC only	$65,624.12
Clinic Revenue Gain From New Outreach Patients	$23,269.72
CDHC Clinic Revenue	$0.00
Total Revenue	$105,299.86

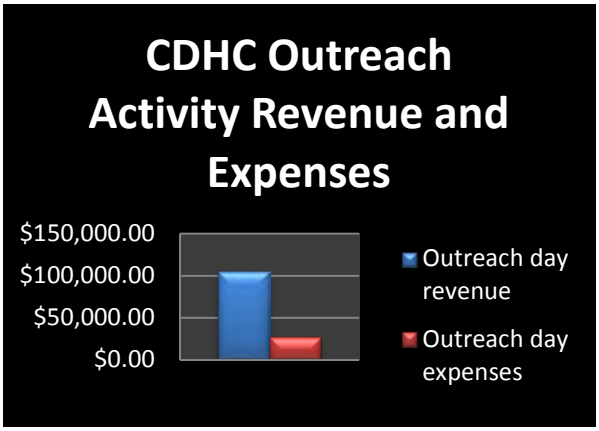
Expense Statistics

CDHC Salary and Benefits	$35,251.20
Equipment	$13,933.33
Supplies	$8,951.25
Clinic Dentist Revenue Lost	$3,797.62
Clinic Hygienist CDHC Revenue Lost	$0.00
Total Expenses	$61,933.40

Net Income

Net Income to Clinic with CDHC	$43,366.46
Net Income From CDHC Outreach Activities	$78,617.66





Dental Assistant – CDHC (15 Outreach Days with 75/25 Payment Mix) (created 09/03/2013)

Scenario Parameters	Input Values
CDHC existing occupation	Dental assistant
CDHC salary	$27,648
Total outreach days per year	15
Percent outreach days with dentist	20%
Percent outreach days CDHC only	80%
Total	0%
Clinic payment mix (FFS to MC)	75% 25%
Percent of outreach patients seen in clinic	15%
Period of amortization for CDHC outreach equipment	Three year

Revenue Statistics

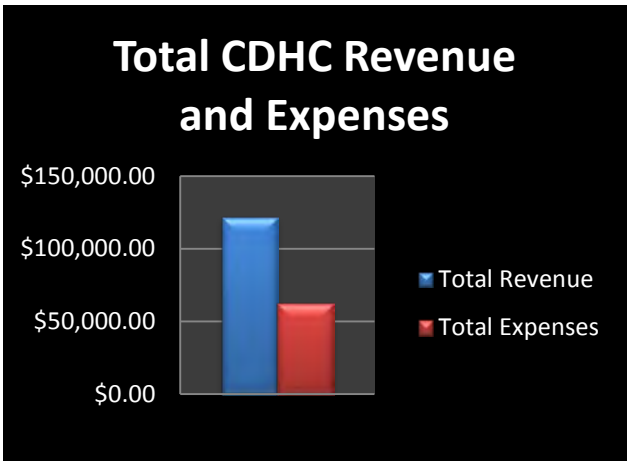
Outreach Revenue with Dentist	$19,031.00
Outreach Revenue CDHC only	$76,123.98
Clinic Revenue Gain From New Outreach Patients	$26,992.87
CDHC Clinic Revenue	$0.00
Total Revenue	$122,147.85

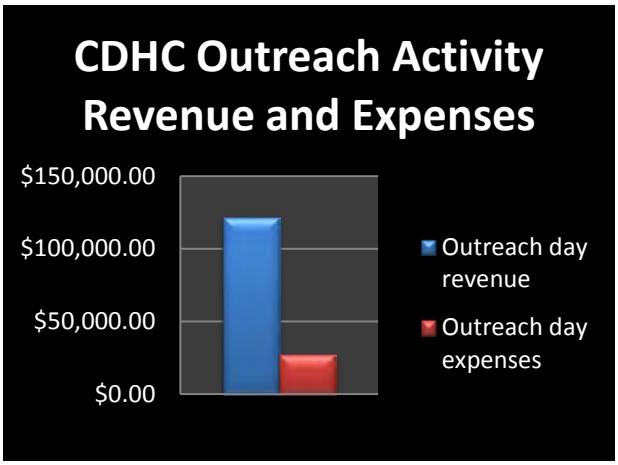
Expense Statistics

CDHC Salary and Benefits	$35,251.20
Equipment	$13,933.33
Supplies	$8,951.25
Clinic Dentist Revenue Lost	$4,405.24
Clinic Hygienist CDHC Revenue Lost	$0.00
Total Expenses	$62,541.02

Net Income

Net Income to Clinic with CDHC	$59,606.83
Net Income From CDHC Outreach Activities	$94,858.03





Dental Assistant – CDHC (30 Outreach Days with 50/50 Payment Mix) (created 09/03/2013)

Scenario Parameters	Input Values
CDHC existing occupation	Dental assistant
CDHC salary	$27,648
Total outreach days per year	30
Percent outreach days with dentist	20%
Percent outreach days CDHC only	80%
Total	0%
Clinic payment mix (FFS to MC)	50% 50%
Percent of outreach patients seen in clinic	15%
Period of amortization for CDHC outreach equipment	Three year

Revenue Statistics

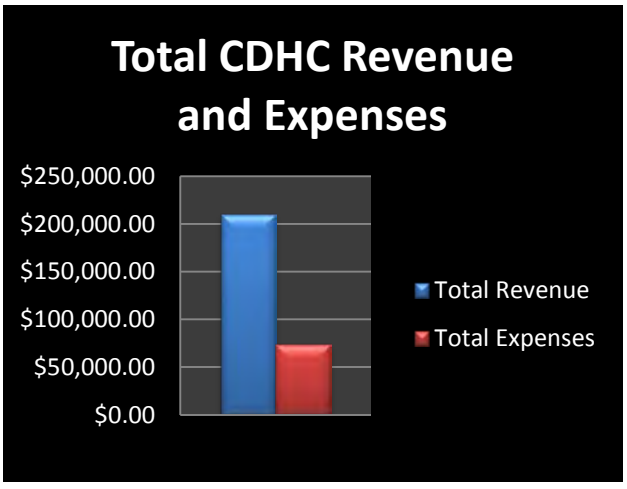
Outreach Revenue with Dentist	$32,812.06
Outreach Revenue CDHC only	$131,248.23
Clinic Revenue Gain From New Outreach Patients	$46,539.43
CDHC Clinic Revenue	$0.00
Total Revenue	$210,599.73

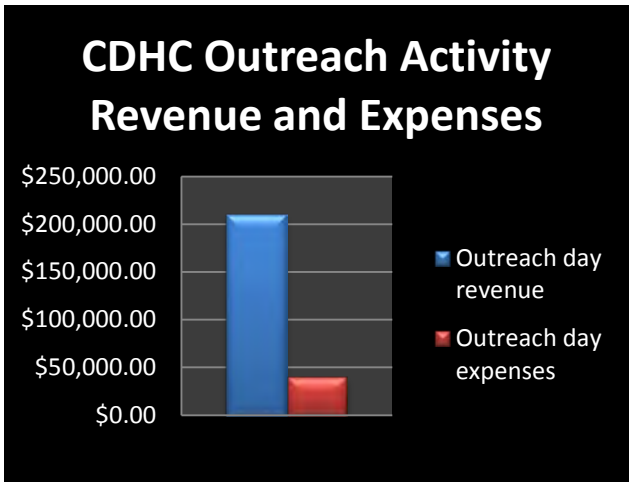
Expense Statistics

CDHC Salary and Benefits	$35,251.20
Equipment	$13,933.33
Supplies	$17,902.50
Clinic Dentist Revenue Lost	$7,595.23
Clinic Hygienist CDHC Revenue Lost	$0.00
Total Expenses	$74,682.27

Net Income

Net Income to Clinic with CDHC	$135,917.45
Net Income From CDHC Outreach Activities	$171,168.66





Dental Assistant – CDHC (30 Outreach Days with 75/25 Payment Mix) (created 09/03/2013)

Scenario Parameters	Input Values
CDHC existing occupation	Dental assistant
CDHC salary	$27,648
Total outreach days per year	30
Percent outreach days with dentist	20%
Percent outreach days CDHC only	80%
Total	0%
Clinic payment mix (FFS to MC)	75% 25%
Percent of outreach patients seen in clinic	15%
Period of amortization for CDHC outreach equipment	Three year

Revenue Statistics

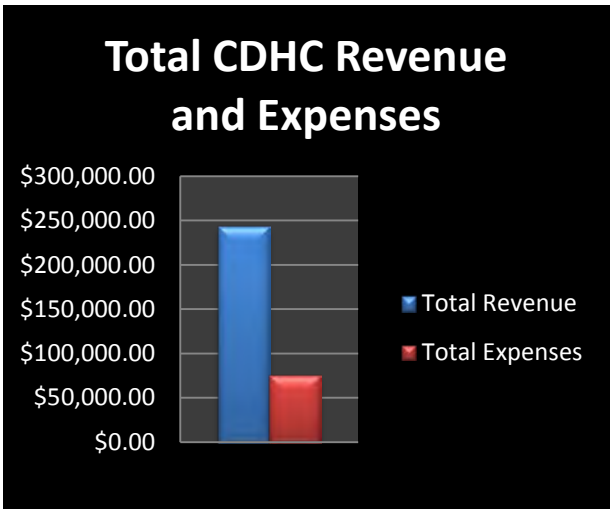
Outreach Revenue with Dentist	$38,061.99
Outreach Revenue CDHC only	$152,247.97
Clinic Revenue Gain From New Outreach Patients	$53,985.74
CDHC Clinic Revenue	$0.00
Total Revenue	$244,295.70

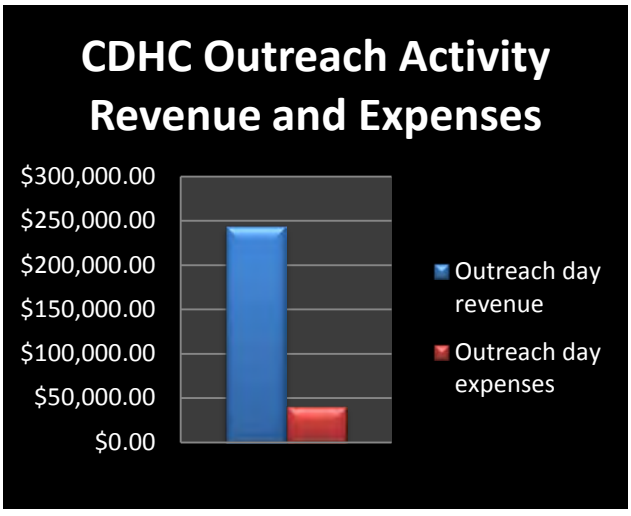
Expense Statistics

CDHC Salary and Benefits	$35,251.20
Equipment	$13,933.33
Supplies	$17,902.50
Clinic Dentist Revenue Lost	$8,810.47
Clinic Hygienist CDHC Revenue Lost	$0.00
Total Expenses	$75,897.50

Net Income

Net Income to Clinic with CDHC	$168,398.20
Net Income From CDHC Outreach Activities	$203,649.39





Proforma Scenarios for a CDHC

Proforma Scenarios for a CDHC

Hygienist – CDHC (5 Outreach Days with 50/50 Payment Mix) (created 09/03/2013)

Scenario Parameters	Input Values
CDHC existing occupation	Hygienist
CDHC salary	$58,560
Total outreach days per year	5
Percent outreach days with dentist	20%
Percent outreach days CDHC only	80%
Total	0%
Clinic payment mix (FFS to MC)	50% 50%
Percent of outreach patients seen in clinic	15%
Period of amortization for CDHC outreach equipment	Three year

Revenue Statistics

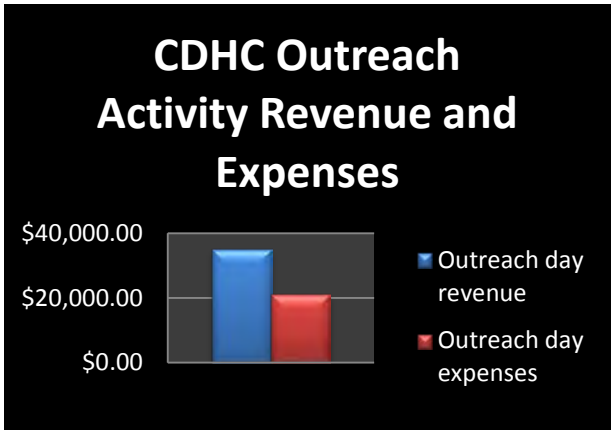
Outreach Revenue with Dentist	$5,468.68
Outreach Revenue CDHC only	$21,874.71
Clinic Revenue Gain From New Outreach Patients	$7,756.57
CDHC Clinic Revenue	$133,295.70
Total Revenue	$168,395.66

Expense Statistics

CDHC Salary and Benefits	$74,664.00
Equipment	$13,933.33
Supplies	$2,983.75
Clinic Dentist Revenue Lost	$1,265.87
Clinic Hygienist CDHC Revenue Lost	$3,099.90
Total Expenses	$95,946.86

Net Income

Net Income to Clinic with CDHC	$72,448.80
Net Income From CDHC Outreach Activities	$13,817.10



Hygienist – CDHC (5 Outreach Days with 75/25 Payment Mix) (created 09/03/2013)

Scenario Parameters	Input Values
CDHC existing occupation	Hygienist
CDHC salary	$58,560
Total outreach days per year	5
Percent outreach days with dentist	20%
Percent outreach days CDHC only	80%
Total	0%
Clinic payment mix (FFS to MC)	75% 25%
Percent of outreach patients seen in clinic	15%
Period of amortization for CDHC outreach equipment	Three year

Revenue Statistics

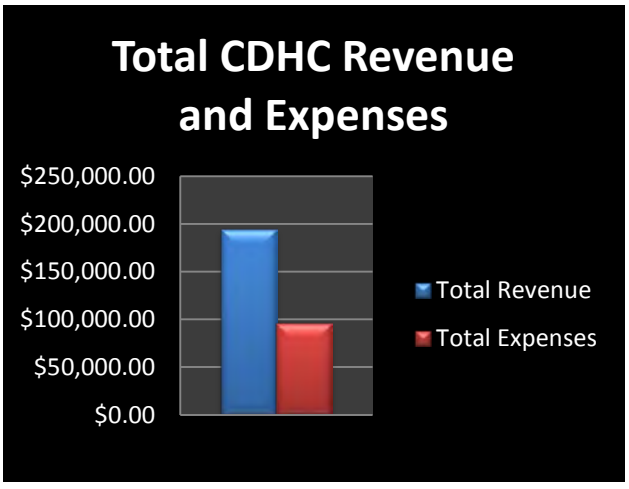
Outreach Revenue with Dentist	$6,343.67
Outreach Revenue CDHC only	$25,374.66
Clinic Revenue Gain From New Outreach Patients	$8,997.62
CDHC Clinic Revenue	$154,623.02
Total Revenue	$195,338.96

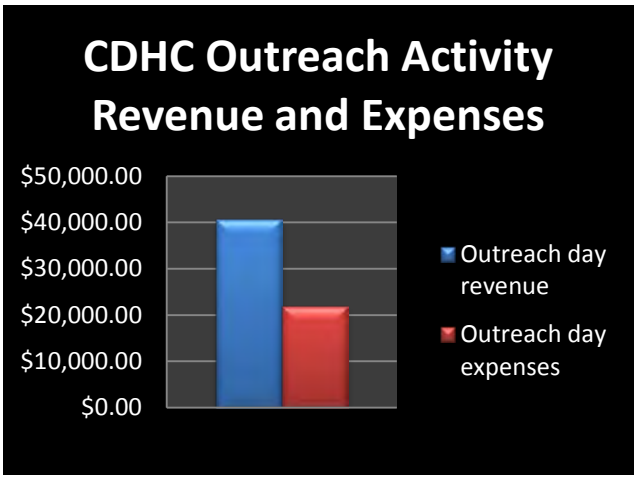
Expense Statistics

CDHC Salary and Benefits	$74,664.00
Equipment	$13,933.33
Supplies	$2,983.75
Clinic Dentist Revenue Lost	$1,468.41
Clinic Hygienist CDHC Revenue Lost	$3,595.88
Total Expenses	$96,645.38

