

2014

Supplement to
Annual Reports and Resolutions
Volume 1

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Board Report 1/ Credentials, Rules and Order

Resolution No. 30 NewReport: Board Report 1 Date Submitted: July 2014Submitted By: Board of TrusteesReference Committee: N/ATotal Net Financial Implication: None Net Dues Impact: 0

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

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

Background: This is the first in a series of reports to be presented by the Board of Trustees to the House of Delegates at the 155th Annual Meeting of the American Dental Association.

Appreciation to the Council on ADA Sessions and the 2014 Committee on Local Arrangements: The American Dental Association is pleased to have its 155th Annual Meeting in San Antonio, TX.

The Council on ADA Sessions has created a meeting that lives up to the ADA's reputation for delivering an extraordinary education and exhibition experience. The Board of Trustees wishes to express its sincere gratitude to the Council, and the exceptional leadership of Dr. James E. Galati, 2013-2014 council chair and Dr. John P. Pietrasik, program chair. They have planned and produced not only an innovative continuing education program, but an exhibition that allows dental professionals to experience firsthand the latest in cutting edge dental materials, services and new technologies.

Council Members. Dr. Barry I. Cohen, Dr. Sally J. Cram (general chair 2015 Washington, DC Committee on Local Arrangements), Dr. Grace A. Curcuru, Dr. Sheri B. Doniger (CAS continuing education consultant), Dr. James R. Foster, Dr. Charles B. Foy, Jr., Dr. David J. Fulton, Jr., Dr. Chris Hasty (NDC liaison), Dr. Gregory LaMorte, Dr. T. Harold Lancaster, Dr. Calbert M. Lum, Dr. Steven E. Parker, Onika R. Patel (ASDA liaison), Dr. Gary L. Roberts (Board of Trustees liaison), Dr. Robert E. Roesch (2015 chair-designate), Dr. S. Shane Samy, Dr. Neil E. Torgerson, Dr. Sidney R. Tourial, Dr. James H. Van Sicklen, Jr., and Dr. Douglas A. Wyckoff are all to be recognized for their commendable achievement.

The Board also extends its sincere thanks for those chairpersons who so capably assisted Dr. Risé L. Martin, general chair of the 2014 San Antonio Committee on Local Arrangements: Dr. Lisa B. Masters, vice chair; Dr. Joseph A. Ferro, operations co-chair; Dr. Maria Lopez Howell, program co-chair; Dr. C. Roger Macias, Jr., operations co-chair and Dr. Karen B. Troendle, program co-chair.

Finally, the Board expresses tremendous appreciation to all of the volunteers on the Committee on Local Arrangements for the assistance they provide to the Council in the operation of this annual meeting. The Board recognizes and thanks the Texas Dental Association and the San Antonio District Dental Society for their contributions to the success of the 2014 San Antonio Annual Meeting.

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

Remembrance of Former Leaders: Since the last meeting of the House of Delegates, the following ADA officers have passed away: Dr. Rogert M. Hehn, former vice president, 1982-83; Dr. Joseph W. Jones, Jr., former vice president, 1984-85; and Dr. Gordon G. Pejsar, former vice president, 1986-87.

The profession also mourns the passing of Dr. Connie Drisko, chair of the Joint Commission on National Dental Examinations, who died on June 22, 2014; and Dr. Jiwon Lee, former ASDA president, who died on May 4, 2014.

Election of Honorary Membership: In accordance with Resolution 78H-1980 (*Trans.980:590*), which empowers the Board of Trustees to elect members of the Association, the following individuals have been elected to Honorary Membership:

Orlando Monteiro da Silva, D.M.D.
Alice Horowitz, Ph.D., M.A., B.A., R.D.H.
Professor Poul Erik Petersen
James J. Williamson

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

Distinguished Service Award: Established in 1970, the Distinguished Service Award is the highest honor conferred by the Association's Board of Trustees. Each year the Board may select one recipient for the Award. The Board is pleased to announce that the recipient of the 2014 Distinguished Service Award is Dr. Carl E. Misch.

Carl E. Misch, D.D.S., M.D.S.: Dr. Carl E. Misch is Clinical Professor in the Department of Periodontology and Oral Implantology, and Director of Oral Implantology (hon) in the School of Dentistry, Temple University. Dr. Misch serves on the Board of Trustees at the University of Detroit Mercy where he is also an Adjunct Professor in the Department of Prosthodontics. He is Adjunct Professor at the University of Michigan, School of Dentistry in the Department of Periodontics/Geriatrics and Adjunct Professor at the School of Engineering in the Department of Biomechanics, at the University of Alabama at Birmingham. He was the Director of the Oral Implantology Residency Program at the University of Pittsburgh School of Dental Medicine from 1989 to 1996. Dr. Misch has maintained a private practice restricted to implant surgery (bone grafting and implant placement) and related prosthetics for more than 30 years. He currently practices in Beverly Hills, Michigan.

Dr. Misch graduated Magna Cum Laude in 1973 from the University of Detroit Dental School, then went on to receive his Prosthodontic Certificate, Implantology Certificate and Master's Degree in Dental Science from the University of Pittsburgh. The University of Yeditepe in Istanbul, Turkey and Carol Davila University of Medicine and Pharmacy in Bucharest, Romania each awarded Dr. Misch a Ph.D. (honoris causa). He holds several other post-graduate honors including 12 fellowships in dentistry, including the American College of Dentists, International College of Dentists, Royal Society of Medicine, American Association of Hospital Dentistry and the Academy of Dentistry International.

Dr. Misch holds Diplomate status at the American Board of Oral Implantology / Implant Dentistry and served as Board President and member of the examining committee. He has also served as President of several implant organizations including the International Congress of Oral Implantologists, American Academy of Implant Dentistry, Academy of Implants and Transplants and the American College of Oral Implantologists. He is currently Co-Chairman of the Board of Directors of International Congress of Oral Implantologists, which, has more than 90 countries represented, and is the world's largest implant organization.

In 1984, Dr. Misch founded the Misch International Implant Institute (MIII) a one year continuum for implant education. The MIII which now has locations in Florida and Nevada. Over the years, the MIII has been present in Brazil, Canada, France Italy, Japan, Korea, Monaco, Spain, and the United Kingdom. This program has (or is currently) the primary implant education forum for six dental school specialty residencies. As Director, he has trained more than 4,500 doctors in a hands-on, yearly forum of education in implant dentistry. Programs are offered in both the surgical and prosthetic aspects of care. Dr. Misch has more than ten patents related to implant dentistry and is co-inventor of the BioHorizons® Maestro™ Dental Implant System.

Dr. Misch has written three editions of Contemporary Implant Dentistry (Elsevier), which has become the most popular book in dentistry and has been translated into 9 languages, including, Japanese, Spanish, Portuguese, Turkish, Italian and Korean. He has also written Dental Implant Prosthetics (Elsevier). He has published over 250 articles and has repeatedly lectured in every state in the United States as well as in 47 countries throughout the world.

Retiring Officers and Trustees: The Board of Trustees wishes to express its gratitude to the following officers and trustees for services rendered to the Association during their tenure on the Board: Dr. Brian E. Scott, first vice president; Dr. Steven Gounardes, trustee, Second District; Dr. Joseph J. Hagenbruch, trustee, Eighth District; Dr. Roger L. Kiesling, trustee, Eleventh District; and Dr. Carol Gomez Summerhays, trustee, Thirteenth District.

Appreciation to Employees: The Board of Trustees is pleased to bring to the attention of the House of Delegates 27 members of the Association staff for their years of service.

Thirty-Five Years: Helen Cherrett, Global Affairs; Annette Daniel, Finance and Operations; Judy Friend, Education and Professional Affairs; Hwai-Nan Chou, Science and Professional Affairs; Theresa Campbell, Finance and Operations

Thirty Years: Heather Burns, Product and Development, Publishing Division

Twenty-Five Years: MariAnn Swan, Member and Client Services; Jane Jasek, Education and Professional Affairs; Paul Methot, Finance and Operations

Twenty Years: Ronald Polaniecki, Member and Client Services; Anita Mark, Science and Professional Affairs; Wendy Wils, Legal Affairs; Lynetta Smith, Finance and Operations; Jesse Sala, Information Technology; David Slatton, Finance and Operations; Earl Sewell, Legal Affairs; Lisbeth Maxwell, Publishing Division, Mary Salerno, Information Technology

Fifteen Years: Margaret Soeldner, Education and Professional Affairs; Robert Raible, Government and Public Affairs; Joseph Martin, Member and Client Services; Andrew Reynolds, Members and Client Services; Stanislav Frukhtbeyn, ADAF, Anthony Volpe Research Center; Diane Bushemi, Finance and Operations; Chien-Lin Yang, Education and Professional Affairs; Ed Kramer, Information Technology; Matthew Mikkelsen, Health Policy Institute

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

1 The qualifications of these nominees appear on Page 1007.
2

**ACCESS, PREVENTION AND
INTERPROFESSIONAL RELATIONS**

Scott W. Cashion, North Carolina
Timothy R. Fagan, Oklahoma
William H. Gerlach, Texas
Melanie Lang, Washington
Todd A. Pancratz, Nebraska
Rhonda Switzer-Nadasdi, Tennessee

ADA SESSIONS

Henry F. Evans, Washington
Howard I.A. Lieb, New York
C. Roger Macias, Jr., Texas
Andrea Richman, Massachusetts

COMMUNICATIONS

Canise Y. Bean, Ohio
Yvonne S. Hanley, Minnesota
Kurt S. Lindemann, Montana
Robin S. Reich, Georgia

DENTAL ACCREDITATION

Loren Feldner, Illinois*

DENTAL BENEFIT PROGRAMS

C. Scott Davenport, North Carolina
David L. Hamel, Kansas
Steven I. Synder, New York
Matthew J. Vaillant, Minnesota

DENTAL EDUCATION AND LICENSURE

David F. Halpern, Maryland
Edward J. Hebert, Louisiana

DENTAL PRACTICE

Leigh Kent, Alabama
Craig S. Ratner, New York
Scott L. Theurer, Utah
Michael S. Wojcik, Michigan

ETHICS, BYLAWS AND JUDICIAL AFFAIRS

Gary N. Herman, California
Don J. Ilkka, Florida
PuneetKochhar, New Hampshire
J. David Moss, South Carolina

GOVERNMENT AFFAIRS

K. Jean Beauchamp, Tennessee
Marty B. Garrett, Louisiana
Frank J. Graham, New Jersey
David M. Minahan, Washington

MEMBERSHIP

Alejandro M. Aguirre, Minnesota, *ad interim*
Steven P. Ellinwood, Indiana
Marc Muncy, Arkansas
Rodrigo Romano, Florida
Jonathan P. Woller, Alaska

**MEMBERS INSURANCE AND RETIREMENT
PROGRAMS**

Naomi L. Ellison, California, *ad interim*
Peter D. Hehli, Wisconsin
James M. Lipton, Indiana
Marshall H. Mann, Georgia
Eric L. Shirley, Pennsylvania, *ad interim*
D. Scott Wieting, Nebraska

NATIONAL DENTAL EXAMINATIONS

Dr. Lisa A. Heinrich-Null, Texas

NEW DENTIST

Brittany T. Dean, Washington
Jonathan R. Pascarella, California
Martin Smallidge, Federal Dental Services
Nipa R. Thakkar, Pennsylvania

SCIENTIFIC AFFAIRS

Anita Aminoshariae, Ohio
Paul D. Eleazer, Alabama
Paul A. Moore, Pennsylvania
Howard W. Roberts, Federal Dental Services
Thomas G. Wilson, Jr., Texas, *ad interim*

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

1 **Resolution**

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

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

**ACCESS, PREVENTION AND
INTERPROFESSIONAL RELATIONS**

Timothy D. Chase, Arkansas
Rocky L. Napier, South Carolina
Matthew B. Roberts, Texas
W. Roy Thompson, Tennessee

ADA SESSIONS

James R. Foster, Texas
James E. Galati, New York
John P. Pietrasik, Massachusetts
S. Shane Samy, Oregon

COMMUNICATIONS

Jeffrey A. Campbell, Ohio
William E. Chesser, Alabama
Sally J. Hewett, Washington
James F. Jenkins, Nebraska

DENTAL ACCREDITATION

Steven E. Schonfeld, California

DENTAL BENEFIT PROGRAMS

Gavin G. Harrell, North Carolina
Mark W. Jurkovich, Minnesota
Andrew G. Vorrasi, New York
Rieger C. Wood, III, Oklahoma

DENTAL EDUCATION AND LICENSURE

Teresa Dolan, Pennsylvania
Donna J. Stenberg, Minnesota
Ronald D. Venezie, North Carolina

DENTAL PRACTICE

Joanne Dawley, Michigan
Brendan Dowd, New York
Kevin D. Sessa, Colorado
Douglas B. Torbush, Georgia

ETHICS, BYLAWS AND JUDICIAL AFFAIRS

Ethan A. Pansick, Florida
Elizabeth C. Reynolds, Virginia
Richard J. Rosato, New Hampshire
Charlotte L. Senseny, California

GOVERNMENT AFFAIRS

William M. Hall, Jr., Louisiana
H. Fred Howard, Kentucky
Mary S. Jennings, Washington
Carmine J. LoMonaco, New Jersey

MEMBERSHIP

Kevin M. Cassidy, Kansas
Thomas S. Kelly, Ohio
Randall H. Ogata, Washington
Stephen J. Zuknick, Florida

**MEMBERS INSURANCE AND RETIREMENT
PROGRAMS**

Robert A. Coleman, Michigan
Richard F. Hettinger, Iowa
Thomas M. Paumier, Ohio
L. Wayne Yarbrough, Alabama

NATIONAL DENTAL EXAMINATIONS

Lorin D. Peterson, Washington

NEW DENTIST

Daniel S. Bruce, Idaho
Edgar M. Radjabli, Maryland
Brian M. Schwab, Pennsylvania
Rex R. Yanase, California

SCIENTIFIC AFFAIRS

Bryan S. Michalowicz, Minnesota
Kirk W. Noraian, Illinois
Brian B. Novy, Massachusetts
Edmond L. Truelove, Washington

ADA Institute for Diversity in Leadership

The Institute Program: In proposing the Institute to the ADA 2002 House of Delegates, the ADA Board described the objectives of the Institute as: "... to build lifetime relationships with minority dentists; to mentor promising leaders with potential to impact diverse communities; and to strengthen alliances with stakeholder institutions, including dental leaders, industry, public and governmental communities of interest."

Each year, the ADA Board's Diversity and Inclusion Committee reviews applicants and recommends the new class for approval by the ADA Board. The program for the class spans one year, including: a) three leadership training seminars at the American Dental Association Headquarters Building; b) periodic conference calls with faculty and c) experiential learning through personal leadership projects. For 2013-2014, the committee members are: Dr. Steven Gounardes, chair (ADA trustee, 2nd District); Dr. Terry Buckenheimer (ADA trustee, 17th District); Dr. Andrew Kwasny (ADA trustee, 3rd District); Dr. Gary Yonemoto (ADA trustee, 14th District); Dr. Keith Beasley (2006-2007 Institute class); Dr. Maria Maranga (2012-2013 Institute class); and Dr. Veronika Vazquez (2010-2011 Institute class).

Program faculty is from Northwestern University's Kellogg School of Management and Duke University's Fuqua School of Business.

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

Alumni Leadership Roles: Each year the Institute alumni record notable instances of "giving back" through leadership service in both organized dentistry and their communities. Highlights include:

- ADA House of Delegates: 13 delegates or alternates in 2013; eight, 2012; six, 2011
- ADA Council on Membership: two current members.
- The Indiana Dental Association leadership diversity program launched by a 2012 graduate of the Institute.
- Service as officers and board members for the: National Dental Association, Hispanic Dental Association, Society of American Indian Dentists, and American Association of Women Dentists.
- From the annual surveys of 117 Institute alumni, 85 dentists reported involvement with leadership work since completing the program. Together, they report involvement with 422 activities, an average of five for each graduate. Activities span ADA at the local, state and national level as well as other dental and community organizations.

Project Plan: Increase the class size of the Institute: Given successful program outcomes since the program began in 2003, the ADA Board of Trustees adopted a resolution at its June 2014 meeting to increase the Institute class to 16 dentists from 12, selecting the following dentists to begin the program in September 2014 as the class of 2014-15:

Dr. Abdul Abdulwaheed, Cambridge, Massachusetts
Dr. Xochiti Anderton, Lubbock, Texas
Dr. Kevin Bolden, Waco, Texas
Dr. Darwin Hayes, Bronx, New York
Dr. Amanda Hemmer, Phoenixville, Pennsylvania
Dr. Shih-Yen Hsiao, Fresno, California
Dr. Malieka Johnson, San Diego, California
Dr. Mark Limosani, Weston, Florida
Dr. Carliza Marcos, San Carlos, California
Dr. Christina Meiners, San Antonio, Texas

1 Dr. Shane Murphy, Anchorage, Alaska
2 Dr. Robin Nguyen, Trinity, Florida
3 Dr. Deryck Pham, Mays Landing, New Jersey
4 Dr. Inna Piskorska, San Antonio, Texas
5 Dr. Zellisha Quam, SAbuquerque, New Mexico
6 Dr. Rico Short, Smyrna, Georgia
7

8 **Leadership Development Network:** The proposed 2015 operating budget includes funds for a
9 Leadership Development Network to serve dental societies by building on the Institute's success.
10 Through this initiative, state and local dental societies would be invited to send emerging leaders to a
11 national conference (with faculty and alumni from the Institute), potentially during *ADA 2015*. After
12 participants return home, they would be engaged as volunteers in their societies and stay in touch with
13 each other to share leadership experiences and insights through ADA Connect and webinars. Their work
14 could potentially include state and local leadership programs, as well as other programs benefitting the
15 membership and their communities. The proposed Network funding also covers grants to state
16 associations for developing leadership programs.
17

18 **Response to 2013 Resolutions**

19 **Expanding Research Efforts in the Area of Dental Education Financing:** In response to Resolution
20 5H-2013 (*Trans.*2013:332), the Health Policy Institute (HPI) focused considerable effort on disseminating
21 key findings from the task force's work. HPI published an article focusing on trends in education costs and
22 earnings for several health care occupations that was published in *The New England Journal of Medicine*,
23 one of the most respected and most widely read journals in the health care field. The article remained in
24 the top ten most read list for several weeks. HPI published an article focusing on the impact of
25 educational debt on career intentions of dental school graduates in the *Journal of the American Dental*
26 *Association*. The article was selected as the cover story. A third article is currently under review at a top
27 health policy journal.
28

29 The impact of these analyses has been remarkable. Numerous dental school deans have invited the
30 Health Policy Institute to meet with their strategic planning committee, student body, and Boards to
31 discuss the key findings. The American Dental Education Association invited the Chief Economist and
32 Vice President of the Health Policy Institute to present findings and to gain insight into the key research
33 results and recommendations on how dental schools can adapt to the new economic paradigm of dental
34 education.
35

36 Going forward, efforts have shifted to initiating new research initiatives focused on filling key knowledge
37 gaps identified by the Taskforce. For example, HPI has launched a research initiative to understand the
38 role of student debt and other individual characteristics on the likelihood of entering group practice. The
39 House of Delegates approved funding for a new position within HPI in order to expand this line of
40 research and establish ADA expertise. During the budgeting process, however, it was requested that HPI
41 delay filling this new position for 6 months in order to generate budgetary savings. Recruitment, therefore,
42 has been postponed and some of the research has been delayed.

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

Cashion, Scott W., North Carolina, 2018. Dr. Scott Cashion has been in private solo practice in pediatric dentistry since 1999. He graduated from Wofford College and the University of North Carolina School of Dentistry where he was chief resident of hospital dentistry in 1995. He is presently an adjunct instructor in pediatric dentistry at UNC School of Dentistry and serves as president of the North Carolina Dental Society. Dr. Cashion has given presentations involving Access to Care for Children in the North Carolina Medicaid Program and has been a contributor to publications concerning Children's Utilization of Dental Care and Pediatric and General Dentist Participation in the North Carolina Medicaid Program. He has served in numerous civic and outreach activities both in his community and abroad. He will bring incredible insight and knowledge to the Council. His experience in all of these areas makes him a perfect fit.

Fagan, Timothy R., Oklahoma, 2018. Dr. Timothy Fagan is a pediatric dental specialist in Enid, Oklahoma. He has served the Oklahoma Dental Association in every major position from secretary/treasurer to president. He has been a member of several state committees including the Governor's Task Force on Oral Health Implementation and as chair for the Oklahoma Mission of Mercy for the last few years. He is a Fellow of the American College of Dentists and the Pierre Fauchard Academy. Dr. Fagan is a clinical associate professor at the University of Oklahoma College of Dentistry. Through his service to his patients, his associations, and his unending work to bring care to the underserved, he is prepared to be a valuable addition to CAPIR.

Gerlach, William H., Texas, 2018. Dr. William Gerlach currently serves on the Texas Dental Association (TDA) Board of Directors. He serves as the board's liaison to the Council on Legislative and Regulatory Affairs. He was very active with the TDA Smiles Foundation where he was a founding member and has served as president. He has and is active in the Texas Mission of Mercy's and has served as chair of 3 Dallas TMOM's. He initiated the Children's Dental Clinic in both McKinney, Texas and Plano, Texas through the community dental centers. Dr. Gerlach is qualified for this position and will be an active participant in the Council.

Lang, Melanie, Washington, 2015. Dr. Lang completed her undergraduate training at Union College in Lincoln, Nebraska. After graduating with High Distinction with her Doctor of Dental Surgery in 1991 from the University of Nebraska, Dr. Lang completed a one-year General Practice Residency in Hospital Dentistry at the University of Washington and affiliated hospitals in Seattle, Washington. In 1992, she returned to the University of Nebraska where she completed a one-year Oral & Maxillofacial Surgery Clinical and Research Fellowship. In 1993 Dr. Lang began a six-year dual degree Oral & Maxillofacial Surgery Residency program at the University of Florida in Gainesville which she completed in 1999. She graduated with honors with her Doctor of Medicine from the University of Florida in 1996. Dr. Lang has a special interest in Facial Cosmetic Surgery and pursued subspecialty training in Maxillofacial Cosmetic Surgery at the University of Alabama in Birmingham which she completed in 2000. Dr. Lang has enjoyed practicing in Spokane since she joined Spokane Oral & Maxillofacial Surgery in July of 2000. Dr. Lang works at both the Spokane Valley Ambulatory Surgical Center and Spokane Oral & Maxillofacial Surgery satellite office on the South Hill. Both facilities are accredited by AAAHC and JCAHO. Dr. Lang is also on staff at all the major Spokane hospitals and medical centers and is a Board Certified Surgeon and Diplomate of the American Board of Oral & Maxillofacial Surgery. Currently, Dr. Lang is President of the Washington State Society of Oral & Maxillofacial Surgeons and serves on the Executive Council for the Spokane District Dental Society. She is also a member of several local Dental, Hospital and Medical committees. In addition, Dr. Lang is a member of several professional organizations including: American Association of Oral & Maxillofacial Surgeons, American College of Oral & Maxillofacial Surgeons, American Academy of Cosmetic Surgeons, American Academy of Facial Plastic Surgeons, American Dental Society of Anesthesiologists, American Medical Association, American Dental Association, Washington State Society of Oral & Maxillofacial Surgeons, Spokane County Medical Society, Spokane

County Dental Society, American College of Oral Implantologists and International Congress of Oral Implantologists. Dr. Lang has volunteered her time on several occasions to provide surgical care in South America with a non-profit organization, Hearts in Motion. In addition, she has also traveled on a surgical mission to Bosnia with a non-profit group, Care for Children.

Pankratz, Todd A., Nebraska, 2015. Dr. Todd Pankratz is a partner with OB/GYN Associates in Hastings, Nebraska. He is a graduate of Hastings College, the University of Nebraska-College of Medicine, and completed his residency at Truman and St. Lukes's Hospitals in Kansas City, Missouri, where he served as chief resident. Dr. Pankratz has served in numerous leadership roles in the medical community. Within the Nebraska Medical Association (NMA) his leadership positions include serving as a trustee, president of the Greater NE Caucus, the legislative committee, the maternal child health committee, and the Medicaid committee. He was also a director with the Nebraska Medical Insurance Services. Dr. Pankratz has been also been active within the Mary Lanning Memorial Hospital medical staff including chairing the credentials committee, chairing OB/pediatrics committee, and the executive committee. He is a member of the American College of Obstetricians and Gynecologists and serves as a Nebraska state officer. He has also been a delegate for the Young Physician's Society of the AMA. Dr. Pankratz has been recognized with numerous honors with the most prestigious one being the AMA's Foundation Leadership Award. He resides in Hastings, Nebraska with his wife, Jessica Meeske, a pediatric dentist and their two children.

Switzer-Nadasdi, Rhonda, Tennessee, 2018. Dr. Rhonda Switzer-Nadasdi is the executive director of the Interfaith Dental Clinic in Nashville. She manages a team of 25 employees and is very organized. She knows every aspect of community based care. She knows the FQHC model. She knows the ins and outs of Medicaid. Dr. Switzer-Nadasdi has a heart of compassion for those underserved and uninsured. She already has contacts nationally in the community based care network. She is chair of the Tennessee Dental Association Oral Health Taskforce. She will be a great asset to CAPIR and the ADA as a council leader. Dr. Switzer-Nadasdi actually spoke on faith-based models of care at a recent CAPIR meeting. With her knowledge and network, she will be able to engage with CAPIR activities more quickly than most.

ADA SESSIONS

Evans, Henry F., Washington, 2018. Dr. Henry (Bud) Evans graduated from Washington University School of Dental Medicine in Saint Louis in 1976. He served four years practicing for the Indian Health Service in North Dakota and Alaska before entering private practice in the state of Washington. He is a Fellow and Master in the Academy of General Dentistry and received the Academy's Lifetime Learning Service Award in 2013. He has served in numerous leadership positions in dental study clubs as well as completing many dental volunteer missions overseas. He is a past committee member and chair of Washington State Dental Association Pacific Northwest Dental Conference. Dr. Evans will bring a broad range of relevant experience and leadership to the Council on ADA Sessions.

Lieb, Howard I.A., New York, 2018. Dr. Howard Lieb has extensive administrative and logistical experience and skill in planning a dental meeting. He served the Greater New York Dental Meeting in the following capacities: Assistant to the Executive Director, 1999-2004; General Chairman, 2002-2003; Advisory Chairman, 2004-2005; and a member of the Advisory Committee, 2006-present. At the local dental component level he served as president, program committee chair, and continuing education chair. Dr. Lieb is a member of the International Scientific Advisory Board, and the United Arab Emirate International Dental Conferences & Arab Dental Exhibition, 2003-present. He is also a member of the International Review Board for *Smile Dental Journal*, Amman, Jordan, 2008-present. Dr. Lieb has great interest and enthusiasm for developing potential and current exhibitor relationships. He is well qualified, capable and will be an asset to the ADA.

Macias, C. Roger, Jr., Texas, 2018. Dr. Roger Maciashas been a member of the American Dental Association since 1983. He has been involved at the national level as a member of Dr. Geraldine

Morrow's "Task Force for Women and Minorities in Dentistry," the Commission on the Young Professional, later known as the Committee on the New Dentist, the ADA Strategic Planning Committee, and the 2008 ADA Meeting Committee on Local Arrangements. At a the Texas state level, Dr. Macias has been on several TDA committees and served from 2007 to 2012 on the Council on Annual Sessions. In 2011, he served as chair of the Annual Sessions which still holds the record for attendees at over 13,000. During his tenure on this council, he scouted for the general meeting at most of the major dental meetings here in the U.S. and in Canada. Dr. Macias is bi-lingual and fluent in Spanish. As a scout, he is well thought of by his fellow scouts across the U.S. and has helped to elevate the level of speakers that attend the Texas Meeting. He and his council have been able to enhance the Texas meeting to one of the premier meetings in America. Dr. Macias is very in tune with the latest technologies in his private dental practice, and in his communication, public speaking, and writing skills.

Richman, Andrea, Massachusetts, 2018. Dr. Andrea Richman graduated from Tufts University School of Dental Medicine in 1978, and since that date has been very active in, and committed to, organized dentistry. Dr. Richman has risen through the chairs to serve as president and/or chair of her state and district dental societies in Massachusetts, as well as having served the Massachusetts Dental Society's (MDS) representative to their malpractice insurance company, Eastern Dental Insurance Company (EDIC), a for profit subsidiary. Throughout her career, Dr. Richman has also been passionate about dental education and has pursued a parallel track with Yankee Dental Congress. "Yankee" was started in 1976 by the MDS, and Dr. Richman has attended every one. It wasn't long before she was serving on committees, eventually chairing many and serving as general chair in 2000. Dr. Richman's experience with Yankee has given her the background and expertise in meeting planning which is essential to serving on the Council on ADA Sessions. She has broad experience in programming, administration, scouting, and logistics which makes this an ideal fit for her skill set. Dr. Richman is accustomed to working with meeting planning staff, and has a reputation for attention to detail and for knowing how to get things done. As a delegate and individual dentist, Dr. Richman has attended about 12 ADA sessions, and has a very good feel for the scope and expectation of this important national meeting. At this point in her professional life, she has cut back on her day's in-office, and has the time and energy to devote to this Council.

COMMUNICATIONS

Bean, Canise Y., Ohio, 2018. Dr. Canise Bean is an associate professor at the Ohio State University College of Dentistry in the division of Pediatric Dentistry and Community Oral Health. She also serves as the director of the Office of Community Education and the director of the OHIO Project (Oral Health Improvement through Outreach). At the Ohio Dental Association, she currently serves as a member of the Council on Dental Care Programs and Dental Practice and the Subcouncil on Judicial Affairs. She has also served as a member of a reference committee. Dr. Bean is also a member of the American Dental Education Association, Academy of General Dentistry, International College of Dentists, National Dental Association, Pierre Fauchard Academy, Columbus Association of Dentists, and American Association of Women Dentists. She is the former president, treasurer, and program chair for the Forest City Dental Society, an Ohio Society of the National Dental Association.

Hanley, Yvonne S., Minnesota, 2018. Dr. Yvonne Hanley is a practicing general dentist in Fergus Falls, Minnesota. Besides being an excellent and respected dentist, Dr. Hanley has been actively involved in organized dentistry since joining the ADA in 1978. Presently she is using her skills as a journalist and author. She serves on the editorial board of *Northwest Dentistry* – the professional journal of the Minnesota Dental Association. For the Past 25 years, Dr. Hanley has also served on the faculty of the Pankey Institute. Yvonne has the gift of being an excellent communicator - she is both precise and creative. She has developed teaching modules and videos to aid her skills and passion for teaching. Dr. Hanley is a willing volunteer. She is the first to say yes to any request in participating in organized dentistry – from GKAS, Mission of Mercy, and Donated Dental Services, to teaching children in her local public schools during February Dental Health Month.

Lindemann, Kurt S., Montana, 2018. Dr. Kurt Lindemann graduated from Loma Linda University School of Dentistry in 1999. He is a Fellow of the American and International College of Dentists as well as the International Congress of Oral Implantologists. He has served as president of his component dental society and as president of the Montana Dental Association (MDA), from 2012 to 2013. He is currently chair of the MDA Government Affairs Committee and the MDA Public Affairs Workgroup overseeing the association's prevention and public awareness campaigns. His extensive experience as an early career dentist in numerous leadership positions and communications initiatives will bring a valuable perspective to the ADA Council on Communications.

Reich, Robin S., Georgia, 2018. Dr. Robin Reich has practiced general dentistry in Smyrna, Georgia, since 1984. Dr. Reich has been actively involved in organized dentistry at the component and constituent level. She was president of her component dental society and served on numerous committees ranging from Dental Benefits and Insurance to Long-Range Planning. At the constituent level, Dr. Reich has been a member of the Georgia Dental Association's Board of Trustees for the past seven years and an alternate delegate to the ADA House of Delegates for two years. Dr. Reich has extensive experience in the communications arena. She is the current chair of the Georgia Dental Association's Public Relations Committee and has served in that capacity since 2008. As chair of the Public Relations Committee, Dr. Reich works and develops with both internal and external communications strategies and provides oversight to the Georgia Dental Association's communications programs. She is also a trained spokesperson for the GDA to speak on issues that may arise through the media or through the legislative process.

Dr. Reich also coordinated the public relations and communication efforts of the Georgia Dental Association's two Georgia Mission of Mercy events. This included working with the print and broadcast media to disseminate press releases and do on camera interviews. Dr. Reich is knowledgeable on issues related to the dental profession and oral health and would be an asset to the ADA Council on Communications.

DENTAL ACCREDITATION

Feldner, Loren J., Illinois, 2019. Dr. Loren Feldner began his exemplary, selfless service to organized dentistry shortly after graduation from dental school and it continues to be robust and praiseworthy to the present. Most recently, Dr. Feldner completed a remarkable stint as co-chair of the ADA's ADPAC National Board (sharing the chair position with Dr. Gordon Isbell). Prior to that he worked for four outstanding years as the Eighth District Representative to ADPAC. Dr. Feldner is an extremely bright and a most gifted individual; he has a remarkable personality and he is knowledgeable in a great many avenues of the dental profession and healthcare matters – not merely the governmental/regulatory advocacy and political elements. He is well-spoken and remarkably comfortable discussing a whole host of topics with anyone at any level, especially those matters related to healthcare, dentistry, and education. His overwhelming willingness and exemplary ability to get difficult tasks completed successfully, regardless of the challenges or complexities and despite the barriers or sacrifices, is well-known, award-recognized and gladly celebrated by those (ADA member-dentists who know and respect him, as well as those members of the public who are cognizant of his service on their behalf) who have witnessed and benefited from his unselfish service performed alongside the efforts of a choice few other individuals also of remarkable quality, resolve, and capability.

Dr. Feldner's background and experience is markedly unique and refreshingly diverse. He served a five-year medical externship (1984-1989) with the Chicago Tribune, which undoubtedly has contributed to his obviously remarkable ability to interact with the media, educators, public officials, legislators, and others on a whole host of issues, which include, but are certainly not limited to media communication, education, healthcare, dental, dental education, legal, legislative, and regulatory. From 1986 through 1991, Dr. Feldner served on the faculty of the Loyola University School of Dentistry as an assistant clinical professor in Endodontics, receiving the Distinguished Faculty Award in 1990. He interacts with local dental students at both schools in the Chicago area regularly as special functions and social get-

togethers arise through the school year. He has enjoyed extensive experience, since 1988, in private dental practice as a general dentist. He participated significantly, from 1990 through 1993, at the Dawson Center for Advanced Dental Study and completed the program there. For several years he served as the dental director at the Alden Nursing Home in suburban Chicago, both in the administration of the dental program there and in treating the elderly and medically compromised resident patients. In 2011, Dr. Feldner completed the ADA's Kellogg Graduate Executive Management Program, known to all of us as a very challenging and highly praised program, which has been touted as being among the absolute finest in the nation, if not the world. Clearly, he understands the value of advanced education and has demonstrated this, through voluntarily applying, participating, and completing these stimulating, demanding, and noteworthy programs.

Dr. Feldner's professional affiliations are solid and long-standing. The main ones include: American Dental Association, Illinois State Dental Society, Chicago Dental Society, Academy of General Dentistry, American Equilibration Society, Odontographic Society of Chicago, International College of Dentists, American College of Dentists, Members Group of the Chicago Dental Society, and Center for Advanced Dental Study.

Dr. Feldner has served a term as a director for the Chicago Dental Society (CDS); in fact, he has served in all capacities of the branch through president of that branch (South Suburban) which is one of the larger branches of the CDS and he has served in all capacities through president of the Illinois State Dental Society Political Action Committee (DENT-IL-PAC) in addition to a plethora of other areas of professional and community service. He has served as a key organizer, presenter, and participant in a whole host of volunteer circumstances, over a good many years, including such activities as the Annual National Children's Dental Health Month, Give Kids A Smile, and the Illinois Mission of Mercy. Brevity is necessary here, but time and space permitting, this list could go on and on.

Dr. Feldner possesses all the drive, ethics, dedication, energy, expertise, and personality necessary to excel as an ADA-appointed commissioner/representative to the Commission on Dental Accreditation (CODA). Dr. Feldner's service experience thus far (although he never planned it, imagined it, or asked for it) has simply been a step-by-step, natural pathway toward CODA service on behalf of the ADA. As we all know, many entities have representation on CODA, the ADA being just one. The ADA's voice on CODA is absolutely crucial. Dr. Feldner would tirelessly and unequivocally represent the ADA exceptionally well, should he be designated to serve as a commissioner/representative with CODA.

DENTAL BENEFIT PROGRAMS

Davenport, C. Scott, North Carolina, 2018. Dr. Scott Davenport graduated from UNC Charlotte in 1980 and the UNC School of Dentistry in 1984. He has served in leadership positions in North Carolina at both the component and constituent levels and is the immediate past president of the North Carolina Dental Society. Dr. Davenport has served as a steering committee member, on the subcommittee for exhibits, and the president of the Holiday Dental Conference Foundation. He is a Fellow in the American College of Dentist, the International College of Dentists, the Pierre Fouchard Academy, and the Academy of Dentistry International. He received the UNC Dental Alumni Association Distinguished Service Award in 2013.

Dr. Davenport is very civic minded and has volunteered for activities throughout his community. He has especially been active and involved with the Boy Scouts of America where he received the Scoutmaster of the Year Award in in 2009. Dr. Davenport's commitment to our profession, his communication and consensus building skills, and his propensity for learning will make him a valuable asset to the Council on Dental Benefit Programs.