Net Income

Net Income to Clinic with CDHC	$98,693.59
Net Income From CDHC Outreach Activities	$18,734.57





Hygienist – CDHC (15 Outreach Days with 50/50 Payment Mix) (created 09/03/2013)

Scenario Parameters	Input Values
CDHC existing occupation	Hygienist
CDHC salary	$58,560
Total outreach days per year	15
Percent outreach days with dentist	20%
Percent outreach days CDHC only	80%
Total	0%
Clinic payment mix (FFS to MC)	50% 50%
Percent of outreach patients seen in clinic	15%
Period of amortization for CDHC outreach equipment	Three year

Revenue Statistics

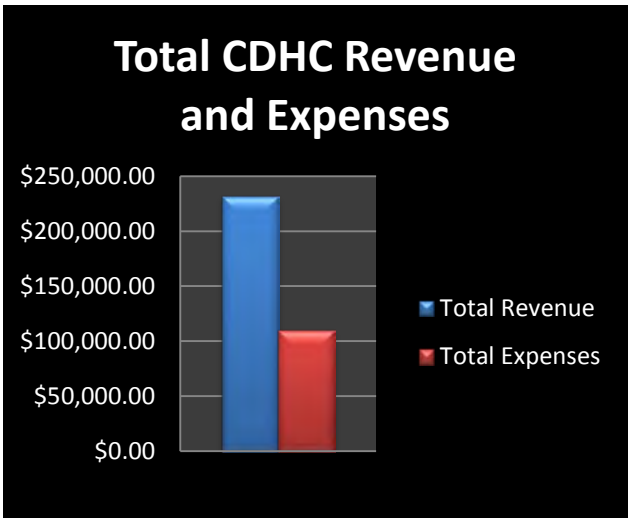
Outreach Revenue with Dentist	$16,406.03
Outreach Revenue CDHC only	$65,624.12
Clinic Revenue Gain From New Outreach Patients	$23,269.72
CDHC Clinic Revenue	$127,095.90
Total Revenue	$232,395.76

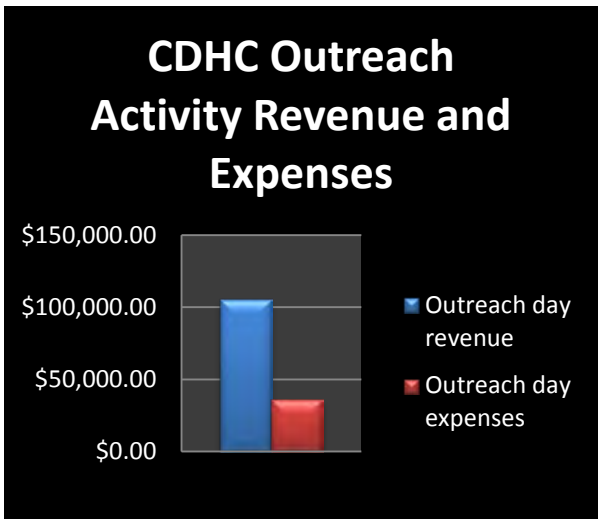
Expense Statistics

CDHC Salary and Benefits	$74,664.00
Equipment	$13,933.33
Supplies	$8,951.25
Clinic Dentist Revenue Lost	$3,797.62
Clinic Hygienist CDHC Revenue Lost	$9,299.70
Total Expenses	$110,645.90

Net Income

Net Income to Clinic with CDHC	$121,749.86
Net Income From CDHC Outreach Activities	$69,317.96





Hygienist – CDHC (15 Outreach Days with 75/25 Payment Mix) (created 09/03/2013)

Scenario Parameters	Input Values
CDHC existing occupation	Hygienist
CDHC salary	$58,560
Total outreach days per year	15
Percent outreach days with dentist	20%
Percent outreach days CDHC only	80%
Total	0%
Clinic payment mix (FFS to MC)	75% 25%
Percent of outreach patients seen in clinic	15%
Period of amortization for CDHC outreach equipment	Three year

Revenue Statistics

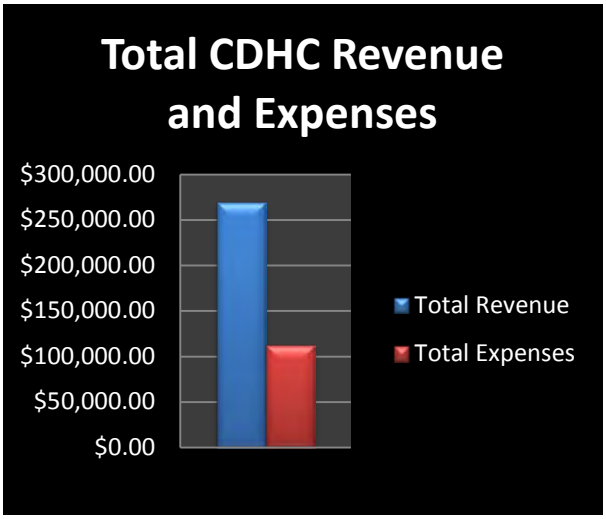
Outreach Revenue with Dentist	$19,031.00
Outreach Revenue CDHC only	$76,123.98
Clinic Revenue Gain From New Outreach Patients	$26,992.87
CDHC Clinic Revenue	$147,431.25
Total Revenue	$269,579.10

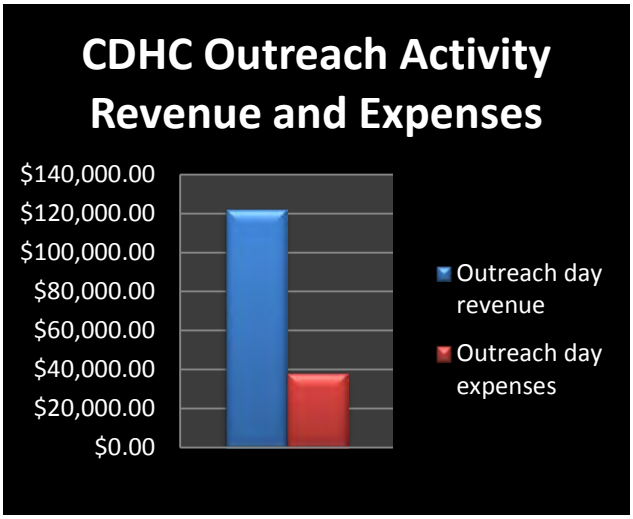
Expense Statistics

CDHC Salary and Benefits	$74,664.00
Equipment	$13,933.33
Supplies	$8,951.25
Clinic Dentist Revenue Lost	$4,405.24
Clinic Hygienist CDHC Revenue Lost	$10,787.65
Total Expenses	$112,741.47

Net Income

Net Income to Clinic with CDHC	$156,837.63
Net Income From CDHC Outreach Activities	$84,070.38





Hygienist – CDHC (30 Outreach Days with 50/50 Payment Mix) (created 09/03/2013)

Scenario Parameters	Input Values
CDHC existing occupation	Hygienist
CDHC salary	$58,560
Total outreach days per year	30
Percent outreach days with dentist	20%
Percent outreach days CDHC only	80%
Total	0%
Clinic payment mix (FFS to MC)	50% 50%
Percent of outreach patients seen in clinic	15%
Period of amortization for CDHC outreach equipment	Three year

Revenue Statistics

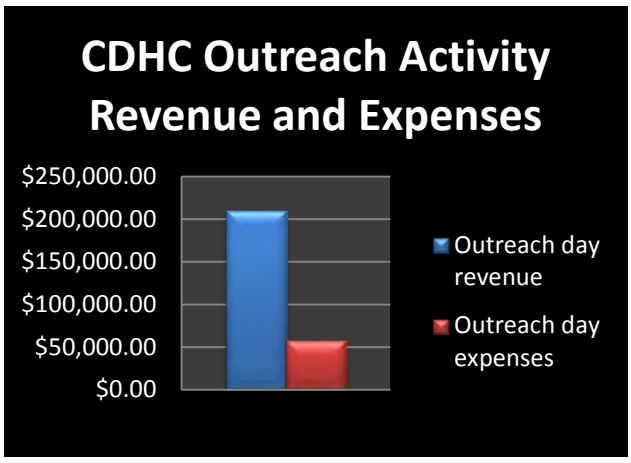
Outreach Revenue with Dentist	$32,812.06
Outreach Revenue CDHC only	$131,248.23
Clinic Revenue Gain From New Outreach Patients	$46,539.43
CDHC Clinic Revenue	$117,796.20
Total Revenue	$328,395.93

Expense Statistics

CDHC Salary and Benefits	$74,664.00
Equipment	$13,933.33
Supplies	$17,902.50
Clinic Dentist Revenue Lost	$7,595.23
Clinic Hygienist CDHC Revenue Lost	$18,599.40
Total Expenses	$132,694.47

Net Income

Net Income to Clinic with CDHC	$195,701.47
Net Income From CDHC Outreach Activities	$152,569.27



Hygienist – CDHC (30 Outreach Days with 75/25 Payment Mix) (created 09/03/2013)

Scenario Parameters	Input Values
CDHC existing occupation	Hygienist
CDHC salary	$58,560
Total outreach days per year	30
Percent outreach days with dentist	20%
Percent outreach days CDHC only	80%
Total	0%
Clinic payment mix (FFS to MC)	75% 25%
Percent of outreach patients seen in clinic	15%
Period of amortization for CDHC outreach equipment	Three year

Revenue Statistics

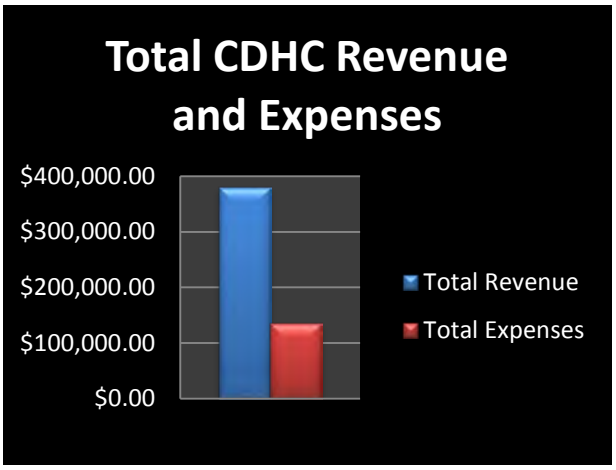
Outreach Revenue with Dentist	$38,061.99
Outreach Revenue CDHC only	$152,247.97
Clinic Revenue Gain From New Outreach Patients	$53,985.74
CDHC Clinic Revenue	$136,643.59
Total Revenue	$380,939.30

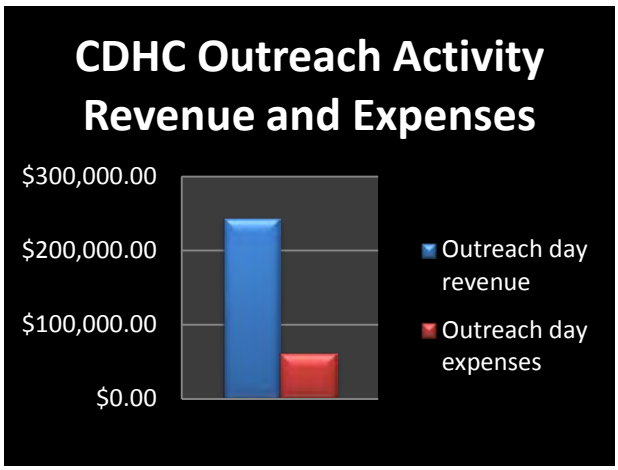
Expense Statistics

CDHC Salary and Benefits	$74,664.00
Equipment	$13,933.33
Supplies	$17,902.50
Clinic Dentist Revenue Lost	$8,810.47
Clinic Hygienist CDHC Revenue Lost	$21,575.30
Total Expenses	$136,885.61

Net Income

Net Income to Clinic with CDHC	$244,053.69
Net Income From CDHC Outreach Activities	$182,074.09





Transition of the CDHC Program

As the ADA CDHC pilot program completes the final phase of the evaluation, it is key to the success of the model for various institutions of higher learning to adopt CDHC training programs and state practice acts to include CDHCs as part of the dental team workforce.

In transitioning the CDHC program to a viable and sustainable career track option for a new member of the dental team, it is important to consider the following key points:

1. The CDHC program is the first-to-market, actually graduating and deploying a new model before competing models are truly "on the ground" with the exception of Alaska DHATs.
2. Leveraging the ADA's name recognition provides an opportunity to enhance efforts to call attention to the CDHC story through numerous lobbying, media and other outreach efforts.
3. The CDHCs' origins in the same types of underserved communities in which they will work, highlights both cultural sensitivity and job creation in the nearly recession-proof health care sector.

The CDHC's emphasis on prevention and education—in addition to actually providing those services—accentuates the critical importance of those elements in stemming the tide of untreated disease. Emphasis on prevention and education under the supervision of a licensed dentist distinguishes the program from competing models.

1. The CDHC curriculum is based upon a proven model the public health community already understands.
2. There is an increased awareness of the critical importance of oral health to overall health, owing to mainstream media having covered several tragedies due to unmet dental needs, such as the Diamonte Driver story.
3. There is renewed public policy interest in solving access problems of the underserved, and concerns about cost.
4. Opportunity to put in perspective the misguided notion that midlevel providers are a panacea for access problems with an alternative model that works.

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

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

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

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

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

Ownership of CDHC Curriculum: At the completion of the pilot program the ADA retained ownership or otherwise have the right to the entire CDHC curriculum. As a result, the Association will be free to license the curriculum to any entity and on any terms it sees fit.

Modifications to Curriculum: Unique circumstances may warrant modifications to the current curriculum and licensees should be free to do so. Examples of such circumstances might include opposition to particular aspects of the CDHC scope of practice in a particular state. This approach has the potential to lead to CDHCs with different training and capacities in different parts of the country. While this may not be ideal similar conditions exist for other members of the dental team, including hygienists and assistants. The license agreements from the ADA provide the Association with rights to approve any proposed substantial modifications to the curriculum and the right to be informed in advance of any other modifications to the CDHC curriculum to assure that the programs operating under license meet the standards and guidelines for the CDHC position adopted by the ADA.

Marketing of the CDHC Program and License Opportunities: The ADA has developed a communications plan to reach out to potential licensees, so that they are aware of the potential opportunity. In addition efforts are underway to engage the involvement of constituent societies in identifying potential schools and in marketing the opportunity.

Reaching out to the Indian Health Service, American Indian Communities, and Federally Qualified Health Centers and the Community Health Worker Community is also essential to educate their leadership about the inherent value of CDHCs as valuable members of the facility team. Similar to the value of a front desk person who is critical for programmatic success, CDHCs have the potential to increase facility efficiency, effectiveness, productivity and outreach to the community.

Beyond the pilot phase there will clearly need to be funding sources to ensure sufficient resources are available to implement programs at the state level. In all likelihood there will have to multiple funders ranging from federal program and foundation, corporate/industry sponsors and private donors.

In June, 2011 the Council on Access, Prevention and Interprofessional Relations (CAPIR) adopted the following resolutions to assure the transition of the CDHC pilot program:

> **Resolved,** that the appropriate agencies identify states interested in initiating CDHC training programs; and be it further
>
> **Resolved,** that staff immediately contact current pilot program sites to assess their interest in continuing the program.

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

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

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

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

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

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

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

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

In September, 2012, the ADA created a staff workgroup to focus specifically on the transition of the CDHC model and to promote the CDHC through the Action for Dental Health Initiative that launched in May 2013. The goal of the initiative is to expand the number of community dental health coordinators (CDHC) working within the community health center environment and the private practice environment to reduce barriers to access.

Presently, CDHCs are employed in 7 states: Arizona, Wisconsin, Minnesota, Oklahoma, California, Montana, and Pennsylvania. Ongoing activities have resulted in interest in the pilot program in several states. In May, 2013, a pilot program trainee began a sabbatical at an FQHC in New Mexico to demonstrate the skills and outreach opportunities that a CDHC can bring to the dental team. A second sabbatical is planned in Vermont later this year.

The job description for the CDHC can be reviewed in the Appendix. ADA staff will continue to monitor the progress of the CDHC in 2014 through the State Government Affairs division.

SUMMARY

In 2006, the ADA initiated a pilot project to educate, train and deploy a new type of community health worker, one with a focus on patient education, disease prevention and patient navigation. The Community Dental Health Coordinator (CDHC) pilot project graduated 34 students, who are now working in underserved areas such as remote rural communities, inner cities and American Indian communities. The ADA invested thousands of hours and millions of dollars in making the Community Dental Health Coordinator a reality. The students invested their hopes for meaningful careers. All have done so with the conviction that the Community Dental Health Coordinator will be a significant element in a larger effort to break down barriers that impede many Americans from achieving good oral health.

The pilot program will be completed at the end of 2013. Training of the students and the evaluation of the program have been accomplished. The remainder of 2013 will be spent transitioning the program and curriculum to colleges and universities interested in developing a CDHC program. In addition, work will continue with the State constituent societies to encourage adoption of the CDHC as a viable member of the dental team.

As the program draws to a close, below are key highlights of the past 7 years:

- 34 CDHC from 7 states completed the CDHC pilot program in 3 training cohorts.
- 4 universities were involved in the pilot program training.
- With the support of Henry Schein and the ADA Foundation, the program was able to be completed under the budget of $7 million appropriated by the HOD.
- The independent evaluation of the training of the CDHCs was positive with the conclusion that the CDHC curriculum is very appropriate for educating this new category of dental health care worker.
- The CDHCs impacted over 11,000 patient lives at their respective clinics and contributed to total revenues of approximately 1.85 million dollars.
- Comparing the geographic locations of the clinics, the data demonstrate the greatest impact to the dental practice was in the American Indian settings.
- The total value of services provided through school-based outreach events was $ 1,396,106.00.
- 20 of the case studies targeted specific populations such as diabetic patients, foster children, perinatal patients or HIV patients.
- The model is sustainable as evidenced by case study data. The results clearly emphasize the value of the CDHC in the field with more revenue generated through outreach activities.
- The data support the fact that the CDHC has significant impact in reaching out to those in their communities who lack access to care; key to the work of the CDHC is patient navigation and improving access.
- Transition of the curriculum to interested colleges and universities is underway with CDHCs presently employed in 9 states.

It is the ADA's belief the CDHC will be a legacy program that dentists will be proud of for generations to come and CDHCs will continue to serve in their communities providing preventive services, promoting oral health and, through patient navigation and care coordination, increase access to dental care for those in need in order to help them maintain their oral and overall health.

Resolution No. 89 New

Report: N/A Date Submitted: October 2013

Submitted By: Fifth Trustee District

Reference Committee: Legislative, Health, Governance and Related Matters

Total Net Financial Implication: None Net Dues Impact:

Amount One-time Amount On-going FTE .05

ADA Strategic Plan Goal: Public Health (Required)

USE OF HEALTH CARE EFFECTIVENESS DATA AND INFORMATION SET (HEDIS) FOR UTILIZATION MEASURES

The following resolution was submitted by the Fifth Trustee District and transmitted on October 16, 2013, by Dr. Mark Donald, chairman of the Fifth Trustee District.

Background: The Georgia Dental Association (GDA) is concerned that continued reliance upon the Health Care Effectiveness Data and Information Set (HEDIS) scores for dental utilization through the single dental measure in the HEDIS set commonly known as the Annual Dental Visit (ADV) is misleading and does not identify the level of care received by children enrolled in Medicaid. The GDA has proposed using the CMS-416 EPSDT data as a more reliable data source or some other appropriate measurement tool that accurately measures dental treatment. The CMS-416 is a form state programs must submit annually to the Centers for Medicare and Medicaid Services (CMS) that details utilization of a scope of services for children who receive services through the Early Periodic Screening, Diagnosis and Treatment Program (EPSDT). The 416 form includes a number of specific dental questions including "total eligible receiving any dental services," "total eligible receiving any preventive dental service," and "total eligible receiving any dental treatment service," among other dental questions. The 416 categories use CDT billing codes to categorize the services that are reported.

HEDIS v. CMS-416. HEDIS and the CMS-416 measure utilization of services. They do not measure quality of care. The two measurements are quite different. In general, HEDIS scores are typically greater than those reported on the 416 form. HEDIS measures utilization for children continuously enrolled in Medicaid for 11 months of the year while the 416 includes children enrolled continuously for 90 days. The denominator population included in the HEDIS scores is much lower than in the 416, which results in higher utilization rates under HEDIS. At any given time, a single measure of utilization does not provide an adequate picture of quality or utilization. HEDIS is endorsed by the National Quality Forum (NQF) and is used by plans that contract with Medicaid programs as well as commercial plans. The 416 is used by policymakers and state and federal officials to compare Medicaid dental programs.

Dental Quality Alliance. The Dental Quality Alliance (DQA) endorsed a measure set (as of July 19, 2013) that aims to overcome the limitations of **both** HEDIS and the 416. The DQA measures provide a mechanism to evaluate the complementary aspects of utilization, quality and cost. They were developed by the dental community and have been validated through a number of studies. Members of the DQA are working to promote the measures at the state level to continue to improve access to and utilization of dental services for children enrolled in Medicaid. In addition, members of the ADA Council on Government Affairs, Council on Access, Prevention and Interprofessional Relations, and the Council on Dental Benefit Programs have reviewed and approved the use of these guidelines for measuring dental services in the Medicaid/CHIP programs.

Resolution

89. Resolved, that the ADA promote the adoption of the comprehensive measures developed by the Dental Quality Alliance for assessing quality of state Medicaid/CHIP programs, and be it further

Resolved, that the ADA provide technical support to the constituent dental societies to assist them with this issue.

BOARD RECOMMENDATION: Received after the October Board of Trustees session.

Resolution No. 93 New

Report: N/A Date Submitted: October 2013

Submitted By: Fourteenth Trustee District

Reference Committee: Legislative, Health, Governance and Related Matters

Total Net Financial Implication: $20,000 Net Dues Impact: .18

Amount One-time $20,000 Amount On-going FTE 0

ADA Strategic Plan Goal: Public Health (Required)

CONTINGENCY BASED MEDICAID AUDITS

The following resolution was submitted by the Fourteenth Trustee District and transmitted on October 24, 2013, by J. Jerald Boseman, chairman, Resolutions Committee.

Background: It is common for practices offering services to Medicaid populations to be subjected to audits by CMS and state Medicaid programs looking for fraudulent practices and abuses of the system. These audits are typically conducted by Recovery Audit Contractors (RAC's) working on a contingency fee basis. While the ADA does not condone Medicaid fraud by any dental practitioner, and believes that any person that knowingly commits willful fraud should be prosecuted to the fullest extent of the law, there should be reasonable controls governing the scope of operation of Recovery Audit Contractors.

Some of the issues surrounding these audits that raise concern are:

1. Audits typically do not directly involve either a dentist on the RAC who understands dentistry or the particular specialty of dentistry being audited, or an individual that is in direct contact with a qualified consulting dentist.

2. Contingency based audits encourage RAC's to vigorously seek out and potentially maximize alleged infractions in order to receive remuneration for an audit.

There are several known examples of audits that have led to practitioners needing to defend practices that adhere to standards of care accepted by the ADA and/or a recognized specialty organization (e.g. AAPD) through an often long, protracted and expensive process.

Aggressive audits performed by decision makers with little or no dental expertise will discourage dentists from continuing to participate in the system and discourage new dentists from treating this population, thereby being detrimental to maintenance of a robust provider network that is needed to meet the oral health needs of Medicaid eligible populations.

Resolution

93. Resolved, that the appropriate agencies of the ADA study and evaluate how Medicaid audits are conducted, as well as explore options for improving the current audit system by revising contingency based audits, and be it further

Resolved, that the appropriate agencies of the ADA coordinate with other healthcare organizations/associations to develop a politically prudent, fiscally responsible federal legislative

effort to revise contingency based audits as determined by the ADA Council of Governmental Affairs and/or the ADA Board of Trustees, and be it further

Resolved, that the ADA advocate for auditing procedures that include appropriate professional participation, and be it further

Resolved, that a report of activities and its findings be made to the 2014 HOD.

BOARD RECOMMENDATION: Received after the October Board of Trustees session.

Resolution No. 94 New

Report: N/A Date Submitted: October 2013

Submitted By: First Trustee District

Reference Committee: Legislative, Health, Governance and Related Matters

Total Net Financial Implication: None Net Dues Impact:

Amount One-time Amount On-going FTE 0

ADA Strategic Plan Goal: Collaboration (Required)

DESIGNATE INDIVIDUALS WITH INTELLECTUAL DISABILITIES AS A MEDICALLY UNDERSERVED POPULATION

The following resolution was submitted the First Trustee District and transmitted on October 23, 2013, by Judith M. Fisch, ADA first district caucus chair.

Background: For individuals with intellectual disabilities (ID) the public impression about their access to care opportunities is overly optimistic. The reality is that access to care for people with ID falls short of their needs in the areas of assessment and primary, secondary, tertiary and rehabilitative care.

People with ID experience the same type of health challenges as the general population, but their experience is exacerbated through both basic metabolic factors and their cognitive deficits, which increase their risk of disease, their likelihood of not seeking early treatment and the likelihood of suffering greater adverse effects including pain, generalized infections, further disability and social isolation.

Designating these individuals as Medically Underserved Population (MUP) could open the door to tuition reimbursement programs, special clinical research programs, and serve as a platform for special Medicaid reforms that could be utilized by dentists who treat this patient population. The American Medical Association passed a resolution in 2011 encouraging the federal government to designate individuals with intellectual disabilities as a medically underserved population, potentially providing resources to these persons to access care.

Resolution

94. Resolved, that the American Dental Association supports a simplified process across appropriate governmental agencies to designate individuals with intellectual disabilities as a medically and dentally underserved population, and be it further

Resolved, that the ADA seek to collaborate with the American Medical Association and American Academy of Developmental Medicine and Dentistry to promote this process to appropriate governmental agencies.

BOARD RECOMMENDATION: Received after the October Board of Trustees session.

Resolution No. 95 New

Report: N/A Date Submitted: October 2013

Submitted By: Fourteenth Trustee District

Reference Committee: Legislative, Health, Governance and Related Matters

Total Net Financial Implication: $120,000 Net Dues Impact:

Amount One-time $120,000 Amount On-going FTE 0

ADA Strategic Plan Goal: Members (Required)

ASSIGNMENT OF BENEFITS

The following resolution was submitted by the Fourteenth Trustee District and transmitted on October 24, 2013, by J. Jerald Boseman, chairman, Resolutions Committee.

Background: ADA policy supports the rights of every patient to select the dentist of their choice and recognizes that many considerations are factored into that patient's choice. ADA also has policy which recognizes the right of every patient to authorize and/or assign their contractual benefit payment to be directly paid to their treating dentist. ADA policy recognizes that when a third party payer provides for treatment by non-contracted dentists, yet refuses to honor the patient's directive to assign payment to their dentist, they interfere with the doctor-patient relationship, restrict access to care, inhibit competition and compromise the consumer benefit of dental care coverage.

Resolution

95. Resolved, that appropriate ADA agencies review case law, contract law, statutory law and other appropriate resources, then prepare an analysis of the legal rights of patients to assign the payment due and payable to them from third party payers, to the dentist of their choosing, and be it further

Resolved, that appropriate ADA agencies prepare suitable documentation that can be disseminated to each constituent society to facilitate its efforts in working with its state's insurance commissioner and legislature to enact measures that support these patient rights, and be it further

Resolved, that the ADA directly communicate to Human Resource Associations and trade publications, employers, third-party payers and insurance commissioners that the anti-assignment of benefit clause in employer-payer contracts is against ADA policy inasmuch as it: 1) limits access to all available providers-some of which may provide unique and valuable services not readily available in other dental practices, 2) is anti-competition, 3) compromises the consumer's dental coverage benefit, 4) unfairly implies that patients can use their benefits with both contracted and non-contracted dentists, while imposing unspoken barriers that restrict access to a smaller pool of dentists.

BOARD RECOMMENDATION: Received after the October Board of Trustees session.

Resolution No. 95S-1 Citation for Original Resolution: Gray:5159

Submitted By: Fourteenth Trustee District Date Submitted: November 3, 2013

Substitute x Amendment ☐

Reference Committee Report On: Legislative, Health, Governance and Related Matters

Financial Implications (if different from original resolution): $ None

SUBSTITUTE FOR RESOLUTION 95: ASSIGNMENT OF BENEFITS

The following substitute for Resolution 95 was submitted by the Fourteenth Trustee District and transmitted on November 3, 2013, by J. Jerald Boseman, chairman, Resolutions Committee.

Background: ADA policy supports the rights of every patient to select the dentist of their choice and recognizes that many considerations are factored into that patient's choice. ADA also has policy which recognizes the right of every patient to authorize and/or assign their contractual benefit payment to be directly paid to their treating dentist. ADA policy recognizes that when a third party payer provides for treatment by non-contracted dentists, yet refuses to honor the patient's directive to assign payment to their dentist, they interfere with the doctor-patient relationship, restrict access to care, inhibit competition and compromise the consumer benefit of dental care coverage.

Resolution

95S-1. Resolved, that appropriate ADA agencies develop model Assignment of Benefits legislation and seek the endorsement of applicable stakeholder organizations, and be it further

Resolved, that the ADA transmit the model legislation to every constituent society to introduce in their legislature as appropriate.

Membership and Related Matters

Resolution No. 44 New

Report: NA Date Submitted: August 2013

Submitted By: Council on Membership

Reference Committee: Membership and Related Matters

Total Net Financial Implication: None Net Dues Impact:

Amount One-time Amount On-going FTE 0

ADA Strategic Plan Goal: Members (Required)

DUES STRUCTURE

Background: (*Reports*:97)

As part of its role as outlined in the ADA *Bylaws*, the Council on Membership formulates and recommends policies related to membership recruitment and retention. As such, it has traditionally played a role in reviewing ADA dues amounts, rate percentages and membership categories in order to make dues recommendations to the Board of Trustees and House of Delegates that positively impact both market share and revenue contribution. While the House gives significant attention to the amount of full active dues in relation the other fully privileged categories, due to the complexity of the separate dues structures and pricing methodologies that exist at the constituent and component levels it is difficult to fully consider the cost of membership to the individual dentist. The Council in concert with the administrative review committee and the Board continue to address implications and opportunities relative to this situation.

Furthermore, other categories are often reviewed every few years, in isolation from other dues categories and without full consideration to the overall financial and market impact. Typically, it is in response to a resolution that has been sent to the House of Delegates.

In 2012, the House of Delegates voted to remove the amount of Affiliate Membership dues from the ADA's *Bylaws* to allow the ADA greater price-setting flexibility when providing member value to global entities seeking ADA membership. This action was consistent with the removal of Active Member dues amounts from the *ADA Bylaws* in a previous year.

The Council discussed the flexibility that would result from removing all dues amounts and percentage structures from the *ADA Bylaws.* After reviewing the pros and cons of this approach, the Council concluded that the dollar amounts for the dues of the student and graduate student member categories should be removed from the *Bylaws* and that the Board of Trustees should be authorized to set these dues amounts with recommendations from the Council on Membership. The changes to the *Bylaws* are proposed in the following resolution offered for the consideration of the House of Delegates.