Hamel, David L., Kansas, 2018. Dr. David Hamel has served in many capacities for the Kanas Dental Association, including president in 2011. He is a long standing member of the ADA House of Delegates. He is a member of the Kanas Dental Charitable Foundation, a Fellow of the American College of

Dentistry, and an alumnus of the LD Pankey Institute. Dr. Hamel has a keen interest in third party intrusion in dentistry. He worked with his state senator, the ADA, and other associations to author a patient dental benefit protection statute. Through his work within his state, and his desire to protect our patients and members from onerous insurance company interference, Dr. Hamel has positioned himself to be a valuable member of CDBP.

Snyder, Steven I., New York, 2018. Dr. Steven Snyder is a well versed, articulate, and seasoned leader in our tripartite. His thirty years of private practice have given him sufficient experience and familiarity with dental plans including managed care, indemnity plans, preferred provider organizations, and direct reimbursement. Dr. Snyder has held numerous leadership roles some of which include:

- Chairman, Council on Insurance, New York State Dental Association, 2001-2003
- President, Suffolk Count Dental Society, 2004
- Trustee, New York State Dental Association, 2010-2013
- President, New York State Society of Oral and Maxillofacial Surgeons, 2013-2014

Vaillant, Matthew J., Minnesota, 2018. Dr. Matthew Vaillant is a practicing general dentist in Red Wing, Minnesota. Besides being an excellent and respected dentist, Dr. Vaillant continues to be actively involved in organized dentistry. Currently, Dr. Vaillant is a trustee to the Minnesota Dental Association (MDA) representing the Southeast District. He has served as chair of the MDA Dental Marketplace Committee giving him additional knowledge of third party and government program concerns. Dr. Vaillant has also served as a chair of the Southeast District Dental Society Peer Review Committee.

DENTAL PRACTICE

Kent, Leigh, Alabama, 2018. Dr. Leigh Kent is the current president of the Alabama Dental Association. She has served at the local, state, and national levels of her specialty organization in periodontics in a number of leadership and delegate positions. She has served all the officer positions of the Birmingham District Dental Society, the largest district dental society in Alabama. In addition, Dr. Kent has served as chair of the Birmingham District Peer Review Committee. She is the founder and director of the Birmingham Comprehensive Dental Seminars and founder of the Birmingham Spear Study Club. She is presently chair of the Special Committee to Study ALDA Policies, Practices, and Procedures. Dr. Kent was named University of Alabama School of Dentistry Young Alumnus of the Year in 2006.

Ratner, Craig S., New York, 2018. Dr. Craig Ratner has served both his local and state constituency with distinction. Some of his many qualifications for this Council appointment include: Trustee to the New York State Dental Association, 2009–present; member of the New York State Dental Association Executive Committee in 2008; delegate to the American Dental Association, 2008–present; president of the Second District Dental Society in 2008; editor of Second District Dental Society Bulletin, 2005–present; governor of the New York State Dental Association, 2005–2009; and member, Council on Dental Practice for the New York State Dental Association for the years 2001-2003. Dr. Ratner works well with everyone. He is a team player, open minded, and creative. He will be an asset to the ADA.

Theurer, Scott L., Utah, 2018. Dr. Scott Theurer served as Utah Dental Association president from February 2012 to March 2013. He served as a Utah Dental Association officer 2009-2014, and has been a member of the ADA since 1984. Dr. Theurer has been an owner dentist of a private general practice in Logan, Utah, since June 1984. He is a member of Utah Oral Health Coalition, 2010-2013 (chair 2011). He is a member of the Bridgerland Applied Technology College Dental Assisting Advisory Board, 1998-2013. Also, he is a Bear River Head Start Health Advisory Committee member, 2000-present, and sponsor/coordinator of their fluoride varnish program. Dr. Theurer has an interest and advisory role to son-in-law, pediatric dentist (Sequin, Texas), daughter-in-law, general dentist (lives in Falls Church Virginia) and son entering dental school at The University of Texas Health Science Center at San Antonio July 2014.

Wojcik, Michael S., Michigan, 2018. Dr. Michael Wojcik is a 1988 graduate of the University of Michigan School of Dentistry. He subsequently completed a general practice residency at St. Joseph Mercy Hospital (Pontiac, Michigan) and postgraduate education in periodontology at The Ohio State University in 1992. He is a Diplomate of the American Board of Periodontology and has been in private practice since 1992. Dr. Wojcik was an assistant clinical professor at the University of Michigan School of Dentistry (1992-1993), and since 2001 he has been an adjunct instructor at the University of Detroit Mercy School of Dentistry/Detroit Receiving Hospital. Dr. Wojcik holds membership in numerous professional organizations including the American Dental Association, American Academy of Periodontology, Michigan Dental Association (MDA), American Association of Dental Editors, International College of Oral Implantologists, American College of Dentists, Pierre Fauchard Academy, Russell Bunting Periodontal Study Club, Detroit Dental Clinic Club, and Delta Sigma Delta Fraternity.

Dr. Wojcik has published a number of peer reviewed journal articles and abstracts, and he has presented numerous table clinics and oral presentations. He is an ADA CERP-recognized CE provider. Dr. Wojcik has been very active in organized dentistry. He is past president of the Macomb Dental Society (2009-2010) and has represented his local component as a delegate for Michigan's Eighth District in the MDA House of Delegates since 2002. He just concluded a four-year term on the Michigan Dental Association's Committee on Peer Review/Ethics and previously served as chair of the MDA Committee on Peer Review/Dental Care. Dr. Wojcik has been an examiner for the State of Michigan Specialty Board (Periodontology). He also served as a member of the Blue Cross/Blue Shield of Michigan Dental Advisory Committee, Macomb Dental Society Membership co-chair, director of the Periodontal Section for the Detroit Dental Clinic Club, and a member of the Advanced Continuing Dental Education Advisory Committee for the University of Detroit Mercy School of Dentistry. Dr. Wojcik's wealth of experience and leadership skills and his commitment to lifelong learning and the well-being of the entire dental team make him a worthy nominee for an appointment to the ADA Council on Dental Practice.

EDUCATION AND LICENSURE

Halpern, David F., Maryland, 2018. Dr. David Halpern is a private practicing general dentist who currently serves as president of the Howard County Dental Society and is a past president of the Maryland State Dental Association's Charitable and Educational Foundation. He has been involved in dental education issues for his entire professional career, starting from involvement early in his career with continuing education course development and promotion at the Baltimore College of Dental Surgery, through immersion in dental education in the Academy of General Dentistry's Committee for Certification of General Dentists and Council on Dental Education. Dr. Halpern has experience in the development of innovative educational programming and dental education and licensure policies. He is fully knowledgeable in the standards associated with both ADA's CERP and AGD's PACE approval programs.

Recently, Dr. Halpern has been involved in an advisory capacity with the development of a two-year Hygiene degree program at the Howard Community College, and serves on the Dental Auxiliary Learning and Education Foundation (the DALE Foundation) Editorial Board, having been the lead reviewer for an interactive online dental auxiliary course, and serves on the DALE Foundation Board of Trustees. His local, state, and national organizational experiences provide necessary perspectives of budgeting, council/committee structure, operations, strategic planning, policy-making, and project implementation that will be an asset to the Council of Dental Education and Licensure.

Hebert, Edward J., Louisiana, 2018. Dr. Edward Hebert served as a delegate and alternate delegate to the ADA House of Delegates from 2004 to 2009. He is a past present and secretary/treasurer of the Louisiana Dental Association. He is a Fellow of the International College of Dentists, the American College of Dentists, and the Pierre Fauchard Academy. He has served as a grader for State Boards through the Council of Interstate Testing Agencies since 2009. With his interest in dental education and testing, he will be a great addition to CDEL.

1 ETHICS, BYLAWS AND JUDICIAL AFFAIRS

2 *Herman, Gary N., California, 2018.* Dr. Herman is well qualified for this position based on his experience
3 with California Dental Association (CDA). He has spent the last six years serving on the CDA Board of
4 Trustees as well as a year on The Dentists' Insurance Company Board of Directors and four years as a
5 founding member of the CDA's Policy Development Council. Through those experiences, Dr. Herman
6 has a very good understanding of the role and value of all levels of the tripartite system we call organized
7 dentistry. Although he does not have specific service with CDA's Judicial Council, his background in
8 dental ethics from an academic teaching position would provide a valuable viewpoint on CEBJA. He has
9 participated with his components Ethics Committee, currently teaches professionalism through
10 appropriate communication and patient management, and presents to the dental community on current
11 issues in the profession and their ethical implications. Additionally, Dr. Herman provides remediation for
12 the Dental Board of several states to dentists who have suffered ethical lapses that have resulted in
13 violations of the law. His service on many committees and councils, both in organized dentistry and in
14 academia, have prepared him to provide leadership and the interpersonal skills to move agendas forward.

15 *Kochhar, Puneet, New Hampshire, 2018.* Dr. Puneet Kochhar graduated from Boston University School of
16 Dental Medicine in 2003 and since then has practiced general dentistry in Rochester, New Hampshire.
17 He is the immediate past president of the New Hampshire Dental Society and is a Fellow of the
18 International College of Dentists. Dr. Kochhar served the ADA Reference Committee on Membership,
19 and also chaired the First District Reference Committee on Membership, at the House of Delegates,
20 2012. He has also served on numerous councils and committees at the state level and has actively
21 participated in the Dentistry with a Heart Program in New Hampshire that delivers free dental care to the
22 underserved.

23 *Moss, J. David, South Carolina, 2018.* Dr. David Moss has been in private practice in Florence, South
24 Carolina, since 1980. He graduated from the University of South Carolina in 1975 and the MUSC College
25 of Dental Medicine in 1978. He has distinguished himself at all levels of the tripartite and is presently
26 serving as the president of the South Carolina Dental Association (SCDA). He has served on the
27 Florence – Darlington Technical College Advisory Board and also as an instructor at the college. He is a
28 member of the American Academy of Cosmetic Dentistry, the Academy of General Dentistry, and is a
29 Fellow in the American College of Dentists. Dr. Moss is very civic minded and has been very active in his
30 community. He has been honored as Rotarian of the year, serves on the Board of Directors for the Mercy
31 Free Clinic, and has served as mission captain for several mission trips to Honduras. Dr. Moss has
32 served on the SCDA Peer Review and chaired the committee in 2003 and 2004. As an officer and leader
33 at both the state and local levels he has overseen many constitution and bylaws changes. He is uniquely
34 qualified to serve on CEBJA and his dedication and communication skills will be an asset to the Council.

35 *Ilkka, Don J., Florida, 2018.* Dr. Don Ilkka has been practicing general dentistry in Leesburg, Florida, for
36 over thirty years. He has been a trustee of the Florida Dental Association (FDA) for 6 years and just
37 termed out of office this past June. Dr. Ilkka currently serves as the Florida Dental Association's liaison to
38 the Florida Board of Dentistry. In this role, he is responsible for providing input on how the board's rules
39 and regulations affect practicing dentists and also gives testimony to the board in regard to changes in
40 policy of the Florida Dental Association. He is instrumental in assisting the board in their role to protect
41 the public.

42 Dr. Ilkka chaired the Peer Review Committee in Lake County, Florida, from 1989 to 1999 and served as
43 trustee liaison to the FDA CEBJA for 5 years. Dr. Ilkka completed the first continuum of the American
44 Institute of Parliamentarians nearly 5 years ago. He has also served in all line officer positions of the
45 Central District Dental Association (a component of the ADA) and was president in 1999-2000. His
46 passion is the ethical practice of dentistry, but he still finds time to serve as the dental director of the St.
47 Luke's Free Medical and Dental Clinic in Lake County, Florida, since 2005 until the present.
48

1 GOVERNMENT AFFAIRS

2 *Beauchamp, K. Jean, Tennessee, 2018.* Dr. K. Jean Beauchamp attended the University of Tennessee
3 College of Dentistry and earned her D.D.S. degree in 1991. She completed a residency in pediatric
4 dentistry in 1993. She currently practices pediatric dentistry in Clarksville, Tennessee. Dr. Beauchamp
5 has a long history of service to the profession at all three levels of the tripartite. She has served as the
6 president of the Eighth District Dental Society, served as a trustee to the Tennessee Dental Association
7 (TDA), and currently serves as the secretary of the TDA. She has been a member of the ADA Council on
8 Access, Prevention and Interprofessional Relations, and has been a delegate to the ADA House of
9 Delegates for seven years. Dr. Beauchamp has held several positions in the American Academy of
10 Pediatric Dentistry. Her keen interest in government affairs and her dedication to the profession of
11 dentistry will make her an outstanding member of the Council on Government Affairs.

12 *Garrett, Marty B., Louisiana, 2018.* Dr. Marty Garrett has served his association in many capacities. He is
13 a past president of the Louisiana Dental Association (LDA), chair of the State Ethics Committee, chair of
14 the State Peer Review Committee, and current chair of the LDA Council on Government Affairs. Through
15 his past experiences and his willingness to serve he is well qualified to be a valuable member of CGA.

16 *Graham, Frank J., New Jersey, 2018.* Dr. Frank Graham has been an Action Team Leader (ATL) for
17 former Representative Rothman (10 years) and currently ATL for Representative Pascrell (1 year). He
18 has been a member of the NJDPAC executive committee since 2004 and is a member of the NJDA
19 Council on Government and Public Affairs. A trustee and officer of the NJDA for 13 years, he was NJDA
20 President 2004-2005. An alternate delegate and then delegate to the ADA House of Delegates for 11
21 years, he is the chair of the New Jersey delegation. Dr. Graham was also a member of the ADA Council
22 on Dental Practice from 2005 to 2009, serving as vice chair, 2007-2008, and chair 2008-2009. He served
23 on the special ADA HOD Task Force on Healthcare Reform and the Future of Dentistry and also on the
24 ADA Board of Trustees Task Force on the Dental Team. He was a co-author of the Systematic Review of
25 Mid-level Providers that was produced at the request of the ADA House of Delegates by the Council on
26 Scientific Affairs and published in *JADA*. Most recently, Dr. Graham served as the Fourth District
27 representative to ADPAC (2009-2013) and continues to serve as a consultant to the Independent
28 Expenditures Committee (super PAC). Dr. Graham's extensive background will make him an asset to the
29 Council on Government Affairs.

30 *Minahan, David M., Washington, 2018.* Dr. David Minahan received his D.D.S. degree from the University
31 of Washington School of Dentistry in 1975. He is serving as the president of the Washington State Dental
32 Association (WSDA), 2013-2014. He has been extensively involved with the Dean's Club of the
33 University of Washington (chair) as well as the UW Dental Alumni Association (chair). He is the current
34 chair of the WSDA Committee on Government Affairs. Dr. Minahan is a past chair of the Pacific
35 Northwest Dental Conference and served on its Scientific Committee for several years. He has
36 represented WSDA for many years as an alternate delegate and delegate to the ADA House of
37 Delegates. He is a Fellow of the International College of Dentists, American College of Dentists, and the
38 Pierre Fauchard Academy (PFA), having served as the section chair for that state of Washington for PFA.
39 Dr. Minahan has an extensive civic and community service record.

40 MEMBERSHIP

41 *Aguirre, Alejandro M., Minnesota, 2016.* In February 2014, Dr. Alejandro Aguirre was appointed to
42 complete the unexpired term of Dr. Steven Bradley as a member of the Council on Membership. Dr.
43 Aguirre has a private practice in endodontics in Plymouth, Minnesota. He began his dental education and
44 career in Mexico and moved to America in 1994 to continue his training in endodontics. He has been
45 very involved in his profession and organized dentistry. Dr. Aguirre served on several committees in the
46 Minnesota Dental Association (MDA) and was a member and chair of the MDA Membership Committee.
47 He has always been involved at the local level, serving as an officer and now trustee for the Minneapolis
48 District Dental Society. Dr. Aguirre has served as chair for the MDA Mission of Mercy Task Force

bringing two successful MOM events to Minnesota with the third event planned for the summer of 2014. Dr. Aguirre was selected to the ADA Institute for Diversity in Leadership and the ADA Kellogg Executive Management Program. These programs help to enhance the leadership potential of members of racial and ethnic groups that have been traditionally under-represented in leadership positions. Dr. Aguirre continues to be a cheerleader for these programs and encourages others to participate. Dr. Aguirre will be an excellent addition to the Council on Membership and will always come prepared and ready to participate; bring great ideas and enthusiasm to his position.

Ellinwood, Steven P., Indiana, 2018. Dr. Steven Ellinwood has served on the ADA House of Delegates delegation for the Indiana Dental Association (IDA) for nine years and has served the last three years as the Seventh District co-chair for the membership work group. He is a former member of the IDA Council on Membership, serving as chair from 1996 to 1998. Dr. Ellinwood will make an excellent addition to the ADA Council on Membership.

Muncy, Marc, Arkansas, 2018. Dr. Marc Muncy has served his association in many ways. He served as secretary/treasurer of the Arkansas State Dental Association (ASDA) from 2011 to 2014. He was a member of the Arkansas State Board of Dental Examiners from 2004 to 2009. He is a member of the Southern Regional Testing Agency. As secretary/ treasurer of ASDA, he learned the importance of a strong membership and how to work with others to achieve the same. Dr. Muncy will make a great addition to the Council on Membership.

Romano, Rodrigo, Florida, 2018. Dr. Rodrigo Romano is a practicing periodontist in the Miami, Florida, area. He graduated from Autonomous University of Guadalajara, Mexico, in 1998. He then went to the Boston area and worked as a dental assistant until he was accepted into Tufts University for his periodontal specialty certification course. He stayed at Tufts and received a Masters Degree in 2007. Dr. Romano has been practicing in Miami as a periodontist since 2008. Dr. Romano has served as alternate trustee for the Florida Dental Association from the South Florida District Dental Association (SFDDA) (a component of the ADA) for the past two years. He has also served as treasurer of the SFDDA since 2010 and the SFDDA Foundation during those same years. Rodrigo has a keen eye for finances and has recently served on the FDA's Council on Financial Affairs. He has been an alternate delegate to the ADA House of Delegates since 2012.

During his time as line officer for the Miami Dade Dental Society (an affiliate society of the SFDDA Component), until his year as president in 2012-2013, membership growth went from 30 dentists to 85 dentists. This is remarkable considering the SFDDA has consistently shown a membership market share around the 35% mark (lowest among the 6 components in Florida). Being young and of Hispanic descent, it is very refreshing to see the level of energy that Dr. Romano has to dedicate to the dental profession and the ADA. He shares that passion with residents that he interviews for placement in the Community Smiles Advanced Dental Education program in Miami where he is the chair of the perio department.

Woller, Jonathan P., Alaska, 2018. Dr. Jonathan Woller is a 2004 graduate of the University of Louisville School of Dentistry. He worked for private practices in the state of Minnesota prior to returning home to Fairbanks, Alaska, to practice in 2007. He served as president of the Alaska Dental Society (ADS) North Central District Dental Society in 2009, and president of the ADS in 2012-2013. Dr. Woller has served as an alternate delegate and delegate to the ADA House of Delegates since 2011. His early involvement as an early career dentist in numerous leadership positions in the state of Alaska, including small constituent membership initiatives, will provide a valuable perspective to the ADA Council on Membership.

MEMBERS INSURANCE AND RETIREMENT PROGRAMS

Ellison, Naomi L., California, 2015. In March 2014, Dr. Naomi Ellison was appointed to complete the unexpired term of Dr. Sanjay Patel as a member of the Council on Members Insurance and Retirement Programs. Dr. Ellison has had leadership positions at the local, state, and national level of organized dentistry. She also served on the California Dental Association's (CDA) TDIC/TDIC IS Board from 2003

1 to 2009. She chaired the CDA Finance Committee and served as chair of the board in 2007 and 2008.
2 She is familiar with liability insurance, property insurance, workers' compensation, health and life
3 insurance, etc. Dr. Ellison also understands financial investment strategies, running an insurance
4 business and member/policyholder value and risk.

5 *Hehli, Peter D., Wisconsin, 2018.* Dr. Peter Hehli practices general dentistry with an emphasis on
6 conscious sedation and cosmetic dentistry in Appleton and Sheboygan, Wisconsin. He is a 1988
7 graduate of the University of Minnesota School of Dentistry as well as an AEGD residency at the
8 University of Minnesota the following year. He has served as an alternate delegate to the ADA House of
9 Delegates on several occasions and has also served on the ADA Tripartite Task Force from 2004 to
10 2006. Dr. Hehli has been very active in organized dentistry in his state and local societies. He is past
11 president of the Outagamie County Dental Association and currently serves the Wisconsin Dental
12 Association (WDA) as its Region 2 Trustee and as a member of the WDA Long Range Planning
13 Committee. Dr. Hehli has been vice chair of the WDA Membership Committee and has also served on
14 the WDA Annual Session and Legislative Committees. He is an effective communicator and proven
15 leader who knows how to gain consensus on difficult issues. Dr. Hehli will serve the ADA well on the
16 Council on Members Insurance and Retirement Programs.

17 *Mann, Marshall H., Georgia, 2018.* Dr. Marshall Mann has practiced general dentistry in Rome, Georgia,
18 since 1979. Dr. Mann has been actively involved in organized dentistry for many years and has served in
19 leadership roles at the component and constituent level. He was president of his component dental
20 society in 2002-2003 and is the immediate past president of the Georgia Dental Association (GDA). In
21 his role as president and president-elect of the GDA, Dr. Mann served as an *ex officio* member of the
22 GDA insurance subsidiary's Board of Directors. In that capacity he reviewed the numerous insurance
23 products provided by the agency and is knowledgeable on these products, which include major medical
24 professional liability, business owner's property/casualty, workers' compensation, disability, and ERISA
25 bonds. He rotated off this board when his term expired as GDA president on July 20, 2014. In addition,
26 Dr. Mann has served on the Fifth District's Reference Committee on Budget that thoroughly reviews and
27 analyzes the ADA budget each year, and has been a delegate or alternate delegate to the ADA House of
28 Delegates for seven years.

29 Dr. Man also has experience and knowledge of retirement plans obtained from two positions that he held.
30 The GDA also manages a 401k plan for its employees and Dr. Mann was involved in reviewing and
31 understanding this employee benefit as GDA president. He also served on the Coosa County Club
32 Board of Directors for nine years and as a president for two of those years. In that capacity he reviewed
33 and understood the plan and he held a fiduciary responsibility for the employees' retirement plan.
34 Throughout his years in leadership, Dr. Mann has demonstrated his ability to communicate effectively in
35 numerous arenas such as legislative, colleague to colleague, and as chairman of the GDA Board of
36 Trustees. His skill set is well suited to participation on the Council on Members Insurance and Retirement
37 Programs and would be an asset to this ADA Council.

38 *Lipton, James M., Indiana, 2018.* Dr. James Lipton is a 1982 graduate of Indiana University School of
39 Dentistry. He currently serves of the Indiana Dental Association Council on Insurance, serving as chair
40 from 2000 to present. In addition, Dr. Lipton is the 2014 president of the Indiana Medical Insurance Trust.

41 *Shirley, Eric L., Pennsylvania, 2016.* In June 2014, Dr. Eric Shirley was appointed to complete the
42 unexpired term of Dr. Lois Rubino as a member of the Council on Members Insurance and Retirement
43 Programs. Dr. Eric Shirley earned is D.M.D. degree from the University of Pittsburgh School of Dental
44 Medicine in 1991. He served in the United States Dental Corps from 1991 to 1994. He is currently a
45 general dentist practicing in Harrisburg, Pennsylvania.

46 *Wieting, D. Scott, Nebraska, 2018.* Dr. Scott Wieting is a general dentist in York, Nebraska, and has been
47 in private practice for 35 years. Dr. Wieting has been involved in organized dentistry since graduation
48 from University of Nebraska-Lincoln School of Dentistry. He has served as his component president and

trustee of his state district. He also served as a Nebraska officer and completed his term of president of the Nebraska Dental Association in March of 2014. Dr. Wieting wants to stay involved in a leadership role in organized dentistry and will serve the ADA well as a representative of the Council on Members Insurance and Retirement Programs. He will do his homework and come well prepared to Council meetings. Dr. Wieting has served on many community organizations as a leader and has experience in members insurance and retirement programs. He is excited for his nomination to this position, understands "member value," and will do a good job in helping our members answer the question: Why should I be a member of the ADA.

NATIONAL DENTAL EXAMINATIONS

Heinrich-Null, Lisa A., Texas, 2018. Dr. Lisa Heinrich-Null is a private practitioner who has been in her own practice for 28 years. She is in good standing with the ADA. She has served as an alternate and delegate to the ADA House of Delegates since 2009. She is involved with Texas TMOM's. Dr. Heinrich-Null fulfills all the criteria needed to serve on this Commission. Over the years she has been actively involved as a mentor to dental students and through this has an interest in dental testing. She also has a strong desire to increase and maintain ADA membership. Dr. Heinrich-Null has the full support of her nominating trustee and will be an asset to the Commission.

NEW DENTIST COMMITTEE

Dean, Brittany T., Washington, 2018. Dr. Brittany Dean is a 2012 graduate of the University of Washington School of Dentistry. She completed a general practice residency from the University of Washington in 2013. She is currently working for the Snohomish County Community Health Center in Everett, Washington. Dr. Dean served as ASDA national vice president from 2011 to 2012 as well as an ASDA delegate and alternate delegate to the ADA House of Delegates from 2009 to 2012. She has been selected by the Washington State Dental Association to serve as a new dentist delegate to the ADA House of Delegates in 2014. She serves on the AGD Legislative and Governmental Affairs Council. She served on the Seattle/King County New Dentist Committee 2012-2013. She has extensive experience both as a dental student and new dentist with legislative, PAC, and other governmental affairs at the local, state, and national level. Dr. Dean will provide the ADA New Dentist Committee an experienced early career leadership perspective.

Pascarella, Jonathan R., California, 2018. Dr. Jonathan Pascarella has served on the California Dental Association (CDA) Committee on the New Dentist for the past 3 years. He has looked at the available options in which to continue his leadership training through volunteer opportunities, and has become increasingly more excited about the thought of pursuing a position on the ADA New Dentist Committee. He has thoroughly studied the roles of this position, as well as the time commitments involved, and is well suited to take on this role. He has become very familiar with the student dentist and new dentist population of California, and believes he would be able to represent these individuals to the ADA. Additionally, Dr. Pascarella looks forward to having the chance to remain involved with the New Dentist Committee at CDA, keeping them informed of the things going on at the national level.

Smallidge, Martin, Federal Dental Services, 2018. Dr. Martin Smallidge has been a proven leader as a dental student. Last year, Dr. Smallidge served as vice president of the American Student Dental Association. He has served many roles in the ADA. In 2013, he was appointed to represent ASDA on the Task Force on Dental Education Economics and Student Debt. He will serve as a delegate or alternate delegate to the ADA House of Delegates in 2014 for the third year. Dr. Smallidge also served on the Council on Dental Practice as the ASDA Liaison. Few new dentists have had this level of experience within the ADA. Prior to entering dental school, Dr. Smallidge committed to serving as a dentist for the US Army. Upon graduation from dental school he entered active duty. His experience as a new dentist in the armed forces will bring a needed perspective to the New Dentist Committee and the ADA. Combining his proven leadership, experience within the ADA, perspective as a new dentist in the

1 military, and his enthusiasm for the profession of dentistry, Dr. Smallidge will make an excellent addition
2 to the New Dentist Committee.

3 *Thakkar, Nipa R., Pennsylvania, 2018.* Dr. Nipa Thakkar continues to be a leading advocate for
4 maintaining an effective and productive involvement of new dentists in our profession through her service
5 on Pennsylvania Dental Association's New Dentist Committee. She received her D.M.D. degree summa
6 cum laude from Temple University Kornberg School of Dentistry and completed a general practice
7 residency program at the St. Joseph's Medical Center. She has served as a member of the Pennsylvania
8 delegation to America's Dental Meeting for the past two years and also as the delegate to the 2011 ADA
9 Annual Session from the American Student Dental Association (ASDA). Dr. Thakkar currently serves as
10 the executive committee secretary to the Berks County Dental Society and her list of personal awards
11 include the 2012 Outstanding Student Leader Award from the American College of Dentists and
12 Community Dentistry and Dental Public Health Award from the American Association of Public Health
13 Dentistry. She also received the 2011 National Delegate of the Year Award from ASDA and the 2010
14 Award of Excellence from the Temple University Kornberg School of Dentistry. Dr. Thakkar will also be
15 completing the ADA Diversity in Leadership program in 2014 with her continued emphasis on achieving
16 access to dental care for our underserved population in Pennsylvania.

17 **SCIENTIFIC AFFAIRS**

18 *Aminoshariae, Anita, Ohio.* Dr. Anita Aminoshariae received her D.D.S. degree from the Case Western
19 Reserve University and her M.S. degree in endodontics from Virginia Commonwealth University.
20 Dr. Aminoshariae is an assistant professor and the director of Predoctoral Endodontics at the Case
21 Western Reserve University School of Dental Medicine and a Diplomate of the American Board of
22 Endodontics. She currently serves as a member of the *Journal of Endodontics'* Scientific Advisory Board,
23 a reviewer for the *Journal of the American Dental Association*, a member of the Test Construction
24 Committee for the Joint Commission on National Dental Examinations, a member of the Board of
25 Directors of the American Association of Endodontists; and has served as the past chair of the
26 Endodontic Section of the American Dental Education Association, and a past member of the Evidence-
27 Based Endodontics Committee of the American Association of Endodontists.

28 At the Case Western Reserve University School of Medicine, Dr. Aminoshariae spends 60% of her time
29 teaching, 20% of her time performing research, and 20% of her time is devoted to providing clinical care
30 for patients. She is aware of the time commitment needed to serve as a member of the ADA Council on
31 Scientific Affairs including attending council meetings and participating in council projects. Dr.
32 Aminoshariae is a published researcher and has been a speaker at dental meetings across the nation as
33 well as in Canada. She understands the importance of promoting oral health and advocating
34 interdisciplinary collaboration with other health professions to keep abreast of the best available current
35 evidence, as well as the importance of informing the public and making recommendations to the ADA's
36 policymakers on scientific issues.

37 *Eleazer, Paul D., Alabama.* Dr. Paul Eleazer has is master's degree in basic science and oral biology
38 with an emphasis in microbiology and pharmacology. He has published a wide range of scientific articles
39 based on his research and that of others he mentors. He has a vast knowledge of scientific methods,
40 terminology, experimental design and biostatistics and can apply this expertise to help the CSA develop and
41 implement standards. Dr. Eleazer has a proud tradition of training endodontic residents for the delivery of
42 the highest quality care, through both a clinical and research based program. With this being said, each
43 resident spends approximately 29% of their time devoted to research under a close mentorship with Dr.
44 Eleazer. This research follows the translational research model. Dr. Eleazer has a large range of
45 research interests which include metallurgy with nickel titanium root canal instruments. He also has a
46 keen interest in pulpal regeneration. Dr. Eleazer has taught pharmacology at Darton College Dental
47 Hygiene Program in Albany, Georgia and continues to lecture on pharmacology, in particular local
48 anesthesia and antibiotics.

1 Dr. Eleazer has proven himself over time to be an active member of numerous committees and
2 subcommittees at all levels of the tripartite structure, ultimately serving as Georgia State [Dental
3 Association] President. He fully understands the time, dedication and commitment it takes to be a valued
4 member of any academic, clinical, scientific or community-based committee.

5 Dr. Eleazer is a tenured professor and chairman for the Department of Endodontics at the University of
6 Alabama at Birmingham. During his tenure, he has been involved in standard-setting activities and
7 ensures that bylaws and standards are carried out both in his department, but school-wide as well. He
8 has strong problem solving strategies. That coupled with his interest in U.S. and international standards
9 ensures that he will help the council with their goals. Dr. Eleazer is not only a teacher, but he is a
10 translational researcher and published author as well. His CV clearly shows his capability to relate
11 scientific and technical issues to dental practices. He continues to publish articles based on scientific
12 research and translates his findings into dental practice. He has published over 70 journal articles during
13 his career as well as several text book chapters and monographs. Dr. Eleazer is a world-wide speaker
14 who continues to provide lectures and CE courses filled with both in-depth clinical and research finding.

15 *Moore, Paul A., Pennsylvania.* A review of Dr. Paul Moore's career clearly indicates that he is highly
16 qualified and fulfills the eligibility requirements and selection criteria for an appointment to the ADA
17 Council on Scientific Affairs. His experience in clinical research and dental education has been recently
18 acknowledged by receiving the 2013 American Dental Association's Norton M. Ross Award for
19 "Excellence in Clinical Research." Dr. Moore received his D.M.D. and Ph.D. in pharmacology from the
20 University of Pittsburgh School of Dental Medicine. His professional career has included private practice
21 in Oakmont, Pennsylvania, a hospital residency in dental anesthesiology at the Presbyterian Hospital
22 Medical Center in Pittsburgh, a postdoctoral fellowship in chronic pain management at the University of
23 North Carolina, and faculty appointments Harvard School of Dental Medicine, University of
24 Massachusetts Medical Center and Forsyth Dental Center.

25 Dr. Moore is active in clinical dental research, having served as the principal investigator of over 20
26 clinical research projects sponsored by the NIH as well as industry. Additionally, he has authored over
27 200 scientific articles on clinical pharmacology/dental therapeutics in peer reviewed journals and has
28 presented over 150 invited lectures throughout the world on the topics of local anesthetics, antibiotics,
29 analgesics, sedation, drug interactions and oral complications of diabetes.

30 During his extensive academic career, he has served as director of the Oral Health Science Institute,
31 director of research, director of graduate education and chair of the Department of Dental Anesthesiology
32 for the University of Pittsburgh School of Dental Medicine. He is a member of the editorial boards of
33 several journals including the *Journal of American Dental Association*. He has recently been asked to
34 serve on the U.S. Surgeon General's Expert Panel of Prescription Drug Abuse. Dr. Moore has been
35 honored extensively over his professional career, receiving the Harald Loe National Scholars Award in
36 2000, the Distinguished Alumnus Award for Advanced Education at the University of Pittsburgh School of
37 Dental Medicine in 2005, and the PTT Distinguished Scientist Award of the International Association for
38 Dental Research in 2005, the ADSA Heidbrink Award from the American Dental Society of
39 Anesthesiology in 2013, and most recently the Norton M. Ross Award for Excellence in Clinical Research
40 from the American Dental Association in 2013.

41 *Roberts, Howard W., Federal Dental Services.* Col. Howard Roberts is extremely well qualified for a
42 position on the Council on Scientific Affairs. Currently, Col. Roberts serves as director, Dental Graduate
43 Research, and chief, Hospital Dentistry, 81 Medical Group, Keesler AFB, Mississippi. Col. Roberts also
44 serves as professor, comprehensive dentistry, Uniformed Services Health University in Bethesda,
45 Maryland, and serves as consultant to the Air Force Surgeon General for Dental Materials. He is an
46 adjunct associate professor, Department of Comprehensive Dentistry, University of Texas Health Science
47 Center San Antonio and adjunct associate professor, dental biomaterials, Marquette University,
48 Milwaukee, Wisconsin. Previously, Col. Roberts served as the director of dental biomaterials evaluations,
49 USAF Dental Evaluations and Consulting Service, Great Lakes Training Center, Illinois.

1 Col. Roberts' advanced degree in dental biomaterials with his background in comprehensive and
2 hospital/special patient care dentistry, as well as his background in endodontic and dental biomaterials
3 research, would make him an asset to the Council on Scientific Affairs.

4 *Wilson, Thomas G., Jr., Texas, 2015.* In January 2014, Dr. Thomas Wilson was appointed to complete
5 the unexpired term of Dr. Geoffrey Thompson, Wisconsin, as a member of the Council on Scientific
6 Affairs. Dr. Thomas Wilson is highly qualified for this position. He has the unique advantage of being a
7 private practitioner limiting his practice to periodontology and concurrently is involved with scientific
8 research at both the clinical and basic science levels. He understands science and the research that is
9 involved and is able to analyze and make decisions beneficial to the topic that is being discussed. He is
10 qualified to be included in any aspect of a scientific study. Dr. Wilson is a full time practitioner who
11 understands science and therefore his input will be valuable in helping advance the profession.

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

Additional Nominations to ADA Councils and Commissions: Following the distribution and posting to the House of Delegates of the nominees to ADA councils and commissions, an additional nomination was submitted to complete the unexpired term of a member of the Council Members Insurance and Retirement Programs.

Members Insurance and Retirement Programs

Hokanson, Brian N., Wyoming, 2017. In August 2014, Dr. Brian Hokanson was appointed to complete the unexpired term of Dr. Bradley B. Kincheloe as a member of the Council on Members Insurance and Retirement Programs. Dr. Hokanson is the recent past president of the Wyoming Dental Association. He recently spear-headed the effort to obtain a medical Insurance package for Wyoming members that was both comprehensive and affordable. Dr. Hokanson has knowledge and interest in both retirement and various insurance products.

Resolution No. 30 NewReport: Board Report 1 Date Submitted: July 2014Submitted By: Board of TrusteesReference Committee: N/ATotal Net Financial Implication: None Net Dues Impact: _____Amount One-time _____ Amount On-going _____ FTE 0**NOMINATIONS TO COUNCILS, COMMISSIONS AND THE NEW DENTIST COMMITTEE****Background:** (See Page 1007 for qualification of nominees)**ACCESS, PREVENTION AND
INTERPROFESSIONAL RELATIONS**Scott W. Cashion, North Carolina
Timothy R. Fagan, Oklahoma
William H. Gerlach, Texas
Melanie Lang, Washington
Todd A. Pancratz, Nebraska
Rhonda Switzer-Nadasdi, Tennessee**ADA SESSIONS**Henry F. Evans, Washington
Howard I.A. Lieb, New York
C. Roger Macias, Jr., Texas
Andrea Richman, Massachusetts**COMMUNICATIONS**Canise Y. Bean, Ohio
Yvonne S. Hanley, Minnesota
Kurt S. Lindemann, Montana
Robin S. Reich, Georgia**DENTAL ACCREDITATION**

Loren Feldner, Illinois*

DENTAL BENEFIT PROGRAMSC. Scott Davenport, North Carolina
David L. Hamel, Kansas
Steven I. Synder, New York
Matthew J. Vaillant, Minnesota**DENTAL EDUCATION AND LICENSURE**David F. Halpern, Maryland
Edward J. Hebert, Louisiana**DENTAL PRACTICE**Leigh Kent, Alabama
Craig S. Ratner, New York
Scott L. Theurer, Utah
Michael S. Wojcik, Michigan**ETHICS, BYLAWS AND JUDICIAL AFFAIRS**Gary N. Herman, California
Don J. Ilkka, Florida
Puneet Kochhar, New Hampshire
J. David Moss, South Carolina**GOVERNMENT AFFAIRS**K. Jean Beauchamp, Tennessee
Marty B. Garrett, Louisiana
Frank J. Graham, New Jersey
David M. Minahan, Washington**MEMBERSHIP**Alejandro M. Aguirre, Minnesota, *ad interim*
Steven P. Ellinwood, Indiana
Marc Muncy, Arkansas
Rodrigo Romano, Florida
Jonathan P. Woller, Alaska**MEMBERS INSURANCE AND RETIREMENT
PROGRAMS**Naomi L. Ellison, California, *ad interim*
Peter D. Hehli, Wisconsin
Brian N. Hokanson, Wyoming, *ad interim*
James M. Lipton, Indiana
Marshall H. Mann, Georgia
Eric L. Shirley, Pennsylvania, *ad interim*
D. Scott Wieting, Nebraska**NATIONAL DENTAL EXAMINATIONS**

Dr. Lisa A. Heinrich-Null, Texas

NEW DENTIST

Brittany T. Dean, Washington
Jonathan R. Pascarella, California
Martin Smallidge, Federal Dental Services
Nipa R. Thakkar, Pennsylvania

SCIENTIFIC AFFAIRS

Anita Aminoshariae, Ohio
Paul D. Eleazer, Alabama
Paul A. Moore, Pennsylvania
Howard W. Roberts, Federal Dental Services
Thomas G. Wilson, Jr., Texas, *ad interim*

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

Resolution

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

BOARD RECOMMENDATION: Vote Yes.

BOARD VOTE: UNANIMOUS*

Resolution No. 31-33 NewReport: Credentials, Rules and Order Date Submitted: July 2014Submitted By: Standing Committee on Credentials, Rules and OrderReference Committee: N/ATotal Net Financial Implication: None Net Dues Impact: _____

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

1 REPORT OF THE STANDING COMMITTEE ON CREDENTIALS, RULES AND ORDER

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

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

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

12 **Minutes of the 2013 Session of the House of Delegates:** The minutes of the 2013 session of the
13 House of Delegates have been posted (*Trans.*2013:277) in the House of Delegates Community of ADA
14 Connect and on ADA.org at [https://www.ada.org/en/member-center/leadership-governance/house-of-](https://www.ada.org/en/member-center/leadership-governance/house-of-delegates/2014-house-of-delegates)
15 [delegates/2014-house-of-delegates](https://www.ada.org/en/member-center/leadership-governance/house-of-delegates/2014-house-of-delegates)

16 Questions or corrections regarding the minutes may be forwarded to Michelle Kruse, manager, House of
17 Delegates at krusem@ada.org. The Committee presents the following resolution for House action.

18 **31. Resolved**, that the minutes of the 2013 session of the House of Delegates, as published in
19 *Transactions*, 2013 (pages 277-375), be approved.

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

25 **32. Resolved**, that the agenda as presented in the *2014 Manual of the House of Delegates and*
26 *Supplemental Information* be adopted as the official order of business for this session, and be it
27 further

28 **Resolved**, the Speaker is authorized to alter the order of the agenda as deemed necessary in order
29 to expedite the business of the House.

30 **Referrals of Reports and Resolutions:** A standing rule of the House of Delegates directs that prior to
31 each session of the House, the Speaker shall prepare a list of recommended referrals to reference

committees with the list to be available at the opening meeting of the House and be subject to amendment or approval on vote of the House of Delegates.

This preliminary list of referrals (circulated in the form of an All Inclusive General Index to the resolution worksheets) will be provided with the second posting of resolution worksheets in late-September and updated and posted again on Thursday, October 9. The Speaker will announce additional referrals during the first meeting of the House of Delegates. A complete list of referrals by reference committee, in the form of an agenda, will be available in the reference committee hearing rooms on Saturday morning, October 11.

33. Resolved, that the list of referrals recommended by the Speaker of the House of Delegates be approved.

The American Institute of Parliamentarians Standard Code of Parliamentary Procedure: In 2011, the House of Delegates adopted Resolution 56H-2011 (*Trans.*2011:541) which identifies the current edition of the *American Institute of Parliamentarians Standard Code of Parliamentary Procedure (AIPSC)* as the document that governs the deliberations of the House of Delegates in all cases in which they are applicable and not in conflict with the standing rules or the *ADA Bylaws*. The current edition of the *AIPSC Standard Code* was released in May 2012.

Annual Reports and Resolutions, Manual of the House of Delegates and Resolution Worksheets: The publication, *Annual Reports and Resolutions 2014* was posted in July on ADA Connect and ADA.org and can be accessed through the following link: <https://www.ada.org/en/member-center/leadership-governance/historical-publications-policies>.

In addition, the first set of resolution worksheets will be posted on ADA Connect and ADA.org by the end of day, Friday, August 1. Per 74H-2012, effective in 2013, all materials of the House of Delegates are provided in an electronic format only, with the exception of reference committee reports and agendas; no paper copies of worksheets will be distributed.

The second set of resolution worksheets will become available shortly after the Board of Trustees' September 18-20 session. The second set of resolution worksheets will be posted on ADA Connect and ADA.org by end of day, Thursday, September 25.

The *Manual of the House of Delegates and Supplemental Information* has been developed to complement the resolution worksheets. This document incorporates the "Rules of the House of Delegates" and all pertinent meeting information (*i.e.*, House agendas, members of the Standing and Reference Committees, reference committee hearing schedule, and schedule of the district caucuses). Any modifications to the *Manual* and specifically the Standing Rules of the House of Delegates reflect either actions of the previous House of Delegates, details regarding dates, times and locations of the 2014 meetings, or editorial corrections.

Supplement to Annual Reports and Resolutions is prepared primarily for historical purposes only since it reprints in resolution worksheet form all the reports and resolutions presented to the House of Delegates. This publication will be available online in the first quarter of 2015.

Hearing of Reference Committees: The reference committees of the House of Delegates will hold hearings on Saturday, October 11, in various rooms of the Grand Ballroom of the Marriott Rivercenter. The list of reference committee hearing rooms appears in the *Manual of the House of Delegates and Supplemental Information*.

Saturday, October 11

7:00 a.m. to 9:00 a.m. Committee B (Dental Benefits, Practice and Related Matters)

8:00 a.m. to 10:00 a.m. Committee D (Legislative, Health, Governance and Related Matters)

1 9:00 a.m. to 11:00 a.m. Committee A (Budget, Business and Administrative Matters)

2 10:00 a.m. to 12 p.m. Committee C (Dental Education, Science and Related Matters)

3 11:00 a.m. to 1:00 p.m. Committee E (Membership and Related Matters)

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

6 In accordance with the *Manual of the House of Delegates*, section "General Procedures for Reference
7 Committees," any member of the Association, whether or not a member of the House of Delegates, is
8 privileged to attend and participate in the discussion during the reference committee hearings.

9 Nonmembers of the Association are also welcome to attend reference committee hearings provided they
10 identify themselves to the committee. Nonmembers of the Association may participate at hearings only at
11 the invitation of a majority of the reference committee. At reference committees, everyone
12 (individuals/members) will be obligated to disclose any personal or business relationship that they or their
13 immediate family may have with a company or individual doing business with the ADA, when such
14 company is being discussed, prior to speaking on an issue related to such a conflict of interest.

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

17 **Reports of Reference Committees:** Printed copies of reference committee reports will be made
18 available to the chair of record of each delegation on Sunday, October 12. A sufficient number of copies
19 of each report will be provided for each delegation's delegates, alternate delegates, secretary, executive
20 director, trustee and editor. Reference committee reports will also be posted on ADA Connect and will be
21 available early morning on October 12.

22 Delegates must bring their copies of reference committee reports to the meetings of the House of
23 Delegates since additional printed copies will be limited. However, if using an electronic version of the
24 reference committee report during the meetings of the House, it is imperative that the documents be
25 downloaded prior to the Monday, October 13 meeting. The Speaker would like to remind everyone that
26 this is a "paperless" House of Delegates, not necessarily a wireless House. Wi-Fi is available in the
27 House of Delegates as a convenience, and advance preparation is extremely important.

28 **Nominations of Officers:** The nominations of officers (president-elect and second vice president) will
29 take place at the first meeting of the House on Friday afternoon, October 10. Candidates for elective
30 office will be nominated from the floor of the House by a simple declaratory statement, which may be
31 followed by an acceptance speech not to exceed four minutes by the candidate. Seconding nominations
32 is not permitted.

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

34 **Nomination of Trustees:** Nominations of members of the Board of Trustees from Districts 2, 8, 11 and
35 13 will take place at the first meeting of the House. Prior to such nominations, the delegates from each of
36 the districts concerned must caucus for the purpose of determining their nominee or nominees in
37 accordance with the provisions of Chapter VII, Section 40, of the *Bylaws*. A list of caucus meetings
38 appears in the *Manual of the House of Delegates and Supplemental Information*.

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

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

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

Only votes cast by voting members of the House of Delegates either for or against a pending motion shall be counted. Abstentions shall only be counted in determining if a quorum is present. If the result of a vote is uncertain or if a division is called for, the Speaker may use the electronic voting method or may call for a standing vote. If a standing vote is requested, the Speaker will request all members in favor of the motion to stand. Beginning with the first row, each person counts off and sits down, with the count running back and forth along the rows in a serpentine fashion. When all who voted in the affirmative are seated, the same is done with the negative vote. The vote will be monitored by the Standing Committee on Credentials, Rules and Order.

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

Election Procedures: Voting for the offices of president-elect and second vice president will be conducted in a separate room located in the vicinity of the House of Delegates (Room 214 C-D), from 6:30 a.m. to 8:00 a.m. on Monday, October 13. Members should bring their number 6 meeting card and vote early in order to avoid a delay at the voting machines. If at all possible, delegation changes should be made by the end of the day Sunday, October 12, to expedite the check-in process for voting.

In the event a second balloting is necessary, the number 6 meeting card will be reused. The second balloting will be conducted on Monday, October 13, at a time announced by the Speaker.

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

Standing Order of Business—Installation of New Officers and Trustees: The installation ceremony for new officers and trustees will take place on Tuesday, October 14, as the first item of business with the time to be specified by the Speaker of the House of Delegates.

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

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

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

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

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

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

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

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

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

Dedicated Pro and Con Microphones: To help ensure a balanced opportunity for debate during all House discussions, microphones 1, 3, and 5 will be identified for pro testimony and microphones 2, 4, and 6 will be identified for con testimony throughout the session. To preserve the microphone queue for debate on the main motions, the Speaker has indicated that two microphones at the front of the room labeled “A” and “B” will be used for debate on subsidiary motions. A third microphone will be placed front and center, labeled “P” for parliamentary inquiries, point of order, point of information or to appeal ruling from the chair. Microphone “P” may also be used for a question of privilege that has to do with the convenience, comfort, rights, or privileges of a member or of the assembly that is urgent and must be decided immediately. Offering to give information is debate and is not a point of information, and should be given at one of the six microphones in the queue.

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

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

Access to Floor of House: Access to the floor of the House of Delegates is limited to officers and members of the House of Delegates, the elective and appointive officers of the Association, the former presidents, the members of the Board of Trustees, the chairs of the councils and commissions, the secretaries and executive directors of constituent societies, the executive director and president of the American Student Dental Association, an officially designated representative from each of the American Hospital Association and American Medical Association and members of the Headquarters Office staff. Council and commission chairs are responsible for requesting floor access for any non-delegate council or commission member who desires to speak during debate on the report of the council or commission consistent with the *Bylaws* and the Rules of the House of Delegates.

Alternate delegates, former officers and former trustees do not have the privilege of access to the floor but will be seated in a special area reserved for them.

Admission to the House will begin 30 minutes prior to the start of each meeting of the House and will not be granted without the display of the appropriate annual session badge. Every delegate must also hand the appropriately numbered card to the attendant at the door for each meeting so that the official attendance record may be maintained. Former officers and former trustees will also be admitted to the section reserved for alternate delegates and upon request will receive access to all reference committee reports available to delegates and alternates.

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

Substitution of Alternate Delegates for Delegates: Delegates wishing to substitute alternate delegates from their delegation for themselves during a meeting of the House of Delegates must complete the appropriate delegate-alternate substitution form. Delegates are required to sign the form and surrender their admission cards for the meeting or meetings not attended before admission cards will be issued to alternate delegates by the Committee on Credentials, Rules and Order. Substitution of alternate delegates may be made during all four meetings of the House of Delegates. In order for a complete and accurate attendance record for all meetings of the 2014 House of Delegates, submission of these completed substitution forms is essential.

For temporary substitutions, for the purpose of allowing an alternate to replace a delegate for a specific resolution or issue, the substitution forms do not have to be completed. And, again this year for these temporary substitutions, the switch can take place at the staffed openings between the delegate and alternate sections of the House. This will be in effect for the Second, Third and Fourth meetings of the House.

Closed Session: A closed session is any meeting or portion of a meeting of the House of Delegates with limited attendance in order to consider a highly confidential matter. A closed session may be held if agreed upon by general consent of the House or by a majority of the delegates present at the meeting in which the closed session would take place. In a closed session, attendance is limited to officers of the House, delegates and alternates, and the elective and appointive officers, trustees and general counsel of the Association. In consultation with the Secretary of the House, the Speaker may invite other persons

with an interest in the subject matter to remain during the closed session. In addition to senior staff, this is likely to include members and staff of the council(s) or commission(s) involved with the matter under discussion and executive directors of constituent societies and the American Student Dental Association. No official action may be taken nor business conducted during a closed session.

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

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

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

Manual of the House of Delegates: Each member of the House of Delegates has access to the *2014 Manual of the House of Delegates* through ADA Connect. The *Manual* contains the standing rules of the House of Delegates and the pertinent provisions of the *Bylaws*.

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

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

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

House of Delegates Information and Resource Office: An Information and Resource Office will be open Thursday, October 9 through Sunday, October 12, and will be located in the Marriott Rivercenter, Registration 2 Office. This office will be open to delegates, alternates, constituent society officers and staff. The office will be equipped with computers with printing capability, a copying machine, and general

1 information about the meetings of the House of Delegates and related activities. Everyone is urged to
2 use the Information and Resources Office when drafting resolutions or testimony.

3 Individuals having resolutions for submission to the House of Delegates will be directed to the
4 Headquarters Office where final resolution processing will occur.

5 **Resolutions**

6 Resolution 31 (Worksheet:1032)

7 Resolution 32 (Worksheet:1033)

8 Resolution 33 (Worksheet:1034)

Resolution No. 31 New
Report: Credentials, Rules and Order Date Submitted: July 2014
Submitted By: Standing Committee on Credentials, Rules and Order
Reference Committee: N/A
Total Net Financial Implication: None Net Dues Impact: _____
Amount One-time _____ Amount On-going _____ FTE _____

- 1 **MINUTES OF THE 2013 HOUSE OF DELEGATES**
- 2 **Background:** The minutes of the 2013 session of the House of Delegates have been posted
3 (*Trans.*2013:277) in the House of Delegates Community of ADA Connect and on ADA.org at
4 [https://www.ada.org/en/member-center/leadership-governance/house-of-delegates/2014-house-of-](https://www.ada.org/en/member-center/leadership-governance/house-of-delegates/2014-house-of-delegates)
5 [delegates](https://www.ada.org/en/member-center/leadership-governance/house-of-delegates/2014-house-of-delegates)
- 6 Questions or corrections regarding the minutes may be forwarded to Michelle Kruse, manager, House of
7 Delegates at krusem@ada.org. The Committee presents the following resolution for House action.
- 8 **Resolution**
- 9 **31. Resolved**, that the minutes of the 2013 session of the House of Delegates, as published in
10 *Transactions, 2013* (pages 277-375), be approved.

Resolution No. 32 NewReport: Credentials, Rules and Order Date Submitted: July 2014Submitted By: Standing Committee on Credentials, Rules and OrderReference Committee: N/ATotal Net Financial Implication: None Net Dues Impact: Amount One-time Amount On-going FTE 1 **ADOPTION OF AGENDA AND ORDER OF AGENDA ITEMS**

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

6 **Resolution**

7 **32. Resolved,** that the agenda as presented in the *2014 Manual of the House of Delegates and*
8 *Supplemental Information* be adopted as the official order of business for this session, and be it
9 further

10 **Resolved,** the Speaker is authorized to alter the order of the agenda as deemed necessary in order
11 to expedite the business of the House.

Resolution No. 33 NewReport: Credentials, Rules and Order Date Submitted: July 2014Submitted By: Standing Committee on Credentials, Rules and OrderReference Committee: N/ATotal Net Financial Implication: None Net Dues Impact: _____

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

1 **REFERRAL OF REPORTS AND RESOLUTIONS**

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

6 This preliminary list of referrals (circulated in the form of an All Inclusive General Index to the resolution
 7 worksheets) will be provided with the second posting of resolution worksheets in late-September and
 8 updated and posted again on Thursday, October 9. The Speaker will announce additional referrals
 9 during the first meeting of the House of Delegates. A complete list of referrals by reference committee, in
 10 the form of an agenda, will be available in the reference committee hearing rooms on Saturday morning,
 11 October 11.

12 **Resolution**

13 **33. Resolved,** that the list of referrals recommended by the Speaker of the House of Delegates be
 14 approved.

Resolution No. 106 NewReport: N/A Date Submitted: September 2014Submitted By: Seventh Trustee DistrictReference Committee: N/ATotal Net Financial Implication: TBD Net Dues Impact: _____

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

ADA Strategic Plan Objective: Organizational Capacity-Obj. 6: Role and responsibility of each element of the tripartite clearly defined and agreed upon

How does this resolution increase member value: Not Applicable

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

The following resolution was adopted by the Seventh Trustee District and transmitted on September 19, 2014, by Mr. Doug Bush, executive director.

Background: Currently, the ADA Second Vice President serves a one-year term, then automatically advances to a one-year term as First Vice President, for a total of two years service on the Board of Trustees. During some President-elect campaigns, candidates who had served as Vice Presidents were discounted for not having four years of experience on the Board of Trustees, thereby not possessing the knowledge and experience of Trustees who had served a full four-year term. Vice Presidents have often referred to their position as the "at large House of Delegates trustee" or "trustee at large." The term of Vice President has been used by the ADA for years and is used in many organizations' governance structure. The election to the office of Vice President does not imply succession to the office of President-elect. The creation of a Vice President who shall serve a single four-year term will allow a pathway for a member to gain the knowledge and experience to become a well-qualified candidate for the office of President-Elect.

The Association can be better served by eliminating the First and Second Vice President positions and instead establishing a single Vice President who serves the same four-year term as Trustees, allowing them to gain the knowledge and experience to become a viable candidate for the office of President-elect. The Association will also benefit financially, as the size of the Board of Trustees will be reduced by one person. Therefore be it

Resolution

106. Resolved, that beginning with the 2017 election, a single Vice President be elected to a four-year term, and be it further

Resolved, that the Constitution and *Bylaws* of the American Dental Association be amended as follows (additions are underscoring; deletions are ~~stricken~~):

1 CONSTITUTION

2 ARTICLE V OFFICERS

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

6 BYLAWS

7 CHAPTER VI • CONFLICT OF INTEREST

8 It is the policy of this Association that individuals who serve in elective, appointive or employed
9 offices or positions do so in a representative or fiduciary capacity that requires loyalty to the
10 Association. At all times while serving in such offices or

11 positions, these individuals shall further the interests of the Association as a whole. In addition,
12 they shall avoid:

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

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

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

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

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

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

34 CHAPTER VII • BOARD OF TRUSTEES

35 *Section 10. COMPOSITION:* The Board of Trustees shall consist of one (1) trustee from each of
36 the seventeen (17) trustee districts. Such seventeen (17) trustees, the President-elect and the
37 ~~two~~ Vice Presidents shall constitute the voting membership of the Board of Trustees. In addition,
38 the President, the Treasurer and the Executive Director of the Association, except as otherwise
39 provided in the *Bylaws* shall be *ex officio* members of the Board without the right to vote.
40

1 Section 130. OFFICERS:

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

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

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

9 CHAPTER VIII ELECTIVE OFFICERS

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

13 Section 30. NOMINATIONS

14 A. Nominations for the offices of President-elect and ~~Second Vice President~~ shall be made in
15 accordance with the order of business. Candidates for these elective officers shall be nominated
16 from the floor of the House of Delegates by a simple declaratory statement, which may be
17 followed by an acceptance speech not to exceed four (4) minutes by the candidate from the
18 podium, according to the protocol established by the Speaker of the House of Delegates.
19 Seconding a nomination is not permitted.

20 ~~Section 50. TERM OF OFFICE: The President, and President-elect, First Vice President, and~~
21 ~~Second Vice President~~ shall each serve for a term of one (1) year, except as otherwise provided
22 in this chapter of the *Bylaws*, or until their successors are elected and installed. The Speaker of
23 the House of Delegates shall be limited to two (2) terms of three (3) years each in total,
24 consecutive or otherwise, excepting the case of a former Speaker of the House who has been
25 elected Speaker of the House as provided in Chapter VIII, Section 30 of these *Bylaws*, who may
26 serve until the House of Delegates can elect a Speaker of the House of Delegates. Serving any
27 portion of a three (3) year term shall be considered service of a full three (3) year term. The term
28 of office of the Treasurer shall be three (3) years, or until a successor is elected and installed.
29 The Treasurer shall be limited to two (2) consecutive terms of three (3) years each, excepting the
30 case of a former Treasurer who has been elected Treasurer as provided in Chapter VIII, Section
31 30 of these *Bylaws*, who may serve until the House of Delegates can elect a Treasurer. Serving
32 any portion of a three (3) year term shall be considered service of a full three (3) year term. The
33 term of office of the Vice President shall be four (4) years, or until a successor is elected and
34 installed.

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

39 Section 80. VACANCIES:

40 A. VACANCY OF ELECTIVE OFFICE: In the event the office of President becomes vacant, the
41 President-elect shall become President for the unexpired portion of the term. In the event the
42 office of President becomes vacant for the second time in the same term or at a time when the
43 office of President-elect is also vacant, the ~~First Vice President~~ shall become President for the
44 unexpired portion of the term. In the event the office of ~~First Vice President~~ becomes vacant, the
45 ~~Second Vice President shall become the First Vice President for the unexpired portion of the~~

1 ~~term.~~ A vacancy in the office of the ~~Second~~ Vice President shall be filled by a majority vote of the
2 Board of Trustees. In the event of a vacancy in the office of Speaker of the House of Delegates,
3 the President, with approval of the Board of Trustees, shall appoint an interim Speaker who shall
4 serve until the House of Delegates can elect a Speaker of the House of Delegates for a three (3)
5 year term. Service as an interim Speaker shall not count toward the term of office limitation for
6 Speaker of the House as set forth in Section 50 of this Chapter. In the event the office of
7 President-elect becomes vacant by reason other than the President-elect succeeding to the office
8 of the President earlier than the next annual session, the office of President for the ensuing year
9 shall be filled at the next annual session of the House of Delegates in the same manner as that
10 provided for the nomination and election of elective officers, except that the ballot shall read
11 "President for the Ensuing Year." A vacancy in the office of Treasurer shall be filled with an
12 interim Treasurer by a majority vote of the Board of Trustees until the process of inviting
13 applications, screening and nominating candidates and electing a new Treasurer has been
14 completed by the Board of Trustees and the House of Delegates. Service as an interim
15 Treasurer shall not count toward the term of office limitation for Treasurer as set forth in Section
16 50 of this Chapter. The newly elected Treasurer shall be limited to two (2) consecutive terms of
17 three (3) years each, excepting the case of a former Treasurer who has been elected Treasurer
18 as provided in Chapter VIII, Section 30 of these Bylaws.

19
20 Section 90. DUTIES:

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

- 22 a. Assist the President as requested.
23 b. Serve as an ex officio member of the House of Delegates without the right to vote.
24 c. Serve as an ex officio member of the Board of Trustees.
25 d. Succeed to the office of President, as provided in this chapter of the *Bylaws*.

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

- 27 a. ~~Assist the President as requested.~~
28 b. ~~Serve as an ex officio member of the House of Delegates without the right to vote.~~
29 c. ~~Serve as an ex officio member of the Board of Trustees.~~
30 d. ~~Succeed to the office of President, as provided in this chapter of the *Bylaws*.~~
31 e. ~~Succeed immediately to the office of First Vice President in the event of vacancy not~~
32 ~~only for the unexpired term but also for the succeeding term.~~

33
34 **SPEAKER'S COMMENT:** The Speaker notes that Resolution 106 requires a change to the ADA
35 Constitution. As such, in accordance with the ADA Constitution, Article VIII. AMENDMENTS, this
36 resolution will lay over to the 2015 House of Delegates.

Budget, Business and Administrative Matters

Resolution No. 21-22 NewReport: Board Report 2 Date Submitted: June 2014Submitted By: Board of TrusteesReference Committee: A (Budget, Business and Administrative Matters)Total Net Financial Implication: See Resolutions 21-22 Net Dues Impact: _____

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

ADA Strategic Plan Objective: 2015 Budget Supports All Strategic Plan Objectives

How does this resolution increase member value: See Background

REPORT 2 OF THE BOARD OF TRUSTEES TO THE HOUSE OF DELEGATES: 2015 BUDGET**Introduction:** *All dollar figures are in thousands with unfavorable variances in parentheses.*

In accordance with its *Bylaws* duties, the Board of Trustees presents the proposed 2015 operating budget for the Association. This report also provides background commentary and analysis of significant budget changes for 2015. The Board of Trustees is recommending a 2015 operating budget of \$134,877 in revenues and \$128,728 in expenses and income taxes, generating net income before reserves of \$6,149. The transfer of \$6,000 royalty revenue from ADA Members Insurance Plans to a designated reserve then brings the operating budget to a surplus of \$ 149. The designated reserve will be dedicated to member value, long term dues and financial stabilization as directed by the House of Delegates Resolution 84H-2013 and Board action. In arriving at this budget proposal, the Board of Trustees and Administrative Review Committee analyzed budget requests relative to the Association's strategic priorities, as directed by the 2011 House of Delegates in resolutions 44H-2011 and 52H-2011 (*Trans.*2011:444;445). Resources were allocated between programs and divisions in an effort to maximize their effective use in executing the ADA's Strategic Plan for 2015-2019.

No dues increase is included in the 2015 proposed budget.

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Overview of Budget Approach and Philosophy

First, it is important to recognize that this report is the result of cumulative efforts of many volunteers and staff over many months that has built on process improvements made over the past few years. The Board of Trustees greatly appreciates heavy involvement of the Councils in the budget process, including each council's participation in the Administrative Budget Review meeting, review of the costs of each of their programs, and the Council Budget Group's rating of every program against the Board's universal assessment criteria. Council involvement is an important link to engage representatives of the House of Delegates. Many thanks are also due to everyone who contributed to both the content and process improvement suggestions during the 2015 budget development. In the spirit of continuous improvement, constructive suggestions are always welcome to ensure that the best information is provided to support quality decision-making.

Early in this process, 2015 budget development was challenged by the parallel creation and implementation of a new strategic plan, **Members First 2020**, which will drive budget years 2015 through 2019.

The ADA Mission Statement is "Helping all members succeed." ADA Core Values related to the mission include:

- Commitment to Members
- Integrity
- Excellence
- Commitment to the Improvement of Oral Health
- Science/Evidence-Based

This new strategic plan consists of the following high level goals, supporting objectives, and strategies:

Membership Goal: The ADA will increase member value and engagement.

Objective 1: The public will recognize the ADA and its members as leaders and advocates in oral health.

- 1.1 Align public awareness efforts across the tripartite concerning oral health issues*
- 1.2 Position ADA membership as a positive differentiating factor for patients*
- 1.3 Promote oral health through advocacy and science*

Objective 2: ADA's member market share will equal at least 70% of active licensed dentists.

- 2.1 Develop and implement collaborative programs with entities that have access to large pools of potential members*
- 2.2 Design unique member benefit programs targeting market segments*

Objective 3: ADA will achieve a 10% increase in the assessment of member value from membership.

- 3.1 Pursue programs that members value and are "Best in class"*

Finance Goal: The ADA will be financially sustainable.

Objective 4: Unrestricted liquid reserves will be targeted at no less than 50% of annual operating expenses.

- 4.1 Budget for a surplus consistently year to year*

Objective 5: Non dues revenue will be at least 65% of total revenue

- 5.1 Develop cooperative ways to increase non-dues revenue across the tripartite*
- 5.2 Increase member utilization of existing products and services and pursue new markets*

Organizational Capacity Goal: All levels of the ADA will have sufficient organizational capacity necessary to meet member needs.

Objective 6: The roles and responsibilities of each element of the tripartite will be clearly defined and agreed upon.

- 6.1 Act in the best interest of the member, rather than the organization when designing processes, programs and services*

1 Because the critical goal of budget development is the prioritization of resources in alignment with the
2 strategic plan, the development of new universal assessment criteria tied to this plan was an important step
3 in the process. Universal Assessment Criteria are intended to provide a framework for common
4 understanding of program prioritization as the Board of Trustees follows the direction of 2011 House
5 resolutions. Specifically, Resolution 44H-2011 asked that the Board develop a set of universal assessment
6 criteria and that each Council use the criteria to evaluate its programs and report to the Administrative
7 Review Committee. Resolution 52H-2011 directed the Board to develop and follow a set of short and long-
8 term financial strategies that identify existing programs, services and products to be sunset so that existing
9 finite human and financial resources may be redeployed for new initiatives that align with the Strategic Plan
10 of the ADA and that deliver greater member value or public health impact.

11
12 The 2015 budget approach again started early to ensure that all Councils, as representatives of the House,
13 could be engaged in the budget process. Decision Lens, a collaborative software tool, again enabled
14 scoring of all ADA programs using one set of universal assessment criteria with involvement by multiple
15 stakeholders. However, it must be noted that Decision Lens scoring is still only one of many inputs to the
16 overall budget process and the final decisions are still made by volunteer leaders. Councils of the House
17 are uniquely positioned to aid the House in fulfillment of its fiduciary responsibilities and compare all
18 programs within the Association against one set of universal assessment criteria. Councils are also best
19 informed in their particular areas of bylaws authority.

20
21 Similar to last year, Council leaders formed a separate group of senior representatives, two from each
22 Council, to rate all programs against the universal assessment criteria. These ratings were combined with
23 Administrative Review Committee criteria weightings to generate the Decision Lens scores which resulted
24 in program rankings. Consistent with last year's process, the Administrative Review Committee meeting
25 was dedicated to taking input from Council chairs and ADA staff to discuss their programs, including factors
26 outside the universal assessment criteria. ALL programs across the ADA were evaluated on a consistent
27 basis by one group of representatives of the House and each Council also had a forum for additional input
28 beyond the criteria-based program rankings.

29
30 Following the same method as last year, the 2015 budget prioritization of programs represents a process
31 which is closer to an ideal "zero based" budget because all programs, new and old, were assessed together
32 using one set of criteria. This is fundamentally different than older ADA presentations of base budgets,
33 which included ongoing legacy programs, plus new programs. It should be noted that House resolutions
34 passed after this budget process will not go through this same review and prioritization process, but it is
35 hoped that the House of Delegates, at its annual session, will share this high level view of the ADA and that
36 all resolutions introduced will also be reviewed and prioritized with consideration to the same criteria.

37
38 With this background, it should be noted that this 2015 budget represents the estimates of ADA revenue
39 and expenses to deliver the listed programs and services based on the best information and assumptions
40 available at the time these detail budgets were created and built into the ADA budget in early 2014. As a
41 result, it is very possible that some estimates or assumptions could change based on new information that
42 becomes available closer to the start of the budget year. If that new information results in significant,
43 quantifiable impacts to the 2015 budget, then those will be reported by the Treasurer to that House at the
44 annual session as possible amendments to the budget subject to the discretion of the House.

45 Unfortunately, potential changes are an inherent risk of the ADA's current budget process due to its long
46 timeline. Some budget estimates made a year before the start of the budget period are often less accurate
47 than those that are built later.

48
49 From a higher level perspective, the ADA's 2015 budget is also a product driven by the ADA's program
50 agenda which has been aligned as much as possible with the ADA's new strategic plan goals as well as the
51 core functions and services required to support a 400+ employee, \$120 million organization and all the
52 supporting governance structures. This budget report is therefore focused more on programs and services
53 being delivered and less on the accounting structures of the ADA already reviewed in detail by councils, the
54 Administrative Review Committee, and the Board of Trustees.

Enhanced Format of this Report

This report continues a more concise format introduced last year that includes the following information:

- Number of Staff Working on Each Program: number of full time equivalent (FTE) employees.
- Revenue generated by the program.
- Expense: Includes both the cost of the staff time and non-staff expenses such as travel and consultants.
- Assessment Score by Council Budget Group (CBG): Council Budget Group's scoring of each program against the six Universal Assessment Criteria defined by the Board of Trustees at the direction of the House of Delegates.

Before last year, Board Report 2 presented budgets only in terms of accounting categories such as "salaries expense" and "office expenses." That approach did not disclose the activities on which the funds were being spent, except for new initiatives in "decision packages." The new program information in this report enables the following new insights:

1. Zero-based budgeting. No automatic grandfathering of old programs. All programs are evaluated together at one time.
2. Staff time allocations across programs. For example, 6 staff are working on Program A versus only 1 staff working on Program B.
3. Program assessment scores: How well does each ADA activity in every agency division align with the Strategic Plan Goals? These program assessments were a specific requirement of House resolutions 44H-2011 and 52H-2011.

It should also be noted that the presentation of the ADA's operating surplus/deficit is based on "net income before reserve spending." This change is the result of action by the 2012 House of Delegates to create and annually contribute to a capital replacement reserve fund as a means of reducing the likelihood of future special dues assessments. The ADA's annual budgets have historically included capital spending in the "net depreciation and capital add back." Budgets from 2004 through 2012 included only "operating capital" spending and did not include contribution to a capital replacement reserve fund before the House approved this funding for the 2013 budget. As a result, the first two budget summary statements show a bottom line "net revenue / (expense) after taxes" while the next page shows the surplus/(deficit) consistent with prior budgets and includes the impact of new capital replacement reserve contributions budgeted in 2014 and 2015.

Budget Process Overview

The ADA *Bylaws* charge the Treasurer with design of the budgetary process in concert with the Board of Trustees and oversight of the Association finances and development of a budget for approval by the House of Delegates. The process now stretches over more than a year due to: multiple layers of volunteer involvement; the timing of council, committee and Board meetings; and the *Bylaws* requirement that the House be informed of the membership dues 30 days before the annual session. Over the past few years, several changes to the budget process have been layered on top of this traditional framework. In compliance with House resolution 44H-2011, ADA expenditures are now grouped by activity (aka "program") and scored against a set of Universal Assessment Criteria.

- 1 The outline below illustrates the various volunteer oversight bodies that are involved with the budget during
2 the year. Each step in the outline is explained below.

Councils	<ul style="list-style-type: none"> • <i>November-February</i> • Define programs and initial draft budgets
Council Budget Group	<ul style="list-style-type: none"> • <i>February-March</i> • Score programs against Universal Assessment Criteria
Administrative Review Committee	<ul style="list-style-type: none"> • <i>April</i> • Review budgets with every council
Board of Trustees	<ul style="list-style-type: none"> • <i>June-July</i> • Review and adjust in two Board meetings
House of Delegates	<ul style="list-style-type: none"> • <i>October</i> • Resolutions and approval

3 Councils

4 In the first stage of this process, ADA staff worked with over 200 council members to determine which
5 programs should be included in the 2015 budget. Each agency division defined a list of programs that
6 represent their work products, i.e., what the division accomplishes that creates member value. This
7 provided councils with better visibility at a summary level of the planned activities and resources required.

8 Next, staff input the initial draft budgets for these programs into the Hyperion budget system. Every hour of
9 staff time and every dollar of non-staff expense were planned against the programs. The sum of the staff
10 time in the programs equals the total staffing budget.