If the House adopts the proposed Resolution 44, the Board of Trustees would then review the current dues structure following the close of the House to establish the dues of the predoctoral and postdoctoral dues categories. If Resolution 44 fails to be adopted by the House of Delegates, the Council offers the House Resolutions 45 and 46 on setting dues amounts for these categories for its consideration. If Resolution 44 is adopted, then Resolutions 45 and 46 are moot.

Resolution

44. Resolved, that the ADA *Bylaws*, CHAPTER I. MEMBERSHIP, Section 20. QUALIFICATIONS, PRIVILEGES, DUES AND SPECIAL ASSESSMENTS, Subsection E. STUDENT MEMBER, subsection c. DUES AND SPECIAL ASSESSMENTS, paragraph 1, be amended as follows (new language underscored; deletions ~~stricken through~~):

(1) PREDOCTORAL STUDENT MEMBERS: The dues of predoctoral student members shall be established by the Board of Trustees. ~~five dollars ($5.00)~~ Predoctoral student member dues shall be due January 1 of each year. Such student members shall be exempt from the payment of any special assessment.

and be it further

Resolved, that the ADA *Bylaws*, CHAPTER I. MEMBERSHIP, Section 20. QUALIFICATIONS, PRIVILEGES, DUES AND SPECIAL ASSESSMENTS, Subsection E. STUDENT MEMBER, subsection c. DUES AND SPECIAL ASSESSMENTS, paragraph 2, be amended as follows: (new language underscored; deletions ~~stricken through~~).

(2) POSTDOCTORAL STUDENTS AND RESIDENTS: The dues of dentists who are student members pursuant to Chapter I, Section 20E shall be established by the Board of Trustees. ~~thirty dollars ($30.00)~~ Postdoctoral students and resident dues shall be due January 1 of each year. Such student members shall be exempt from the payment of any special assessment.

and be it further

Resolved, that the ADA *Bylaws*, CHAPTER I. MEMBERSHIP, Section 20. QUALIFICATIONS, PRIVILEGES, DUES AND SPECIAL ASSESSMENTS, Subsection A. ACTIVE MEMBER, subsection c. DUES AND SPECIAL ASSESSMENTS, paragraph 2, be amended as follows (new language underscored; deletions ~~stricken through~~):

(2) Dentists who are engaged full-time in (a) an advanced training course of not less than one (1) academic year's duration in an accredited school or a residency program in areas neither recognized by this Association nor accredited by the Commission on Dental Accreditation or (b) a residency program or advanced education program in areas recognized by this Association and in a program accredited by the Commission on Dental Accreditation shall pay an amount to be established by the Board of Trustees, ~~pay thirty~~ and shall be ~~dollars ($30.00)~~ due on January 1 of each year until December 31 following completion of such program. For dentists who enter such a course or program while eligible for the dues reduction program, the applicable reduced dues rate shall be deferred until completion of that program. Upon completing the program, the dentist shall pay dues and any special assessment for active members at the reduced dues rate where the dentist left off in the progression. This benefit shall be conditioned on maintenance of continuous membership or payment of post-graduate student dues and active member dues and any special assessment for years not previously paid, at the rates current during the missing years. The dentist who is engaged full-time in (a) an advanced training course of not less than one (1) academic year's duration in an accredited school or residency program in areas neither recognized by this Association nor accredited by the Commission on Dental Accreditation or (b) a residency program or advanced education program in areas recognized by this Association and in a program accredited by the Commission on Dental Accreditation shall be exempt from the

payment of any active member special assessment then in effect through December 31 following completion of such course or program.

BOARD COMMENT: The Board agrees with the Council on Membership that removing the flat rate dues amount for the student and graduate student categories is consistent with earlier changes regarding affiliate dues. Timing of any changes to ADA student dues rate is complicated due to the fact that 38 dental schools automatically collect ASDA and ADA dues along with tuition. As such, it is noted that the Board intends to consult with ASDA leadership regarding any changes to ADA dues to facilitate appropriate timing.

BOARD RECOMMENDATION: Vote Yes.

Vote: Resolution 44

BUCKENHEIMER	Yes	FEINBERG	Yes	NORMAN	Yes	VERSMAN	Yes
CROWLEY	Yes	GOUNARDES	No	ROBERTS	Yes	WEBER	Yes
DOW	Yes	HAGENBRUCH	No	SCOTT	Yes	YONEMOTO	Yes
ENGEL	Yes	ISRAELSON	Yes	SEAGO	Yes	ZENK	Yes
FAIR	Yes	KIESLING	Yes	SUMMERHAYS	Yes	ZUST	Yes

Resolution No. 45 New

Report: NA Date Submitted: August 2013

Submitted By: Council on Membership

Reference Committee: Membership and Related Matters

Total Net Financial Implication: None until 2016 Net Dues Impact:

Amount One-time Amount On-going FTE 0

ADA Strategic Plan Goal: Members (Required)

REVIEW OF STUDENT DUES CATEGORY

Background: (*Reports*:97)

Pre-doctoral student members of ADA pay $5 annually. This student dues amount has not changed in 25 years. For their annual investment, student members receive essentially the same benefits as dentist members do, plus specific resources just for students. The American Student Dental Association (ASDA) collects ADA student dues concurrently with ASDA dues. In 2013, dental students pay $70 for ASDA dues, plus $5 for ADA dues (or $75 in total), and any applicable local ASDA chapter dues. Student dues for both memberships are paid to the American Student Dental Association; ASDA, in turn, remits $5 for each student member to the ADA. This arrangement demonstrates the relationship among the two organizations and allows a streamlined experience for the student. In order to maintain the data records of the student members until graduation, student market share is measured on July 1. As of July 1, 2012, there were 18,092 pre-doctoral student ADA members for a market share of 85.2% and associated dues revenue of $90,460.

It is important to note that any change proposed for ADA student membership dues to the House of Delegates in 2013 would not go into effect until the 2016 membership year to accommodate the current dues collection process used by ASDA. In addition to updating its operational systems and dues billing communications, ASDA would be afforded the time to give appropriate notice to the dental schools that automatically bill student members, currently 38. These schools include ASDA and ADA membership dues as part of the tuition payment, which is billed in advance of the academic year, and a handful receive payment or partial payment from state and local dental societies. This timeframe is necessary to allow the dental schools and constituent and component dental societies that pay full or partial membership dues for their student members the opportunity to make their billing changes in time for the collection of ADA student dues beginning with the 2015–2016 academic year and then remittance of those ADA dues effective January 1, 2016, by ASDA. Therefore, any additional dues revenue would not be received until the 2016 ADA fiscal year. It may be helpful to know that ASDA has adopted a resolution to increase its dues by $5 to a total $75 for 2015. Recent conversations with ASDA regarding dues have been beneficial. ASDA recognizes that close collaboration and coordination is necessary to work through the process when ADA student dues are raised. In addition, the Council took into consideration the results of the dues pricing survey conducted by McKinley Advisors wherein the student[1] members responded that the student dues of the ADA are priced below common perceptions of cost compared to value. About 50% of the dental student respondents considered $5 so cheap that the quality of the membership came into question; less than 20% considered $30 or less to be too expensive, while the

[1] Student members as defined in the McKinley study were composed of both predoctoral and postdoctoral students combined.

optimal range of dues landed between $30 and $75. The Council reviewed the pros and cons and recommends that student dues be increased by a total of $5. Doing so accomplishes the following:

—Keeps the financial burden on the student member low;
—Doubles the revenue gained from student dues; and
—Compares favorably to ASDA's practice of raising dues.

This would bring the ASDA and ADA dues to $85 for the 2016 membership year. This total does not include local ASDA chapter dues, which vary.

The following resolution requesting an amendment of ADA *Bylaws* regarding the dues of predoctoral dental student members is offered for consideration of the House of Delegates.

If the House adopts the proposed Resolution 44, the Board of Trustees would then review the current dues structure following the close of the House to establish the dues of the predoctoral and postdoctoral dues categories. If Resolution 44 fails to be adopted by the House of Delegates, the Council offers the House Resolutions 45 and 46 on setting dues amounts for these categories for its consideration. If Resolution 44 is adopted, then Resolutions 45 and 46 are moot.

Resolution

45. Resolved, that effective January 1, 2016, the ADA *Bylaws*, CHAPTER I. MEMBERSHIP, Section 20. QUALIFICATIONS, PRIVILEGES, DUES AND SPECIAL ASSESSMENTS, Subsection E. STUDENT MEMBER, subsection c. DUES AND SPECIAL ASSESSMENTS, paragraph 1, be amended as follows (new language underscored; deletions ~~stricken through~~):

(1) PREDOCTORAL STUDENT MEMBERS: The dues of predoctoral student members shall be ten dollars ($10.00) ~~five dollars ($5.00)~~ due January 1 of each year. Such student members shall be exempt from the payment of any special assessment.

BOARD COMMENT: The Speaker has advised that if Resolution 44 is adopted by the House of Delegates, Resolution 45 will be declared moot. However, the Board considered Resolution 45 in the event that the House of Delegates does not adopt Resolution 44. The Board recognizes the importance of maintaining a strong ADA student membership. Further, it appreciates the cooperative arrangement with ASDA, who collects ADA dues along with ASDA dues. Additionally, it notes that the ADA provides considerable value to students through various benefits and services. Of note, ADA student dues have not changed in 25 years. A dues study authorized by the Council on Membership and conducted by an outside entity supported the conclusion that the optimal dues range based on the student respondents' perception of value was between $30 and $75. The sentiment of the Board was that the current student ADA dues does not reflect the true value of ADA membership. The Board also believes that the ADA student dues should be increased commensurate with the value of membership.

BOARD RECOMMENDATION: Vote No.

Vote: Resolution 45

BUCKENHEIMER	No	FEINBERG	No	NORMAN	No	VERSMAN	No
CROWLEY	Yes	GOUNARDES	Yes	ROBERTS	No	WEBER	Yes
DOW	Yes	HAGENBRUCH	No	SCOTT	Yes	YONEMOTO	No
ENGEL	No	ISRAELSON	Yes	SEAGO	No	ZENK	Yes
FAIR	Yes	KIESLING	No	SUMMERHAYS	No	ZUST	Yes

Resolution No. 45S-1 Substitute

Report: NA Date Submitted: October 2013

Submitted By: Fifth Trustee District

Reference Committee: Membership and Related Matters

Total Net Financial Implication: None until 2016 Net Dues Impact:

Amount One-time Amount On-going FTE 0

ADA Strategic Plan Goal: Members (Required)

SUBSTITUTE FOR RESOLUTION FOR 45: REVIEW OF STUDENT DUES CATEGORY

The following resolution was submitted by the Fifth Trustee District on October 16, 2013, and transmitted by Dr. Mark Donald, chairman of the Fifth Trustee District.

Background: The Council on Membership reports that dental students believe current ADA student dues ($5.00) are so cheap that the quality of the membership came into question. However, the Council's recommendation that the dues be increased by only five dollars ($5.00) could result in the request for an additional bylaws change to increase the dues yet again in the near future. If the dental student dues were tied to full member ADA dues as a percentage, then the students would be connected to additional programs and services that ADA members receive. Therefore, the dental students would more clearly recognize the benefits of membership. In addition, this would mean that regular bylaws changes would not be needed to address this issue. Based on current full member dues and a factor of 3%, student dues would be approximately $16 currently, which lies within the range perceived as appropriate by the dental students.

In order to keep ADA predoctoral student dues consistent with dues increases of active ADA members, a percentage of active ADA member dues would more accurately reflect a consistent student dues policy. For instance, 3% of the current ADA member dues is around $16. It is the House of Delegates responsibility to keep ADA predoctoral student dues from becoming meaningless and at the same time to reflect our consideration of their student status.

Resolution

45S-1. Resolved, that effective January 1, 2016, the ADA *Bylaws*, CHAPTER I. MEMBERSHIP, Section 20. QUALIFICATIONS, PRIVILEGES, DUES AND SPECIAL ASSESSMENTS, Subsection E. STUDENT MEMBER, subsection c. DUES AND SPECIAL ASSESSMENTS, paragraph 1, be amended as follows (new language underscored; deletions stricken through):

(1) PREDOCTORAL STUDENT MEMBERS: The dues of predoctoral student members shall be ~~five dollars ($5.00)~~ 3% of the dues of active members calculated from the full ADA member dues (rounded to the nearest dollar amount) of the prior year and are due January 1 of each year. Such student members shall be exempt from the payment of any special assessment.

BOARD RECOMMENDATION: Received after the October Board of Trustees session.

Resolution No. 46 New

Report: NA Date Submitted: August 2013

Submitted By: Council on Membership

Reference Committee: Membership and Related Matters

Total Net Financial Implication: 168,950 Net Dues Impact:

Amount One-time Amount On-going FTE 0

ADA Strategic Plan Goal: Members (Required)

REVIEW OF GRADUATE DUES CATEGORY

Background: (*Reports*:97)

Graduate student member dues have not changed in 22 years. In 1991 graduate student dues increased from $5 to $30. Many graduate students enter their advanced dental education program in the same year they receive their DDS or DMD degrees. If recent graduates enter a postdoctoral program immediately following graduation and pay graduate student dues during that time, they will be eligible for the reduced dues schedule upon completion of their postdoctoral program. As noted previously, new dentists in the reduced dues program pay a percentage of full active dues according to the following rate schedule:

- 0% for their first year
- 25% for their second year
- 50% for their third year
- 75% for their fourth year; and
- 100% of full active dues in their fifth year and thereafter.

The Reduced Dues Program continues to be an appealing offer for recent dental school graduates who enter a graduate program or residency following graduation or within their first few years out of school. The program now allows those who enter a graduate program or residency to put their reduced dues on hold while they are in training and then pick up where they left off following completion of the program. Graduate students may hold direct or tripartite membership, and 42 constituent societies offer a special rate. All but two of these societies offer a reduced rate that is equal to or less than the ADA's $30 rate. About half of the graduate student members hold direct membership.

Revenue Impact of Dues Increase

Using the 2012 graduate student membership count as a base, Table 2 shows the changes in revenue contribution that could be obtained by increasing member dues by $10 increments.

Table 2. Potential Revenue Contributions

Dues	2012 Graduate Student Members	Potential Revenue Contribution
$30 (current)	3,379	$101,370
$40	3,379	$135,160
$50	3,379	$168,950
$60	3,379	$202,740
$70	3,379	$236,530
$80	3,379	$270,320

The Council reviewed the pros and cons of raising graduate student dues, including the large amount of debt a graduate student member may have acquired. In addition, the group discussed the fact that this is a transient population and additional outreach will need to occur in order to grow the 61.8% market share. Again, the Council took into consideration the results of the dues pricing survey conducted by McKinley Advisors wherein the student[1] members responded that the student dues of the ADA are priced below common perceptions of cost compared to value. About 50% of the dental student respondents considered $5 so cheap that the quality of the membership came into question; less than 20% considered $30 or less to be too expensive, while the optimal range of dues landed between $30 and $75. Taking all this into consideration, the Council offers the following resolution requesting amendments of ADA *Bylaws* regarding the dues of postdoctoral dental student and resident members for the consideration of the House of Delegates.

If the House adopts the proposed Resolution 44, the Board of Trustees would then review the current dues structure following the close of the House to establish the dues of the predoctoral and postdoctoral dues categories. If Resolution 44 fails to be adopted by the House of Delegates, the Council offers the House Resolutions 45 and 46 on setting dues amounts for these categories for its consideration. If Resolution 44 is adopted, then Resolutions 45 and 46 are moot.

Resolution

46. Resolved, that the ADA *Bylaws*, CHAPTER I. MEMBERSHIP, Section 20. QUALIFICATIONS, PRIVILEGES, DUES AND SPECIAL ASSESSMENTS, Subsection E. STUDENT MEMBER, subsection c. DUES AND SPECIAL ASSESSMENTS, paragraph 2, be amended as follows (new language underscored; deletions ~~stricken through~~):

> (2) POSTDOCTORAL STUDENTS AND RESIDENTS: The dues of dentists who are student members pursuant to Chapter I, Section 20E shall be fifty dollars ($50.00) ~~thirty dollars ($30.00)~~ due January 1 of each year. Such student members shall be exempt from the payment of any special assessment.

and be it further

Resolved, that the ADA *Bylaws*, CHAPTER I. MEMBERSHIP, Section 20. QUALIFICATIONS, PRIVILEGES, DUES AND SPECIAL ASSESSMENTS, Subsection A. ACTIVE MEMBER, subsection c. DUES AND SPECIAL ASSESSMENTS, paragraph 2, be amended as follows (new language underscored; deletions ~~stricken through~~):

> (2) Dentists who are engaged full-time in (a) an advanced training course of not less than one (1) academic year's duration in an accredited school or a residency program in areas neither

[1] Student members as defined in the McKinley study were composed of both predoctoral and postdoctoral students combined.

recognized by this Association nor accredited by the Commission on Dental Accreditation or (b) a residency program or advanced education program in areas recognized by this Association and in a program accredited by the Commission on Dental Accreditation shall, pay ~~thirty dollars ($30.00)~~ fifty dollars ($50.00) due on January 1 of each year until December 31 following completion of such program. For dentists who enter such a course or program while eligible for the dues reduction program, the applicable reduced dues rate shall be deferred until completion of that program. Upon completing the program, the dentist shall pay dues and any special assessment for active members at the reduced dues rate where the dentist left off in the progression. This benefit shall be conditioned on maintenance of continuous membership or payment of post-graduate student dues and active member dues and any special assessment for years not previously paid, at the rates current during the missing years. The dentist who is engaged full-time in (a) an advanced training course of not less than one (1) academic year's duration in an accredited school or residency program in areas neither recognized by this Association nor accredited by the Commission on Dental Accreditation or (b) a residency program or advanced education program in areas recognized by this Association and in a program accredited by the Commission on Dental Accreditation shall be exempt from the payment of any active member special assessment then in effect through December 31 following completion of such course or program.

BOARD RECOMMENDATION: Vote Yes.

Vote: Resolution 46

BUCKENHEIMER	Yes	FEINBERG	No	NORMAN	No	VERSMAN	No
CROWLEY	Yes	GOUNARDES	Yes	ROBERTS	No	WEBER	Yes
DOW	Yes	HAGENBRUCH	No	SCOTT	Yes	YONEMOTO	Yes
ENGEL	No	ISRAELSON	Yes	SEAGO	No	ZENK	Yes
FAIR	Yes	KIESLING	Yes	SUMMERHAYS	No	ZUST	Yes

Resolution No. 46S-1 Substitute

Report: NA Date Submitted: October 2013

Submitted By: Fifth Trustee District

Reference Committee: Membership and Related Matters

Total Net Financial Implication: $175,708 Net Dues Impact:

Amount One-time Amount On-going $175,708 FTE 0

ADA Strategic Plan Goal: Members (Required)

SUBSTITUTE FOR RESOLUTION 46: REVIEW OF GRADUATE DUES CATEGORY

The following resolution was submitted by the Fifth Trustee District on October 16, 2013, and transmitted by Dr. Mark Donald, chairman of the Fifth Trustee District.

Background: The Council on Membership also studied the graduate student membership dues and found similar results as from the dental student study. That is, graduate students responded that ADA dues are priced below common perceptions of cost compared to value and the optimal range of dues landed between $30 and $75. If the graduate student dues were tied to full member ADA dues as a percentage, then the students would be tied to additional programs and services that ADA members receive. Therefore, the dental students would more clearly recognize the benefits of membership. In addition, this would mean that regular bylaws changes would not be needed to address this issue. Based on current full member dues and a factor of 10%, dental student dues would be approximately $52, which lies within the range perceived as appropriate by the graduate students.

Resolution

46S-1. Resolved, that the ADA *Bylaws*, CHAPTER I. MEMBERSHIP, Section 20. QUALIFICATIONS, PRIVILEGES, DUES AND SPECIAL ASSESSMENTS, Subsection E. STUDENT MEMBER, subsection c. DUES AND SPECIAL ASSESSMENTS, paragraph 2, be amended as follows (new language underscored; deletions ~~stricken through~~):

(2) POSTDOCTORAL STUDENTS AND RESIDENTS: The dues of dentists who are student members pursuant to Chapter I, Section 20E shall be calculated at 10% of the dues of a full active ADA member ~~thirty dollars ($30.00)~~ due January 1 of each year. Such student members shall be exempt from the payment of any special assessment.

and be it further

Resolved, that the ADA *Bylaws*, CHAPTER I. MEMBERSHIP, Section 20. QUALIFICATIONS, PRIVILEGES, DUES AND SPECIAL ASSESSMENTS, Subsection A. ACTIVE MEMBER, subsection c. DUES AND SPECIAL ASSESSMENTS, paragraph 2, be amended as follows (new language underscored; deletions ~~stricken through~~):

(2) Dentists who are engaged full-time in (a) an advanced training course of not less than one (1) academic year's duration in an accredited school or a residency program in areas neither recognized by this Association nor accredited by the Commission on Dental Accreditation or (b) a residency program or advanced education program in areas recognized by this Association and

in a program accredited by the Commission on Dental Accreditation shall, pay ~~thirty dollars ($30.00)~~ dues calculated at 10% of the dues of a full active ADA member due on January 1 of each year until December 31 following completion of such program. For dentists who enter such a course or program while eligible for the dues reduction program, the applicable reduced dues rate shall be deferred until completion of that program. Upon completing the program, the dentist shall pay dues and any special assessment for active members at the reduced dues rate where the dentist left off in the progression. This benefit shall be conditioned on maintenance of continuous membership or payment of post-graduate student dues and active member dues and any special assessment for years not previously paid, at the rates current during the missing years. The dentist who is engaged full-time in (a) an advanced training course of not less than one (1) academic year's duration in an accredited school or residency program in areas neither recognized by this Association nor accredited by the Commission on Dental Accreditation or (b) a residency program or advanced education program in areas recognized by this Association and in a program accredited by the Commission on Dental Accreditation shall be exempt from the payment of any active member special assessment then in effect through December 31 following completion of such course or program.

BOARD RECOMMENDATION: Received after the October Board of Trustees session.

NOTES

Resolution No. 59-60 New

Report: CM Supplemental Report 1 Date Submitted: August 2013

Submitted By: Council on Membership

Reference Committee: Membership and Related Matters

Total Net Financial Implication: None Net Dues Impact:

Amount One-time Amount On-going FTE 0

ADA 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 2013, the Council on Membership met June 14-15, 2013. This report addresses the subjects and resolutions for the 2013 House of Delegates brought forth at that meeting as well as the Council's recommendations to ADA Policies and responses on the 2012 House of Delegates assignments: Resolutions 160H-2012 Extending the New Dentist Discount Program (*Trans.*2012:519*)*; 67H-2012 Amendment of *ADA Bylaws* Regarding Benefits of Affiliate Members *(Trans.*2012:517*)*; 170H-2012 Reaffirming Existing ADA Policy *(Trans.*2012:370*)*; 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: Consistent with its *Bylaws* responsibilities, the Council on Membership continues focusing its efforts on increasing ADA membership value, member count, dues revenue and market share in key segments. 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.

Nomination of Chair and Election of Vice Chair: The Council nominated Dr. Thomas Kelly, Seventh district representative, Beachwood, Ohio, as chair of the Council on Membership for 2013-2014. The Council elected Dr. Michael Durbin, Eighth district representative, Des Plaines, Illinois, as vice chair of the Council on Membership for 2013-2014.

Response to Assignments from the 2012 House of Delegates:

Resolution 67H-2012, Amendment of ADA Bylaws Regarding Benefits of Affiliate Members. Resolution 67H-2012 amended the ADA *Bylaws* so that the Board of Trustees, in collaboration with the Council on Membership, authorizes the products and services affiliate members of the Association receive. The affiliate membership category was analyzed in the Council's 2012 membership dues study, conducted by McKinley Advisor's. The study results on membership value and dues pricing for the affiliate member category are being studied by the Council, in conjunction the Board of Trustees' Committee on International Programs and Development (CIPD). The Council and CIPD will discuss the results via a conference call in August 2013. If the Council has recommendations on the products and services received by those in the affiliate membership category after the conference call with CIPD, they will be forwarded to the Board of Trustees for its review.

Resolution 160H-2012, Extending the New Dentist Discount Program. The Council on Membership, with representation from the New Dentist Committee, studied the impact of extending the time frame for the

ADA Reduced Dues Program and through this exploration, the Council felt that continuing to focus on increasing member value, especially to this segment, consistent with the Board's strategic initiative, should be the first priority to reduce the number of individuals who lapse within the first two years of the program. Further, it was determined that extending the program would result in a significant reduction in revenue that would need to be offset through other revenue sources. In addition, a one-time, potentially significant expense may be incurred by both the ADA and some dental societies to adjust their computer systems to accommodate the dues structure change. Furthermore, the 2012 Member Value and Loyalty Study confirms that while new dentists agree more strongly with positive perceptions of the ADA in comparison to established dentists, they give lower ratings of member value received for the dues paid across the tripartite and lower ratings of many national and all constituent society offerings. Taking these aspects into consideration, the Council recommends that the existing program be maintained at its current rate structure for the 2014 membership cycle.

170H-2012, Reaffirming Existing ADA Policy. In accordance with Resolution 170H-2012, Reaffirming Existing ADA Policy, the Council on Membership reviewed several ADA policies at its June 2013 meeting and presents a series of resolutions with recommendations to maintain, rescind or amend those policies.

Recommendations—Policies to be Maintained

The Council concluded that the following policies should be maintained as written.

Transfer Nonrenews (*Trans.*1995.605)
Utilization of Tripartite Resources (*Trans.*1995.604)
Dentists Retired from Federal Service (*Trans* 1963:285; 1996:671)

Recommendations—Policies to be Amended

The Council recommends the policy on "Qualifications for Membership" be amended for clarity and offers the following resolution:

59. Resolved, that the ADA policy on Qualifications for Membership (*Trans.*1959:219; 1996:672) be amended so that the policy reads as follows (additions are underscored; deletions are ~~stricken~~):

Resolved, that the constituent societies be requested to examine their bylaws ~~with a view~~ and consider ~~to~~ making any changes in the qualifications for an appropriate membership category to permit a dentist licensed in another state to become a member with other than resident active membership category.

The Council believes that the policy "Promoting the Value of Tripartite Dentistry" should be amended to update the intent of the policy by including electronic forms of communication.

60. Resolved, that the ADA policy on Promoting the Value of Tripartite Dentistry (*Trans.*1995:606) be amended with the following language (additions are underscored and deletions are ~~stricken~~).

Resolved, that constituents and components be encouraged to identify new mechanisms to promote the value of tripartite membership, and be it further

Resolved, that these mechanisms include a focus on tripartite membership as a foundation for a successful practice and career, and be it further

Resolved, that constituent and component societies be encouraged to communicate these messages through their respective programs and ~~publications.~~ printed and electronic communication channels.

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.

Council Minutes: For more information on recent activities, see the Council's minutes on ADA.org https://www.ada.org/members/1293.aspx#membership

Resolutions

(Resolution 59:Worksheet:6014)
(Resolution 60:Worksheet:6015)

Appendix

RESPONSE TO RESOLUTION 92H-2009—FIVE-YEAR PROJECTED DUES REVENUE IMPACT FROM MEMBERS TRANSITIONING TO LIFE MEMBERSHIP

Overview: The Council on Membership is providing this informational report to the House of Delegates in response to Resolution 92H-2009, which states:

> **Resolved,** that the appropriate ADA agency report yearly to the House of Delegates the five-year anticipated (projected) dues revenues impact from member's transition to life membership.

Background: The Health Policy Resources Center, in conjunction with the Division of Membership, Tripartite Relations and Marketing, developed projections of the dues revenue impact from members' transition to life membership. The projections were developed through statistical modeling and extensive review of retirement trends among dentists. It should be noted that retirement rates among dentists have dropped slightly both as a result of the economic downturn and also as part of a longer term trend. The most significant component of the drop in retirement rates took place in 2009. Accordingly, the projections are more likely to overstate than understate the financial impact. Finally, these projections do not include the added dues revenues associated with new members and dental students transitioning from student status to member status and the associated dues increases.

Based on historical patterns and the current age and member longevity, it is estimated that the dues revenue impact from members transitioning to life membership will be as follows (Table 1):

Table 1

Year	Estimated Dues Reduction from Members Transitioning to Life Membership	Increase in Dues Revenue Due to Increase in Active Life Dues**
2013	($396,444)*	$293,604
2014	($410,322)*	$249,262
2015	($386,756)*	$288,828
2016	($391,468)*	$287,700
2017	($393,545)*	N/A

*Note: See Table 4 for calculations.
**Increase in Active Life Member dues to 75% of full dues beginning in 2013.

At the end of 2012, there were 13,806 active life members and 23,456 retired life members. Although the ADA should be mindful about the anticipated transition of baby boom dentists into different membership categories and also into retirement, it also is appropriate for the ADA to recall that current workforce projections indicate that the dental workforce will continue to grow continuously through 2030, and this projection does not incorporate potential graduates from dental schools that have not opened their doors (Table 2).

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[1]	171,110[12]	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*, *2012 ADA Dental Workforce Model: 2009-2030*.

Table 3 shows the number of projected members who will become eligible for life membership from 2013 to 2017. This projection assumes that there will be no dues increase during the next five years and that all members will retain membership. It is likely there will be more non-renewing members in the active life category beginning in 2013 due to the dues increase for this category from 50% of full dues to 75% of full dues. There is also an assumption that the retirement rate will remain the same during the same time period.

Table 4 shows the number of members who begin paying in the life membership dues rates over the next five years is expected to increase from 2,952 in 2013 to 2,992 by 2017. It should be noted that the further out in the projection, the less accurate the forecast.

[1] 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 2013-2017

Year Paying Life Dues for First Time	2013	2014	2015	2016	2017
Expected Retired Life	673	696	656	664	682
Expected Active Life	2,279	2,360	2,225	2,249	2,310
Total Projected to Become Life Members	**2,952**	**3,056**	**2,881**	**2,913**	**2,992**

Table 4-Five Year Projected Impact from Members Moving to Life Membership

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	2017	Estimated Reduction from Prior Year
3.8% who paid full active dues ($522) to retired life($0)	112	($58,464)	116	($60,552)	109	($56,898)	111	($57,942)	114	($59,508)
10.4% who paid retired dues ($128) to retired life($0)	307	($40,217)	317	($41,527)	300	($39,300)	303	($39,693)	311	($32,344)
Paid full dues and expected to pay active life dues (77.0% of estimated total elected) ($392)*	2,273	($297,763)	2,353	($308,243)	2,218	($290,558)	2,243	($293,833)	2,303	($301,693)
Total Estimated reduction in dues revenue		($396,444)		($410,322)		($386,756)		($391,468)		($393,545)

Note:
Total to be elected to life membership for 2013 as of 1-18-13.
Assumes no dues increase and no assessment in years 2013-2017
*New Active life dues rate begins in 2013. Active life members now pay 75% of full dues
Full dues in 2013 are $522. Assumes retired rate will remain the same in future years and 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. 59 New

Report: CM Supplemental Report 1 Date Submitted: August 2013

Submitted By: Council on Membership

Reference Committee: Membership and Related Matters

Total Net Financial Implication: None Net Dues Impact:

Amount One-time Amount On-going FTE 0

ADA Strategic Plan Goal: Members (Required)

AMENDMENT OF ADA POLICY ON QUALIFICATIONS FOR MEMBERSHIP

Background: (See CM Supplemental Report 1 to the House of Delegates, Worksheet:6008)

Resolution

59. Resolved, that the ADA policy on Qualifications for Membership (*Trans.*1959:219; 1996:672) be amended so that the policy reads as follows (additions are underscored; deletions are ~~stricken~~):

> **Resolved,** that the constituent societies be requested to examine their bylaws ~~with a view~~ and consider ~~to~~ making any changes in the qualifications for an appropriate membership category to permit a dentist licensed in another state to become a member with other than resident active membership category.