11 Council Budget Group

12 Next, a Council Budget Group rated each program from every agency division against the Universal
13 Assessment Criteria. The Council Budget Group includes two senior representatives from each of 15
14 Councils and committees. The seven Universal Assessment Criteria listed below were created by the
15 Board pursuant to House resolution 44H-2011.

- 16
- 17 1. **Attracts and Retains Members:** Among the top reasons why dentists join the ADA.
- 18 2. **Competitive Advantage / Avoids Redundancy with the Tripartite:** Program cannot be easily
19 duplicated by other members of the tripartite or other organizations. ADA has little competition in
20 this area because dentists have few or no alternatives to the ADA.
- 21 3. **Enhances Members' Pride in Their ADA Membership by Serving Society or the Public:**
22 Program altruistically serves the public rather than ADA members. Most members are
23 aware of the program and are proud to contribute a portion of their membership dues
24 to fund this public service.
- 25 4. **Direct Member Benefit Engages a Large Number of Members:** A direct interaction between
26 members and the ADA that only helps those members that actively engage in
27 the program. A significant percentage of ADA members actively engage in this program.
- 28 5. **Direct Member Benefit Has High Satisfaction Among Users:** A direct member benefit that only
29 helps those members that actively engage in the program. Members that use the program are very

1 satisfied and would recommend it to other members.

2 6. **Interacts with Third Parties on Behalf of All Members and is Highly Valued By Members:**

3 Program interacts with third parties rather than member dentists and most members are aware of
4 the program and view it is very important.

5 7. **Interacts with Third Parties on Behalf of All Members and is Highly Effective in Achieving its**
6 **Goals:** Program interacts with third parties rather than member dentists, and meaningfully alters
7 the course of the third parties with which it interacts. Program delivers results, outcomes, achieves
8 intended accomplishments.

9 Weightings of these criteria were determined by the Administrative Review Committee after the CBG had
10 completed their assessments.

11 The program scores and criteria weightings were collected in a web-based software called Decision Lens,
12 which enabled independent voting by each participant. This Decision Lens tool is not responsible for the
13 program scores any more than a voting machine is responsible for the results of a public election.

14
15 **Administrative Review Committee**

16 Before the Administrative Review Committee met for its formal budget review, its chair (the ADA Treasurer),
17 the Executive Director, and ADA Financial management reviewed all budget materials in detail. This helped
18 to identify some of the more substantive issues to be considered at the subsequent Committee meeting.

19 The full Administrative Review Committee was provided with budgets including the following for every
20 program: program description, notes on the program's alignment with each assessment criteria, the CBG's
21 assessment scores, revenue, staff full time equivalent employees (FTE), expense including staff time,
22 market research conducted by Kantar on members' perceptions of ADA programs, as well as consolidated
23 ADA budget financial statements versus prior year actual and budget. The Committee meeting included
24 discussions with each council and committee chair regarding their programs. The Committee typically
25 asked the council chair about the expected outcomes of a program, or the strategies that the council is
26 pursuing, or current status against goals mentioned in the program's budget materials. This dialog served
27 as a two-way education—the council shared their knowledge of the programs while the Committee offered
28 the perspectives of their broader view across the ADA.

29 **Board of Trustees**

30 The Administrative Review Committee, led by the Treasurer, made its final budget recommendation to the
31 full Board of Trustees, first at the June Board meeting. The Board reviewed the Committee's report
32 recommendations and asked questions and requested additional information as needed. Budget
33 adjustments agreed upon by the Board were then reflected in the subsequent budget draft presented to the
34 Board of Trustees at their second summer session, which this year was held in late July.

35 **House of Delegates Meeting**

36 The final budget will reflect any changes adopted by the House of Delegates, including any financial impact
37 of all House resolutions.

38 **Final Comments on 2015 Budget Targets**

39 For many years, the ADA has been challenged by falling membership market share. Even though the ADA
40 has enjoyed very positive bottom line financial results in recent years, membership market share is the most
41 critical need for the ADA and is reflected in the focus of the new **Members First 2020** strategic plan. As a
42 result, this 2015 budget includes important new initiatives for members to help drive change and turnaround
43 this trend. Alignment of the entire organization to drive value to attract and retain members and improve
44 non-dues revenue is critical to the long term success and financial stability of the ADA. As part of this effort,
45 the ADA also recognizes its important role working with state and local components to deliver member

- 1 value through the Power of 3. It's important for everyone to recognize that the ADA has started a major
- 2 transition that must engage all stakeholders across the Association to align with the new strategic plan
- 3 goals.

American Dental Association Operations

Budget Summary: Products and Services Sold versus Activities Funded by Membership Dues

Dollars in Thousands

	2013 Actual	2014 Budget	2015 Budget	2015 variance vs:			
				2013		2014 B	
				\$	CAGR % *	\$	%
<u>Revenues:</u>							
Insurance Royalty	6,270	-	6,000	(270)		6,000	
Product & Service Sales	49,425	49,849	55,379	5,954	5.9%	5,531	11.1%
Activites Funded by Member Dues							
Membership Dues	56,935	58,146	57,663	727	0.6%	(483)	-0.8%
Other Non-Product & Service Revenue	16,612	14,249	15,835	(776)	-2.4%	1,586	11.1%
Total	73,547	72,395	73,498	(49)	0.0%	1,103	1.5%
Total Revenues	129,241	122,244	134,877	5,636	2.2%	12,633	10.3%
<u>Expenses & Taxes:</u>							
Products & Services							
Cost of Products & Services Sold	34,168	38,680	39,964	5,796	8.1%	1,285	3.3%
Income Taxes	1,817	1,300	1,300	(517)	-15.4%	-	0.0%
Total	35,985	39,980	41,264	5,279	7.1%	1,285	3.2%
Activites Funded by Member Dues							
Employee Costs	53,132	58,935	58,851	5,719	5.2%	(85)	-0.1%
Other Period Costs	23,209	25,042	28,613	5,404	11.0%	3,571	14.3%
Total	76,340	83,977	87,463	11,123	7.0%	3,486	4.2%
Total Expenses & Taxes	112,325	123,957	128,728	16,402	7.1%	4,771	3.8%
<u>Net Income Before Reserves</u>							
Insurance Royalty	6,270	-	6,000	(270)	-2.2%	6,000	
Activites Funded by Member Dues	(2,794)	(11,582)	(13,966)	(11,172)	123.6%	(2,384)	
Product & Service Sales	13,440	9,869	14,115	675	2.5%	4,246	
Total	16,916	(1,713)	6,149	(10,767)	-39.7%	7,862	
Transfers to Insurance Royalty Reserve			(6,000)				
Operating Surplus			149				

* CAGR % = Compound Annual Growth Rate

1 The above table is a summary of the proposed 2015 budgets for "Sales of Products and Services" versus
2 "Activities funded by Membership Dues".
3

4 **Products & Services:** Net Income before reserves from products and services is expected to grow at an
5 annual rate of 2.5% over 2013 actual. Most of this growth is due to strong price increases in testing
6 services, primarily one-time adjustments. Many of the other products and services were created years ago,
7 have already reached their full potential, and now have an aging customer base. Growth in most products
8 will remain flat until new lines of business are created with greater appeal to early and mid-career dentists.
9

10 **Activities Funded by Membership Dues:** The decline of \$(11,172) in net income before reserves shown
11 versus 2013 reflects expense growth of \$(11,123) on revenue declines of \$(49).
12

13 As shown on page 2014, the ADA has steady declines in the number of full dues paying members despite
14 growth in the market of active licensed dentists. Not enough younger dentists are joining the ADA to
15 replace the older members that are retiring. Apart from membership dues, the \$(776) decline in non-
16 product revenue is driven by loss of tenants in the ADA Chicago headquarters building. The 2015 budget
17 anticipates some new leases but still not back to the 2013 level.
18

19 Costs funded by membership dues are projected to grow by 7.0 % per year (or 14.6 % over two years).
20 Both the 2015 budget and especially the 2014 budget layered new initiatives on top of the existing base of
21 older activities. Growing costs on flat revenue therefore causes the net loss on Activities Funded by
22 Membership Dues to widen from \$(2,794) in 2013 to \$(13,966) in 2015.

American Dental Association Operating Fund									
2015 Budget Summary by Natural Account									
\$ 000					2015 B v 2013A		2015 B v 2014B		
	2012	2013	2014	2015	Fav / (Unfav)		Fav / (Unfav)		
	Actual	Actual	Budget	Budget	\$	%	\$	%	
Revenues									
Membership Dues	54,552	56,935	58,146	57,858	923	1.6%	(288)	-0.5%	
Advertising	8,156	8,145	9,483	6,926	(1,219)	-15.0%	(2,557)	-27.0%	
Rental Income	5,579	5,579	3,855	4,685	(894)	-16.0%	829	21.5%	
Publication & Product Sales	7,448	7,920	7,034	6,840	(1,079)	-13.6%	(193)	-2.7%	
Testing Fees & Accreditation	18,855	19,805	20,130	24,852	5,046	25.5%	4,722	23.5%	
Meeting & Seminar Income	11,315	9,342	9,429	10,811	1,469	15.7%	1,382	14.7%	
Grants & Contributions	1,987	2,690	2,260	2,606	(84)	-3.1%	345	15.3%	
Royalties	6,609	13,054	7,127	14,951	1,898	14.5%	7,825	109.8%	
Investment Income	2,362	2,271	1,476	1,591	(680)	-30.0%	115	7.8%	
Other Income	2,934	3,501	3,304	3,758	256	7.3%	454	13.7%	
Total Revenues	119,797	129,241	122,244	134,877	5,636	4.4%	12,633	10.3%	
Expenses									
Salaries and Temporary Help									
Salaries (Base Compensation)	37,522	37,591	40,917	40,930	(3,339)	-8.9%	(13)	0.0%	
Temporary Help	1,158	1,151	285	426	725	63.0%	(141)	-49.4%	
Agency Compensation Adjustment	1,575	882	700	1,415	(533)	-60.4%	(715)	-102.1%	
Total Salaries and Temporary Help	40,255	39,624	41,902	42,771	(3,147)	-7.9%	(868)	-2.1%	
Fringe Benefits									
Pension Fund - Normal Cost	1,496	1,718	2,339	2,715	(997)	-58.0%	(376)	-16.1%	
Pension Catchup Supplemental Funding	5,065	3,191	5,252	3,824	(633)	-19.8%	1,428	27.2%	
401K	1,843	1,429	1,741	1,683	(254)	-17.8%	58	3.3%	
All Other Benefit Costs	4,444	4,445	4,885	5,088	(643)	-14.5%	(203)	-4.2%	
Total Fringe Benefits	12,847	10,784	14,216	13,310	(2,526)	-23.4%	906	6.4%	
Total Payroll Taxes	2,727	2,723	2,817	2,769	(46)	-1.7%	48	1.7%	
Total Travel Expenses	5,646	6,053	6,335	7,457	(1,404)	-23.2%	(1,122)	-17.7%	
Printing, Publication & Marketing	9,668	9,214	11,263	9,391	(178)	-1.9%	1,872	16.6%	
Meeting Expenses	3,054	2,079	2,388	2,643	(564)	-27.1%	(255)	-10.7%	
Consulting and Outside Services	7,602	6,485	7,289	10,911	(4,426)	-68.2%	(3,622)	-49.7%	
Professional Services	8,672	8,931	9,468	10,065	(1,134)	-12.7%	(597)	-6.3%	
Bank & Credit Card Fees	1,136	1,322	1,222	1,214	108	8.1%	8	0.7%	
Office Expenses	4,781	4,576	5,270	5,717	(1,141)	-24.9%	(447)	-8.5%	
Facility & Utility Costs	6,318	5,750	6,068	6,273	(523)	-9.1%	(205)	-3.4%	
Grants and Awards	2,304	2,586	2,741	2,756	(170)	-6.6%	(16)	-0.6%	
Endorsement Costs	660	718	803	827	(109)	-15.2%	(24)	-3.0%	
Depreciation/Amortization	6,563	6,469	6,342	6,424	45	0.7%	(82)	-1.3%	
Other Expenses	1,352	1,287	2,634	2,833	(1,545)	-120.0%	(199)	-7.6%	
ADA Health Foundation - Grant	1,907	1,907	1,900	2,067	(160)	-8.4%	(167)	-8.8%	
Total Expenses	115,491	110,508	122,657	127,428	(16,919)	-15.3%	(4,771)	-3.9%	
Net Income (Loss) before Income Tax	4,306	18,733	(413)	7,449	(11,284)	-60.2%	7,862	1904.0%	
Income Taxes	(1,109)	(1,817)	(1,300)	(1,300)	517	28.5%	-	0.0%	
Net Income Before Reserves	3,197	16,916	(1,713)	6,149	(10,767)	-63.6%	7,862		
Transfers to Insurance Royalty Reserve				(6,000)					
Operating Surplus				149					

American Dental Association Operations

Calculation of Net Operating Surplus/(Deficit)

\$ 000

	2013 Actual	2014 Budget		2015 Budget
		As Reported	Restated *	
Net Income Before Reserve Contributions and Expenditures	\$ 16,916	\$ (1,713)	\$ 4,287	\$ 6,149
Add Back Depreciation (non-cash)	6,469	6,342	6,342	6,359
Operating Capital Expenditures	(2,854)	(3,331)	(3,331)	(1,962)
Contribution to Capital Replacement Reserve Fund	(3,500)	(3,011)	(3,011)	(4,397)
Subtotal: Net Non-Cash Depreciation Add Back and Capital Funding Items	115	-	-	-
Contribution to Insurance Royalty Reserve Fund			(6,000)	(6,000)
Total: Operating Surplus/(Deficit)	17,031	(1,713)	(1,713)	149

* Restatement shows 2014 budget including the insurance royalty revenue, to be comparable to 2015 budget.

- 1 The House of Delegates created the capital replacement reserve fund beginning with the 2013 budget.
- 2 For the 2013-2015 budgets, the amount of the contributions to the capital replacement reserve fund is
- 3 determined by the excess of depreciation over the operating capital expenditures. This assumes that over
- 4 a multi-year period depreciation is a rough indicator of the future capital expenditures that will be required
- 5 to replace ageing assets.
- 6
- 7 For planning purposes, the total operating capital spending plus capital reserve contributions will be equal
- 8 to and offset the depreciation expense "add back." This set aside of funds for capital spending is
- 9 consistent with goals of long term financial and dues stability by reducing the need for future special
- 10 assessments.

Revenues

- 11 Total revenues in the 2015 budget are \$ 134,877. Highlights of various revenue categories are provided
- 12 below.
- 13

14 **Membership Dues:** The Division of Member and Client Services (formerly the Division of Membership,

15 Tripartite Relations and Marketing) estimates the future membership levels for each of 28 dues paying

16 categories and multiplies by the 28 dues rates. The 2015 budget anticipates 183,826 members, of which

17 91,500 will pay full dues of \$522 per year. The average dues rate per member is \$314 per year including

18 discounts such as Active Life and Recent Graduate. These figures do not reflect any dues increase or

19 assessment on U.S. members, as no such dues increase for 2015 has been put forth by the Board of

20 Trustees. The 2015 budget does include an increase in affiliate (international) membership dues.

21

22 **Advertising:** This category primarily includes advertising sales in ADA publications and new initiatives in

23 electronic media, and secondarily, exhibits at the ADA annual session. The 2015 revenue of \$6,926 is a

24 (27) % decline from 2014 budget. The decline is driven by the net effect of outsourcing production of the

25 *Journal of the American Dental Association* ("JADA") to Reed Elsevier Group plc ("Elsevier") based on a

26 plan which the Board approved via Resolution B-33-2014. The outsourcing decreases advertising revenue,

27 increases royalty income, and affects several other revenues and expenses, for a total net

revenue/expense benefit of \$395 in 2015. Additionally, traditional advertising in *ADA News* is expected to decline in 2015.

Rental Income: This revenue category primarily includes rental income from the Chicago Headquarters and Washington DC Buildings. Revenue of \$4,685 is an increase of 21.5 % from 2014 budget, although still below 2013. The 2015 budget is anticipating a 95.1 % occupancy rate by the end of 2015 due to lease expansions, renewals and new tenants.

Publication and Product Sales: The decrease of \$(193) or (2.7) % is due to the net effect of outsourcing production of JADA to Elsevier which decreases direct publication sales revenue but increases royalty income.

Testing Fees and Accreditation: This has been the ADA's largest source of revenue growth over the last few years. Revenues from testing and accreditation fees are expected to rise by \$4,722 or 23.5 % versus 2014 budget. 2015 budget includes fee increases in the Dental Admissions Test, National Board Dental Exam (NBDE) and Optometry Admissions Test. Accreditation revenue in 2015 is 33.5 % above 2014 budget, primarily due to fee increases that average 40 %.

Meeting and Seminar Income: Most of the \$ 1,382 increase is related to increasing registration fees and additional revenue generated from hotel rebates from contracted hotels in Washington DC. Additionally, revenue from ticket sales related to continuing education courses is expected to increase in 2015.

Grants, Contributions and Sponsorships: Grants, contributions and sponsorships are projected to increase by \$345 or 15.3 %. The 2015 budget anticipates additional grant revenue related to the Give Kids A Smile/NASCAR events. Additionally, a new RWJ grant in the Council on Access and Prevention and Inter-professional Relations commenced in January 2014 will conclude at year-end 2015.

Royalties: Includes royalties received from Member Insurance Plans, the *ADA Business Resources* program, CDT licenses, domestic and international product licenses, selling of mailing lists and JADA royalties to be paid by Elsevier. Royalties from Member Insurance Plans were not included in the 2014 operating budget and therefore contribute \$ 6,000 of the \$ 7,825 increase. Elsevier added \$1,646 of additional revenue to this category. Additionally, growth in *ADA Business Resources* offerings is anticipated in the 2015 budget.

Investment Income: A conservative projection for revenue of \$1,591 for 2015 includes both interest and dividends on reserve fund assets and investment earnings on cash in the operating account. The increase of \$115 in 2015 is primarily due to an increase in projected dividend income.

Other Income: This category is composed of miscellaneous revenue, including such items as overhead reimbursement from subsidiaries and the Member Insurance Program, and Seal Program revenues. The \$454 increase is partially due to reimbursement from the Member's Insurance Program for a benchmarking study of the rates and benefits of the member's insurance plans. Additionally, a \$200 increase is a contract signing bonus from Elsevier for JADA outsourcing. The full bonus is \$ 1,000, reported as income over each year of the five year contract.

Expenses

Total operating expenses are budgeted at \$127,428, an increase of \$(4,771) or (3.9) % versus the 2014 budget.

Highlights of various expense categories are provided below.

Salaries (Base Compensation): Base salary expenses are budgeted at \$40,930 which is unfavorable by \$13 or 0 % from the 2014 budget. As shown in the table on page 2015, the number of full time equivalent employees is projected at 428.3, a decline of 0.5 compared to the 2014 budget. The 2015 budget assumption for unfilled positions is \$ 903, which reduces the budget expense.

Agency Compensation (includes Severance): This category includes expense associated with severance pay and service awards and is projected to be unfavorable by \$(715) or (102.1) %. The increase is due to the 2015 budget including an increase in severance pay from expected staff reductions based on a historical analysis of actual results.

Temporary Help: The ADA hires temporary staff for annual session and to assist divisions when staff positions are open during the year. This category is expected to increase by \$(141) when compared to the 2014 budget. Increases in Testing Services programs bring those budgets more in line with actual trends, and separately a freelance public relations person will be hired for communications to state dental societies.

Pension – Normal Cost: This category is to cover annual contributions to the scaled back new pension plan that went into effect January 1, 2012. The cost reflected in this category represents estimated plan contributions required by the IRS rules for current employees, based on actuarial assumptions. The increase of \$(376) over 2014 budget reflects an increase in the statutory discount rate. However, the annual cost is still over \$3 million less than under the prior pension plan.

Pension – Catch-up Supplemental Funding: The ADA must continue to fund the liability of the full employee pension plan that was offered to employees prior to 2012. The costs associated with this category declined by \$1,428 when compared to 2014.

401K Contribution: No significant change is anticipated for 2015.

All Other Benefit Costs: Expenses in this category include group medical premiums, dental direct reimbursement, life insurance and workers compensation. The expenses in this category are expected to increase by \$(203) or (4.2) % from 2014, driven by Group medical costs.

Payroll Taxes: This category includes expense associated with employer related taxes such as FICA, SUI and FUI. This category is expecting a minimal decline in 2015.

Travel Expenses: Travel expenses are usually comprised of about three quarters volunteer travel and one quarter staff travel. Budget expenses for travel are projected to increase by \$(1,122) or (17.7) % versus the 2014 budget. The increase in travel expense is due to: Deployment of the Aptify system to state and local societies, new activities to assist states' member recruitment efforts, airline and hotel rate increases, and a new international travel policy allowing for business class travel for extended flights consistent with best practices.

Printing, Publications and Marketing: This expense item declined due by \$1,872 or 16.6 % largely due to outsourcing of JADA production. Additional savings are projected as a result of reduced variable costs related lower advertising revenue for MouthHealthy.org. Catalog product sales are expected to have lower costs due to production efficiencies.

Meeting Expenses: The 2015 budget anticipates an unfavorable variance of \$(255), largely attributable to expenses associated with the ADA's Annual Meeting site in 2015.

Consulting Fees and Outside Services: Expenses in this area increase by \$(3,622) or (49.7 %).

2015 Budget Variance from 2014 Budget
Millions of Dollars

JADA production outsourcing to Elsevier	\$1.0
Integrated National Board Dental Examination	1.0
New agency experts for recruitment and retention	0.5
IT Consultants for Aptify Deployment	0.6
Video Studio Consultant	0.3
Give Kids a Smile/NASCAR	<u>0.2</u>
Total	3.6

Professional Services: Most of the \$(597) increase in this expense category is due to test administration fees paid to third party administrators of the NBDE, DAT and OAT exams. This increase is directly related to the increase in testing revenue. Also contributing to this increase are expenses related to the stipends paid to the ADA Board of Trustees and the Treasurer, the latter of which is now accounted for under Professional Services rather than employee salary expense.

Bank and Credit Card Fees: This category represents transaction fees paid to financial institutions and reimbursements to state and local societies for credit card fees related to ADA membership dues collection. The National ADA pays all credit card fees on national, state, and local member dues collections. States having higher credit card usage receive larger subsidy payments from the ADA.

Office Expenses: The \$(447) increase versus 2014 budget in office expenses is primarily driven by transfer of ongoing support of Ad Council public service advertising into the operating budget. These costs were previously reported as direct charges against ADA reserves. Also, the location of the ADA 2015 meeting in Washington DC results in higher audio/visual costs. Other contributors to expense growth include a new in-house video production studio and membership dues for the ADA to secure a seat on the Institute of Medicine.

Facility and Utility Costs: These expenses represent costs for building management and operations, maintenance, and real estate taxes for the ADA Headquarters and Washington DC buildings. The increase of \$(205) is mainly the result of increased property taxes for the headquarters building. Also, the expected increase in building occupancy will increase janitorial services and cleaning supplies.

Grants and Awards: The ADA distributes grants to support various organizations, primarily state and local dental associations. The net increase of \$(16) includes increased grants to ASDA, the New Dentist Committee, and state and local dental organizations under Membership Program for Growth. However, these increases are largely offset by a \$ 150 reduction in State Public Affairs grants to state dental associations.

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

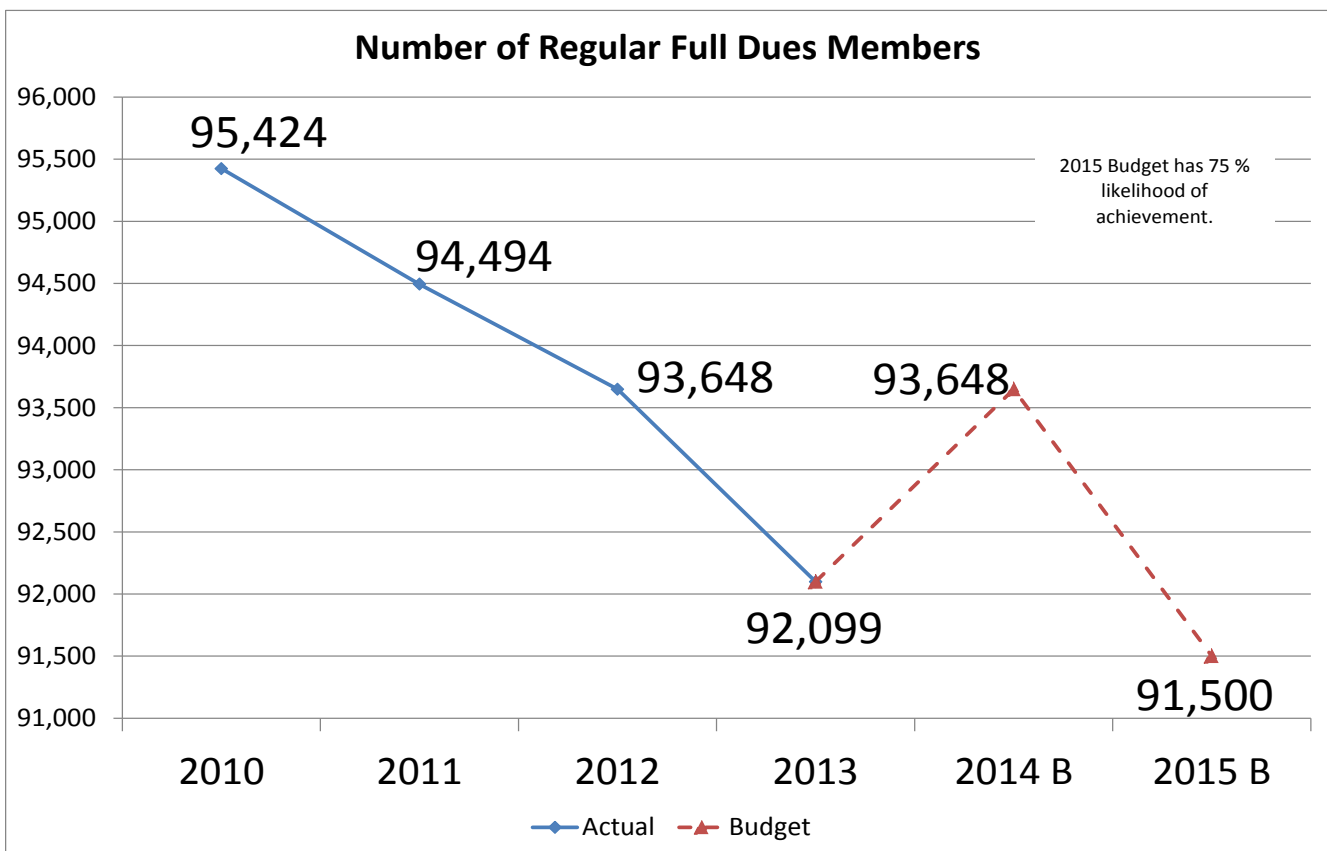
Depreciation and Amortization: The 2015 budget expense is nearly the same as the 2014 budget. Depreciation is calculated annually based on prior year and proposed current year capital acquisitions.

Other Expenses: Other expenses include general insurance, recruiting costs, staff development, overhead recovery, and the contingent fund. The ADA budgets \$1,000 per year in the contingent fund, against which spending during the year is approved by the Board of Trustees. Other Expenses category is expected to increase by \$(199) when compared to 2014. However, most of this expense increase is a \$(131) accounting entry for Members Insurance Plans that has no net impact on the budget surplus. Additionally, business skills training for staff is projected to increase in 2015.

ADA Foundation Grant: The Association's annual grant to the Foundation is budgeted to increase by \$(167) to \$ 2,067 based on funding of a potential transfer of the International Humanitarian Outreach program from the ADA to the ADA Foundation in 2015. Although this program has been discussed with the Foundation, this transfer is subject to final review and approval of the ADA Foundation board. If not transferred, it is assumed that this program would continue for one last year in a phase out period. Therefore, this cost represents no increase to the ADA budget compared to the 2014 budget because these costs were included in Global Affairs. Longer term, beyond 2015, if the program does transfer to the Foundation, it's possible that ADAF may be able to raise other donor contributions to support it. In this potential future scenario, the Foundation has an advantage because ADAF donors can receive tax deductions for their charitable contributions and this is something that the ADA cannot provide. As a result, it is possible that it may be wise for the ADA to consider offering other public health programs to the Foundation provided they align with that organization's mission.

Additional Information on Membership Trends

The ADA has had a steady decline in the number of regular (full dues paying) members. This trend slightly accelerated in 2013, as indicated in the chart below by the slightly steeper downslope for 2013.



The 2014 budget intended to maintain the same number of regular members as the 2012 actual result, helped by a growing market of active licensed dentists. However, the ADA's membership base includes older cohorts with high ADA market share and younger cohorts with lower market share. Not enough younger members are joining to replace the older members retiring. With these underlying dynamics now

better understood, the 2014 budget is now recognized as unachievable and even the 2015 budget of 91.5 thousand members has an estimated 25 % risk of not being achieved.

The ADA is now realigning its recruiting strategies with the recognition that most non-member dentists leave the ADA at a young age and that local outreach activities are critical. However, reversal of the downward trend will take time because older non-members dentists rarely join the ADA late in their careers. Therefore, the ADA must first begin to fill the pipeline with higher share classes of new dentists.

ADA Agency Programs and Shared Services Functions

Agency Programs versus Shared Services Functions

Agency Divisions directly interact with either members or third parties on behalf of members. Shared Services Divisions include the following areas that support other ADA Divisions: Administrative Services, Human Resources, Legal Affairs, Finance, Operations & Buildings, Central Administration, and Information Technology. In addition, some agency divisions perform shared services functions, assisting other ADA divisions.

The major efforts of agency divisions have been grouped into “programs”, and similarly the shared services divisions have primary “functions”. For the 2015 budget, the ADA defined 66 agency programs and 38 shared services functions, with the employee staff deployed to each as shown below:

American Dental Association Operations

Year End Full Time Equivalent Employees and Number of Agency Programs and Shared Services Functions

	Number of FTE Employees			Number of Programs / Functions
	2014 Budget	2015 Budget	Change	
Agency Programs	280.2	280.6	0.4	66
Shared Services Functions in Agency Divisions	29.6	27.3	(2.3)	5
Shared Services Functions in Shared Services Divisions	119.0	120.4	1.4	33
Total ADA	428.8	428.3	(0.5)	104
<i>2014 restated to reclassify programs moving between groupings (eg-Member Service Center becoming an Agency program in 2015.)</i>				

List of Programs Sorted by Decision Lens Ranking

The listings below provide the rank order of all programs as well as the number of FTE employees, revenue, expense and the net revenue/(expense) of each. These schedules capture every dollar of ADA expenses and every ADA staff member, so that the totals below equal the totals shown in other presentations of the budget in this report. A detailed description of each program and shared services function is available in the HOD Financial and Organization Communications Library of ADA Connect.

Following the program list is a chart showing each program plotted in four quadrants. The horizontal axis is the program net revenue/expense, and the vertical axis is the CBG's program rankings. For example, in the upper left corner is a point marked "64". The program list shows that the program ranked # 64 is "Dental Testing Services – Testing Services for Outside Clients". Programs in this upper left quadrant are high in net revenue but low in program ranking. Although this particular program may not align well with the non-financial aspects of ADA Members First 2020 strategic plan, these testing services provide revenue that helps fund other programs that are valuable to members. This grid therefore shows program assessments against both the financial and non-financial aspects of the strategic plan.

1 **List of Programs Sorted by Decision Lens Ranking**

2

3 **Top Ranked Third of Programs****American Dental Association**

2015 Budget Agency Programs

Sorted by Decision Lens Rank; Dollars in Thousands

Decision Lens Rank	Program	Division	Decision Lens Score	Number of Employees	Revenue \$	Costs		Net Income Before Reserves
						Employees \$	Other \$	
1	81201100 Advocacy for Dent Pract, Fed Dental Svcs	Govt	0.646	4.7	-	763	120	(883)
2	81302500 Council on Members Ins&Retmnt Programs	MTRM	0.621	3.4	7,898	576	865	6,457
3	81353800 JADA_	Publish	0.621	1.8	2,549	347	1,949	253
4	81504900 Dental Code Development&Maintenance	PractInst	0.620	3.0	-	437	81	(518)
5	81247700 Public Affairs_	Comm	0.617	4.4	-	660	97	(757)
6	81201200 Advocacy Access, Dental Coverage	Govt	0.615	2.6	-	418	334	(752)
7	81201000 Advocacy Science, Educ, Approp, Well Issues	Govt	0.610	2.8	-	503	282	(785)
8	81655400 ADA Seal	Science	0.609	4.2	733	589	32	111
9	81201700 Fluoridation and Prevention	Govt	0.607	2.7	-	375	159	(533)
10	81353900 ADA News_	Publish	0.577	12.1	4,571	1,442	3,259	(130)
11	81655600 Center Evidence Based Dentistry	Science	0.576	7.2	113	809	359	(1,055)
12	81302400 ADA Student Membership Activities	MTRM	0.575	2.4	145	284	316	(455)
13	81504600 CDBP Third Party Issues	PractInst	0.575	3.0	-	433	38	(471)
14	81655500 Science Liaison & Advocacy	Science	0.568	3.6	-	455	21	(476)
15	81303100 Member Service Cntr	MTRM	0.567	15.1	-	1,456	73	(1,528)
16	81655800 Product Evaluation	Science	0.548	8.3	-	975	284	(1,259)
17	81201500 State Public Affairs Prog.	Govt	0.536	6.2	23	901	2,833	(3,711)
18	81384100 Product Development & Sales	PDS	0.532	9.4	9,331	1,286	3,045	5,000
19	81607000 Dental Education and Licensure Policy	Educat	0.529	3.0	4	404	90	(490)
20	81353600 ADA Session	DCCE	0.527	13.4	10,975	1,558	6,881	2,537
21	81601000 Dental Specialty Recognition	Educat	0.521	2.3	-	302	24	(326)
22	81247500 Professional Web and Digital	Comm	0.519	5.8	-	640	124	(764)

1 Middle Ranked Third of Programs

American Dental Association

2015 Budget Agency Programs

Sorted by Decision Lens Rank; Dollars in Thousands

Decision Lens Rank	Program	Division	Decision Lens Score	Number of Employees	Revenue \$	Costs		Net Income Before Reserves
						Employees \$	Other \$	
23	81302900 New Dent Committee&New Dentist Prog	MTRM	0.517	3.1	335	393	391	(450)
24	81807200 Give Kids a Smile/National Children's Dental Health Month	CorpRel	0.512	1.6	383	223	383	(223)
25	81555000 Policy Research	HPI	0.505	9.2	20	1,387	905	(2,272)
26	81606100 Department of Continuing Education	DCCE	0.503	1.9	500	290	244	(34)
27	81247300 Public&Professional Comm	Comm	0.500	5.7	154	871	729	(1,446)
28	81651000 Standards for Materials, Instruments, and Equipment	Science	0.499	1.3	-	160	24	(184)
29	81201900 Access Comm Oral Health Infra&Capacity	Govt	0.495	1.7	-	314	93	(408)
30	81606200 CERP and CE Oversight	Educat	0.495	2.6	282	311	52	(81)
31	81201800 Interprofessional Relations_	Govt	0.494	2.7	103	321	166	(384)
32	81655700 Scientific Lit Research, Analysis&Education	Science	0.485	7.1	36	977	173	(1,114)
33	81655900 Standards Administration	PractInst	0.485	4.5	63	577	416	(929)
34	81302200 Member Recruitment and Retention Marketing	MTRM	0.480	4.2	10	510	722	(1,222)
35	81302800 Success Dental Student Program	MTRM	0.462	0.0	-	-	-	-
36	81201300 Washington Leadership Conference_	Govt	0.455	1.9	-	233	213	(445)
37	81656000 Exp Lab Research on Emerging&Critical Issues	Science	0.452	4.2	-	569	42	(611)
38	81504200 Center Profess Success (CPS)	PractInst	0.449	5.4	315	726	363	(774)
39	81504700 Department Dental Informatics	PractInst	0.448	3.5	-	541	145	(686)
40	81302300 Tripartite Membership Growth Assistance & Consultation	MTRM	0.446	6.3	33	857	848	(1,673)
41	81606500 JC-National Board Dental Exams	Educat	0.433	19.6	12,999	2,001	6,250	4,748
42	81606400 CODA(Accreditation)	Educat	0.432	15.4	3,356	1,574	1,386	396
43	81606900 Library and ADA Archive Services_	Educat	0.432	5.3	10	601	208	(798)
44	81201600 ADPAC Marketing Campaign	Govt	0.426	3.0	-	347	169	(516)

1 Bottom Ranked Third of Programs**American Dental Association**

2015 Budget Agency Programs

Sorted by Decision Lens Rank; Dollars in Thousands

Decision Lens Rank	Program	Division	Decision Lens Score	Number of Employees	Revenue \$	Costs		Net Income Before Reserves
						Employees \$	Other \$	
45	81504800 CDBP Quality Assess&Improvement	PractInst	0.417	3.0	-	452	60	(512)
46	81202000 Geriatrics and Special Needs	Govt	0.410	1.7	-	266	110	(376)
47	81247400 Consumer Outreach	Comm	0.408	3.1	200	382	339	(522)
48	81247800 Public Relations Agency	Comm	0.404	1.8	-	333	853	(1,186)
49	81302600 Dept Dental Society Services	MTRM	0.398	4.0	110	573	215	(678)
50	81303300 International Humanitarian Outreach	Global	0.381	0.0	-	-	-	-
51	81303200 International Collaboration	Global	0.377	2.6	-	354	145	(500)
52	81201400 Lobbyist Conference	Govt	0.376	0.2	-	33	10	(43)
53	81555300 Research Serv Ext Clients	HPI	0.371	1.3	180	186	-	(6)
54	81303500 FDI World Dental Federation	Global	0.370	0.5	-	69	561	(630)
55	81551000 Services to CODA	HPI	0.369	2.8	-	307	-	(307)
56	81504500 Group Practice Models and Economics	PractInst	0.358	3.5	-	554	69	(623)
57	81302700 Inst for Diversity in Leadership	MTRM	0.355	0.5	40	92	122	(173)
58	81606300 Dental Testing Services-Dental Aptitude Test (DAT)	Educat	0.351	9.5	6,508	993	1,614	3,901
59	81504300 Dent Team Liaison Relation	PractInst	0.350	0.0	-	-	-	-
60	87207100 Grant to ADA Foundation	NoDiv	0.341	0.0	-	-	2,067	(2,067)
61	81504400 Dent Health Wellness&Well-Being	PractInst	0.339	2.3	25	327	112	(414)
62	81303400 International Business Activities	Global	0.315	0.0	-	-	-	-
63	81354000 Digital Advertising_	Publish	0.308	6.8	1,929	784	302	843
64	81606800 Dental Testing Services- Testing Services for Outside Clients	Educat	0.276	4.6	1,896	474	653	769
65	81607900 Internt'l Consulting for Dental Educ Programs	Educat	0.261	0.9	192	138	54	(0)
Programs Not Ranked								
	81241000 Video Studio - Communications	Comm	NA	1.0	-	119	-	(119)
	81351000 Video Studio - DCCE	DCCE	NA	0.0	-	-	393	(393)
	Total Programs			280.6	66,022	35,832	42,865	(12,675)
	Depreciation						6,424	(6,424)
	Non-Agency (Shared Services) Functions			147.7	68,854	23,018	19,288	26,548
	Taxes						1,300	(1,300)
	Total ADA			428.3	134,877	58,851	69,877	6,149

1

ADA 2015 Budget Programs Program Surplus / (Deficit) versus CBG Program Ranking



Administrative Review Committee Budget Decisions and Discussion of Council Budget Group's Decision Lens Rankings

Decision Lens scores are only one input for the ADA's volunteer Leadership to consider. The Administrative Review Committee fully funded many programs in the lower left quadrant of the above chart without any reservations. Below are items from the Administrative Review Committee's and Board of Trustees' deliberations, with all decisions noted here reflected in the budget as presented in this report.