BOARD RECOMMENDATION: Vote Yes.

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

Resolution No. 60 New

Report: CM Supplemental Report 1 Date Submitted: August 2013

Submitted By: Council on Membership

Reference Committee: Membership and Related Matters

Total Net Financial Implication: None Net Dues Impact:

Amount One-time Amount On-going FTE 0

ADA Strategic Plan Goal: Members (Required)

AMENDMENT OF ADA POLICY ON PROMOTING THE VALUE OF TRIPARTITE DENTISTRY

Background: (See CM Supplemental Report 1 to the House of Delegates, Worksheet:6008)

Resolution

60. Resolved, that the ADA policy on Promoting the Value of Tripartite Dentistry (*Trans.*1995:606) be amended with the following language (additions are underscored and deletions are ~~stricken~~).

Resolved, that constituents and components be encouraged to identify new mechanisms to promote the value of tripartite membership, and be it further

Resolved, that these mechanisms include a focus on tripartite membership as a foundation for a successful practice and career, and be it further

Resolved, that constituent and component societies be encouraged to communicate these messages through their respective programs and ~~publications.~~ printed and electronic communication channels.

BOARD RECOMMENDATION: Vote Yes.

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

Resolution No. 86 New

Report: N/A Date Submitted: October 2013

Submitted By: Eleventh Trustee District

Reference Committee: Membership and Related Matters

Total Net Financial Implication: ($136,320) reduction in dues revenue Net Dues Impact:

Amount One-time Amount On-going ($136,320) FTE 0

ADA Strategic Plan Goal: Members (Required)

LIFETIME MEMBERSHIP RULE OF 95

The following resolution was submitted by the Eleventh Trustee District on October 22, 2013, and approved by the Eleventh District on October 12, 2013.

Background: The current retired Lifetime rule states a member must be 65 years of age and have 30 or more years of consecutive membership then they will not pay any dues. Our proposal is to allow a RETIRED member who has a total of 95 years of membership plus age would qualify for Lifetime retired status and not pay any dues. For example, a member who retires at 63 and has 32 years of consecutive membership would qualify or a member who is 63 with 35 years of membership who had to drop their membership for three years.

The purpose of the proposed change is honoring those members who have given to organized dentistry at the time of their retirement. We have had some loyal members who retired prior to turning 65 and did not want to continue paying dues. They leave believing the ADA and the state association is treating them unfairly. The pass on the message to younger dentists and associates that being loyal and giving back is not appreciated upon retirement.

Also, the change will provide for retention of long time members.

Financial Impact: The financial impact to the ADA would be $136,320 or only .002 of the 2013 dues income of the $56,792,418.

Strategic Plan: This resolution links to the ADA Strategic Plan Goal: Membership

Resolution

86. Resolved, that the ADA *Bylaws*, Chapter I MEMBERSHIP, *Section* 20 QUALIFICATIONS, PRIVILEGES, DUES AND SPECIAL ASSESSMENTS, Subsection B. LIFE MEMBER be amended as follows (additions underscored, deletions ~~stricken through~~):

B. LIFE MEMBER

a. QUALIFICATIONS. A life member shall be a member in good standing of this Association who (1) does not meet the qualifications of retired or retired life membership set forth in Chapter I, Section 20Ca~~(1)~~; (2) has been an active and/or retired and/or retired life member in good standing of this Association for thirty (30) consecutive years or a total of forty (40) years of active and/or retired and/ or retired life membership or has been a member of the National Dental Association for twenty-five (25) years and subsequently held at least ten (10) years of

membership in the American Dental Association; (~~2~~3) has attained the age of sixty-five (65) years in the previous calendar year; and (~~3~~4) has submitted an affidavit attesting to the qualifications for this category through said component and constituent societies, if such exist.

A dentist who immigrated to the United States may receive credit for up to twenty-five (25) consecutive or total years of membership in a foreign dental association in order to qualify for the requirements for life membership.

Years of student membership shall not be counted as active membership for purposes of establishing eligibility for life membership unless the dentist was an active member in good standing prior to becoming a student member.

The Association will give notification to members who are eligible for life membership. Life membership shall be effective the calendar year following the year in which the requirements are fulfilled. Maintenance of membership in good standing in the member's constituent and component societies, if such exist, shall be a requisite for continuance of life membership in this Association.

b. PRIVILEGES. A life member in good standing of this Association shall receive annually a membership card. A life member shall be entitled to all the privileges of an active member~~, except that a retired life member shall not receive The Journal of the American Dental Association except by subscription~~.

A life member under a disciplinary sentence of suspension or probation shall not be privileged to hold office, either elective or appointive, including delegate and alternate delegate, in such member's component and constituent societies and this Association. A life member under a disciplinary sentence of suspension shall also not be privileged to vote or otherwise participate in the selection of officials of such member's component and constituent societies and this Association.

c. DUES AND SPECIAL ASSESSMENTS.

(1) ~~ACTIVE LIFE MEMBERS~~DUES. The dues of life members ~~who have not fulfilled the qualifications of retired membership pursuant to Chapter I, Section 20C~~a~~(1) of these *Bylaws* with regard to income related to dentistry~~ shall be 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 seventy-five percent (75%) of any active member special assessment, due January 1 of each year.

~~(2) RETIRED LIFE MEMBERS. Life members who have fulfilled the qualifications of Chapter I, Section 20C of these Bylaws with regard to income related to dentistry shall be exempt from payment of dues and any special assessment.~~

(~~3~~2) ACCEPTANCE OF BACK DUES AND SPECIAL ASSESSMENTS. For the purpose of establishing continuity of active membership to qualify for life membership, back dues and any special assessment, except as otherwise provided in these *Bylaws*, shall be accepted for not more than the three (3) years of delinquency prior to the date of application for such payment. The rate of such dues and/or any special assessment, except as otherwise provided in these *Bylaws*, shall be in accordance with Chapter I, Section 40 of these *Bylaws*.

For the purpose of establishing continuity of active membership in order to qualify for life membership, an active member, who had been such when entering upon active duty in one of the federal dental services but who, during such federal dental service, interrupted the continuity of active membership because of failure to pay dues and/or any special assessment and who, within one year after separation from such military or equivalent duty, resumed active membership, may

pay back dues and any special assessment for any missing period of active membership at the rate of dues and/or any special assessment current during the missing years of membership.

and be it further

Resolved, that the ADA *Bylaws*, Chapter I. MEMBERSHIP, *Section* 20 QUALIFICATIONS, PRIVILEGES, DUES AND SPECIAL ASSESSMENTS, Subsection C. RETIRED MEMBER, be amended as follows (additions underscored, deletions ~~stricken through~~):

C. RETIRED MEMBER.

a. QUALIFICATIONS.

(1) RETIRED MEMBER. A retired member shall be an active member in good standing of this Association who is now a retired member of a constituent society, if such exists, and is no longer earning income from the performance of any dentally related activity. An affidavit attesting to qualifications for this category must be submitted through said component and constituent society, if such exists. Maintenance of active or retired membership in good standing in the member's component society and retired membership in good standing in the member's constituent, if such exist, entitling such member to all the privileges of an active member, shall be requisite for entitlement to and continuance of retired membership in this Association.

(2) RETIRED LIFE MEMBER. A member shall be eligible for retired life membership if, in addition to meeting the qualifications for retired membership set forth in Chapter I, Section 20Ca(1) of these *Bylaws*, the sum of the member's chronological age as of January 1 of the membership year and the number of years the member has been an active and/or retired member in good standing of this Association equals or exceeds ninety-five (95).

b. PRIVILEGES. A retired or retired life member in good standing shall be entitled to all the privileges of an active member, except that a retired life member shall not receive *The Journal of the American Dental Association* except by subscription.

A retired or retired life member under a disciplinary sentence of suspension or probation shall not be privileged to hold office, either elective or appointive, including delegate and alternate delegate, in such member's component and constituent societies and this Association. A retired or retired life member under a disciplinary sentence of suspension shall also not be privileged to vote or otherwise participate in the selection of officials of such member's component and constituent societies and this Association.

c. DUES AND SPECIAL ASSESSMENTS.

(1) RETIRED MEMBER. The dues of retired members shall be twenty-five percent (25%) of the dues of active members, due January 1 of each year. In addition to their annual dues, retired members shall pay twenty-five percent (25%) of any active member special assessment, due January 1 of each year.

(2) RETIRED LIFE MEMBER. A member who has fulfilled the qualifications of retired life membership set forth in Chapter I, Section 20Ca(2) of these *Bylaws* shall be exempt from the payment of dues and any special assessment.

and be it further

Resolved, that the ADA *Bylaws*, Chapter I. MEMBERSHIP, *Section 50.* DUES OR SPECIAL ASSESSMENT RELATED ISSUES, Subsection A. PAYMENT DATE AND INSTALLMENT PAYMENTS be amended as follows (deletions ~~stricken through~~):

Section 50. DUES OR SPECIAL ASSESSMENT RELATED ISSUES.

A. PAYMENT DATE AND INSTALLMENT PAYMENTS. Dues and any special assessment of all members are payable January 1 of each year, except for active and ~~active~~ life members who may participate in an installment payment plan. Such plan shall be sponsored by the members' respective constituent or component dental societies, or by this Association if the active or ~~active~~ life members are in the exclusive employ of, or are serving on active duty in, one of the federal dental services. The plan shall require monthly installment payments that conclude with the current dues and any special assessment amount fully paid by December 15. Transactional costs may be imposed, prorated to this Association and the constituent or component dental society. The installment plan shall provide for the expeditious transfer of member dues and any special assessment to this Association and the applicable constituent or component dental society.

and be it further

Resolved, that the ADA *Bylaws*, CHAPTER XVIII. FINANCES, *Section* 40. SPECIAL ASSESSMENTS, be amended as follows (deletions ~~stricken through~~):

Section 40. SPECIAL ASSESSMENTS: In addition to the payment of dues required in Chapter I, Section 20 of these Bylaws, a special assessment may be levied by the House of Delegates upon active, ~~active~~ life, retired and associate members of this Association as provided in Chapter I, Section 20 of these *Bylaws*, for the purpose of funding a specific project of limited duration. Such an assessment may be levied at any annual or special session of the House of Delegates by a two-thirds (2/3) affirmative vote of the delegates present and voting, provided notice of the proposed assessment has been presented in writing at least ninety (90) days prior to the first day of the session of the House of Delegates at which it is to be considered. Notice of such a resolution shall be sent by a certifiable method of delivery to each constituent society, federal dental service and the American Student Dental Association not less than ninety (90) days before such session to permit prompt, adequate notice by each constituent society, federal dental service and the American Student Dental Association to their delegates and alternate delegates to the House of Delegates of this Association, and shall be announced to the general membership in an official publication of this Association at least sixty (60) days in advance of the session. The specific project to be funded by the proposed assessment, the time frame of the project, and the amount and duration of the proposed assessment shall be clearly presented in giving notice to the members of this Association. Revenue from a special assessment and any earnings thereon shall be deposited in a separate fund as provided in Chapter XVII, Section 30 of these Bylaws. The House of Delegates may amend the main motion to levy a special assessment only if the amendment is germane and adopted by a two-thirds (2/3) affirmative vote of the delegates present and voting. The House of Delegates may consider only one (1) specific project to be funded by a proposed assessment at a time. However, if properly adopted by the House of Delegates, two (2) or more special assessments may be in force at the same time. Any resolution to levy a special assessment that does not meet the notice requirements set forth in the previous paragraph also may be adopted by a unanimous vote of the House of Delegates, provided the resolution has been presented in writing at a previous meeting of the same session.

and be it further

Resolved, that the foregoing amendments to the ADA *Bylaws* shall take effect on January 1, 2014.

BOARD COMMENT: The Board appreciates the thoughtful work of the Idaho State Dental Association and values those members who have been long-time members of the American Dental Association. The Board believes the current requirements for life membership that reward continuous membership are sufficient and no change to life membership is required.

1 **BOARD RECOMMENDATION: Vote No.**

2 **Vote: Resolution 86**

BUCKENHEIMER	No	FEINBERG	Yes	NORMAN	No	VERSMAN	No
CROWLEY	No	GOUNARDES	No	ROBERTS	No	WEBER	No
DOW	No	HAGENBRUCH	No	SCOTT	No	YONEMOTO	No
ENGEL	No	ISRAELSON	No	SEAGO	No	ZENK	No
FAIR	No	KIESLING	No	SUMMERHAYS	No	ZUST	No

Resolution No. N/A N/A

Report: Board Report 16 Date Submitted: October 2013

Submitted By: Board of Trustees

Reference Committee: Membership and Related Matters

Total Net Financial Implication: None Net Dues Impact:

Amount One-time Amount On-going FTE 0

ADA Strategic Plan Goal: Members (Required)

REPORT 16 OF THE BOARD OF TRUSTEES TO THE HOUSE OF DELEGATES: ANNUAL REPORT OF THE NEW DENTIST COMMITTEE

The following report has been prepared for the Board's consideration and transmittal to the 2013 House of Delegates.

Background: 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. .

Committee Composition: The following individuals served as members of the Standing New Dentist Committee in 2012-2013: Dr. Christopher Salierno, New York, chair; Dr. Brian Schwab, Pennsylvania, vice chair; Dr. Dan Bruce, Idaho; Dr. Eric Childs, Michigan; Dr. Rachel Dasher-Hymes, Tennessee; Dr. Madalyn Davidson, Illinois; Dr. Jennifer Enos, Arizona; Dr. Chris Hasty, Georgia; Dr. Andrea Janik, Texas; Dr. Michael LeBlanc, Kansas; Dr. Irene Marron-Tarrazzi, Florida; Dr. Heather Maupin, Indiana; Dr. Timothy Oh, Maine; Dr. Edgar Radjabli, Maryland; Dr. Ryan Ritchie, Minnesota; Dr. Shamik Vakil, Virginia; Dr. Rex Yanase, California.

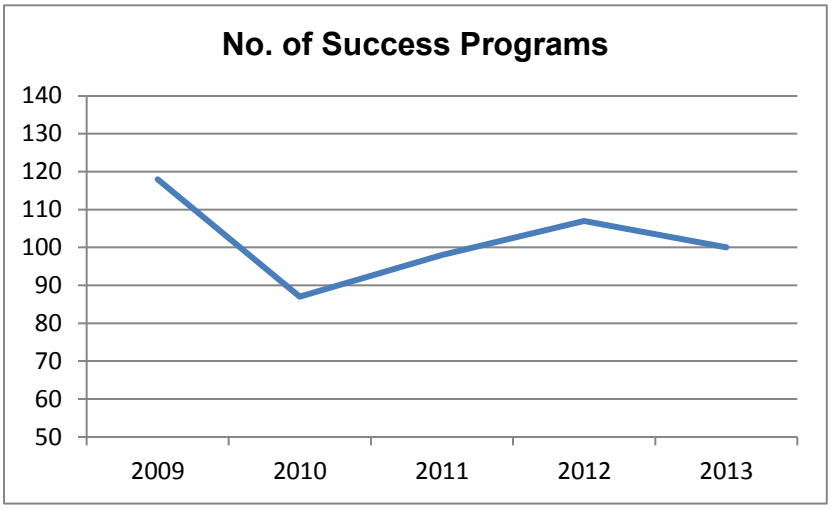
The Committee's liaisons include Alex Barton, American Student Dental Association and Federal Dental Services consultants, LCDR Dea Bruggemeyer (Navy), CPT Archie Cook (Air Force), LT Traci Tiley-Espinosa (Public Health), CPT Michael Hoffman (Army) and Jennifer Fong (VA).