1. On the lowest ranked program, International Consulting for Dental Education Programs, the Committee asked the Education Division to increase budget revenue by \$74, as this program should at least break even on a pre-overhead basis.
2. The Committee reviewed trends on international revenue, and decided not to fund the "International Business Activities" program (ranked # 62 out of 65). One employee in this program will be transferred to the Business and Publishing area and a proposed new hire and all non-staff costs are eliminated.
3. The Committee was mindful that the Foundation grant was positioned on the lower left corner of the chart (ranked # 60 out of 65 for a cash grant of \$ 2.1 million). The Committee voted to reject the Foundation's request for additional funding to hire an additional employee for activities such as expanded grant application processing. Instead, the Committee suggested that the Foundation begin to assume public service missions that were formerly performed by the ADA but do not fit with the Members First 2020 Strategic Plan. As a starting point, the Committee discussed with the ADAF Executive Director the potential transfer of the International Humanitarian Outreach program (ranked # 50 out of 65) from the ADA to the Foundation. If the Foundation Board agrees, for 2015, the ADA will increase its grant to the Foundation to help offset the cost of this transfer, taking into account the synergies that the Foundation Executor Director indicated would be created and the Foundation's potential in future years to raise its own funds for International Humanitarian outreach. Separately, the ADA will continue to provide in-kind donations to the Foundation which are not separately disclosed in this budget but remain part of the ADA's overhead and infrastructure costs.
4. The Committee endorsed elimination of the Dental Team Liaison Program (# 59 out of 65) due to concerns about program effectiveness. The program and its associated travel cost were eliminated and employees working on this program are shifted to higher valued activities in the Practice Institute Division. The Board of Trustees subsequently restored a small portion of this program, attendance at inter-professional meetings, which is now included in other Practice Institute programs.
5. The Committee endorsed elimination of the Success Program in favor of new outreach efforts to students and dental schools that are expected to be more effective.
6. Although the financial impact, if any, has not yet been determined, the Committee endorsed moving the New Dentist Conference to the annual session. Staff support for the New Dentist Committee will be shifted from the Membership Division to the Board staff.
7. The Committee endorsed sunseting the Committee on International Programs (part of the International Collaboration Program, # 51 out of 65.)
8. The Committee endorsed a reconfiguration of the Department of Dental Society Services (ranked # 49 out of 65). Four employees will be transferred to IT Division and the rest of the team will eventually be absorbed into new membership activities to support state and local dental societies.
9. The Committee had lengthy discussion about FDI (ranked # 54 out of 65) but decided not to change funding nor recommend renegotiation of membership fees at this time.

1 10. The Product Evaluation Program (# 16 out of 65) is a rare exception in which the Committee
2 sharply disagreed with the Council Budget Group's assessment of a program. The Committee was
3 surprised that the Product Evaluation Program placed at #16 and resolved to give this program one
4 more year to demonstrate competitiveness versus perceived best-in-class alternatives such as
5 Clinicians Report (aka Gordon Christensen DDS) or else the program could be recommended for
6 elimination in the 2016 budget.

7 11. The Committee decided to increase funding for Policy Research (ranked # 25 out of 65) by \$ 163 in
8 order to fund additional workforce research such as geographic mapping.

9 12. The AdCouncil Campaign had previously been funded from reserves. The Committee therefore
10 decided to shift this \$ 275 into the ADA 2015 operating budget.

11 13. The Board decided to admit 16 dentists into the Institute for Diversity in Leadership (#57 out of 65)
12 in 2014 and 2015, versus 12 attendees in recent years.

13 **ADA Shared Services Functions:** Shared services functions are not assessed against the Strategic Plan
14 in Decision Lens, and therefore the order in which the functions are listed below has no significance.
15 However, these tables provide new detail on how the ADA proposed to deploy its resources across each
16 shared services area. For example, the first program listed below indicates that the Administrative Services
17 Division devotes 5 employees to supporting the Board of Trustees, and that the total cost of the Board
18 including travel and other expenses is \$ 3,431.

19
20 This information provides an additional level of budget transparency that the ADA has never provided in any
21 past year.

ADA Shared Services Functions (Page 1 of 2)**American Dental Association**

2015 Budget Shared Services Functions

Dollars in Thousands

Ref #	Function	Number of Employees	Revenue \$	Costs		Net Income Before Reserves
				Employees \$	Other \$	
1	81058000 Board of Trustees_	5.0	-	1,122	2,309	(3,431)
2	81058100 House of Delegates_	2.5	-	415	817	(1,232)
3	81058200 Strategy	1.0	-	165	42	(207)
4	81058300 Operational Management	4.5	-	912	127	(1,038)
5	Administrative Services Division	13.0	-	2,614	3,294	(5,907)
6	81151000 Governance	3.9	-	697	685	(1,381)
7	81151100 Contracts	5.0	-	758	7	(765)
8	81151200 Litigation Management and Support	1.0	-	184	180	(364)
9	81151300 Legal Advice and Counsel-Int of Assoc.	3.7	70	734	310	(974)
10	81151400 Review and identif potential risk to Assoc	2.1	-	386	59	(445)
11	Legal Affairs Division	15.6	70	2,759	1,241	(3,930)
12	81401000 Budget and Forecasting	3.9	-	651	26	(677)
13	81401100 Financial Reporting, Compliance, Treasury	5.4	-	717	38	(755)
14	81401200 Transaction Accounting	11.2	-	1,062	48	(1,110)
15	81401300 Association-Wide Governance and Volunteer S	1.6	1,591	295	74	1,223
16	81401400 Purchasing/Mail/Shipping	6.1	25	534	73	(582)
17	81401500 Printing/Duplicating	4.5	-	386	-	(386)
18	81401600 HQ Building	0.3	2,791	65	5,593	(2,867)
19	81401700 Washington_Building	0.2	1,861	25	1,018	818
20	Depreciation				786	(786)
21	Finance, Operations, and Buildings Division	33.0	6,269	3,735	7,656	(5,122)
22	81051000 Benefits-HRIS	1.8	-	298	3	(301)
23	81051100 Employee Relations	1.5	-	283	105	(388)
24	81051200 Recruiting	1.6	-	231	192	(423)
25	81051300 Employee Development	0.9	-	273	382	(656)
26	81051400 Talent Management, Pay and Organizational D	1.0	-	201	55	(256)
27	Human Resources Division	6.8	-	1,286	739	(2,024)

ADA Shared Services Functions (Page 2 of 2)**American Dental Association**

2015 Budget Shared Services Functions

Dollars in Thousands

Ref #	Function	Number of Employees	Revenue \$	Costs		Net Income Before Reserves
				Employees \$	Other \$	
28	81411200 Royalties__	0.0	3,805	-	544	3,261
29	81411400 Benefits not allocated to divisions	0.0	-	-	17	(17)
30	81411500 Expense Offsets	0.0	-	(1,265)	(200)	1,465
31	81411600 Association-wide expenses	0.0	32	2,793	962	(3,724)
32	87207100 Grant to ADA Foundation	0.0	-	-	2,067	(2,067)
33	Grants to Other Health Related Groups				73	(73)
34	Depreciation				3,681	(3,681)
35	Central Administration Division	0.0	4,302	1,878	7,144	(4,719)
36	81451000 ADA Tripartite Support	11.8	-	1,546	1,488	(3,034)
37	81451200 ADA Finance and Enterprise Support	10.8	-	1,706	454	(2,160)
38	81451300 Websites	5.8	-	826	220	(1,046)
39	81451400 Collaboration and Governance	7.8	-	1,071	648	(1,719)
40	81451500 Infrastructure	15.8	-	2,122	1,133	(3,254)
41	Depreciation				1,667	(1,667)
42	Information Technology Division	52.0	-	7,271	5,609	(12,880)
43	Contingency Funds	0.0	-	-	1,000	(1,000)
44	81353700 Meeting Room Mgt	5.7	276	701	232	(656)
45	81303000 Department of Membership Information	10.1	57,938	1,148	131	56,659
46	81247600 Marketing Shared Services	6.3	-	779	193	(972)
47	81555200 Research Serv Int Clients	1.8	-	223	-	(223)
48	81801000 Corporate Relations	3.4	-	627	252	(879)
49	Shared Services Functions in Agency Divisions	27.3	58,214	3,477	807	53,930
50	Total Shared Services Functions	147.7	68,854	23,018	27,489	18,347
51	Agency Programs	280.6	66,022	35,832	42,865	(12,675)
52	Remove Foundation already in Agency Programs	0.0	-	-	(2,067)	2,067
53	Depreciation In Agency Divisions				290	(290)
54	Taxes				1,300	(1,300)
	Total ADA	428.3	134,877	58,851	69,877	6,149

Capital Expenditures:

The ADA has two types of capital expenditures, each with its own procedures for reporting and approvals: Reserve Capital and Operating Capital. In order to ensure that funding is available to cover major capital replacement projects as well as "Operating Capital" projects which are included in annual operating budgets, the ADA defines each category as follows:

1. **Operating Capital** spending to add, upgrade, or replace more common and short-lived fixed assets. This category should include all items replaced within five years. A good example of this would be the ongoing annual replacement of computer equipment which is done on a continuing annual basis with 1/3 of all PC equipment turned over each year such that every computer at the ADA is retired and replaced every three years. Operating Capital Spending is included as a line item with detail support in the annual operating budget in Board Report 2.
2. **Reserve Capital** spending is a separate category of larger and much less frequent building repairs, replacements, and renovations to ADA buildings. Such renovations will include the cost of tenant improvements (TI) and related one-time costs to secure long term leases. Because this type of major capital spending comes from a dedicated capital replacement reserve account, each actual project must be reviewed and approved by the Finance Committee and Board. Costs of tenant leasehold improvements must be justified as part of a complete capital authorization request (CAR) in a board report with appropriate economic analysis.

Capital Replacement Reserve Fund (New as of 2013): This was created by the 2012 House of Delegates to eliminate the need for special membership dues assessments to fund large asset replacements. In the long run, funding will be determined by the projected needs, but during the first few years the fund contributions are equal to depreciation less operating capital expenditures. In other words, in each year the excess of depreciation over operating capital is contributed to the capital reserve fund, as shown in the table below.

Insurance Royalty Reserve Fund (New as of 2014): This reserve account was created by 2013 Reference Committee Resolution 84H-2013, regarding the Study of a Potential Approach to On-Going Royalty Revenue, and resolved that the Board of Trustees is urged to maintain the royalties received from the ADA Members Insurance Plans in a designated account. The designated reserve will be dedicated to member value, long term dues and financial stabilization as recommended by the 84H-2013 workgroup and subsequent Board action. As a result, there is \$6,000 of new royalty revenue included in the 2015 budget with an offsetting \$6,000 transfer to the new insurance royalty reserve shown in the operating budget. In addition, it should be noted that in June 2014 the ADA received royalties recommended by CMIRP and approved by the Board in 2013 plus accrued interest that totaled \$6,227. These assets will be managed under the existing ADA long term investment policy and tracked in a separate royalty reserve account which is reported separately consistent with other reserves in ADA financial reports.

Uncommitted Operating Reserves: As a reminder, it should be noted that there is no member dues increase included in the 2015 budget. Although ADA reserves at the end of 2013 and early 2014 are very high reflecting the historic high levels of investment markets, the ADA's reserve balance should remain above the 50% minimum threshold defined by the new strategic plan goal.

American Dental Association		
Budget Depreciation and Capital Expenditures		
\$ 000		
	2014 Budget	2015 Budget
Depreciation/Amortization	\$6,342	\$6,424
Operating Capital Expenditures:		
Conferences and Continuing Education	(271)	(70)
Finance and Operations, Buildings	(823)	(507)
Information Technology	(2,091)	(1,385)
Practice Institute	(95)	-
Science	(50)	-
Total	(3,330)	(1,962)
Net-Contribution to Replacement Fund	(3,012)	(4,462)
Total Operating Capital + Contribution to Replacement Fund	(6,342)	(6,424)
Capital Replacement Fund:		
Contributions	(3,012)	(4,462)
Replacement Fund Capital Expenditures		
Finance and Operations, Buildings	(2,566)	(4,067)
Replacement Fund Net Contributions Less Expenditures	\$ 446	\$ 395

- 1 2014 and 2015 are expected to be years of heavy investment in long term assets funded from the Capital
- 2 Replacement Reserve Fund, largely due to spending required for new tenant leases in the ADA
- 3 Headquarters Building. Therefore, in 2014 and 2015 withdraws from the fund are nearly as large as
- 4 contributions. Although this avoids the need for special assessments, the fund balance is not expected to
- 5 grow much until the future years.

List of Capital Expenditures (Page 1 of 3)

List of 2015 Capital Expenditures by Division					
Thousands of Dollars					
Division Name: Conferences and Continuing Education					
	<u>Q1</u>	<u>Q2</u>	<u>Q3</u>	<u>Q4</u>	<u>2015</u>
Camera Package for Auditorium	15				15
2nd FI Conf Center Furniture	40				40
Exec Dinning Room Catering & China Replacement	15				15
Total Division	70	0	0	0	70
Division Name: Information Technology					
	<u>Q1</u>	<u>Q2</u>	<u>Q3</u>	<u>Q4</u>	<u>2015</u>
High-Speed Scanners				12	12
22nd Floor AV Computer Hardware Upgrades			75		75
Annual Desktop Replacements		132			132
Annual Monitor Replacements				75	75
Annual B&W and Color Printer Replacements				45	45
Network Server Replacements & Network Upgrades				345	345
Annual BOT Laptop Replacement			29		29
Annual Laptop Replacement				219	219
22nd Floor AV Upgrades			40		40
Annual ARCServer Backup Software				10	10
Business Objects Software Upgrade				80	80
Reporting Tool Software Implementation				75	75
ADA Connect Redesign				20	20
MS SharePoint Plug Ins		15			15
ADA Connect (States & Members)		45			45
pmPoint Project Management (internal)			18		18
Telephone System Upgrade (AVAYA)				100	100
Mobile Point of Sale w/Aptify			25		25
Mobile Application Development		13		12	25
Total Division	0	205	187	993	1385

List of Capital Expenditures (Page 2 of 3)

List of 2015 Capital Expenditures by Division					
Thousands of Dollars					
Division Name: Finance & Operations					
	<u>Q1</u>	<u>Q2</u>	<u>Q3</u>	<u>Q4</u>	<u>2015</u>
Headquarters Building - Operating					
Repainting Stairwells		77			77
Replacement of Fire Pumps			120		120
Replacement of 2 Sump Pumps		60			60
DC Building - Operating					
Engineering Fees for Capital Work	20				20
Hallway Renovation		108			108
Electrical Work		6			6
Fire Life Safety		6			6
Plumbing-Buck Pumps			10		10
Common Area Stairwell & Machine Room		30			30
Garage Door Replacement				30	30
					14
Central Services					
Furniture Association-Wide		40			
Total Division	20	327	130	30	507

List of Capital Expenditures (Page 3 of 3)

List of 2015 Capital Expenditures by Division					
Thousands of Dollars					
Division Name: Finance & Operations					
	<u>Q1</u>	<u>Q2</u>	<u>Q3</u>	<u>Q4</u>	<u>2015</u>
Headquarters Building - From Capital Replacement Fund					
Tenant A TI&Comm	20				20
Israel Center for Excellence		32			32
Tenant K-TI&Comm	392				392
Tenant L-TI&Comm			1,123		1,123
Tenant M-TI&Comm		278			278
Spec Tenant C Comm			58		58
Spec Tenant d Comm				27	27
Spec Tenant e Comm				38	38
Spec Tenant f Comm				23	23
10th FL Common Corridor & Restrooms		190			190
Spec Floor (9th Fl)		1,021			1,021
9th Floor Common Corridor & Restrooms		190			190
Waterproofing 3rd & 23rd Mechanical Rooms			195		195
					-
DC Building - From Capital Replacement Fund					
Exterior Façade	250				250
New Lease	50				50
Renewal Lease		50			50
Renewal Lease			50		50
Leasing Fees-New	22				22
Leasing Fees-Ren		22			22
Leasing Fees-Ren2			22		22
Architectural & Construction Mgmt Fees			14		14
Total Division	734	1,783	1,462	88	4,067
	<u>Q1</u>	<u>Q2</u>	<u>Q3</u>	<u>Q4</u>	<u>2015</u>
Total ADA Operating Capital	90	532	317	1,023	1,962
Total ADA Capital Replacement Fund	734	1,783	1,462	88	4,067
Grand Total - 2015 Capital Requests	824	2,315	1,779	1,111	6,029

ADA Operations**2013 Variance versus 2013 Budget**

\$ 000

Budget Net ADA Operations - 2013				1,034
<u>Revenue variances - Central Admin and FinOps/Buildings</u>				
Membership dues	Unfavorable	Declining market share	(615)	
Royalty revenue	Favorable	ADABEI & CDT royalties	1,096	
Short-term investment earnings	Unfavorable		(403)	
Rental income	Favorable	Tenant early termination	567	
Remainder of variances	Unfavorable		(219)	426
<u>Expense variances - Compensation, Travel, Depreciation, and Income Taxes</u>				
Open positions	Favorable		1,201	
Temporary help	Unfavorable	Fill open positions	(693)	
Severance payments	Favorable	Less than expected	418	
Pension expense	Favorable	Lower interest rates	2,285	
Life insurance/disability costs	Favorable	Renegotiated contract	473	
Group medical insurance	Favorable	Renegotiated contract	635	
401k employer expense	Favorable	Open positions	289	
Remainder of compensation variances	Unfavorable		(144)	
Travel expenses	Unfavorable		(139)	
Depreciation expenses	Unfavorable		(111)	
Income taxes	Unfavorable	More profitable taxable net revenue	(517)	3,697
<u>Division variances (without salaries/travel/depreciation - includes revenues)</u>				
Contingency General	Favorable		226	
Legal Affairs	Favorable	Less usage of external legal counsel	452	
Government & Public Affairs	Favorable	SPA grants	806	
Communications	Favorable		209	
Member and Client Services	Favorable	Great West royalty	7,185	
Conferences and Continuing Education	Unfavorable	New Orleans annual meeting	(420)	
Product Development and Sales	Favorable	Increased product sales	1,391	
ADA Publishing	Unfavorable	Advertising revenues below budget	(307)	
Information Technology	Favorable		269	
Practice Institute	Favorable		159	
Science	Favorable		172	
Education	Favorable	Testing revenues exceeded budget	1,395	
Remainder of variances	Favorable		222	11,759
Total Variances				15,882
Actual Net ADA Operations				16,916

Headquarters Building Valuation

The House adopted Resolution 69H-2002 (*Trans.*2002:372), directing that the estimated market value of the ADA headquarters building be included in Board Report 2. The two most likely uses of the ADA building by a purchaser would be as an office building or a conversion to a residential property. The ADA's property management and leasing agent prepared a comprehensive HQ building valuation analysis based on a third party sale of the property as office space in the current Chicago market under several scenarios and arrived at an estimate of \$45.7 million. This valuation estimate takes current vacancies into consideration and this estimate will increase as more space is leased to tenants. This amount represents a gross selling price before any related sale and closing costs.

Appendix: Division Detail**American Dental Association Operations**

Revenue Summary by Division

\$ 000

	2012	2013	2014	2015	2015 v 2013		2015 v 2014B	
	Actual	Actual	Budget	Budget	Fav / (Unfav)		Fav / (Unfav)	
					\$	%	\$	%
Shared Services:								
Contingency General	-	100	-	-	(100)	-100.0%	-	NA
Administrative Services	-	-	-	-	-	NA	-	NA
Human Resources	-	-	-	-	-	NA	-	NA
Legal Affairs	76	60	85	70	10	17.0%	(15)	-17.7%
Finance and Operations, Buildings	7,378	6,804	5,311	6,269	(536)	-7.9%	958	18.0%
Central Administration	58,983	62,103	62,238	4,302	(57,801)	-93.1%	(57,936)	-93.1%
Information Technology	-	-	-	-	-	NA	-	NA
Total	66,437	69,067	67,634	10,641	(58,426)	-84.6%	(56,994)	-84.3%
Agencies:								
Education	19,224	20,155	20,539	25,247	5,093	25.3%	4,708	22.9%
ADA Publishing	9,222	9,574	10,034	9,049	(525)	-5.5%	(985)	-9.8%
Corp. Rel & Strat. Mkng Alliances	208	332	190	383	51	15.2%	193	101.5%
Conferences and Continuing Education	12,443	10,078	10,690	11,752	1,674	16.6%	1,062	9.9%
Product Development and Sales	9,019	9,618	8,586	9,331	(287)	-3.0%	746	8.7%
Communications	90	144	688	354	210	145.6%	(334)	-48.5%
Government & Public Affairs	55	256	30	126	(131)	-51.0%	96	322.8%
Division of Global Affairs	101	33	-	-	(33)	-100.0%	-	NA
Member and Client Services	1,931	8,906	2,205	66,509	57,602	646.8%	64,303	2915.9%
Practice Institute	101	349	748	403	54	15.4%	(345)	-46.1%
Health Policy Institute	131	45	70	200	155	344.5%	130	185.7%
Science	836	684	830	882	199	29.0%	52	6.3%
Total	53,361	60,174	54,609	124,236	64,062	106.5%	69,627	127.5%
Total ADA	119,797	129,241	122,244	134,877	5,635	4.4%	12,633	10.3%

American Dental Association Operations

Expense Summary by Division

\$ 000

	2012	2013	2014	2015	2015 v 2013		2015 v 2014B	
	Actual	Actual	Budget	Budget	Fav / (Unfav)		Fav / (Unfav)	
					\$	%	\$	%
Shared Services:								
Contingency General	216	893	1,000	1,000	(107)	-11.9%	-	0.0%
Administrative Services	5,522	5,529	5,787	5,907	(379)	-6.8%	(120)	-2.1%
Human Resources	1,666	1,854	2,081	2,024	(170)	-9.2%	56	2.7%
Legal Affairs	4,005	3,559	4,007	4,000	(440)	-12.4%	7	0.2%
Finance and Operations, Buildings	11,465	10,058	11,086	11,391	(1,333)	-13.3%	(305)	-2.7%
Central Administration	10,396	9,557	7,756	9,021	536	5.6%	(1,265)	-16.3%
Information Technology	8,995	9,387	11,418	12,880	(3,493)	-37.2%	(1,462)	-12.8%
Total	42,266	40,838	43,135	46,223	(5,386)	-13.2%	(3,088)	-7.2%
Agencies:								
Education	14,361	13,413	15,390	17,129	(3,716)	-27.7%	(1,739)	-11.3%
ADA Publishing	8,901	8,713	9,272	8,189	524	6.0%	1,083	11.7%
Corp. Rel & Strat. Mkng Alliances	1,048	1,119	924	1,485	(366)	-32.7%	(561)	-60.7%
Conferences and Continuing Education	9,617	8,009	9,525	10,421	(2,412)	-30.1%	(897)	-9.4%
Product Development and Sales	4,205	4,033	4,492	4,225	(192)	-4.8%	267	6.0%
Communications	4,197	4,900	6,022	6,120	(1,220)	-24.9%	(99)	-1.6%
Government & Public Affairs	8,512	8,469	9,023	8,962	(493)	-5.8%	61	0.7%
Division of Global Affairs	1,332	1,280	1,480	1,130	150	11.7%	351	23.7%
Member and Client Services	8,648	8,705	9,304	9,571	(865)	-9.9%	(266)	-2.9%
Practice Institute	4,220	3,849	5,020	5,437	(1,589)	-41.3%	(418)	-8.3%
Health Policy Institute	2,507	2,329	2,883	3,008	(679)	-29.2%	(125)	-4.3%
Science	5,678	4,852	6,185	5,527	(675)	-13.9%	658	10.6%
Total	73,225	69,671	79,521	81,204	(11,534)	-16.6%	(1,683)	-2.1%
Total ADA	115,491	110,508	122,657	127,428	(16,919)	-15.3%	(4,771)	-3.9%

American Dental Association Operations

1 Net Income Before Reserves
\$ 000

	2012	2013	2014	2015	2015 v 2013		2015 v 2014B	
	Actual	Actual	Budget	Budget	Fav / (Unfav)		Fav / (Unfav)	
					\$	%	\$	%
Shared Services:								
Contingency General	(216)	(793)	(1,000)	(1,000)	(207)	26.1%	-	0.0%
Administrative Services	(5,522)	(5,529)	(5,787)	(5,907)	(379)	6.8%	(120)	2.1%
Human_Resources	(1,666)	(1,854)	(2,081)	(2,024)	(170)	9.2%	56	-2.7%
Legal Affairs	(3,929)	(3,500)	(3,922)	(3,930)	(430)	12.3%	(8)	0.2%
Finance and Operations, Buildings	(4,088)	(3,254)	(5,775)	(5,122)	(1,868)	57.4%	653	-11.3%
Central Administration	48,588	52,546	54,482	(4,719)	(57,265)	-109.0%	(59,201)	-108.7%
Information Technology	(8,995)	(9,387)	(11,418)	(12,880)	(3,493)	37.2%	(1,462)	12.8%
Total	24,171	28,229	24,499	(35,582)	(63,812)	-226.0%	(60,082)	-245.2%
Agencies								
Education	4,863	6,742	5,149	8,119	1,377	20.4%	2,970	57.7%
ADA Publishing	321	861	761	859	(1)	-0.1%	98	12.9%
Corp. Rel & Strat. Mkng Alliances	(839)	(787)	(734)	(1,102)	(315)	40.0%	(368)	50.1%
Conferences and Continuing Education	2,827	2,069	1,165	1,330	(739)	-35.7%	165	14.2%
Product Development and Sales	4,813	5,585	4,093	5,106	(479)	-8.6%	1,013	24.8%
Communications	(4,107)	(4,756)	(5,334)	(5,766)	(1,011)	21.2%	(432)	8.1%
Government & Public Affairs	(8,457)	(8,212)	(8,994)	(8,836)	(624)	7.6%	157	-1.7%
Division of Global Affairs	(1,231)	(1,247)	(1,480)	(1,130)	117	-9.4%	351	-23.7%
Member and Client Services	(6,717)	201	(7,099)	56,938	56,737	28229.9%	64,037	-902.0%
Practice Institute	(4,119)	(3,499)	(4,272)	(5,034)	(1,535)	43.9%	(762)	17.8%
Health Policy Institute	(2,376)	(2,284)	(2,813)	(2,808)	(524)	23.0%	5	-0.2%
Science	(4,842)	(4,169)	(5,355)	(4,645)	(476)	11.4%	710	-13.3%
Total	(19,865)	(9,496)	(24,912)	43,032	52,528	-553.1%	67,944	-272.7%
Income Taxes	1,109	1,817	1,300	1,300	517	28.5%	-	0.0%
Total ADA	3,197	16,916	(1,713)	6,149	(10,767)	-63.6%	7,862	-459.0%
Transfers to Insurance Royalty Reserve				(6,000)				
Operating Surplus				149				

Resolutions

1
2
3
4
5

(See Resolution 21; Worksheet:2036)
(See Resolution 22; Worksheet:2037)

Report 2

Resolution No. 21 NewReport: Board Report 2 Date Submitted: July 2014Submitted By: Board of TrusteesReference Committee: A (Budget, Business and Administrative Matters)

Total Net Financial Implication:	\$ 134,877 (Revenue)	Net Dues Impact:	\$0
	\$ 128,728 (Ongoing Expense)		

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

ADA Strategic Plan Objective: None 2015 Budget Supports All Strategic Plan Objectives

How does this resolution increase member value: See Background

1 APPROVAL OF 2015 BUDGET

2 **Background:** (See Report 2 of the Board of Trustees to the House of Delegates: 2015 Budget,
3 Worksheet:2000). It should be noted that although budgeted revenue and expense result in net income
4 before reserves of \$6,149. The transfer of \$6,000 royalty revenue from ADA Members Insurance Plans
5 to a designated reserve then brings the operating budget to a surplus of \$149. This designated reserve
6 will be dedicated to member value, long term dues and financial stabilization as directed by the House of
7 Delegates Resolution 84H-2013 and Board action.

Resolution

8 **21. Resolved,** that the 2015 Annual Budget of revenues and expenses, including net capital
9 requirements be approved.

10 BOARD RECOMMENDATION: Vote Yes.**11 BOARD VOTE: UNANIMOUS*.****12 *Dr. Fair was absent****13** Res. 21 (Bd. Rpt. 2)

Resolution No. 22 NewReport: Board Report 2 Date Submitted: July 2014Submitted By: Board of TrusteesReference Committee: A (Budget, Business and Administrative Matters)Total Net Financial Implication: None Net Dues Impact: _____Amount One-time _____ Amount On-going _____ FTE 0

ADA Strategic Plan Objective: None 2015 Budget Supports All Strategic Plan Objectives

How does this resolution increase member value: See Background

1 **ESTABLISHMENT OF DUES EFFECTIVE JANUARY 1, 2015**

2 **Background:** The Board of Trustees at its July 2014 meeting approved a preliminary budget with net
3 income before reserves of \$6,149,000 based on the current full dues rate of five hundred and twenty-two
4 dollars (\$ 522). After planned transfer of \$ 6,000,000 in Member Insurance royalties into a designated
5 reserve fund, the net operating surplus is \$149,000. A dues increase is not being sought. Notification of
6 the proposed dues level will be circulated electronically to all constituent dental societies and announced
7 in an official Association publication. The following resolution is submitted by the Board of Trustees.

8 **Resolution**

22. Resolved, that the dues of ADA active members shall be five hundred twenty-two dollars
(\$522.00), effective January 1, 2015.

9 **BOARD RECOMMENDATION: Vote Yes.**

10 **BOARD VOTE: UNANIMOUS*.**

11 ***Dr. Fair was absent.**

Res. 22 (Bd. Rpt. 2)

Resolution No. None N/AReport: Board Report 4 Date Submitted: June 2014Submitted By: Board of TrusteesReference Committee: A (Budget, Business and Administrative Matters)Total Net Financial Implication: None Net Dues Impact: _____Amount One-time _____ Amount On-going _____ FTE 0

ADA Strategic Plan Objective: None

REPORT 4 OF THE BOARD OF TRUSTEES TO THE HOUSE OF DELEGATES: STRATEGIC PLANNING ANNUAL REPORT

Background: The Board of Trustees is pleased to present Members First 2020, the next strategic plan for the Association. This report will provide a summary of the development of the plan and its key elements.

In 2012, the House urged the Board “to seek input from communities of interest, including representatives from the House of Delegates, in the development of the ADA Strategic Plan”, Res. 82H-2012 (*Trans.*2012:517). That year, in furtherance of the House resolution, the Board established the Strategic Plan Steering Committee to oversee development of the next strategic plan. The initial committee members were Trustees Drs. Hilton Israelson (chair), Roger Kiesling and Mark Zust, and House of Delegate members Drs. James Antoon and Thomas Paumier. Ex officio members were the President, President-Elect and the Executive Director. In 2013-2014 Dr. Alvin (Red) Stevens was appointed to the committee, replacing Dr. Kiesling.

Since that time, the Committee undertook significant effort to seek input from many communities of interest. This report will summarize the process followed and the resulting plan, Members First 2020.

External Environmental Scanning: An essential step to develop a new strategic plan is external environmental scanning. The goal of environmental scanning is to alert decision makers to potentially significant external changes before they crystallize, so that decision makers have sufficient lead time to react and incorporate these factors into the strategic planning process.

The Strategic Planning Steering Committee requested that the ADA’s Health Policy Resources Center lead the environmental scan. A full report on the scanning results, *A Profession in Transition: Key Forces Reshaping the Dental Landscape*, may be found at <http://www.ada.org/escan.aspx>. (The report was also attached to 2013 Board Report 8.)

Key findings from the scanning related to important structural changes which have occurred in the dental care sector in recent years:

- Utilization of dental care has declined among working age adults, particularly the young and the poor, a trend that is unrelated to the recent economic downturn.
- Dental benefits coverage for adults has steadily eroded in the past decade, again particularly for young and poor adults. Not surprisingly, more and more adults in all income groups are experiencing financial barriers to care.
- Total dental spending in the U.S. slowed considerably in the early 2000s and has been flat since 2008, with public financing accounting for an increasing share.
- Trends for children are very different than for adults. Dental care utilization among children has increased steadily in the past decade, a trend driven entirely by gains among poor and near-poor

children. The percent of children who lack dental benefits has declined, driven by the expansion of public programs.

- The shifting patterns of dental care utilization and spending have had a major impact on dentists. Average net incomes declined considerably beginning in the mid-2000s. They have held steady since 2009 but have not rebounded. Two out of five dentists indicate they are not busy enough and can see more patients, a significant increase over past years.
- Most importantly, all of these trends were established well before the recent economic downturn.

It is a critical moment for dentistry and a time for the profession to define its destiny. Given the significant environmental changes occurring and on the horizon, this is a watershed moment for the profession. It is not a time for complacency. Understanding the key forces at work will assist the profession in defining its own destiny. Ignoring what is happening in the health and consumer environment will mean ceding the future of the profession to others. This first step of scanning the environment through thoughtful, objective, empirical research provided the ADA with key facts and information needed to help shape a strategy for navigating the challenges ahead and charting a course for the dental profession.

Internal Scan: Similar to the external environmental scan, the internal scan informs the Association about the thoughts, priorities and concerns of internal stakeholders, including the Board, the House, Staff and general members. ADA strategic plan consultants, OPIS LLC, conducted confidential telephone and in person interviews with current Board officers, trustees, delegates, past presidents, state presidents and executive directors, new dentists and ADA senior staff.

The purpose of the interviews was to get each leaders input on their perception of the mission of the organization, factors that help or hinder the achievement of that mission, the ADA's strengths and weaknesses and key issues facing the profession. In addition, the consultants conducted focus groups of general ADA members at the 2013 Annual Session.

At the 2013 House of Delegates meeting, the Steering Committee hosted an open forum to seek even more input into the developing plan. The Committee was pleased with the large showing for this open forum and the valuable input from House members to the developing plan. In December 2013, the entire ADA Board, council chairs and co-chairs, and ADA senior staff and council directors met for an entire day to develop strategies the ADA will follow under the plan. The Board subsequently refined those strategies, which are now part of Members First 2020. Finally, the Steering Committee hosted a Stakeholders Meeting of 50 state and local volunteer leaders, executive directors, ADA volunteer leaders and ADA staff prior to finalizing an initial draft Plan. This meeting built on the 2013 mega topic and focused on the respective roles of each part of the ADA Organization, national, state and local.

Board Approval: At its March meeting, the Board thoroughly reviewed the draft plan and approved Members First 2020 as the next plan of the American Dental Association. Although this plan will not go into effect until January 1, 2015, the Association needed it to be finalized in time to properly inform the budget development process. The Board appreciates the hard and productive work of the Steering Committee and wishes to recognize the many others—House members and state, local and national volunteers and staff and general members—who provided such valuable input into the development of this new plan.

Members First 2020: A copy of Members First 2020 is attached here as Appendix 1 and can be found on ADA.org <http://www.ada.org/strategicplan.aspx>. The following reviews the critical components of this new plan, and addresses the Association's ongoing commitment to public health.

The strategic plan is built around (1) a mission statement, (2) a statement of core values, (3) goals, (4) objectives and (5) strategies. These key elements of the plan are described below. In addition, the ADA retained its existing vision statement, "The American Dental Association: To be the recognized leader on oral health."

The mission statement is the primary filter to be used for all major ADA decisions—we must constantly be moving towards achieving this mission statement. The new ADA mission statement is *Helping All Members*

Succeed. The focus of the mission statement is on members. Through members, we will advance the public health and, without the success of the Association members, the ADA cannot exist.

The core values statement is meant to reflect who we are. It is not an aspirational statement but a test against which ADA decisions need to be measured. The core values statement is the result of extensive and successive work of staff workgroups, senior staff, the Steering Committee and the Board. ADA core values are:

- Commitment to Members
- Integrity
- Excellence
- Commitment to the Improvement of Oral Health
- Science/Evidence-Based

Goals are aspirational statements of desired outcomes – they are neither specific nor measurable. Goals are intended to continue throughout the five years of the plan without change. Under this plan, the three goals are the necessary conditions for successfully navigating the future. They are listed (not in order of importance, as all are equally weighted):

- Membership: The ADA will increase member value and engagement
- Finance: The ADA will be financially sustainable
- Organizational Capacity: All levels of the ADA will have sufficient organizational capacity necessary to meet member needs

Objectives are specific measureable statements of desired output. Because objectives are measurable, they may be altered if the targets are met or circumstances changes. Members First 2020 has six objectives:

- The public will recognize the ADA and its members as leaders and advocates in oral health.
- ADA's member market share will equal at least 70% of active licensed dentists.
- ADA will achieve a 10% increase in the assessment of member value from membership.
- Unrestricted liquid reserves will be targeted at no less than 50% of annual operating expenses.
- Non-dues revenue will be at least 65% of total revenue.
- The roles and responsibilities of each element of the tripartite will be clearly defined and agreed upon.

Strategies describe what will be done to meet the objectives. Strategies need to be revisited often and modified as needed. In December 2013 the Board, council chairs and co-chairs, ADA senior staff and council directors met for a daylong session to develop the strategies under the Members First 2020 plan. The Committee and the Board then refined the specific strategies included in Members First 2020. Tactics will be developed by staff and councils to carry these strategies out.

An ongoing commitment to public health remains an integral part of the Association's work. The Steering Committee and the Board heard concern that the new plan may represent a turning away by the Association of its obligations to the public. That is not the case. The ADA remains committed to advancing the health of the public and this is made clear in several important ways.

First, the ADA's commitment is evident in several ways outside the plan:

- The ADA *Constitution* describes as one of the objects of the Association "to encourage the improvement of the health of the public." ADA *Constitution*, Article. II.
- The Association funds the work of the American Dental Association Foundation.
- The work of the Council on Access, Prevention and Interprofessional Relations continues to focus on public health.
- A major initiative of the ADA is the Action for Dental Health, a collection of initiatives to address access to care by the public.

Second, ADA mission statement, Helping All Members Succeed, illustrates a key approach to improving public health. We will advance public health *through* and *on behalf of* ADA members. To be able to do this, members must be successful in their profession.

Third, in developing Members First 2020, although not included in the Strategic Plan document, the Association made a conscious decision to retain its vision statement: The American Dental Association: To be the recognized leader on oral health. This reflects the ADA's continued desired contribution to society.

Fourth, Members First 2020 lists as one of five core values guiding the Association, Commitment to the Improvement of Oral Health.

Fifth, the very first objective listed in Members First 2020 is "The public will recognize the ADA and its members as leaders and advocates in oral health." The Board of Trustees identified strategies under this objective including:

- Align public awareness efforts across the tripartite concerning oral health issues
- Promote oral health through advocacy and science.

Implementation of Members First 2020: An excellent strategic plan has no value if it is not implemented. The plan needs to guide all decisions by the House, the Board and staff. It also needs to be monitored on an ongoing basis. The simplicity of the new plan will help make this possible. In addition, the Board has created a new Strategic Planning Committee to aid the Board in this work. That committee will come into place after the 2014 House and will include representatives of the House of Delegates.

Conclusion: The Board believes the Association has a valuable strategic tool in this new plan. It is focused and easy to understand. More important, it is implementable; we can turn the plan into real action and real progress. To do so, we must all work together and allow Members First to guide association decisions. We need to ask ourselves at all decision points: Does this action advance the Association in meeting its strategic plan goals and objectives? Does this action advance the ADA mission? And, is this action consistent with the core values? This work must be done by the House as it considers resolutions and by the Board, staff and councils, as we implement those resolutions.

Resolutions

This report is informational and no resolutions are presented.

BOARD RECOMMENDATION: Vote Yes to Transmit.

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

Appendix 1

**Members First 2020
Strategic Plan 2015-2019**

ADA Mission Statement: Helping all members succeed.

Core Values:

- Commitment to Members
- Integrity
- Excellence
- Commitment to the Improvement of Oral Health
- Science/Evidence-Based

Membership Goal: The ADA will increase member value and engagement.

Objective 1: The public will recognize the ADA and its members as leaders and advocates in oral health.

- 1.1 Align public awareness efforts across the tripartite concerning oral health issues*
- 1.2 Position ADA membership as a positive differentiating factor for patients*
- 1.3 Promote oral health through advocacy and science*

Objective 2: ADA's member market share will equal at least 70% of active licensed dentists.

- 2.1 Develop and implement collaborative programs with entities that have access to large pools of potential members*
- 2.2 Design unique member benefit programs targeting market segments*

Objective 3: ADA will achieve a 10% increase in the assessment of member value from membership.

- 3.1 Pursue programs that members value and are "Best in class"*

Finance Goal: The ADA will be financially sustainable.

Objective 4: Unrestricted liquid reserves will be targeted at no less than 50% of annual operating expenses.

- 4.1 Budget for a surplus consistently year to year*

Objective 5: Non dues revenue will be at least 65% of total revenue

- 5.1 Develop cooperative ways to increase non-dues revenue across the tripartite*
- 5.2 Increase member utilization of existing products and services and pursue new markets*

Organizational Capacity Goal: All levels of the ADA will have sufficient organizational capacity necessary to meet member needs.

Objective 6: The roles and responsibilities of each element of the tripartite will be clearly defined and agreed upon.

- 6.1 Act in the best interest of the member, rather than the organization when designing processes, programs and services*

Resolution No. None N/AReport: Board Report 5 Date Submitted: July 2014Submitted By: Board of TrusteesReference Committee: A (Budget, Business and Administrative Matters)Total Net Financial Implication: None Net Dues Impact: _____Amount One-time _____ Amount On-going _____ FTE 0

How does this resolution increase member value: See Background

REPORT 5 OF THE BOARD OF TRUSTEES TO THE HOUSE OF DELEGATES: COMPENSATION AND CONTRACT RELATING TO THE EXECUTIVE DIRECTOR

Background: This report is provided for informational purposes and does not include any resolutions. In June 2012, the Board of Trustees executed a second three-year employment agreement with the current Executive Director, which expires on March 31, 2015. The Executive Director is the only member of the ADA staff with a written employment contract.

Compensation and Benefits: The Executive Director's current annual base salary is \$450,000 and is paid in accordance with the Association's standard payroll schedule and policies. The current salary level was set in 2012 based on external review by Sullivan and Cotter of comparable compensation for Executive Directors at national not-for-profit associations with revenues generally above \$100 million. The comparable median market base salary at that time was \$541,496.

The contract provides that the Executive Director's performance is to be reviewed by the Board on an approximately annual basis or more frequently, as deemed appropriate by the Board, at the Board's sole discretion. The Executive Director is eligible to receive an annual bonus ranging from 0%-3% of her base salary, as determined by the Board, based upon criteria jointly approved by the Executive Director and the Board, and subject to the availability of funds.

In March 2014, the Executive Director received a bonus in the amount of \$22,500 (5% of base), based on the assessment of 2013 performance which exceeded the goals that had been set. Of particular note was a \$16 million budget surplus. The Board exercised its discretion to provide a bonus amount that included a portion worth 2% of base in lieu of increasing base salary.

Periodically, the Board collects data from outside consultants and various published reports in order to compare the compensation and benefits package of the Executive Director to packages offered by other similarly sized non-profit organizations. This year, a consultant, Arthur J. Gallagher & Company, will conduct a market analysis of the compensation package for the Executive Director during July through September 2014.

The Executive Director is entitled to the fringe benefits offered during the term of this Agreement similarly situated Association employees having her length of service in the employ of the Association; provided, however, that such fringe benefits do not include "Severance Pay" under the ADA Employee Handbook or any other ADA policy or procedure relating to severance pay because such severance pay is covered by the terms of the employment contract.

Additional fringe benefits include a \$5,000 annual contribution to the Great-West Variable Annuity Plan; a parking space in the Association Headquarters building; the reimbursement of reasonable, substantiated

1 expenses incurred to purchase and maintain a membership in one city or athletic club in the Chicago
2 area; one cellular telephone, spousal travel to the Association's annual session; and membership dues in
3 professional associations (except the dues of the American Dental Association and its constituent and
4 component dental societies).

5 **Resolutions**

6 This report is informational and no resolutions are presented.

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

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

10 ***Dr. Fair was absent.**

Resolution No. None N/AReport: Board Report 6 Date Submitted: July 2014Submitted By: Board of TrusteesReference Committee: A (Budget, Business and Administrative Matters)Total Net Financial Implication: None Net Dues Impact: Amount One-time Amount On-going FTE 0

ADA Strategic Plan Objective: Finance-Obj. 4: Unrestricted liquid reserves targeted at no less than 50%.

How does this resolution increase member value: See Background

1 **REPORT 6 OF THE BOARD OF TRUSTEES TO THE HOUSE OF DELEGATES: INFORMATION**
 2 **TECHNOLOGY INITIATIVES, EXPENDITURES AND ESTIMATED COSTS, AND ANTICIPATED**
 3 **FUTURE PROJECTS**
 4

5 **Background:** This report to the House of Delegates on the ADA's Information Technology initiatives,
 6 expenditures and future projects is submitted as required by Resolution 30H-2003 (*Trans.2003:334*),
 7 which urged the Board to provide an annual report summarizing technology initiatives, expenditures,
 8 estimated costs, anticipated projects and their sources of funding.

9 The Division of Information Technology (IT) uses an established plan to provide technology staff with the
 10 goals and objectives necessary to support the ADA Strategic Plan. This plan allows the IT division to
 11 address immediate issues and the opportunity to provide quality information technology operations to
 12 service ADA members and the tripartite.

13 **Overview:** This executive summary provides an overview on IT-related projects that were completed in
 14 2013, planned projects for 2014 and projected projects for 2015. Further details on all projects can be
 15 found in the detailed report. This report is informational only; there are no resolutions.

16 **Year 2014 Projects and Expenditures:** In 2014, the IT division continues to move forward with projects
 17 in its core areas. As of this report, the following projects are completed and others are currently in the
 18 working stages with a completion goal by the end of the year.

- 19 • *Document Management (FileWeb).* The Association implemented Open Text Livelink as its
 20 document management system in 2002. This system, which was branded "ADA FileWeb", allows
 21 ADA staff to store and share documents. An upgrade to improve the user interface as well as
 22 provide new user functionalities and features was completed in March 2012. In 2013, an outside
 23 IT consulting firm was retained to assist staff with completing a planning effort, which included a
 24 project scope and budget to migrate away from Open Text Livelink to a Microsoft (MS)
 25 SharePoint solution. Cross-divisional Work Teams were established to define system
 26 requirements documentation and define business processes. In addition, a small upgrade to the
 27 Livelink environment was completed. In 2014, a Request for Proposal (RFP) was sent to MS
 28 SharePoint vendors to assist with the development and implementation of a new ADA Knowledge
 29 Center. This new Knowledge Center will be supported by a MS SharePoint solution and will
 30 replace ADA FileWeb. A vendor has been retained and the project is scheduled to officially
 31 kickoff in July and is anticipated to be completed in June 2015. The ADA is currently reviewing
 32 documents stored on shared drives and ADA FileWeb and performing a cleanup effort to review
 33 and delete any unused or outdated documents.

- 1 • *Data Warehouse.* In 2013, work began on developing a reporting strategy for the ADA. This
2 strategy will ensure data required for reporting is centrally located and standardized methods for
3 creating reports are developed and implemented across the ADA. A cross-divisional Work Team
4 was established to gather software feature and functionality requirements. In 2014, vendor
5 demonstrations have been scheduled and are currently being conducted. The purchase and
6 implementation of a new front-end software tool along with an upgrade to Business Objects, the
7 back-end software tool are scheduled for 2015. Any requests in 2014 or 2015 for new data marts
8 or enhancements to existing data marts will be completed using existing IT staff
- 9 • *ADA.org Reorganization.* In 2013, a project began to move ADA.org and all related microsites
10 from OpenText RedDot, the ADA's old content management software to SiteCore, the ADA's new
11 content management software solution. This website reorganization ensures that the ADA.org
12 matches the brand enhancements that currently exist on MouthHealthy.org, the ADA's consumer
13 website and the Center for Professional Success (CPS) website and improves overall site
14 navigation and content. This project went into production in April 2014. As part of this project,
15 the Evidence-Based Dentistry (EBD) website was also rewritten and updated to address some
16 underlying performance issues. A thorough site review was conducted with Science staff to
17 understand EBD workflows and processes and to identify needed improvements. The new EBD
18 application also launched in April 2014. In addition new mapping software was purchased and
19 implemented onto ADA.org to support the "Action to Dental Health" program. This developed
20 software will be used to display maps overlaid with eight (8) data layers showing where Action for
21 Dental Health initiatives have occurred. An upgrade to the ADA's web analytics software was
22 completed in May 2014. This upgrade provides improved features, functionality and reporting on
23 web traffic. In 2015, site support including updates and enhancements will be completed through
24 a combination of outside IT consulting and internal ADA staff.
- 25 • *Center for Professional Success.* The Center for Professional Success (CPS) website was
26 released into production in September 2013 and officially launched at annual session in October.
27 This new web resource and member benefit provides dentists with an online tool to help with the
28 day-to-day business management of their practices. The website is organized into three (3)
29 areas: Practice, Live, and Learn and is highly interactive with news feeds, trends trackers,
30 research, quality of life, improved video capabilities and financial calculators. On-going content
31 updates will occur throughout 2014, which will include an online financial analyzer tool that ADA
32 members can use to access financial outcomes of network participation. This tool is scheduled to
33 launch in August 2014. In 2015, any programming changes will be completed using existing IT
34 staff.
- 35 • *Mobility.* In 2013, the ADA continued to expand its mobile offerings and capabilities. Mobile
36 applications for Annual Session and the New Dentists' Conference were deployed for the iPhone,
37 Android and Blackberry platforms. These apps allow meeting attendees to locate exhibitors, find
38 continuing education class times and locations and other relevant meeting information. Work is
39 underway on both applications to expand features and functionality in 2014. The CDT mobile
40 app was also updated in 2013 to provide new, revised and changed CDT codes as well as
41 provide an auto-renewing subscription feature that allows users to download and pay for updates
42 as they are pushed out. This application is currently being redesigned onto Apple's most current
43 platform and is scheduled for deployment in early October. A Toothflix Videos mobile application
44 was developed and released in September 2013. This product was previously sold only in DVD
45 format from the ADA Catalog and the Patient Smart web portal. Mobilizing this product provided
46 another format for ADA members to use this educational resource. In 2014, work is underway to
47 expand this app by adding Spanish versions of the videos. The Oral Pathologist and Symptom
48 Checker apps were launched in 2013 in conjunction with the CPS website. In 2014 and 2015,
49 updates and enhancements to existing apps will continue. The majority of this work will be
50 completed by existing IT staff with outside IT consulting retained as needed.

- 1 • *ADA Connect.* In 2013, enhancements were implemented for the 2013 House of Delegates,
2 which made it easier for resolutions to be created and edited. A new Board of Trustees area was
3 added and launched at the June 2013 Board meeting. In 2014, the MS SharePoint environment,
4 which is the platform for ADA Connect will continue to be supported and updated as needed. In
5 2015, MS SharePoint Plug-in software will be purchased that expands the functionality and adds
6 features that will improve document and process management in ADA Connect. New projects in
7 2015 include an overall ADA Connect site redesign and investigating the implementation of new
8 hosted sites for ADA members and the states.
- 9 • *PeopleSoft.* A PeopleTools upgrade to the latest version was completed in 2013. People Tools
10 is the software development environment used by IT developers to create and customize
11 PeopleSoft applications. This upgrade ensured that developers are using the most current
12 software development environment that is compatible with the recent upgrades to the Finance
13 and Human Resource Management (HRMS) systems. An upgrade was also completed in 2013
14 to AdManager Pro, the system used by Publishing staff to manage advertising for *JADA* and *ADA*
15 *News*. This upgrade included rewriting and implementing a new billing interface from AdManager
16 Pro to PeopleSoft. Also in 2013, Oracle's Talent Management solution was purchased. This
17 solution tightly integrates with the PeopleSoft HRMS as they are both Oracle-owned products.
18 This hosted software service will improve many aspects of the eRecruitment operation by
19 providing HR recruiters the flexibility to have extra resources without hiring additional staff. It
20 consolidates key activities such as posting jobs and searching for candidates into a single action
21 and reduces the need for repetitive tasks. It reduces manual entries and time spent on reviewing
22 resumes. This service provides features that quickly link applicants' skills to posted job
23 descriptions. It also reduces the applicants' time filling out multiple pages of web forms thus
24 giving them a more modern, less burdensome and more positive experience as they interact with
25 the ADA and our technology for the first time. This new system implementation is underway and
26 is scheduled to go into production in August. In 2015, a project is planned to begin researching a
27 replacement for PeopleSoft Finance and HRMS. Oracle has informed the ADA that they are
28 eliminating their mid-sized PeopleSoft market and replacing it with a product called Fusion. As
29 part of the replacement planning, a cross-divisional Work Team will be established with Finance
30 and HR staff to look at this new Oracle product as well as other products that will meet the ADA's
31 business requirements.
- 32 • *Hyperion Plan Tool.* In 2013, additional system enhancements were identified by Finance staff
33 and were implemented. In addition to ongoing system enhancement work, outside IT consultants
34 were retained to complete a system audit and to interview budget administrators on their
35 experiences with Hyperion. A system roadmap was developed and presented to appropriate
36 senior staff. The roadmap was prioritized to identify work needing completion in 2013 in time for
37 the 2015 budget cycle and what work could be done in 2014. A system upgrade is also
38 scheduled for 2014, which will bring Hyperion to the most current version. In 2015, any system
39 enhancements or updates will be completed using a combination of existing IT staff and outside
40 IT consultants.
- 41 • *Tripartite System.* In 2012, work began on transitioning from the Tripartite System (TS) to Aptify.
42 The system conversion was completed in October 2013. Once the ADA conversion was
43 completed, a plan was developed to begin converting states and local societies currently using
44 TS as their membership management system to Aptify. The ADA purchased enterprise licensing,
45 which allows all current TS sites to move to Aptify as well as any new sites to come on to Aptify if
46 they so choose. TS continues to be supported for those state and local societies currently using
47 it as their conversion to Aptify is being scheduled.
- 48 • *Infrastructure, Hardware and Software Licenses.* The expenditures reflected in 2013, 2014 and
49 2015 are primarily for hardware and software licenses to maintain the Association's network
50 infrastructure as well as provide end-user equipment such as desktops, laptops and printers. In
51 addition, funding is budgeted annually for a manufacturer-certified on-site technician. As part of

the network server maintenance agreement, this technician is available on-site to fix hardware under warranty instead of depending on “depot warranty service.” This on-site service minimizes downtime for users. As part of the ADA’s continued effort to maintain PCI compliance, a PCI Risk Assessment and Discovery was done on the ADA’s network infrastructure in 2013. This work helped IT staff assess the areas where potential PCI technology risks may occur and implement solutions were needed. In 2014, software and hardware upgrades will be done in the ADA Board Room. Telephone system upgrades are planned for Chicago and Washington DC. Microsoft SQL licenses were purchased to upgrade database servers and Microsoft Office 2013 was purchased to upgrade end-user software tools such as Word, Excel, PowerPoint and Outlook. Staff training is scheduled for this summer and the rollout is scheduled to start in August and be completed by November. In 2015, audio-visual upgrades are planned for the Executive Conference Room and Video Conference Room on the 22nd Floor and a telephone system upgrade is planned for Chicago to maintain software compliance.

- *Aptify.* The ADA implemented the Aptify Association Management System for the ADA’s Call Center, Marketing and Campaign Management, and eCatalog environments in January 2012 replacing the Siebel Customer Relationship Management system. In October 2013, Aptify was deployed at the ADA for membership and event functions replacing the Tripartite System. Once the ADA conversion from TS to Aptify was completed, a plan was developed to convert state and local societies currently using TS as their membership management system to Aptify. Throughout the remainder of 2013, the Aptify team conducted TS/Aptify Awareness programs with current and non-current states to clarify Aptify’s software capabilities for the Tripartite. At their December 2013 meeting, the Board approved \$602,540 to be funded from the ADA’s Reserve account to fund an accelerated Aptify deployment schedule beginning in 2014. This funding covers travel for ADA staff to deployment sites, training and travel for state and local staff, outside IT consulting support to cover the day-to-day job duties of ADA staff traveling to deployment sites and outside consulting services to develop web templates that integrate with Aptify for the state and local society staff to maintain their websites. In February 2014, state deployments of Aptify began with the New Hampshire Dental Society followed by Virginia Dental Association, Minnesota Dental Association, Nevada Dental Association and Indiana Dental Association. The following states are also scheduled for Aptify implementations in 2014: North Carolina, Florida, Washington State, Connecticut, Louisiana, Arizona, Idaho, Mississippi, Vermont, Kentucky and Washington DC. In addition to deployments, the development and implementation of a Legislative module and Peer Review module will also be completed in 2014. These modules will be used for grassroots efforts by the ADA, state and local societies. Additional Education licenses were purchased to support the two (2) separate Education environments within Aptify. The current Education area allows for the Department of Testing Services (DTS) to manage test applications and scores. The second Education area will support the Learning Management system. A goal of 26 deployments is set for 2015. As of this report, Iowa, Oregon, Arkansas, Georgia, Colorado and Illinois are scheduled with the remaining states to be identified and scheduled. The funding needed for the 2015 deployment schedule has been added to IT’s operating budget.
- *Aptify/Learning Management System.* The Aptify Education and eLearning/Learning Management System (LMS) modules provide Continuing Education (CE) and Online Learning Management services that replaced the CE module within the Tripartite System. This system provides new functionality to allow online delivery of CE programs and to facilitate and manage the Tripartite’s online CE activities and provides a variety of other learning activities for ADA members, non-members and ADA staff. This program provides a standardized software platform that leverages existing technology investments to create and distribute learning activities. This system was deployed in October 2013 along with the Membership and Events modules. Work is underway to install and set up the LMS for the Human Resources (HR) department. HR staff will use this module to manage learning activities for all ADA staff. In 2015, any system

enhancements and fixes will be prioritized and implemented using existing IT staff with outside IT consulting services being retained to assist when needed.

- *Aptify/DTS Conversion.* In 2013, Aptify's Education module was implemented in the Department of Testing Services (DTS), which replaced over-developed and antiquated Statistical Analysis Software (SAS) applications. This implementation resulted in improved system performance, as well as offered new and improved system features and functionality for the users. A new process was also developed to import paper application files into Aptify and a system enhancement developed to transmit these files to Prometric, the vendor used by DTS for test development and test delivery. In addition, work began on migrating outdated custom software applications that manage the online application and payment processes from ADA.org to Aptify's eBusiness module. This migration will eliminate custom application support, reduce credit card fees and remove custom integrations. It will also streamline operational efforts between DTS and Accounting for credit card and payment processing, which are currently done manually by both departments. This system is scheduled to go into production in July 2014. In 2015, system enhancements and fixes will be prioritized and implemented using existing IT staff with outside IT consulting services being retained to assist when needed.

The table below outlines actual expenditures in the core areas in 2013; projected spending in 2014 and planned spending in 2015. Also disclosed is spending related to infrastructure hardware and major projects.

IT Core Area	2013 Actual Spending	2014 Projected Spending	2015 Planned Spending
FileWeb	1,200	630,350	359,948
FileWeb (ADA Reserves)	150,000	0	0
Data Warehouse	0	0	265,000
Internet	238,937	252,420	15,000
Ctr. for Professional Success (CPS)	228,543	34,666	0
Mobile Applications	27,350	57,400	55,000
ADA Connect	13,283	15,000	95,000
PeopleSoft	132,908	21,250	25,000
Hyperion Budgeting Plan Tool	90,740	106,000	30,000
Tripartite System	0	0	0
Infrastructure, Hardware & Software Licenses	740,734	1,459,855	1,227,000
Aptify	542,178	254,020	861,700
Aptify Rollouts (ADA Reserves)	0	602,540	0
Total Project Spending	2,165,873	3,433,501	2,933,648
Balance of IT Operating Budget	8,879,031	10,133,746	11,593,580
Total IT Spending	\$11,044,904	13,567,247	14,527,228

The tables below summarize the previous information based on the source of funding. The IT division continues to maintain and upgrade its current core areas while also providing ongoing support and completing various IT-related projects for ADA divisions.

1

2013 Actual Spending	Operating Budget	Capital Budget	Total
FileWeb (1)	151,200	0	151,200
Data Warehouse	0	0	0
Internet (2)	74,754	164,183	238,937
Ctr. for Professional Success (3)	2,500	226,043	228,543
Mobile Applications (4)	4,950	22,400	27,350
ADA Connect (5)	13,283	0	13,283
PeopleSoft (6)	14,393	118,515	132,908
Hyperion Budgeting Plan Tool (7)	59,060	31,680	90,740
Tripartite System	0	0	0
Infrastructure, Hardware & Software Licenses (8)	132,829	607,905	740,734
Aptify (9)	55,000	487,178	542,178
Total Project Spending	507,969	1,657,904	2,165,873
Balance of IT Operating Budget	8,879,031	0	8,879,031
Total IT Spending	<u>\$9,387,000</u>	<u>\$1,657,904</u>	<u>\$11,044,904</u>

2

3

1

2013 Consulting Projects	Operating Budget	Capital Budget	Total Actual Spending
FileWeb Upgrade & Support	1,200	0	1,200
FileWeb Replacement Planning	150,000	0	150,000
FileWeb Totals (1)	151,200	0	151,200
Data Warehouse (DW) Totals	0	0	0
ADA.org Re-Organization	54,166	138,433	192,599
EBD Website support	3,663	0	3,663
Web Analytics Software Upgrade	16,925	3,750	20,675
SiteCore Content Management	0	22,000	22,000
Internet Totals (2)	74,754	164,183	238,937
Ctr. for Professional Success (CPS) Website	2,500	187,500	190,000
Oral Pathologist Mobile Application	0	21,210	21,210
Financial Analyzer Tool Implementation	0	17,333	17,333
CPS Totals (3)	2,500	226,043	228,543
NDC Mobile Application	3,000	0	3,000
CDT Mobile Application	0	12,000	12,000
Toothflix Mobile Application	0	10,400	10,400
Ongoing Mobile Application support	1,950	0	1,950
Mobile Application Totals (4)	4,950	22,400	27,350
MS SharePoint support	13,283	0	13,283
ADA Connect Totals (5)	13,283	0	13,283
PeopleSoft Tools Upgrade	13,330	55,645	68,975
Talent Management Service	1,063	0	1,063
AdManager Pro Upgrade	0	62,870	62,870
PeopleSoft Totals (6)	14,393	118,515	132,908
Hyperion Plan Tool Support	19,920	0	19,920
Hyperion Plan Tool Audit	39,140	0	39,140
Hyperion Plan Tool Enhancements	0	31,680	31,680
Hyperion PlanTool Totals (7)	59,060	31,680	90,740
Tripartite System (TS) Totals	0	0	0
Warranty Technician	69,198	0	69,198
Network Security	16,825	0	16,825
Operating Software	46,806	0	46,806
Capital Hardware	0	382,383	382,383
Capital Software	0	34,218	34,218
Network Infrastructure	0	191,304	191,304
Infrastructure Totals (8)	132,829	607,905	740,734
Aptify/TS Conversion/Events	40,000	425,378	465,378
Aptify LMS	15,000	45,000	60,000
Aptify/DTS Paper Applications	0	16,800	16,800
Aptify Totals (9)	55,000	487,178	542,178
2013 Grand Totals	507,969	1,657,904	2,165,873

1

IT Core Area

2014 Projected Spending	Operating Budget	Capital Budget	Total
FileWeb (1)	230,123	400,227	630,350
Data Warehouse	0	0	0
Internet (2)	91,846	160,574	252,420
Ctr for Professional Success (3)	0	34,666	34,666
Mobile Applications (4)	32,400	25,000	57,400
ADA Connect (5)	15,000	0	15,000
PeopleSoft (6)	6,325	14,925	21,250
Tripartite System	0	0	0
Hyperion Budgeting PlanTool (7)	56,000	50,000	106,000
Infrastructure, Hardware & Software Licenses (8)	145,000	1,314,855	1,459,855
Aptify (9)	105,020	149,000	254,020
Aptify Rollouts (ADA Reserves) (10)	602,540	0	602,540
Total Project Spending	1,284,254	2,149,247	3,433,501
Balance of IT Operating Budget	10,133,746	0	10,133,746
Total IT Spending	<u>\$11,418,000</u>	<u>2,149,247</u>	<u>13,567,247</u>

2

3

1

2014 Consulting Projects	Operating Budget	Capital Budget	Total Projected Spending
FileWeb Support	15,600	0	15,600
ADA Knowledge Center Implementation	214,523	400,227	614,750
FileWeb Totals (1)	230,123	400,227	630,350
Data Warehouse (DW) Totals	0	0	0
ADA.org Reorganization	54,167	138,434	192,601
Mapping Solution Implementation	7,679	13,140	20,819
Web Analytics Software Upgrade	0	9,000	9,000
SiteCore Content Management support	30,000	0	30,000
Internet Totals (2)	91,846	160,574	252,420
Financial Analyzer Tool Implementation	0	34,666	34,666
CPS Totals (3)	0	34,666	34,666
Ongoing Mobile Application support	32,400	0	32,400
Mobile Application Totals (4)	32,400	25,000	57,400
MS SharePoint support	15,000	0	15,000
ADA Connect Totals (5)	15,000	0	15,000
Talent Management Service	6,325	14,925	21,250
PeopleSoft Totals (6)	6,325	14,925	21,250
Hyperion Plan Tool Support	56,000	0	56,000
Hyperion System Upgrade	0	50,000	50,000
Hyperion PlanTool Totals (7)	56,000	50,000	106,000
Tripartite System (TS) Totals	0	0	0
Warranty Technician	75,000	0	75,000
Network Security	20,000	0	20,000
Operating Software	50,000	0	50,000
Capital Hardware	0	499,000	499,000
Capital Software	0	273,855	273,855
Network Infrastructure	0	370,000	370,000
Board Room Upgrades	0	150,000	150,000
Chicago Telephone System Upgrades	0	20,000	20,000
Infrastructure Totals (8)	145,000	1,314,855	1,459,855
Aptify Support	90,000	0	90,000
Aptify EDUC licenses	0	99,000	99,000
Aptify Legislative Module	0	50,000	50,000
Aptify LMS for HR	15,020	0	15,020
Aptify Totals (9)	105,020	149,000	254,020
Aptify Rollouts (ADA Reserves)	602,540	0	602,540
Aptify Totals from ADA Reserves (10)	602,540	0	602,540
2014 Grand Totals	1,284,254	2,149,247	3,433,501

1

IT Core Area

2015 Planned Spending	Operating Budget	Capital Budget	Total
FileWeb/ADA Knowledge Ctr (1)	189,720	170,228	359,948
Data Warehouse (2)	0	265,000	265,000
Internet (3)	15,000	0	15,000
Ctr for Professional Success	0	0	0
Mobile Applications (4)	5,000	50,000	55,000
ADA Connect (5)	15,000	80,000	95,000
PeopleSoft (6)	25,000	0	25,000
Tripartite System	0	0	0
Hyperion Budgeting PlanTool (7)	30,000	0	30,000
Infrastructure, Hardware & Software Licenses (8)	145,000	1,082,000	1,227,000
Aptify (9)	861,700	0	861,700
Aptify Rollouts (ADA Reserves)	0	0	0
Total Project Spending	1,286,420	1,647,228	2,933,648
Balance of IT Operating Budget	11,593,580	0	11,593,580
Total IT Spending	<u>\$12,880,000</u>	<u>1,647,228</u>	<u>14,527,228</u>

2

3

2015 Planned Consulting Projects	Operating Budget	Capital Budget	Total Planned Spending
FileWeb Support	10,000	0	10,000
ADA Knowledge Center Implementation	179,720	170,228	614,750
FileWeb Totals (1)	189,720	170,228	359,948
Business Objects Software Upgrade	0	40,000	40,000
Reporting Tool Software & Implementation		225,000	225,000
Data Warehouse Totals (2)	0	265,000	265,000
SiteCore Content Management support	15,000	0	15,000
Internet Totals (3)	15,000	0	15,000
Ctr for Professional Success Totals	0	0	0
Ongoing Mobile Application support	5,000	0	5,000
Mobile App Enhancements	0	25,000	25,000
Mobile Point-of-Sale with Aptify	0	25,000	25,000
Mobile Application Totals (4)	5,000	50,000	55,000
MS SharePoint support	15,000	0	15,000
ADA Connect Redesign	0	20,000	20,000
ADA Members & State Sites	0	45,000	45,000
MS SharePoint Plug Ins	0	15,000	15,000
ADA Connect Totals (5)	15,000	80,000	95,000
PeopleSoft Replacement Planning	25,000	0	25,000
PeopleSoft Totals (6)	25,000	0	25,000
Hyperion Plan Tool Support	30,000	0	30,000
Hyperion PlanTool Totals (7)	30,000	0	30,000
Tripartite System (TS) Totals	0	0	0
Warranty Technician	75,000	0	75,000
Network Security	20,000	0	20,000
Operating Software	50,000	0	50,000
Capital Hardware	0	512,000	512,000
Capital Software	0	10,000	10,000
Network Infrastructure	0	345,000	345,000
AV Upgrades on 22	0	115,000	115,000
Chicago Telephone System Upgrades	0	100,000	100,000
Infrastructure Totals (8)	145,000	1,082,000	1,227,000
Aptify Rollouts & Support	861,700	0	861,700
Aptify Totals (9)	861,700	0	861,700
Aptify Totals from ADA Reserves	0	0	0
2015 Grand Totals	1,286,420	1,647,228	2,933,648

Resolutions

- 1 This report is informational and no resolutions are presented.
- 2 **BOARD RECOMMENDATION: Vote Yes to Transmit.**
- 3 **BOARD VOTE: UNANIMOUS*. (BOARD OF TRUSTEES CONSENT CALENDAR ACTION—NO**
- 4 **BOARD DISCUSSION)**
- 5 ***Dr. Fair was absent.**

Resolution No. None NewReport: Board Report 7 Date Submitted: July 2014Submitted By: Board of TrusteesReference Committee: A (Budget, Business and Administrative Matters)Total Net Financial Implication: None Net Dues Impact: Amount One-time Amount On-going FTE 0

ADA Strategic Plan Objective: Membership-Obj. 1: Leaders and Advocates in Oral Health

How does this resolution increase member value: See Background

REPORT 7 OF THE BOARD OF TRUSTEES TO THE HOUSE OF DELEGATES: ADA PENSION PLANS**Background:** This report is in response to House of Delegates Resolution 77H-2011 (*Trans.*2011:444).

Resolution 77H-2011 reads as follows:

77H-2011. Resolved, that the Board of Trustees provide to the House of Delegates an annual executive summary on the status of the Pension Plan as reflected in the annual ADA audit reports and the annual actuarial certification of the pension plan funding status.

The ADA reviewed its employee benefits as part of a larger project to assess total compensation in 2011 and made significant changes to retiree benefits effective January 1, 2012 that reduced both future costs and risks while still providing a market competitive total compensation package.

To summarize, that decision was based on the following facts which still apply to the plan:

- The new terms of the pension plan reduce future costs and risks by more than 60% compared to the old plan terms.
- Supplemental pension funding is not optional and represents payment of prior service costs under the old pension plan. This funding is the majority of the ADA's annual budget cost and is required even if the plan is terminated.
- If the pension plan were terminated completely, the ADA would not have access to plan assets to reduce costs in future periods.
- A "hard freeze" plan termination would come at a high price because conservative accounting rules lock in the value of the liability based on an assumed liquidation of pension benefits as of the termination date using current, historic low interest rates. This liability can only be reduced by the future payment of those plan's liabilities.
- The long term economic costs of the plan are ultimately tied to the payout of future benefits over many years, in fact, decades into the future. ADA contributions that go into the plan do not come out except to pay plan benefits. Because pension benefits, since 1993, are only paid as a monthly annuity to retirees, cash flows are predictable and plan assets are invested to balance long term returns, risks, and costs in relation to the maturity of the long term pension liabilities.