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 and communications for students and new dentists, such as the ADA New Dentist News and the new dentist blog New Dentist Now 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. A key metric for the program is looking at the

number of programs held each year. In the 2012-2013 academic year, the ADA presented 100 Success programs in 46 schools, reaching about 32%, or more than 7,000, dental students. The chart below shows the number of programs per year since 2008-2009. Note that participation peaked when Success added the sophomore and junior programs in 2008-2009. New initiatives are in development to reach schools that have not hosted a program to-date, including more outreach from the New Dentist Committee and a greater connection to the student leadership at the schools. The educational focus of the programs is key as an increasing number of schools limit or prohibit outside programs with a marketing focus. The Success Dental Student Programs are presented at no cost to dental schools or dental students. Sponsorship helps underwrite the cost of the program and additional sponsorship revenue has been attained for the 2013-2014 year.



Another important measurement for Success is the program evaluations. Program evaluations from students, speakers and schools are consistently positive, with results in the top quintile.

For the 2012-2013 year, students attending gave an average overall rating on a 1-5 scale, with 5 high, as follows:

Program Name	*Overall Rating of Program*
Smart Start for Freshmen	4.54
Professional Preview for Sophomores	4.58
Career Strategies for Juniors	4.49
Practice Management for Seniors	4.51

In addition to giving numeric feedback, students are invited to comment anonymously on the evaluation forms. These comments suggest that the programs are meeting the needs of dental students.

Success Enhancements. This year, the Committee conducted a strategic review of the programs and made content revisions. The strategy behind the Success Program (every school, every class, every year) and the approach to content delivery (in-person, cross-trained speaker corps) will remain the same. After considering feedback from dental students, speakers and dental schools, as well as the Council on Ethics Bylaws and Judicial Affairs (CEBJA) and the Council on Dental Practice (CDP), the content was

revised for 2013-2014. The result is fewer slides with more opportunities for interaction and breaks. While still remaining educationally focused, a stronger membership message was incorporated into the program. Each presentation includes references to ADA member benefits and the Center for Professional Success. Speakers are also encouraged to talk about why membership is important to them throughout the presentations. Lastly, additional communication efforts are in place to encourage dental societies to coordinate a membership presentation in conjunction with the Success programs, especially the fourth-year program.

Speakers. A corps of trained volunteer member dentists presented the Success programs. In July, the New Dentist Committee selected six new speakers and welcomed six new Committee members to be on the corps, bringing the total to 45 speakers.

New Dentist Communications: The New Dentist Committee develops and distributes a number of communications to help new dentists succeed and to engage members early in their careers. The Committee launched two new communications this year, the Roadmap to Dental Practice and a new dentist blog, New Dentist Now. The Roadmap helps dental students understand the many career pathways after graduation. Previous resources focused primarily on practice ownership, while this one outlines a variety of career paths available. This printed resource will be distributed to both second- and third-year dental students in fall 2013. The blog features resources for new dentists and dental students as well as news and insight on the dental profession and beyond. Recognizing that younger dentists prefer just-in time information and short and visually appealing communications, the blog provides an easy way for this audience to receive relevant information. The tagline “Life as a New Dentist – Let’s Talk About It” indicates the importance of engaging the new dentists in a conversation of what life is like as a new dentist. The blog, the first for the ADA, launched in June and can be accessed at ADA.org/newdentistblog.

In addition to new communications, the Committee continues to produce its quarterly print publication ADA New Dentist News. The goal of this publication is to help new dentists succeed professionally across a wide variety of practice settings. Nonmember new dentists receive two issues per year. The Committee conducted a readership survey in May and August 2013. Wells Fargo Practice Finance (an ADA Business Resources provider offering practice acquisition, start-up and expansion loans) sponsors this publication.

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 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, through its workshops and other resources. The New Dentist Committee is also tapped to assist in the development of new member resources. This year, a Committee member served on the volunteer oversight committee for the Center for Professional Success and the NDC supported the development of the ADA Ethics Hotline and has promoted the new member benefit through its many communications channels. The New Dentist Committee also continues to collaborate with the Council on ADA Sessions (CAS) to encourage new dentists to attend and engage in the ADA Annual Session. New dentist attendance at the 2012 Annual Session was the highest it had been in five years. For 2013, the Committee has prepared a course, “Here’s How I Did It – Real Talk from New Dentists in Private Practice”, which will be moderated by the NDC Chair, Dr. Chris Salierno.

In response to Dr. Faiella’s request for all agencies to create a member value plan, the Committee participated in a discussion on the 2012 Member Value and Loyalty Research at its July meeting. A summary report of recommendation was completed at the meeting and the Committee will further review and discuss these recommendations to determine next steps.

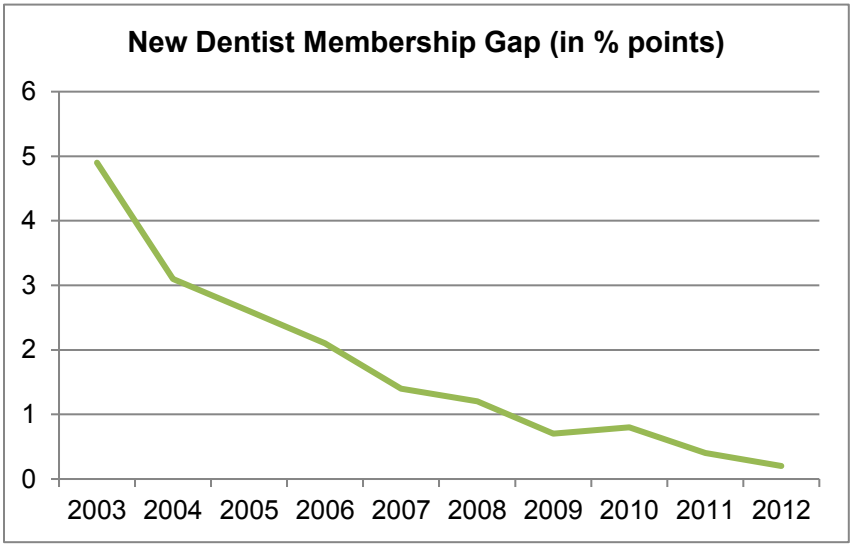
Emerging Issues and Trends: As the voice of the new dentist, the New Dentist Committee is the key agency to monitor professional issues and trends for the newest dental practitioners. In this role, the

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 2012-2013, NDC participation in Council meetings has helped to identify key insights and set the stage for future collaborations and valuable outcomes. Examples include input into the reduced dues program evaluation, support of a new dentist discount and expanded social opportunities at Annual Session, increased collaboration on advocacy issues and new dentist participation in advocacy initiatives, among others.

Board of Trustees Relationship: As a standing Committee of the Board, it is important to have clear communication and involvement between the two agencies. As part of a pilot program, the New Dentist Committee chair attended the March and August Board Meetings to report on Committee activities and provide the new dentist perspective throughout the meeting. **This interaction was deemed valuable and the program will continue. [Dependent on Board Action]**

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. The Committee was interested to learn about the data analytics findings that alumnus from certain dental schools were less likely to join the ADA. This is an area of opportunity for the Committee as the outreach plan is developed.

At the end of 2012, more than 30,000 (66.0%) new dentists are members of the ADA, which is very similar to the membership market share overall at 66.2%. While the number of new dentist members is increasing, the market share decreased since last year, when it was 66.9% at the end of 2011. This is due to market growth. The 0.2 percentage point gap between new dentists and the rest of the membership at the end of 2012 was the narrowest since the ADA began reporting market share. 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. The following chart demonstrates the trend over the past 10 years.



Leadership Development and Recognition: Fostering leadership is one of the Committee's primary goals and it works toward this goal in a number of ways. The Committee put additional focus on leadership development in 2013. Its January strategic discussion centered on ways to enhance the New Dentist Committee Network and the July meeting focused on the transition to leadership positions after dental school graduation. As a result, increased communications are in development and a workgroup will convene to further determine ways to involve new dentists in leadership after graduation.

*New Dentist Committee Network***.** Through the New Dentist Committee Network, new dentists represent new dentist committees across the tripartite. There is new dentist representation by 47 constituent and 168 component societies in the New Dentist Committee Network. The ADA communicates with the network through various means. The Network also receives targeted communications regarding the New Dentist Conference and other issues. An ADA Connect community for the Network is in development to foster greater communication and interaction among new dentist leaders. The Committee also gathered information on the usage of virtual meetings to help decide if virtual meetings help encourage more involvement from new dentists and make it easier for leaders to meet at the state level.

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, one full-day workshop was conducted with the Greater St. Louis Dental Society in August where eight new dentists and three society staff participated. Workshops are free of charge and evaluations have been positive and encouraging. In addition to workshops, Committee members and staff may occasionally participate in local or state new dentist events. Illinois State Dental Society held a New Dentist Network Leader Event this spring, and the chair of the Committee and staff were able to participate.

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.

*New Dentist Conference***.** The mission of the New Dentist Conference 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. Because the Conference provides a unique format for the New Dentist Committee Network to get together, Network members share that connections formed at the Conference often spur greater involvement in organized dentistry.

The 2013 Conference was held July 18-20 in Denver and 300 registered for the meeting. All districts and nearly all states were represented. A full day of leadership programming was open to all attendees at the 2013 New Dentist Conference and included a keynote address on leadership, sessions on getting involved, small group discussions, social media, as well as the interactive Hot Topics in the Round session with ADA leaders, which also featured an open forum on exchanging leadership programming ideas. Nearly all the members of the ADA Board of Trustees participated in this year's Conference. In addition, the American Dental Political Action Committee (ADPAC) Board held its meeting in conjunction with the New Dentist Conference so that they could interact with new dentists. ADPAC continues to be an important Conference sponsor and plans to coordinate its 2014 meeting with the ADA New Dentist Conference in Kansas City.

The Conference offered up to 15 hours of CE, in addition to leadership programming. Attendees gave positive evaluations of both the leadership and CE programming. More than 91% of survey respondents said they would be extremely likely or very likely to recommend the Conference. The most frequent positive comments were on the opportunity to interact with senior ADA Leadership, network with other new dentists and the quality of the CE. Constructive comments were on the baseball game and various recommendations around topics and speakers. Social media efforts were used to help engage dentists who could not attend. The Facebook photo album from Day 1 had the best reach with 7,000 views (individuals) and the other albums were also well-viewed. Several blog posts and ADA News stories have also featured the Conference.

Of the 300 who registered for the meeting, 178 were new dentists, 20 were Officers and Board members, 18 were dental students, 13 were dental society staff. The remainder is a mix of other dentist attendees, speakers, sponsors, ADA staff and guests. Meeting attendance is up from last year, when the total was 263, but down over the past few years. Attendance has averaged at 330 over the past 10 years. Attendance can vary based on location, time of year, support from societies and other factors. Note that the Committee adopted a new Site Selection Process for the conference to allow more fluidity for selecting sites that meet the needs of new dentists. This will go into effect beginning with the 2016 conference.

New Dentist Representation. 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 2012 House of Delegates reveals that a total of seven delegates (1.5%) and eight alternate delegates (1.9%) were new dentists. There was one more new dentist delegate in 2012. Evaluation of the 2013 House of Delegates is not yet complete. This year, six members of the NDC will serve as delegates and alternates, which is an increase from last year. (The *Manual of the House of Delegates* indicates which delegates are new dentists by an asterisk. This information may differ from the official ADA reporting due to the way the information for the *Manual* is gathered.)

Leadership Awards. This year, the Committee recognized Dr. David White, Nevada Dental Association for the Golden Apple Award for New Dentist Leadership, Dr. Daniel Edwards, Michigan Dental Association, for the Golden Apple Award for Outstanding Leadership in Mentoring, the Arizona Dental Association Subcommittee on the New Dentist, for the New Dentist Committee Outstanding Program Award of Excellence, To Help Each Other Succeed (THEOS) and the Oklahoma Dental Association for the Outstanding New Dentist Committee Award. The Golden Apple Award for Dental School/Dental Student Involvement in Organized Dentistry will be announced September 2013.

Advocacy: New dentist participation in advocating for the dental profession is another area of high interest and importance and this was evident in 2013. ADPAC and the New Dentist Committee continued to collaborate through a joint workgroup. As a result of the increased collaboration, the ADA was able to fund four New Dentist Committee members to attend the Washington Leadership Conference in 2013, in addition to the NDC ex officio who is already funded. In all, there were six New Dentist Committee members who participated in the Washington Leadership Conference (WLC). Overall, 16 new dentists attended the WLC, as well as another six who graduated in 2003. The workgroup also outlined interaction opportunities among new dentists and ADPAC at the New Dentist Conference.

The Committee promotes ADPAC membership for new dentists and also strives to participate at 100% each year as well. ADPAC donations at the 2013 conference totaled $9,300 from Conference attendees. 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.

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, at more than $196,000 on average, and more than $236,000 for those in private dental education as reported by the American Dental Education Association (ADEA) Survey of Dental School Seniors. The NDC vice chair served on the Task Force to Study Student Debt as part of Resolution 66H-2011 (*Trans*.2011:410). He gave an oral report on the findings at the Committee's July meeting, highlighting the current financial environment for dental schools, students and new dentists. The Committee looks forward to contributing to new efforts as a result of the findings from the Task Force. One such result was the recommendation to add more information on managing finances and student debt in the ADA Success programs. The Committee will undertake this review and update at the next program cycle that will be for the 2013-2014 academic year.

One of the most relevant and timely discussions regarding new graduate practice options is the trend of large group practices. The Council on Dental Practice (CDP) is the lead agency studying this trend and a research agenda proposed by Health Policy Resources Center is progressing. The Committee is one of many agencies with an interest in the topic. As a result, CDP developed an Interagency Workgroup on Dental Group Practice, which included representation from interested agencies, including a member of the Committee. A Committee member participated in the workgroup conference calls in 2012-2013. Two Board of Trustees members were added to this group at the Board's March 2013 meeting. The New Dentist Committee plans to continue its participation in the discussion on large group practice, especially as the research emerges.

A Committee member served on the Volunteer Oversight Committee for the Center for Professional Success (CPS) as well as the ex officio for CDP and will continue to provide insight and feedback for the duration of the volunteer committee. The Committee is interested in remaining a key contributor to CPS as the benefit rolls out.

Ethics: The Committee is committed to fostering ethics and raising awareness of ethical issues that new dentists face. CEBJA successfully collaborated 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. Following the development of an intake process and system for tracking cases and collecting data, the hotline was launched February 2013. Additional information concerning the ethics hotline service can be found at http://www.ada.org/ethicshotline. CEBJA is tracking the data to measure the program's usage and success as well as to identify emerging trends that impact professionalism and ethics at an earlier time than is currently possible.

The hotline was featured in the *ADA News*, *ADA New Dentist News* and on "Mouthing Off," the official blog of the American Student Dental Association (ASDA). While the hotline was initially promoted to new dentists during the pilot phase, inquiries have been received from all segments of membership and CEBJA has responded to each of those inquiries. Approximately 30 inquiries (five per month) have been received by the hotline since its inception in February 2013; CEBJA and the NDC are engaged in further efforts to make this benefit more widely known to ADA membership.

Responses to 2012 House of Delegates Resolutions: Resolution 160H-2012 (*Trans*.2012:519), Extending New Dentist Discount Program, was assigned to the New Dentist Committee and the Council on Membership.

> **160H-2012. Resolved,** the 2012 House of Delegates directs the appropriate agencies to study the impact of extending the duration of the time frame for the ADA Reduced Dues Program, and be it further.
>
> **Resolved,** that the findings from the appropriate agencies be reported to the 2013 House of Delegates.