Resolution 77H-2011 asks for reporting on the ADA Pension Plan using two sources of information that provide two perspectives of plan status based on two different actuarial calculations of the future pension benefit liability:

- a. the accrual basis liability included in the ADA's 12/31/13 balance sheet (based on ASC 715 accounting rules), and
- b. the "cash basis" liability, percent funded status and funding requirements included in the ADA's 1/1/14 Adjusted Funding Target Attainment Percentage ["AFTAP"] Range Certification Report (based on ERISA calculation rules).

Although these two liability calculation methods differ, in general terms the net Pension liability represents the amount of projected total pension funds needed to cover "100% funding" of future benefits less the value of actual funds invested in pension plan assets. In each case, this "100% funded" liability is an amount calculated by our actuary based on a formula that uses certain assumptions including interest rates and mortality tables determined by either government or accounting rules. When interest rates go down or longevity estimates increase, the amount needed to reach 100% funded status goes up.

The pension liability, under both methods, accrual basis and cash basis, is recalculated by our actuary as of the end of every plan year, December 31.

Accrual Basis Pension Liability (included in the ADA's 12/31/13 audited balance sheet): The following roll-forward analysis of the ADA's 12/31/13 balance sheet liability shows all the changes in the net accrual basis liability since the beginning of the year compared to prior periods.

There are four major types of changes that affect the ADA's net pension liability:

1. The ADA's contribution of cash to the plan assets which reduces the liability includes two parts:
 - a. The funding of "normal service" costs for current employees of the ADA who earn benefits during the plan year; and
 - b. The funding of supplemental payments to help get the plan to 100% funded status which represent "catch up" funding of benefits earned in prior periods as defined by government funding rules initially introduced by the Pension Protection Act ("PPA") of 2006; and
2. The increase in the net plan liability due to the accrual of the "normal service" benefit costs plus interest on the unfunded pension liability; and
3. The decrease in the net pension liability due to the increase in the value of the plans investment assets; and
4. The impact of an increase or decrease in the net pension liability due to the decrease or increase in the "spot rate" of interest used to calculate the actuarial present value of those future retirement benefits at December 31 each year.

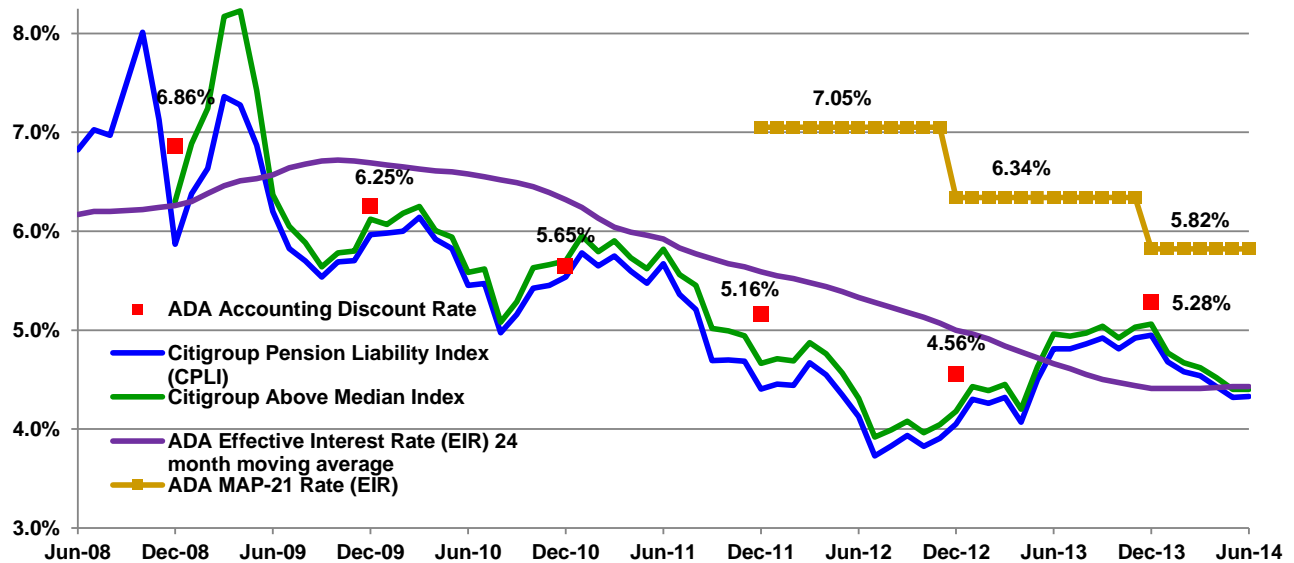
In addition to these changes to the pension liability, the ADA also made the "one time" change to future employee benefits effective January 1, 2012 that significantly reduced the ADA's accrual basis pension liability as well as its ongoing pension expense. This one time change reduced the liability by \$8.9 million at 12/31/2011 and reduces "normal service costs" annually in 2012 and future years by over \$3 million compared to 2011.

The following historical roll-forward analysis chart shows a four year history of the pension plan. The results for fiscal years 2010 and 2011 show normal service costs under the old plan while years 2012 and 2013 present the actual results after plan changes. Beyond normal service costs and interest on the

unfunded pension liability (i.e., Expected Obligation Increase), the biggest change to the accrual basis Net Pension Liability is the non-cash impact of the discount rate on the year-end valuation. For year-end 2012, discount rates dropped from 5.16% to 4.56%, which was offset by favorable investment performance. For year-end 2013, discount rates increased from 4.56% to 5.28% and the Plan experienced favorable investment performance. So far in 2014, interest rates have been declining while asset performance has been mixed. The impact of falling “spot” interest rates has a big impact on the year-end valuations of future benefit liabilities but, fortunately, are non-cash adjustments. For further reference, the rates used for accounting purposes, and approved by our auditors, are shown at the bottom of the chart for each year.

ADA Consolidated					
Net Pension Liability Analysis - Historical					
Millions of Dollars; Increase/(Decrease) in Liability					
	Fiscal Year Ending				Notes
	2010 ¹	2011	2012	2013	
Beginning Balance, December 31 of prior year	32.0	48.8	51.1	56.8	Net Liability, based on discount rate in effect at start of year less plan assets
Contributions (Cash):					Actual cash cost to ADA in each plan year:
Normal Service Cost Funding- current employees	(4.7)	(5.2)	(1.7)	(1.8)	Based on Old Plan formula in 2010 and 2011; New Plan in 2012 and 2013
Supplemental/Catch-up Funding of Prior Service	(0.4)	(7.6)	(4.6)	(4.4)	Required contributions of prior service costs on path to 100% status
Expected Obligation Increase	11.8	13.4	10.0	10.0	Service Cost (benefit accrual) and Interest Cost (interest on prior obligation)
Net Investment (Gains)/Losses	(11.2)	(2.0)	(16.7)	(15.5)	Actual plan investment results based on market values at each year end
Actuarial (Gain)/Loss- incl. rate impact in 2010	21.3	2.1	4.5	0.4	Impact of updated participant population, salaries and mortality assumptions; 2010 also includes net impact of discount rate change
Reduction in Benefits	-	(8.9)	-	-	2011 net impact of Pension Plan design changes effective 1/1/2012.
Annual FAS 158 Actuarial Valuation Adjustment					
Discount Rate	Not Avail.	10.0	14.1	(16.4)	Estimated non-cash impact of changing discount rate per accounting rules
Supplemental Benefit Trust	-	0.5	0.1	(0.1)	Net Change in supplemental plan liability as reported
Ending Balance, December 31	48.8	51.1	56.8	29.0	Net Liability, based on discount rate in effect at end of year less plan assets
Discount Rate					
Beginning of Year	6.25%	5.65%	5.16%	4.56%	
End of Year	5.65%	5.16%	4.56%	5.28%	
¹ Based on prior actuary's results.					

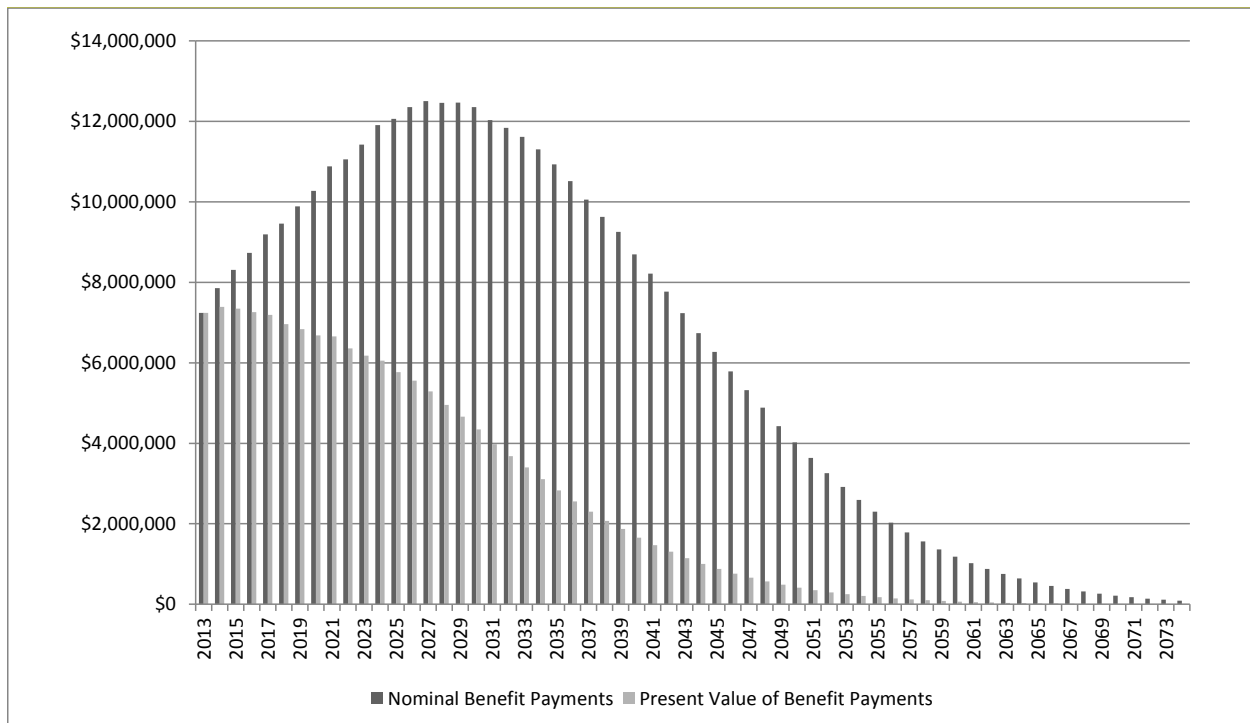
Low interest rates, more than any other factor, result in increases to the yearend valuations of Retirement Benefit Obligations. The next graph shows the general downward trend of the rates used to calculate these long term liabilities. Rates had been increasing during 2013 but have been declining in 2014.



The “ADA Accounting Discount Rate” shown in this graph reflects the rates used for the yearend financial statements. The “ADA Effective Interest Rate (EIR)” is a 24 month moving average of rates published by the IRS which would typically apply to funding requirements. However, the “MAP-21 Rates” reflect higher rates based on a 25 year average to provide pension relief which reduced the Plan’s funding requirements for 2012, 2013 and 2014.

The Citigroup Indexes are also included as an indicator of current interest rate trends. These rates were trending upward in 2013 resulting in a higher accounting rate at 12/31/13 than at 12/31/12. However, so far during 2014, these rates have been declining.

It is important to note that although the use of year-end “spot rates” determines the value of the liabilities for accounting purposes at year-end, and while lower rates can also drive higher contribution rates to plan assets, it is the actual cash payout of the retirement benefits that will only happen over many decades that represents the true economic cost of the plan. Cash contributed to the plan to fund future benefits stays in the plan until those benefits are paid. And the actual payout of the 12/31/13 pension plan liability through monthly benefits to retirees will only happen over the next 30 to 40 years with the final payment expected in the year 2073. The following graph shows these expected annual payments to plan participants from plan assets:



This graph effectively shows that the maturity of the ADA's pension liability is made up of predictable annuities unlike many other plans that allow lump sum benefit payouts.

Pension Relief: Because so many actuaries for large pension plans questioned the use of "spot rates" to value pension liabilities and lobbied legislators to use a longer 25 year average interest rate to calculate the requirements for cash contributions to pension plans, "pension relief" was passed under MAP-21 in 2012 to reduce the short-term funding burden on pension plan sponsors caused by the current, low interest rate environment.

Cash Basis Pension Liability (included in the annual actuarial certification of the pension plan funding status): The other pension liability recalculated by the ADA's actuary each year is the Cash Basis Pension Liability which is published in the ADA's annual Adjusted Funding Target Attainment Percentage ["AFTAP"] Range Certification Report (based on ERISA calculation rules). This report is significant because it includes the annual funded status of the plan. In addition, as this "cash basis" liability fluctuates, the amount of annual cash contributions required from the next year's Operating Budget will also fluctuate.

The following chart shows the Cash Basis Pension Liability based on the AFTAP certification report:

American Dental Association								
Employees' Retirement Trust								
Adjusted Funding Target Attainment Percentage ("AFTAP") Funding Status								
as of January 1, 2014 (valuation date)								
(\$000s)	Year End 2010		Year End 2011		Year End 2012		Year End 2013	
	amount	%	amount	%	amount	%	amount	%
AFTAP Net Effective Interest Rate	6.32%		7.05%		6.35%		5.82%	
Cash Basis Target Liability (= 100% status)	\$ 133,828	100.0%	\$ 131,580	100.0%	\$ 146,710	100.0%	\$ 160,615	100.0%
Less: Plan Assets	(108,810)	81.3%	(112,255)	85.3%	(127,125)	86.7%	(141,689)	88.2%
Net AFTAP Report Unfunded Plan Liability	\$ 25,018	18.7%	\$ 19,325	14.7%	\$ 19,585	13.3%	\$ 18,926	11.8%

The data in this chart also shows, in a simple format, how the year-end valuation of investments also contributes to the funded status of the plan.

Conclusions: Although the use of "spot" rates of interest, in effect at the end of each year, determine the GAAP accounting basis of the liabilities and, although the annual cash basis valuation can drive higher contributions to the plan's assets, the final cost of the plan is ultimately tied to the payment of these benefits to plan participants.

Because the ADA stopped lump sum payments for benefits earned after 1993, the pension plan operates as a simple annuity plan which greatly reduces transactions other than normal portfolio management and the payment of monthly benefits to participants. This results in very predictable cash flows.

Once the ADA contributes cash into the plan, it stays in plan investments to generate long term returns until benefits are paid out. Under this plan structure, the ADA's actuaries and investment advisors have explained that temporary investment valuation and interest rate volatility have minimal impact on the long term economics of the pension plan.

Board changes to retirement benefit plans helped reduce total pension liabilities by over \$7 million at 12/31/11 (all plan changes actually account for \$21.8 million of direct reduction which was partially offset by the impact of interest and investment).

In addition, the significant cut in pension plan benefits reduced "normal" pension costs, for 1 year of service, from \$5.2 million in 2011 to \$1.7 million in 2012 and \$1.8 million in 2013.

Although the historic low "point in time" interest rates at year-end have resulted in higher pension liability valuations, expected long term higher interest rates will turn this liability into an asset in the future. Pension relief intended to reduce the funding burdens on pension plan sponsors caused by the current, low interest rate environment was signed into law in 2012 as part of the MAP-21 Act is expected to reduce ADA contributions.

The continuation of the pension plan at reduced levels is expected to pay for itself with limited risk once 100% funded status is reached.

Over the long term, the plan will provide the ADA with a valuable benefit to attract and retain employees critical to its mission based on an asset that will eventually pay for itself once 100% funded status is reached.

1 Without any continuing pension plan in place, there would be a long term risk of an overfunded pension
2 plan, with the ADA being unable to utilize any portion of the resulting overfunded asset balance.

3 With a continuing pension plan, any overfunding that may occur due to fluctuating interest rates can be
4 used to help minimize annual plan contributions going forward.

5 On a related topic, the Board's action in 2011 to reduce retiree health benefits resulted in an immediate
6 \$10 million improvement in the ADA's financial position at December 31, 2011. That reduction also
7 eliminated the ADA's exposure to escalating health care costs by capping the future maximum annual
8 cost per retiree.

9 **Resolutions**

10 This report is informational and no resolutions are presented.

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

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

14 ***Dr. Fair was absent.**

Resolution No. None NewReport: Board Report 8 Date Submitted: July 2014Submitted By: Board of TrusteesReference Committee: A (Budget, Business and Administrative Matters)Total Net Financial Implication: None Net Dues Impact: Amount One-time Amount On-going FTE 0

ADA Strategic Plan Objective: Finance-Obj. 4: Unrestricted liquid reserves targeted at no less than 50%.

How does this resolution increase member value: See Background

1 **REPORT 8 OF THE BOARD OF TRUSTEES TO THE HOUSE OF DELEGATES: STUDY OF A**
 2 **POTENTIAL APPROACH TO ON-GOING ROYALTY REVENUE FROM THE ADA MEMBERS**
 3 **INSURANCE PLANS**

4 **Background:** This report is in response to House of Delegates Resolution 84H-2013 (*Trans.*2013:297)
 5 regarding the Study of a Potential Approach to On-Going Royalty Revenue from the ADA Members
 6 Insurance Plans. This report is an informational report to the House of Delegates confirming the study
 7 and the actions taken by the Board of Trustees.

8 Resolution 84H-2013 reads as follows:

9 **84H-2013. Resolved,** that the Board of Trustees is urged to maintain the royalties received from the
 10 ADA Members Insurance Plans in a designated reserve account, and be it further

11 **Resolved,** that the Board of Trustees is urged to form a workgroup to explore the benefits and
 12 drawbacks of maintaining all or some portion of the royalties received from the ADA Members
 13 Insurance Plans in a designated reserve account for purposes of dues stabilization and long term
 14 financial stability, and be it further

15 **Resolved,** that the Board of Trustees is urged to include two members from the Council on Members
 16 Insurance and Retirement Programs on its workgroup studying the issue of a designated reserve
 17 account, and be it further

18 **Resolved,** that the Board of Trustees report to the 2014 House of Delegates on its findings.

19 **Evaluation Process and Findings:** The Board of Trustees appointed an ad hoc committee to study and
 20 evaluate approaches to on-going royalty revenue from the ADA Members Insurance Plans. This ad hoc
 21 committee of the Board has also been referred to as the "84H Workgroup" during the course of its work.
 22 The members of the ad hoc committee were ADA Treasurer Dr. Ron Lemmo; ADA Board of Trustees
 23 Members Dr. Jeff Dow, Dr. Steven Gounardes, Dr. Gary Roberts, and Dr. Carol Summerhays; and
 24 Council on Members insurance and Retirement Programs members Dr. Robert Coleman and Dr. Tom
 25 Paumier. The Board thanks the ad hoc committee for its work.

26 Upon completion of its study, the ad hoc committee submitted a report to the Board of Trustees, which is
 27 attached hereto as Appendix A. The ad hoc committee recommended, and the Board agreed, that, in
 28 order to provide a source of additional long-term financial stability to the ADA, royalty revenue generated
 29 from the ADA Members Insurance Plans be set aside in a separate reserve account allowed to

1 accumulate and grow to a level, perhaps \$100 million, to permit the generation of dividends and interest
2 in an amount sufficient to provide the Association with a substantial stream of income.

3 **Board Action:** The Board accepted the ad hoc committee's recommendations, with the exception of the
4 recommendation requiring a two-thirds Board vote for certain actions. The Board was informed that such
5 a requirement is contrary to Illinois law. Accordingly, the Board adopted the following resolution:

6 **B-81. Resolved,** that the Board accepts the following guidelines to establish a separate reserve for
7 the royalties received from the ADA Members Insurance Plans:

- 8 • That the royalty revenue generated from the ADA Members Insurance Plans shall, as
9 received by ADA, be set aside in a separate reserve account known as the "royalty reserve."
- 10 • That the royalty reserve is intended to provide a source of additional long-term financial
11 stability to the ADA.
- 12 • That the funds in the royalty reserve should, as a primary objective, be allowed to accumulate
13 and grow to a level that will permit the generation of dividends and interest in an amount
14 sufficient to provide the Association with a substantial stream of income.
- 15 • That the Board should set a target minimum of \$100 million for the accumulation of funds in
16 the royalty reserve to ensure an adequate stream of future income.
- 17 • That the Board, while acting with a primary intent to maximize the royalty reserve account,
18 shall not be unduly constrained in its ability to utilize some portion of those funds when the
19 use of those funds is necessary or appropriate, in the Board's judgment as evidenced by a
20 vote of the ADA Board of Trustees, to implement essential programs or to limit the need for
21 increases in the dues of the membership.
- 22 • That the Board, in deciding to utilize some portion of the royalty amounts received in any
23 given year, should be guided by the objective of ensuring the stability of Association
24 programs, stabilizing dues, and growing the membership market share of the Association.
- 25 • That the royalty reserve is not intended to replace a permanent loss of funds or to eliminate
26 an ongoing budget gap.
27

28 Resolutions

29 This report is informational and no resolutions are presented.

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

31 **BOARD VOTE: UNANIMOUS*.**

32 ***Dr. Fair was absent.**

1 **REPORT OF THE BOARD OF TRUSTEES' AD HOC COMMITTEE: STUDY OF A POTENTIAL**
2 **APPROACH TO ON-GOING ROYALTY REVENUE FROM THE ADA MEMBERS INSURANCE PLANS**

3 The following report has been prepared by the Board-appointed ad hoc committee to study and evaluate
4 approaches to on-going royalty revenue from the ADA Members Insurance Plans. This ad hoc committee of
5 the Board has also been referred to as the "84H Workgroup" during the course of its work. This report is
6 submitted for the full Board's consideration for transmittal to the 2014 House of Delegates.

7 **Background:** This report is in response to House of Delegates Resolution 84H-2013 (*Trans.*2013:297)
8 regarding the Study of a Potential Approach to On-Going Royalty Revenue from the ADA Members Insurance
9 Plans.

10 Resolution 84H-2013 reads as follows:

11 **84H-2013. Resolved**, that the Board of Trustees is urged to maintain the royalties received from the
12 ADA Members Insurance Plans in a designated reserve account, and be it further

13 **Resolved**, that the Board of Trustees is urged to form a workgroup to explore the benefits and
14 drawbacks of maintaining all or some portion of the royalties received from the ADA Members
15 Insurance Plans in a designated reserve account for purposes of dues stabilization and long term
16 financial stability, and be it further

17 **Resolved**, that the Board of Trustees is urged to include two members from the Council on Members
18 Insurance and Retirement Programs on its workgroup studying the issue of a designated reserve
19 account, and be it further

20 **Resolved**, that the Board of Trustees report to the 2014 House of Delegates on its findings.

21 Led by the ADA Treasurer, Dr. Ron Lemmo, the members of the ad hoc committee were:

22 ADA Board Members, Dr. Jeff Dow, Dr. Steve Gounardes, Dr. Gary Roberts, and Dr. Carol Summerhays; and
23 Council on Members Insurance and Retirement Programs ("CMIRP") members, Dr. Robert Coleman, and Dr.
24 Tom Paumier.

25 In addition to the CMIRP reports to the Board and 2013 House of Delegates which ultimately resulted in
26 Resolution 84, the committee through the course of its work on this initiative also reviewed several other
27 documents and communications to build a comprehensive understanding of the issues, opportunities, and
28 risks associated with long term planning for ADA use of ongoing royalty revenue. These sources included:

- 29 a. 2013 CMIRP Report to the Board
- 30 b. 2013 CMIRP Supplemental Report 1 to the House
- 31 c. Present ADA Policy regarding reserves and investment income
- 32 i. *Bylaws*
- 33 ii. *Board Rules*
- 34 iii. *Investment Policy*
- 35 d. Other Association reserve policies
- 36 e. Projected net annual returns from ADA investments
- 37 f. Tax and legal review of accumulating royalties as additional reserves
- 38 g. Consequences of generating more Association investment income
- 39 h. Multi-year financial projection model for several scenarios

1 This basic research provided a foundation of knowledge which helped the committee develop goals which
2 served as criteria for deciding which options should be considered and ultimately which one provided the
3 most net long term benefits to the Association.

4 **Review and Discussion of the original CMIRP reports to Board and House Royalties from Member**
5 **Insurance Plans:** The committee reviewed the 2013 CMIRP Reports and noted the following specific points
6 quoted here for reference:

- 7 • “The Council recognized that the disposition of on-going royalty revenue is the Board’s responsibility
8 and that the Board is best positioned to understand the overall finances of the ADA.
- 9 • Similarly, the Council expressed confidence in the Board’s ability to carry out this responsibility
10 effectively.
- 11 • The concept offered by the Council for consideration is to set aside some or all of the royalty revenue
12 received from the Plans in a designated reserve which would be allowed to accumulate. Each year,
13 the income from this fund would be used for the purpose of dues stabilization [and long term financial
14 stability].
- 15 • The Council noted that the proposed course of action would require patience with a vision for a
16 predictable, sustainable, long-term approach.
- 17 • The Council also noted that the proposal could provide a financial benefit to future ADA members in
18 terms of possible dues stabilization or other program support from the income that would be
19 generated from the designated reserve.
- 20 • The Council sees merit in this approach but recognizes that the Board will have a broader perspective
21 of ADA finances and the responsibility to address the disposition of royalty income. Further, the
22 Council realizes that this concept would need to be fully developed by the Board before it could be
23 responsibly implemented. For example, the Board would need to consider:
 - 24 ○ What portion of the royalty income should be set aside in a segregated fund?
 - 25 ○ Should this portion vary from year to year based on ADA finances and how would that be
26 done?
 - 27 ○ How do current needs for income compare to the benefits of future dues stabilization?
 - 28 ○ What form should such a segregated fund take and how would it relate to the existing reserve
29 funds and House policy on appropriate reserve levels?
- 30 • Accordingly, the Council did not offer the House a resolution with a final plan for disposition of royalty
31 income. The Council feels strongly that the Board is best positioned to consider its approach and the
32 issues surrounding it. The Council recognizes that the Board may, after study and due diligence,
33 accept its approach, modify it or reject it. The Council is comfortable placing the process to study this
34 concept in the hands of the Board of Trustees.”

35 **Initial Consensus:** The committee agreed with these original CMIRP points and further discussed the intent
36 behind the 2013 CMIRP recommendation that the Board explore the benefits and drawbacks of maintaining
37 all or some portion of the royalties received from the ADA Member Insurance Plans. Based on this initial
38 discussion, the committee unanimously concluded that there was consensus that members would not want
39 the new revenue to enable expanded spending in annual operating budgets without a review of long term
40 goals.

41 The best evidence of this is the first resolving clause of the 2013 House resolution which urged the Board to
42 maintain the royalties received from the ADA Members Insurance Plans in a designated reserve account
43 pending the Board’s study. The committee noted the Board intent to follow the House request and confirmed
44 ADA receipt of royalties recommended by CMIRP and approved by the Board in 2013 plus accrued interest
45 totaling \$6,226,515 in June 2014. These assets are being managed under the existing ADA long term
46 investment policy and tracked in a separate royalty reserve account which has been reported separately
47 consistent with other reserves in ADA financial reports beginning in June 2014.

48 The committee also recognized that the Association’s realization of this new royalty revenue from the ADA
49 Member Insurance Plans represents a unique opportunity to set aside large sums of money to further improve
50 the long term financial and operational sustainability of the ADA.

Approach and Review of options: Early in the committee's deliberations, the group brainstormed on overall approach as well as a list of different scenarios for the potential use of the new, annual ongoing royalty revenues. A subgroup focused on evaluating options and directed staff to build a financial model that could be used to compare the long term results of various scenarios.

The discussion of overall approach to the use of reserve funds led to a discussion of whether the workgroup should look at ADA policy for all reserves. Given the specifics of Resolution 84H-2013, it was quickly concluded that the scope of the scenario analyses should be focused only on the royalty reserve fund. The subgroup then created a financial model that effectively compared different scenarios for use of royalty funds and then presented its findings for discussion by the full workgroup.

The financial model applied a consistent set of assumptions to calculate the impact on ADA revenue, reserves, and specific statistics including metrics for non-dues revenue as a percentage of total revenue and long term reserves as a percentage of total expenses, both strategic plan objectives. The different scenarios were discussed with specific focus on the benefits of building the royalty reserves to a point in time or a dollar threshold when investments could deliver significant returns to the ADA's annual operating budget.

Recommended Option and Discussion of Benefits and Drawbacks: Based on the analyses and discussion, the committee concluded that holding royalty reserves for a period of time or until they grew to a specific threshold amount (such as \$100 million) before withdrawing funds for use in the operating budget would provide a significant return that could offset dues revenue and substantially improve the Association's financial position. Based on the scenarios reviewed, the committee agreed that a \$100 million target amount would generate a significant return on investment that would then contribute new revenue to the ADA's annual operating budget in addition to all future disbursements of royalty income received after the \$100 million threshold was reached.

The committee also discussed benefits and drawbacks of setting aside royalty revenue received from ADA Member Insurance Plans in a designated reserve which would be allowed to accumulate. These included:

Benefits of building a designated royalty reserve:

- Avoids adding revenue to existing ADA operating budgets which may then be used to increase annual spending.
- Enables saving for the future that ensures long term financial stability and sustainability of the ADA's mission.
- Provide a means of collecting royalties and tracking them in a separate account which can later serve as a source of funding for future operating budget spending (within guidelines) or dues relief.
- Not including royalty income from the ADA insurance plans directly in the ADA annual operating budget will help protect member value by eliminating pressure on the plans to compromise quality and/or pricing to provide a specified royalty amount.

Drawbacks of building a designated royalty reserve:

- The ADA does not have immediate use or benefit from the new revenue.
- Some members may feel that because of this use of funds, their dues are funding a reserve that won't benefit them directly.
- Members who buy insurance through the ADA Members Insurance Plans may feel that some of the premiums they pay are subsidizing all members including those who do not buy ADA insurance. However, it was quickly noted that any member who purchases an ADA product or service that generates non-dues revenue is essentially subsidizing all members.

After concluding that, taken together, the benefits outweighed the drawbacks, the committee discussed potential guidelines for spending from this royalty reserves and all agreed that they should be tied to the ADA's strategic "big picture" of Association success. For example, although building a \$100 million reserve may help the ADA's long term financial stability, this would be a hollow victory if, while building that reserve, ADA membership market share falls below 50%. Therefore, guidelines for spending from the reserve need to

1 be very flexible and defer to the Board's judgment and authority because no single strategy could anticipate
2 all future scenarios. In the event that any royalty funds are used by the Board, this would be reported to the
3 next session of the House of Delegates.

4 The committee agreed to balance the need to protect the growth of this fund until it can reach critical mass
5 that can fuel the operating budget and support dues stabilization with the need to allow board discretion for
6 strategic spending to benefit members. During the "buildup period," the committee felt that the royalty reserve
7 account should not be used to fund operations if the level of ADA's long term reserves is already above the
8 strategic plan target of 50% and other reserves were available.

9 While deferring to the Board's authority to oversee all reserves, the committee suggested that the Board
10 consider the following specific guidelines.

11 The Royalty Reserve fund:

12 1. Will be a discrete, designated but not restricted, reserve fund that will be allowed to accumulate to
13 a minimum level of one hundred million dollars (\$100,000,000).

14 2. Will provide investment income revenue that may be used, if needed after the minimum threshold
15 is reached, to supplement the Association's operating budget and assist in its dues stabilization
16 efforts in the future.

17 3. May be used to protect the integrity of the ADA liquid reserves if they fall below the strategic plan
18 target prescribed by the HOD and Board of Trustees. If used for this purpose, the Royalty Reserve
19 will be replenished as soon as possible with liquid reserves that exceed the strategic plan target or
20 surpluses from the Association operating budget.

21 4. May be used for purposes that a vote of 2/3 of the ADA Board of Trustees determines are crucial
22 to the mission of the Association or the success of its members.

23 **A More Complete Definition of Dues Stabilization:** Because the committee agreed that a larger reserve
24 fund, which could generate significant non-dues revenue to the operating budget, would provide a long term
25 benefit to the ADA. And because the new revenue from royalties received from the ADA Members Insurance
26 Plans is a unique opportunity to fund a new designated reserve account for purposes of dues stabilization and
27 long term financial stability, the committee determined that a more complete definition of dues stabilization
28 would be helpful.

29 A broader definition of dues stabilization that does not focus only on limiting the amount of member dues
30 increases in relation to the Chicago CPI, but also considers other factors which influence the total size of the
31 ADA operating budget that includes:

32 a. The number and cost of programs,

33 b. Non-dues revenue,

34 c. ADA dues in relation to market conditions (other competing associations and/or inflation).

35 Overall, it appears that it is better for the Association to adopt smaller member dues increases over time than
36 to wait and have one big dues increase. Under this "pay as you go" approach, higher costs due to inflation or
37 an expanded ADA program agenda are covered, at least partially, by dues on an ongoing basis. Conversely,
38 if costs decrease or non-dues revenue increases and reserves are adequate for anticipated needs and
39 financial stability, a dues rate reduction could be warranted.

40 A good example of this "pay as you go" approach was the establishment of the capital replacement reserve
41 fund which enabled the ADA to set aside specific amounts of cash from each year's annual operating budget
42 based on the amount of net non-cash depreciation expense less other capital spending to avoid future special
43 assessments for major capital projects. As a result, the capital replacement reserve fund also supports long
44 term dues stabilization. This can also be seen in charts of ADA dues history and rates (Exhibits A and B).

Similarly, the creation of a dedicated royalty reserve account using new revenue from the ADA Members Insurance Plans to build to a critical mass that generates investment returns can also support dues stabilization.

Summary Conclusions and Recommendations for Consideration by the Board: After review and discussion of all the options, the committee concluded that the Board is best positioned to oversee the ongoing royalty reserves and makes the following specific recommendations for the Board's consideration:

- That the royalty revenue generated from the ADA Members Insurance Plans shall, as received by ADA, be set aside in a separate reserve account known as the "royalty reserve."
- That the royalty reserve is intended to provide a source of additional long-term financial stability to the ADA.
- That the funds in the royalty reserve should, as a primary objective, be allowed to accumulate and grow to a level that will permit the generation of dividends and interest in an amount sufficient to provide the Association with a substantial stream of income.
- That the Board should set a target minimum of \$100 million for the accumulation of funds in the royalty reserve to ensure an adequate stream of future income.
- That the Board, while acting with a primary intent to maximize the royalty reserve account, shall not be unduly constrained in its ability to utilize some portion of those funds when the use of those funds is necessary or appropriate, in the Board's judgment as evidenced by a vote of 2/3 of the ADA Board of Trustees, to implement essential programs or to limit the need for increases in the dues of the membership.
- That the Board, in deciding to utilize some portion of the royalty amounts received in any given year, should be guided by the objective of ensuring the stability of Association programs, stabilizing dues, and growing the membership market share of the Association.
- That the royalty reserve is not intended to replace a permanent loss of funds or to eliminate an ongoing budget gap.

Although these recommendations are offered to the Board as information only, with the understanding that the Board will take appropriate actions, the committee offers the following resolution for the Board's consideration:

Proposed Resolution

B-81. Resolved, that guidelines be developed for a separate reserve for the royalties received from the ADA Members Insurance Plans generally consistent with the recommendations of the Board workgroup convened in response to Resolution 84H-2013.