The Council on Membership established the Membership Category Review Workgroup to study the reduced dues program and other dues categories. The NDC ex officio member served on the Council's workgroup to provide the new dentist perspective. This workgroup has studied the pros, cons and financial implications of extending this program. Both the Council and the NDC are supportive of maintaining the Reduced Dues Program in its current structure. The Council forwarded these recommendations to the House of Delegates in its supplemental report (Worksheet:6008).

Policy Review: At its January meeting, the Committee reviewed and identified its policy on New Dentist Involvement in Volunteer Leadership in accordance with Resolution 111H-2010. The Committee decided that the policy was still relevant and did not make any recommended changes.

Committee Minutes: For more information on Committee activities, review the full minutes posted here on ADA.org.

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)

REPORT OF PRESIDENT

Mr. Speaker, members of the House, and my dear friends and colleagues.

The late Senator Daniel Patrick Moynihan of New York was likely one of the most insightful minds and articulate voices of the 21st century, and someone who captured his thoughts in memoranda he wrote to himself, something I have learned to do frequently.

In a memo dated March 2003, the month of his death, summing up his central belief about society and culture, he said that in his 40 years of public service, he had learned one thing for certain: That "the central conservative truth is that it is culture—not politics—that determines the success of a society…".

And so it may be that a culture based upon core values—and not the politics of loyalty—will define the true measure of our success as an Association.

The stewardship of our profession is based entirely upon our commitment—as leaders at this point in time—to identify challenges and embrace opportunities through a strategy based upon those core values we work so hard to define and protect today.

As Dr. O'Loughlin outlined so well in her speech last year, core values are the foundation to "make the right decisions happen."

Let me share with you—over the next few moments—how I have invested the privilege of leadership you have given to me during this past year as your President. And leave you with a few thoughts—based upon my experience over the past six years—for you to consider going forward.

As I promised in my speech last year, my first action following the House was to appoint a Strategic Planning Steering Committee, including members of this House, to provide oversight into the development of the next strategic plan, which will take effect in 2015.

And although their work began immediately on development of an environmental scan, my concern was that our work at the Board was immersed primarily in management and review activities, leaving little time left for true strategic discussion.

And so it came to be that I asked Dr. Marko Vujicic, our Managing Vice President for the Health Policy Resources Center, to help create a data-based compelling reason to re-assess the strategic and visionary role of the Board, since without such a role, how we see the future—

- The delivery of oral healthcare
- The development of standards for products and informatics
- Emerging technologies
- The evolving educational model
- And evidence-based translational research

may fail to adequately look "over the horizon" to identify and engage opportunities to plan for solutions tomorrow.

The resulting presentation, "Dentistry at a Crossroads," was discussed in a strategic session of the Board at our December meeting. Unknown to anyone at the time, that presentation became what I considered the foundation for our planned Board retreat in February.

The planning of our next meeting—our retreat—was likely the greatest risk I have taken all year. I decided to approach the retreat in a very different way than in previous years.

I made the decision to facilitate the retreat myself over the two days, but intentionally avoided revealing the intent and scope of the retreat topic to anyone in advance, in order to encourage active participation and reaction "in the moment," and give everyone the equal opportunity to participate without preconception.

It was a risk I was willing to take—to allow the Board the opportunity to think freely, and create change in how we begin to focus on the emerging forces facing the profession in the coming years as a sustainable implementation into our workflow.

Looking back, we accomplished quite a lot in two and a half days—we:

- Reviewed survey data on the landscape of associations published by Lake Mountain, Ltd.
- Considered what Jim Collins and Ken Blanchard, two noted authors and experts on business management, offered on organizational effectiveness and tying actions to core values
- Reviewed the data trends analysis for strategic action compiled by Marko Vujicic
- Accepted the Core Values Workgroup report, and defined the behaviors associated with those values to make them measurable
- Reviewed the outcome of the strategic discussion at the December meeting, which included alignment of our actions with our core values
- Discussed what board "effectiveness" looks like, and identified the barriers to being effective, and their impact on *alignment*
- And finally, developed 11 *Action Items* for implementation into our workflow immediately, including a two hour strategic topic discussion at each meeting of our Board this year.

But this is only the beginning.

There are many emerging issues confronting our profession that demand our strategic attention:

- Decreased adult utilization that precedes the economic downturn
- Expanding large group practice models and the impact they have on both the profession and organized dentistry
- The influence of changing financing models to move more toward outcomes and value
- New school models and the changing educational experience for the next generation of dentists, who are struggling more than ever with an increased debt burden
- And most importantly, remaining relevant by providing value to our members at all stages of their careers

One thing is certain: we need to understand conventional wisdom and accept change as an opportunity for strategic decisions to survive as an organization, and strengthen our profession.

We have both seen and met challenges before, with both the ADA Foundation, and ADA Business Enterprises, Inc. and you already know those stories.

The remaking of the ADA Foundation began in 2010, and it took true courage. The result is an organization with vitality, thanks to the leadership of Dr. Dave Whiston, president of the Foundation and Mr. Gene Wurth, the executive director.

In fact, our foundation research facility has just received a 2.5 million dollar grant from the National Institutes of Health for the continuation and enhancement of its important bench research.

And if that's not inspiring enough, consider the success of our colleague and former Foundation President, Dr. Anthony Volpe. His exemplary life should be an inspiration to us all. Tony is someone who has embraced a culture of change over a lifetime—as a clinician, as a tireless pioneer and advocate for patient access, clinical research, and organized dentistry—and a member of our Association for more than 50 years.

His dedication and vital contributions to enhancing the public's oral health, to clinical research globally and to the future of dentistry cannot be overstated. And to honor Tony's significant legacy, the ADA's premier research facility in Maryland has just been renamed the Volpe Research Center, and a research fellowship has been established in his name, thanks to a very generous gift from Colgate-Palmolive.

So, let's draw energy and strength from our courage to embrace challenges, such as we've done with the ADA Foundation and the Volpe Research Center, and know that if we have the courage to navigate change—we will continue to succeed.

Great challenges present great opportunities.

Here are three areas where I see our greatest immediate strategic challenges—areas that we can and will address:

The **first** area is in the *power of our membership.* I have said before that membership is the *cornerstone* of our success in the past, and the *promise* of our success in the future. We continue to define our increasingly segmented market for membership, and to define the value for each group to help them succeed—no matter how they engage the profession—clinical practice, academics, research, or military service.

In 2012, the ADA's market share was 66.2%, and it's been on the decline. But to a certain extent, the numbers are counterintuitive, because our member numbers are on the rise.

The issue is we're not keeping up with the growth of the profession. Over the past ten years, we have added more than 7,000 net members. But the market has grown by more than 22,000 dentists.

As the country's melting pot grows, the ADA's membership has not kept pace. We have challenges attracting ethnically and racially diverse dentists, women dentists, and non-U.S. trained dentists.

We are also experiencing challenges when it comes to retaining the membership of mid-career general dentists.

To reduce this decline, our rate of membership growth must meet or exceed the rate of dentist market growth.

But *what are we doing* to bring our message to non-members?

And, just as importantly, are we talking to them in one consistent voice? Do they understand that state and local dental societies and the ADA are one and the same? There's a good chance they don't.

We have different names, different websites and different staff. Our focus must now turn to alignment within the tripartite, to allow each level to do what they do best for our members, and avoid duplication of effort.

You will hear much more about this important strategic initiative from Dr. Norman as he assumes the role of the President at the close of this House.

The **second** strategic challenge is the impact of the Affordable Care Act on dental care in the United States. For dentistry, the ACA is more important for what it does not do, than for what it does do. While the ACA expands dental benefits for children in both Medicaid and health benefit exchanges, the impact for adults is less favorable due to the erosion of adult Medicaid benefits in recent years, and the lack of mandated coverage for adults within the exchanges.

Our expectations for the ACA marketplace on dentistry may ultimately be tempered by plan design, network engagement, and forces outside the ACA. Outstanding analysis by both our Washington office and the team at the Health Policy Resources Center demonstrates the opportunity for improving dental utilization for low-income adults now remains with the states—to optimize the marketplace through *Medicaid reforms* and *exchange plan design*.

This brings us to what I consider the **third** strategic challenge—to be viewed as America's leading advocate for oral health by all stakeholders.

According to an analysis by our Health Policy Resources Center, 181 million Americans did not see a dentist in 2010. According to the Centers for Disease Control, nearly half of adults over age 30 suffer from some form of periodontal disease—and nearly one in four children under the age of five already have cavities.

The causes of the dental health crisis are varied and complex. However, we believe it can be solved, and that it's never too late to take on this challenge, both as individuals and as a nation.

The ADA Board recognizes that a suite of existing ADA policies and initiatives needs to be used in advocacy in order to address the shortfall of the Affordable Care Act in providing for low-income adults, and to promote the ADA's positions on oral health.

Thus we developed and launched the ADA's campaign, **Action for Dental Health: Dentists Making a Difference**. This nationwide campaign aims to dramatically reduce the numbers of adults and children with untreated dental disease. I had the privilege to announce this campaign in May at the National Press Club, and the response has been extremely impressive, particularly from some major media outlets.

The *Action for Dental Health* campaign is coordinated in scope, and is designed to address the dental health crisis in three distinct areas:

- Providing care now to people suffering with untreated dental disease.
- Strengthening and expanding the public/private safety net to provide more care to more Americans.
- And to bring dental health education and disease prevention into communities.

I am pleased that so many states have rallied around this campaign, and I am encouraged by all of your ongoing efforts. We must create and seize every opportunity to live the call to action, and to truly own this message if we want all stakeholders, including the public, to view us being the nation's leading advocate for oral health.

Simply stated, I can summarize our major challenges by saying:

- Our membership market share is declining at a steady rate
- Utilization is down among adults, although on the rise for children
- We are seeing a decrease in adult dental benefits, both in offerings by employers and uptake by employees
- The trajectory of dental spending is altered
- And there is declining dentist net income

All starting in the early 2000's, consolidation will continue due to pressures to reduce costs, and value-based payment will begin to emerge in all financing channels.

However…as I said, with challenges come tremendous opportunities, if we are cognizant of the conventional wisdom, plan actively and strategically, and have the courage to think differently.

Finally, I'd like to take a moment to acknowledge a few very important people.

I would be remiss if I did not thank Chuck Norman for his friendship particularly over the past year. He has a keen ability to find common ground between opposing viewpoints, and to build lasting relationships.

We worked closely this year on everything, and I'm happy to tell you we never had a disagreement on any issue—it was truly a great working relationship.

So Chuck, thanks for a great year working together.

And I thank the entire Board of Trustees for their hard work and focus this year, and trusting my ability to manage the agenda and discussions to facilitate our work, maximize efficiency, and manage our energy rather than our time.

Of course, we could never really be effective without a talented, organized staff, and we are privileged to have their dedication and commitment.

They work very hard every day to add value to our membership and to implement our programs. And I have tremendous gratitude, admiration and respect for what they do for us on a daily basis.

Thank you, Kathy, and thanks to the entire hard working staff at the Association for all they do.

My friends and colleagues in the First Trustee District, and particularly the Massachusetts Dental Society, have taught me the value of collaboration and hard work. I am—and will always be—forever grateful for your support and friendship over the past 26 years.

And of course, none of us could devote our time and energy to our profession without the love and support of our families, and their understanding that this is a commitment we make in our heart—second only to our love for them.

To my wife Kelli who taught me every day a sense of balance and responsibility—who laughed with me every day—and kept reminding me all year that I was not "her president!"…

Thank you. Words alone cannot express what you mean to me.

Finally, in the tenure of any elected position the time comes for reflection, and to transition to another opportunity. In spite of all that has been achieved for our organization, one comes to the realization that additional work has yet to be done. As my involvement with organized dentistry progressed, I began to develop a broader view of issues as they applied to the profession.

The leaders I admired—in essence, my mentors—were all those who had "bandwidth" that had evolved beyond those dealing with more parochial and focused initiatives. Their ability to see how problems were

connected, and to empower those around them to think creatively toward solutions, was impressive, and far beyond what I considered within my own capabilities. Yet, I found myself beginning to see certain connections that allowed me to recognize what I have learned through the changes I have lived through professionally and personally.

And so, the need to evolve as a leader is driven more by what we learn from our colleagues than by our intentional effort. Change, for me, occurs by learning.

The pressing issues facing dentistry require the ADA to be a strong advocate, facilitated by a strong financial foundation, without being compromised by cutting valuable member programs or by forgetting *who we are* and *what we value* as a profession. The implementation of any program at the local, state, or national level is dependent upon the commitment of our members to volunteer their time

Let's not suffer the embarrassment of having any initiative fail due to lack of participation, and question our resolve in the future. Our professional reputation is at stake. I think we need to remind ourselves that responsibility and commitment make this organization great.

My covenant to myself, my mentors, and to all of you has always been to do what I can to make a difference in our profession. Serving as your President has and will always be my greatest professional honor.

Thank you.

Respectfully submitted,
Robert A. Faiella, D.M.D., M.M.Sc.
President, American Dental Association

New Business

Resolution No. 102 New ■ Substitute ☐ Amendment ☐

Report: Date Submitted: November 2013

Submitted By: Eighth Trustee District

Reference Committee:

Total Net Financial Implication: None Net Dues Impact: FTE 0

Amount One-time Amount On-going

ADA Strategic Plan Goal: Members (Required)

THE ADA LIBRARY PHYSICAL COLLECTION

The following resolution was submitted by the Eighth Trustee District and transmitted on November 3, 2013 by Dr. Mary Hayes, delegate, Eighth Trustee District.

Background: The Transition Plan Task Force Board Report 6 has several statements within its sections that actually direct that the ADA Library and Archives impact immediately after the 2013 HOD approves this Report as it stands. Even though the Board Report 6 directs the Library Advisory Board to form policies going forward to benefit its members, it also affirms a transitional policy that has been formulated by ADA staff and the BOT, not ADA members.

Specifically, over the last several months, the collections of the current ADA Library have been sorted for de-accessioning **before** the Advisory Board has even met or had any chance to develop Library and Archive policies with member oversight. As it has been demonstrated over the last year, it is important/prudent to avoid the perception that there would be a hurry to rid the Library of its materials before the ADA (Member) Library and Archives Advisory Board is even in place.

Resolution

102. Resolved, that the ADA Library's physical collection shall remain intact until the ADA Library and Archives Advisory Board has been established and has the opportunity to review and confirm the transition policies incorporated in the ADA Library Resource Relevance and Vitality Policy.

Resolution No. 103 New ■ Substitute ☐ Amendment ☐

Report: Date Submitted: November 2013

Submitted By: Second Trustee District

Reference Committee:

Total Net Financial Implication: $ Net Dues Impact: $ 0 FTE 0

Amount One-time $ Amount On-going $

ADA Strategic Plan Goal: Members (Required)

AMENDMENT TO THE MANUAL OF THE HOUSE OF DELEGATES

The following resolution was submitted by the Second Trustee District and transmitted on November 3, 2013, by Dr. Mark J. Feldman, executive director, Second Trustee District.

Resolution

103. Resolved, that the section entitled “Action on Motions Recommended by Reference Committee” of the *Manual of the House of Delegates and Supplemental Information* found on page 13 be amended by the insertion of a new seventh paragraph as follows (new language underscored; ~~deletions stricken through~~):

When it is the reference committee's intent to combine consideration of two or more resolutions on a similar subject matter, the motion in-lieu-of may be used where the recommendation of the reference committee is to adopt. However, in an effort to avoid confusion, reference committees should not use the motion to adopt in lieu of, where none of the resolutions are acceptable and the recommendation of the committee would be to not adopt. Rather the reference committee chair should first "move to substitute" one of the resolutions thereby disposing of the others. Once substituted, that motion can then be appropriately considered.

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* *Resolutions 96-101 will be indexed in* Transactions *2013.*

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