**AMERICAN DENTAL ASSOCIATION
ANALYSIS - MEMBERSHIP DUES, OPERATING RESULTS, RESERVES HISTORY
2004-2013**

EXHIBIT A

	<u>2004</u>	<u>2005</u>	<u>2006</u>	<u>2007</u>	<u>2008</u>	<u>2009</u>	<u>2010</u>	<u>2011</u>	<u>2012</u>	<u>2013</u>
Full dues amount	\$435	\$435	\$435	\$489	\$498	\$498	\$498	\$505	\$512	\$522
Total members	165,764	166,105	169,038	171,014	172,092	172,505	172,348	173,745	174,298	175,782
Total membership dues	\$47,721,745	\$47,706,466	\$47,687,798	\$53,699,666	\$54,323,748	\$53,918,093	\$53,725,594	\$54,289,231	\$54,551,655	\$56,935,135
Average dues/member	\$288	\$287	\$282	\$314	\$316	\$313	\$312	\$312	\$313	\$324
Licensed dentists	125,726	126,562	128,020	129,292	128,910	128,952	128,119	128,719	128,524	128,726
Total market	176,063	177,579	178,192	182,006	183,624	186,589	187,898	191,167	194,160	196,673
Market share	71.4%	71.3%	71.8%	71.0%	70.2%	69.1%	68.2%	67.3%	66.2%	65.5%

ACTUAL RESULTS

Total revenues	\$94,199,301	\$95,545,167	\$100,691,234	\$113,584,420	\$114,407,013	\$113,211,518	\$112,077,878	\$110,644,273	\$119,797,283	\$129,241,416
Total expenses + taxes	(91,122,636)	(93,700,062)	(101,056,757)	(110,144,673)	(112,399,983)	(112,636,572)	(115,630,126)	(116,243,758)	(116,600,329)	(112,325,393)
Operating surplus	3,076,665	1,845,105	(365,523)	3,439,747	2,007,030	574,946	(3,552,248)	(5,599,485)	3,196,954	16,916,023
Capital Expenditures	(1,319,533)	(3,009,086)	(3,364,970)	(3,504,898)	(2,652,075)	(2,922,518)	(2,608,548)	(2,421,988)	(3,439,616)	(2,853,818)
Replacement Capital Fund	(1,000,000)	(1,000,000)	(1,000,000)							(3,500,000)
Depreciation (add back)	3,026,692	3,431,946	4,065,591	3,919,000	6,656,804	6,437,820	6,446,157	6,397,971	6,562,777	6,468,939
Net ADA Operations	\$3,783,824	\$1,267,965	(\$664,902)	\$3,853,849	\$6,011,759	\$4,090,248	\$285,361	(\$1,623,502)	\$6,320,114	\$17,031,145

BUDGET RESULTS

Total revenues	\$91,247,220	\$95,621,300	\$102,099,750	\$109,955,650	\$114,247,550	\$115,892,850	\$114,686,450	\$114,959,650	\$120,540,074	\$119,764,226
Total expenses + taxes	(91,412,100)	(96,268,650)	(104,223,368)	(112,517,750)	(118,310,400)	(119,455,750)	(118,897,900)	(119,244,800)	(121,892,759)	(118,730,001)
Operating surplus	(164,880)	(647,350)	(2,123,618)	(2,562,100)	(4,062,850)	(3,562,900)	(4,211,450)	(4,285,150)	(1,352,685)	1,034,225
Capital Expenditures	(2,539,000)	(2,832,000)	(2,967,600)	(3,529,850)	(2,965,750)	(3,088,750)	(2,606,400)	(2,606,400)	(4,335,414)	(2,855,600)
Replacement Capital Fund	(242,000)	(1,000,000)	(1,000,000)							(3,500,000)
Depreciation (add back)	2,499,900	3,344,150	4,224,200	4,047,100	6,751,900	6,640,500	6,281,800	6,115,700	6,088,203	6,358,196
Net ADA Operations	(\$445,980)	(\$1,135,200)	(\$1,867,018)	(\$2,044,850)	(\$276,700)	(\$11,150)	(\$536,050)	(\$775,850)	\$400,104	\$1,036,821

VARIANCE (\$847,652) \$5,920,010 \$15,994,324

Long-term reserves	\$43,994,473	\$51,077,406	\$58,382,631	\$59,474,378	\$36,204,036	\$43,317,884	\$50,597,762	\$52,980,051	\$57,406,857	\$78,240,559
L/T Reserves/Total Expenses	48%	55%	58%	54%	32%	38%	44%	46%	49%	70%

EXHIBIT A

**AMERICAN DENTAL ASSOCIATION
ACTIVE MEMBER DUES RATE HISTORY**

1923-1926	\$ 2.00
1927-1940	\$ 4.00
1941-1948	\$ 6.00
1949-1950	\$ 12.00
1951-1959	\$ 20.00
1960-1963	\$ 30.00
1964-1968	\$ 40.00
1969-1970	\$ 55.00
1971-1974	\$ 70.00
1975-1977	\$100.00
1978-1981	\$150.00
1982-1986	\$200.00
1987-1989	\$243.00
1990-1992	\$275.00
1993-1995	\$330.00
1996	\$346.00
1997	\$316.00
1998	\$365.00
1999	\$382.00
2000	\$395.00
2001	\$401 + \$30 Assessment=\$431
2002	\$420 + \$30 Assessment=\$450
2003-2006	\$435 + \$30 Assessment=\$465
2007	\$489
2008-2010	\$498
2011	\$505 + \$23 Technology Assessment=\$528
2012	\$512
2013	\$522
2014	\$522

- 1993-1996 Building Asbestos Abatement Assessment \$55.00 for 4 years
- 2001-2006 Building Asbestos Renovation Assessment \$30 for 6 years (everyone pays their percentage of the \$30.00 except students and graduate students and those paying \$0.00 dues amounts (T, P, 9, W))
- 2011 - \$23 Technology Assessment

Resolution No. None N/AReport: Board Report 11 Date Submitted: September 2014Submitted By: Board of TrusteesReference Committee: A (Budget, Business and Administrative Matters)Total Net Financial Implication: None Net Dues Impact: _____Amount One-time _____ Amount On-going _____ FTE 0

How does this resolution increase member value: See Background

**REPORT 11 OF THE BOARD OF TRUSTEES TO THE HOUSE OF DELEGATES: ANNUAL REPORT
ON THE OPERATING RESULTS OF THE CURRENT ADA STRATEGIC PLAN****Background:** This report to the House of Delegates on the American Dental Association's (ADA) current strategic plan is submitted to the House as an informational report.**Overview:** The Board continues to monitor the implementation of the 2011-2014 Strategic Plan and the associated Operating Plan. The Strategic Plan may be found here: <http://www.ada.org/en/member-center/leadership-governance/strategic-planning>. The Association is moving from a culture focusing on activities to one focused on results. The 2014 Operating Plan has included a focus on only those items that materially drive achieving the organization strategy in preparation for the new strategic plan. As such, this report includes only the success measures that directly drive the 2011-2014 strategic plan.**Results:** The Association utilizes a set of performance reports that include an executive summary of divisional activity, a quarterly management report that focuses only on those success measures that materially drive the strategic plan, and financial statements. The quarterly management report is available on ADA.org at <http://www.ada.org/en/member-center/leadership-governance/house-of-delegates/annual-reports>. The quarterly management report allows delegates and the Board to quickly monitor ADA activities and performance against the current strategic/operating plan.

The existing strategic plan includes a series of "outcomes/objectives" for each of the four strategic goals. Of course, our ultimate objective is to create a unique and powerful value for members, prospective members and the public while creating a powerful and influential ADA brand. The remainder of this report will provide information on progress towards reaching these desired outcomes. In the following section of the report, the Goals and Outcomes/objectives are taken directly from the Strategic Plan and Operating Plan.

1 **ADA Goal 1: Provide Support to dentists so they may succeed and excel throughout their careers.**2 **Objective 1.1: Professional Competency and Ethical Standards**

Initiative	Success Measure - Target	Success Measure – Range	Owner	YTD Results June 2014
1.1.1 CPS website will be a center of knowledge for professional competency	20% penetration among active members (each with one or more unique visits) by September 2014	The CPS website will achieve 15-25% penetration among active members in 2014.	Dental Practice	31% penetration among active members
1.1.2 Increase member engagement of professional resources through increased use of EBD and increased downloads of resources through ADA online library	3600 content downloads from ADA online library by December 2014 54,000 unique visitors to EBD website 20 ADA clinical practice guidelines or critical summaries published 80% course enrollment at Science CE conferences	At least 3200 content downloads from ADA online library by December 2014 52,000-56,000 unique visitors to EBD website 15 to 25 ADA Critical Reviews (ACR) published 70 to 100% enrollment capacity	Education Science Science Science	2,824 content downloads from ADA online library 27,940 unique visitors to EBD website 14 ADA critical revisions (ACR) published 150% enrollment at Science CE conferences
1.1.3 Increase member engagement through increased use of ADA provided online CE	10% increase in number of total CE hours completed over 2013	5-15% increase in number of total CE hours completed over 2013	Conferences, Meetings and Continuing Education	+13.5%

1 Objective 1.2: Professional Autonomy

Initiative	Success Measure – Target	Success Measure – Range	Owner	YTD Results June 2014
1.2.1 Encourage constituent dental societies to implement ADA best practices in peer review	3 Tripartite Programs adopt ADA best practices in peer review	2-4 Tripartite Programs adopt ADA best practices in peer review	Dental Practice	0 Tripartite Programs have adopted ADA best practices in peer review*

- 2 *This program was launched in 2014. Currently, best practices criteria developed in consultation with
3 staff from 9 state societies. Final criteria is currently under review by CEBJA. The 9 state societies
4 involved to date include New York, Missouri, Indiana, California, Texas, Colorado, Georgia, Virginia and
5 Michigan.

6 Objective 1.3: Financial Health

Initiative	Success Measure – Target	Success Measure – Range	Owner	YTD Results June 2014
1.3.1 Collaborate with GWL and AXA-Equitable to enhance marketing and increase the number of ADA members overall who utilize one or more CMIRP products with a focus on increasing utilization in lagging segments	750 members purchase their first CMIRP product.	500-1000 members purchase their first CMIRP products.	Membership	424 members purchase their first CMIRP product

7 Objective 1.4: Positive Public Image of the Profession

Initiative	Success Measure – Target	Success Measure – Range	Owner	YTD Results June 2014
1.4.1 Increased coverage in top tier media	18% positive sentiment in media coverage	15-20% positive sentiment in media coverage	Communications	74% positive sentiment in media coverage
1.4.2 Maintain JADA's #1 ranking among dental journals as measured by Kantar Media	#1 ranking	#1 or #2 ranking	Publishing	#2 ranking behind ADA News

1 **ADA Goal 2: Be the trusted resource for oral health information that will help people be good**
2 **stewards of their own oral health.**

3 **Objective 2.1: Oral Health Literacy**

Initiative	Success Measure – Target	Success Measure – Range	Owner	YTD Results June 2014
2.1.1 Increase over-the-counter product submission to the ADA Seal program	Increase submissions by 5% over 2013 submissions by December 2014	Increase submissions by at least 3% over 2013 submissions by December 2014	Science	12 submissions-75% of goal
	50 product evaluations per year	40-60 product evaluations per year	Science	46 products evaluated
2.1.2 Increase unique visitors to MouthHealthy.org	Increase unique visitors to MouthHealthy.org by 12% to 900,000 over 2013 by December 2014	Increase unique visitors to MouthHealthy.org by 8-15% over 2013 by December 2014	Communications	416,492 unique visitors 20% increase

4 **Objective 2.2: Shared Responsibility**

Initiative	Success Measure – Target	Success Measure – Range	Owner	YTD Results June 2014
2.2.1 Narrative on Ad Council program: The Ad Council campaign measures (self-reported) changes in behavior on an annual basis. This is expressed as % of parents and caregivers who report that their child brushes 2x per day. The data is captured as part of an annual tracking study of campaign impact.	Increase in reported twice per day brushing as an indicator of public participation in their own oral health. There is no target metric established, however the base line tracking was established prior to the campaign launch in August 2012 at 48% reporting their child brushed 2x per day.	48% - 55%	Communications	Ad Council results to be reported in September 2014

5 **ADA Goal 3: Improve public health outcomes through a strong collaborative profession; including**
6 **effective collaboration across the spectrum of stakeholders outside of dentistry.**

7 **Objective 3.1: Effective dental professional collaboration**

Initiative	Success Measure – Target	Success Measure – Range	Owner	YTD Results June 2014
3.1.1 Partnership for Healthy Mouths Healthy	Grow visitor traffic to 2min2x.org through the Ad	Minimum 990,000 total visits	Communications	400,000 visitors

Initiative	Success Measure – Target	Success Measure – Range	Owner	YTD Results June 2014
Lives	Council kids' oral health campaign. Base line 990,000 visitors. Ad Council does not provide a target metric.			

1 **Objective 3.2: The public has access to effective prevention and to a quality focused delivery**
2 **system**

Initiative	Success Measure – Target	Success Measure – Range	Owner	YTD Results June 2014
3.2.1 Action for Dental Health CDHC participation	CDHC participation in 10 states by December 2014	CDHC participation in 8-12 states by December 2014	Government Affairs	CDHC participation in 8 states: PA, WI, MT, OK, AZ, MN, SD, SC
3.2.2 Implement state programs to reduce the administrative burden for Medicaid	Implement programs in 4 states by December 2014	Implement programs in 2-6 states by December 2014	Government Affairs	Implemented programs in 9 states: IN, MI, MT, NH, OK, KY, NC, NJ, NM

3 **ADA Goal 4: Ensure that the ADA is a financially stable organization that provides appropriate**
4 **resources to enable operational and strategic initiatives.**

5 **Objective 4.1: Increase the reserves of the Association so that a reserve level of 50% of the**
6 **Association's annual budgeted operating expenses is achieved as urged by the HOD Resolution**
7 **59-2007H-2008**

8

Initiative	Success Measure – Target	Success Measure – Range	Owner	YTD Results June 2014
4.1.1 Maintain reserve level as a percent of budgeted operating expense	50% of annual budgeted operating expense	Minimum of 40% of annual budgeted operating expense	Finance	Uncommitted restricted reserves 73% of annual budgeted operating expense

9 **Objective 4.3: Achieve member growth (active licensed member) that paces with the dentist**
10 **market growth.**

Initiative	Success Measure – Target	Success Measure – Range	Owner	YTD Results June 2014
4.3.1 ADA, constituents, and components increase the number of members through a focus on renewal, student conversion, and recruitment in lagging markets.	129,726 Active Licensed Members by December 2014	128,800-131,000 Active Licensed Members by December 2014	Membership	118,065 active licensed members
4.3.2 Improve member service and loyalty by implementing Power of 3.	<p>Create alignment within the tripartite through 100% of key stakeholders agreeing the reversing the membership trend is one of the top three priorities for the tripartite by June 2014</p> <p>Increase member value ratings by 2% to 55% by December 2014.</p> <p>Create alignment and improved member service within the tripartite through a common infrastructure implementing 16 states on Aptify by December 2014.</p> <p>Ensure member engagement by maintaining or improving metrics from 2012 Member Loyalty Survey Research:</p> <p>Likelihood to recommend 67%</p>	<p>80%-100%</p> <p>1%-3%</p> <p>At least 14 states implemented on Aptify by December 2014.</p> <p>Likelihood to Recommend range: 64% - 70%</p>	<p>Membership</p> <p>Membership</p> <p>Technology and Membership</p> <p>Membership</p>	<p>100% agree</p> <p>Measured through Member Opinion Survey distributed in September 2014.</p> <p>5 states implemented: NH, VA, MN, IN, NV</p> <p>Measured through Member Opinion Survey distributed in September 2014.</p>

Initiative	Success Measure – Target	Success Measure – Range	Owner	YTD Results June 2014
	Likelihood to renew 83%	Likelihood to Renew range: 80% to 86%		Measured through Member Opinion Survey distributed in September 2014.

1 **Resolutions**

2 This report is informational and no resolutions are presented.

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

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

Resolution No. 100 NewReport: N/A Date Submitted: September 2014Submitted By: American Dental Political Action CommitteeReference Committee: A (Budget, Business and Administrative Matters)Total Net Financial Implication: None Net Dues Impact: _____

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

How does this resolution increase member value: See Background

DEVELOPMENT OF A MECHANISM TO ALLOW MEMBERS OF THE ALLIANCE TO THE AMERICAN DENTAL ASSOCIATION TO ACCESS THE MEMBERS ONLY AREA OF THE ADA WEB SITE

The following resolution was submitted by the American Dental Political Action Committee (ADPAC) and transmitted on September 3, 2014, by Dr. Kenneth McDougall, ADPAC chair.

Background: The Alliance is very important to the American Dental Association as Alliance members are advocates for the profession of dentistry and contribute about \$44,000 annually to ADPAC. Alliance members attend the Washington Leadership Conference and have commented that the lack of an ADA member number makes it difficult for them to register for the conference. Also, none of their members can contribute to ADPAC online because it takes an ADA member number to login to the "Donate to ADPAC" area. These roadblocks are interfering with the efforts of the Alliance members as they advocate for dentistry.

The financial impact of this resolution should be minimal as any cost could be offset with a potential for more meeting registrations, more ADA salable products ordered and more money donated to ADPAC.

Resolution

100. Resolved, that a mechanism be developed to allow members of the AADA to access the members' areas of the ADA web site and register for ADA meetings.

BOARD COMMENT: The Board of Trustees appreciates ADPAC's call for a simplified and more direct mechanism for making ADPAC contributions, registration for WLC and other conferences, and the like, and further acknowledges that this need was expressed with particular reference to the Alliance. At this time, the technical challenges inherent in building a user profile for the purposes identified by ADPAC, while at the same time maintaining the security of the "members only" content on ada.org, would require a very significant expenditure of money and would place additional pressures on staff resources. The Board asks ADPAC to find alternative solutions until such time as the ADA is appropriately prepared to address this type of request.

BOARD RECOMMENDATION: Vote No.

Vote: Resolution 100

BUCKENHEIMER	No	FEINBERG	No	KIESLING	No	STEVENS	No
COLE	No	GOUNARDES	No	KWASNY	No	SUMMERHAYS	No
CROWLEY	No	HAGENBRUCH	No	ROBERTS	No	YONEMOTO	No
DOW	No	ISRAELSON	No	SCOTT	Yes	ZENK	No
FAIR	No	JEFFERS	No	SHENKIN	No	ZUST	No

Resolution No. 112 NewReport: NA Date Submitted: October 10, 2014Submitted By: Fifth Trustee DistrictReference Committee: A (Budget, Business and Administrative Matters)Total Net Financial Implication: None Net Dues Impact: _____Amount One-time _____ Amount On-going _____ FTE 0

ADA Strategic Plan Objective: Membership-Obj. 1: Leaders and Advocates in Oral Health

How does this resolution increase member value: See Background

1 **AMENDMENT OF ADA BYLAWS TO INCLUDE THE ADA STRATEGIC PLAN IN THE POWERS OF**
2 **THE BOARD OF TRUSTEES AND EDITORIAL CONTENT OF THE JOURNAL**

3 The following resolution was adopted by the Fifth Trustee District and submitted on October 10, 2014 by
4 Dr. Howard Gamble, chair, Fifth Trustee District.

5 **Background:** *The Journal of the American Dental Association, The Journal*, is considered by many
6 inside and outside the profession of dentistry as the voice for the ADA, and likewise, the profession. It is
7 also an extension of our membership. The 2012 House of Delegates determined it to be important to add
8 three critical criteria or limiting factors in allowing the Board powers of inclusion or omission of any
9 material in our journal. They are ADA policies, advocacy efforts, and legislative agenda. In the recent
10 years, there has been much emphasis placed on our strategic plan. We feel it is important that the pillars
11 of our strategic plan be adhered to in the editorial policies of *The Journal*.

12 The intent of this resolution is to amend the bylaws so as to include our strategic plan as one of the
13 criteria or limiting factors that the Board can use to include or omit material on *The Journal*. Also, the
14 resolution gives the editor direction to adhere to the ADA strategic plan when publishing *The Journal* or
15 determining editorial policies of *The Journal*.

16 **Resolution**

17 **112. Resolved**, that the ADA *Bylaws*, Chapter VII, BOARD OF TRUSTEES, Section 90, POWERS,
18 subsection D., be amended as set forth below (additions underscored):

19 D. Cause to be published in, or to be omitted from, any official publication of the Association any
20 article in whole or in part relating to the ADA Strategic Plan, ADA policies, advocacy efforts and
21 legislative agendas.

22 and be it further

23 **Resolved**, that ADA *Bylaws*, Chapter XVII, PUBLICATIONS, Section 10, OFFICIAL JOURNAL, be
24 amended as set forth below:

25 D. EDITOR OF THE JOURNAL. Except as other provided in the powers of the Board of
26 Trustees under these *Bylaws*, as provided in Chapter VII, Section 90D, the editor of *The Journal*
27 of the American Dental Association shall have the authority to determine the editorial content of
28 *The Journal*, including scientific-based content, and shall, with the assistance of an editorial board

1 nominated by the editor and appointed by the Board of Trustees, establish and maintain a written
2 editorial policy for *The Journal* as long as the editorial policies adhere to the ADA Strategic Plan,
3 ADA policies and support ADA advocacy efforts and legislative agendas.

4 **BOARD RECOMMENDATION: Received after the September Board of Trustees session.**

Dental Benefits, Practice and Related Matters

Resolution No. 4 NewReport: N/A Date Submitted: July 2014Submitted By: Council on Dental Benefit ProgramsReference Committee: B (Dental Benefits, Practice and Related Matters)Total Net Financial Implication: None Net Dues Impact: _____Amount One-time _____ Amount On-going _____ FTE 0

ADA Strategic Plan Objective: Membership-Obj. 1: Leaders and Advocates in Oral Health

How does this resolution increase member value: See Background

AMENDMENT OF POLICY, CLOSED PANEL DENTAL BENEFIT PLANS**Background:** (*Reports: 83*)

Amendment of Policy, Closed Panel Dental Benefit Plans: A resolution (Resolution 10) on the policy on "Closed Panel Dental Benefit Plans" (*Trans.1989:545*) was originally submitted to the 2013 House of Delegates with a recommendation from CDBP that the policy be rescinded. Resolution 10 was referred to the appropriate agency for review with a report to the 2014 House. After further review, the Council recommends that this policy be amended and presents the following new resolution.

Resolution

4. Resolved, that the ADA policy on Closed Panel Dental Benefit Plans (*Trans.1989:545*) be amended through text additions and deletions, so that the amended policy reads as follows (additions are underscored; deletions are ~~stricken~~):

A closed panel dental benefit plan exists when patients eligible to receive benefits can receive them only if services are provided by dentists who have signed an agreement with the benefit plan to provide treatment to eligible patients. As a result of the dentist reimbursement methods characteristic of a closed panel plan, only a small percentage of practicing dentists in a given geographical area are typically contracted by the plan to provide dental services.

While the Association recognizes this concept as one way of ~~providing benefits for delivering and financing~~ dental services, closed panel plans have not ~~been shown demonstrated themselves to~~ be more economical, efficient or otherwise better than other forms of dental benefit plans in ~~effectively providing dental benefits to patients~~. Further, due to the ~~overwhelming economic~~ incentive for patients to choose a personal dentist from a limited number of available contracted dentists, this benefit concept has the potential to reduce the patient's access to ~~comprehensive~~ any dental care.

In view of these concerns, the Association opposes this approach as the only dental benefit plan available to ~~subscribers patients~~. To protect the patient's freedom to receive benefits for dental services provided by any legally qualified dentist of his or her choice, the Association suggests the following guidelines for dental benefit plan sponsors who choose to offer a closed panel dental benefit plan:

1. Benefit programs that offer dental benefits through a closed panel should also offer a plan with equal or comparable benefits that permits free choice of dentist under a fee-for-service arrangement.
2. ~~Equal premium dollars should be allocated between the freedom of choice plan and the closed panel plan. There should be equal premium dollars per subscriber available for all dental plans being offered.~~
3. A complete description of benefits provided under each plan should be given to all eligible individuals prior to each enrollment period. Benefit limitations and exclusions of each plan should be clearly described, and a complete and current list of dentists who participate in the closed panel plan should be provided and updated semi-annually.
4. The freedom of choice plan should be designated the primary enrollment plan, i.e., eligible individuals who fail to enroll in any plan should be enrolled in the freedom of choice plan.
5. Subscribers should have periodic options to change plans.
6. ~~When requested by the patient, the closed panel plan should provide benefits for a second opinion provided by a dentist who does not participate in the closed panel plan.~~

BOARD COMMENT: See Council Substitute Resolution 4S-1 (Worksheet:3001a)

Resolution No. 4S-1 Substitute

Report: N/A Date Submitted: September 2014

Submitted By: Council on Dental Benefit Programs

Reference Committee: B (Dental Benefits, Practice and Related Matters)

Total Net Financial Implication: None Net Dues Impact: _____

Amount One-time _____ Amount On-going _____ FTE 0

ADA Strategic Plan Objective: Membership-Obj. 1: Leaders and Advocates in Oral Health

How does this resolution increase member value: See Background

SUBSTITUTE FOR RESOLUTION 4: AMENDMENT OF POLICY, CLOSED PANEL DENTAL BENEFITS

The following substitute for Resolution 4 (Worksheet:3000) was submitted by the Council on Dental Benefit Programs and transmitted on August 4, 2014, by Dr. Andrew Vorrasi, chair.

Background: The Council has modified Resolution 4 specifically in describing the concept of Closed Panel Benefits that originally used the phrase “delivering and financing dental services”. The amended resolution has been modified to only include “financing dental services” to more appropriately characterize the function of a dental benefit program. The Council therefore recommends the following substitute resolution.

Resolution

4S-1. Resolved, that the ADA policy on Closed Panel Dental Benefit Plans (*Trans. 1989:545*) be amended through text additions and deletions, so that the amended policy reads as follows (additions are underscored; deletions are ~~stricken~~):

A closed panel dental benefit plan exists when patients eligible to receive benefits can receive them only if services are provided by dentists who have signed an agreement with the benefit plan to provide treatment to eligible patients. As a result of the dentist reimbursement methods characteristic of a closed panel plan, only a small percentage of practicing dentists in a given geographical area are typically contracted by the plan to provide dental services.

While the Association recognizes this concept as one way of ~~providing benefits for financing~~ dental services, closed panel plans have not been shown ~~demonstrated themselves~~ to be more economical, efficient or otherwise better than other forms of dental benefit plans in ~~effectively providing dental benefits to patients~~. Further, due to the ~~overwhelming~~ economic incentive for patients to choose a personal dentist from a limited number of ~~available contracted~~ dentists, this benefit concept has the potential to reduce the patient's access to ~~comprehensive any~~ dental care.

In view of these concerns, the Association opposes this approach as the only dental benefit plan available to ~~subscribers~~ patients. To protect the patient's freedom to receive benefits for dental services provided by any legally qualified dentist of his or her choice, the Association suggests

the following guidelines for dental benefit plan sponsors who choose to offer a closed panel dental benefit plan:

1. Benefit programs that offer dental benefits through a closed panel should also offer a plan with equal or comparable benefits that permits free choice of dentist under a fee-for-service arrangement.
2. ~~Equal premium dollars should be allocated between the freedom of choice plan and the closed panel plan.~~ There should be equal premium dollars per subscriber available for all dental plans being offered.
3. A complete description of benefits provided under each plan should be given to all eligible individuals prior to each enrollment period. Benefit limitations and exclusions of each plan should be clearly described, and a complete and current list of dentists who participate in the closed panel plan should be provided and updated semi-annually.
4. The freedom of choice plan should be designated the primary enrollment plan, i.e., eligible individuals who fail to enroll in any plan should be enrolled in the freedom of choice plan.
5. Subscribers should have periodic options to change plans.
6. ~~When requested by the patient, the closed panel plan should provide benefits for a second opinion provided by a dentist who does not participate in the closed panel plan.~~

BOARD RECOMMENDATION: Vote Yes on the Substitute.

BOARD VOTE: UNANIMOUS.

Resolution No. 5 NewReport: N/A Date Submitted: July 2014Submitted By: Council on Dental Benefit ProgramsReference Committee: B (Dental Benefits, Practice and Related Matters)Total Net Financial Implication: None Net Dues Impact: _____Amount One-time _____ Amount On-going _____ FTE 0

ADA Strategic Plan Objective: Membership-Obj. 1: Leaders and Advocates in Oral Health

How does this resolution increase member value: See Background

AMENDMENT OF POLICY ON MEDICALLY NECESSARY CARE**Background:** (*Reports: 84*)

Amendment of Policy on Medically Necessary Care: In 2013, CDBP suggested amendments to the policy titled, Medically Necessary Care (*Trans.1988:474; 1996:686*). The 2013 House of Delegates referred to the appropriate agency Resolutions 20 and 20S-1 for study and report to the 2014 House. Additionally, the 2013 House requested responses to specific questions raised by the reference committee. The Council's responses follow.

Why was this activity discontinued?

The Council did not find any historical records indicating when or why this activity was discontinued.

Upon review of the resolution, at this time, the Council continues to strongly support the original amendment to the policy on Medically Necessary Care as proposed by CDBP in 2013 with minor changes. The Council recommends that employers not be contacted due to privacy provisions of the Health Insurance Portability and Accountability Act (HIPAA) and the resulting business associate agreements that would need to be signed. This may expose the ADA to risk of being found in violation of HIPAA rules which could result in substantial civil monetary penalties. This requirement was not in place when the original resolution was passed in 1988.

What was the original purpose of the allocated funds?

A review of the Resolution Worksheets from 1988 (Resolution 36) and 1996 (Resolution 13) and the Reference Committee reports found that the financial implication was marked as "None." There was no documented allocation of funds associated with these resolutions.

If the funds were budgeted on an ongoing basis, were those funds discontinued or reallocated?

See above.

After further review, CDBP recommends that parts of both Resolution 20-2013 (*Trans.2013:317*) and Resolution 20S-1-2013 (*Trans.2013:318*) be combined into a revised and updated policy and is presenting a new Resolution 5.

Resolution

5. Resolved, that the ADA policy on Medically Necessary Care (*Trans.*1988:474; 1996:686) be amended through text additions and deletions, so that the amended policy reads as follows (additions are underscored; deletions are ~~stricken~~):

Resolved, that the American Dental Association ~~make every effort~~ advocate on behalf of patients to ~~see that~~ ensure the language specifying treatment coverage in health insurance plans is clarified so that medically necessary care, essential to the successful treatment of a medical or dental condition being treated by a multidisciplinary health care team is available to the patient, and be it further

Resolved, that third-party payers and their consultants should appropriately limit their benefit determinations to plan design and make benefit determinations based on medical necessity with the complete information that would be required for a definitive diagnosis. ~~when the ADA is notified of a situation in which a patient's treatment is jeopardized by the narrow interpretation of language contained in a medical benefit policy, the Association, with the assistance of its legal advisor, shall contact the plan purchaser directly in an effort to see that the employer's intentions regarding the benefit purchased for the employee are conveyed to the third-party payer.~~

BOARD RECOMMENDATION: Vote Yes.

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

***Dr. Fair was absent.**

Resolution No. 14 New

Report: N/A Date Submitted: July 2014

Submitted By: Council on Dental Practice

Reference Committee: B (Dental Benefits, Practice and Related Matters)

Total Net Financial Implication: None Net Dues Impact: None

Amount One-time	Amount On-going	FTE	0
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ADA Strategic Plan Objective: Membership-Obj. 1: Leaders and Advocates in Oral Health

How does this resolution increase member value: See Background

AMENDMENT OF THE ADA BYLAWS REGARDING THE DUTIES OF THE COUNCIL ON DENTAL PRACTICE

Background: (*Reports: 131*)

Amendment of the ADA Bylaws Regarding the Duties of the Council on Dental Practice: In accordance with Resolution 1H-2013 (*Trans.*2013:339), the Council on Dental Practice (CDP) conducted a self-assessment based on the topic outline developed by the Board of Trustees. The process was undertaken by the CDP Subcommittee on Policy Revision.

Members agreed that CDP was an essential and integral ADA council because its various programs and activities touch every facet of the personal and professional life of a member. The structure, areas of responsibility, primary issues, agenda and key activities of the CDP were deemed appropriate and efficient.

Discussion of the Council's *Bylaws* revealed that there were two bylaws specific to the dental laboratory profession, and that these could be combined and restated as a single bylaw. Members noted that the origins of CDP go back to 1945 and the Council was formed with the specific purpose of addressing dental trade and laboratory relations. They noted the historical significance of maintaining a vibrant relationship with the dental laboratory industry, concern that only 17 dental laboratory training programs remain operating within the U.S., and that the ongoing trend towards offshore fulfillment of dental laboratory prescriptions all support the maintenance of a bylaw specific to dental laboratory issues.

This resolution increases member value by streamlining the Council *Bylaws* and will help improve operational efficiencies and focus of the Council.

As a result of the assessment, the Council presents the following resolutions to the House of Delegates:

Resolution

14. Resolved, that CHAPTER X. COUNCILS, *Section 120. DUTIES*, Subsection F. COUNCIL ON DENTAL PRACTICE, Paragraphs d and e of the ADA *Bylaws*, be amended as follows (additions are underscored; deletions are stricken):

d. Encourage and develop satisfactory relations with the various organizations representing the dental laboratory industry and craft by aiding in the formation and support of educational programs and appropriate collaborative efforts that help establish and maintain,

1 ~~e. to formulate programs for establishing and maintaining the greatest efficiency, and quality and~~
2 ~~of service by of the dental laboratory industry and craft in their relation to the dental profession.~~

3 and be it further

4 **Resolved**, that subsequent paragraphs f through j of CHAPTER X. COUNCILS, *Section 120.*
5 DUTIES, Subsection F. COUNCIL ON DENTAL PRACTICE, be re-lettered e through i.

6 **BOARD RECOMMENDATION: Vote Yes.**

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

9 ***Dr. Fair was absent.**

Resolution No. 28 NewReport: N/A Date Submitted: May 2014Submitted By: Eighth Trustee DistrictReference Committee: B (Dental Benefits, Practice and Related Matters)Total Net Financial Implication: None Net Dues Impact: _____Amount One-time _____ Amount On-going _____ FTE 0

ADA Strategic Plan Objective: Membership-Obj. 1: Leaders and Advocates in Oral Health

How does this resolution increase member value: See Background

CHAIRSIDE MEDICAL SCREENINGS

The following resolution was submitted by the Eighth Trustee District and transmitted on May 9, 2014, by Mr. Gregory A. Johnson, executive director, Illinois State Dental Society.

Background: A recent study by the ADA Health Policy Resources Center (HPRC) stated screening for diabetes, high blood pressure and high cholesterol in the dental office could save the health care system from \$42.4 million to \$102.6 million each year. The study reviewed data of adults 40 years of age and older that had no reported history of coronary heart disease or diabetes, no disease risk factors, were not taking medication for these conditions and had not seen a physician in the past year.

The Center for Disease Control and Prevention states that 7.8% of the U.S. population has undiagnosed hypertension, 2.7% has undiagnosed diabetes and 8.2% has undiagnosed high cholesterol. The HPRC authors commented that 27 million people visit a dentist but not a physician in a given year and that this presents the opportunity for dentists to assist our medical colleagues in screening for those patients of record who are in need of further medical evaluation. This would also provide the public with an excellent opportunity to have dentistry as a more integral part of what is presently considered by many authorities as a best-practice, thoroughly inclusive, medical healthcare team expressly designed for optimal patient treatment and safety.

Resolution

28.Resolved, that the ADA encourage its members to incorporate appropriate medical screening methods into patient evaluations, where legally permitted by their state dental practice act.

BOARD RECOMMENDATION: Vote Yes.

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

***Dr. Fair was absent.**

Resolution No. 34 NewReport: CDP Supplemental Report 1 Date Submitted: September 2014Submitted By: Council on Dental PracticeReference Committee: B (Dental Benefits, Practice and Related Matters)Total Net Financial Implication: None Net Dues Impact: _____Amount One-time _____ Amount On-going _____ FTE 0

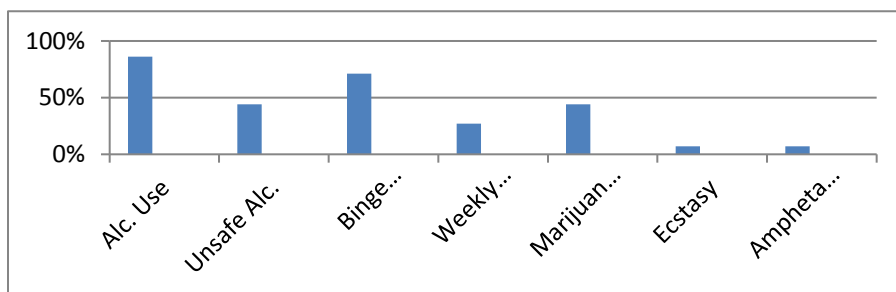
ADA Strategic Plan Objective: Membership-Obj. 2: Market share will equal 70%

How does this resolution increase member value: See Background

**COUNCIL ON DENTAL PRACTICE SUPPLEMENTAL REPORT 1 TO THE HOUSE OF DELEGATES:
ADA POLICY FOR DENTAL SCHOOLS TO PROVIDE EDUCATION TO DENTAL STUDENTS ON
DRUG AND ALCOHOL USE AND MISUSE**

Background: In May 2014, the Council on Dental Practice (CDP) considered the report of the Dental Wellness Advisory Committee (DWAC), which expressed concern for the health and well-being of dental students after learning of the tragic death of a fourth year dental student, an apparent suicide. The report stated a need for appropriate educational resources and support for dental students affected by addiction, burnout and/or depression and asked the American Dental Association Dentist Health and Wellness Program Committee to work with dental Schools and offer [complimentary resources](#) on emotional health and drug and alcohol misuse to dental students. A 2006 study featured in the *British Dental Journal* found alcohol use was reported by 86% of dental students, with 44% of dental students estimating they drank above the recommended safe limits. Binge drinking was reported by 71% of dental students, with weekly binge drinking reported by 27% of dental students. Forty-four percent of the dental students reported that they used marijuana while 7% reported using ecstasy and amphetamines. The report also stressed the importance of higher education becoming more proactive in the prevention of drug and alcohol abuse amongst dental students.¹

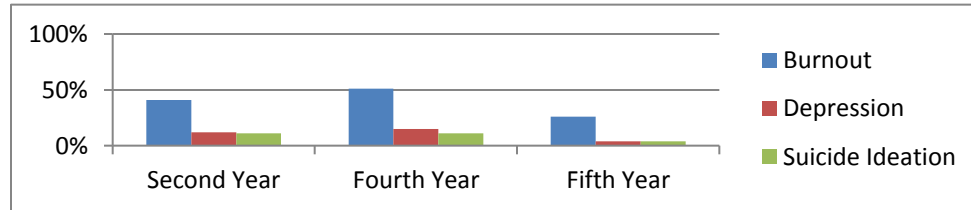
Table 1: Dental Student Rates of Drug Use



A 2013 report by the University of Seville's Department of Medicine brought attention to the high prevalence of burnout and depression and reported for the first time the prevalence of suicidal ideation among dental students in preclinical and clinical years. Forty-one percent of second year dental students experienced burnout while 12% were screened positively for depression. Eleven percent of second year students dealt with suicide ideation. Fifty-one percent of fourth year students experience burnout while 15% were screened positively for depression. Eleven percent of fourth year students had thoughts about

1 suicide. Twenty-six percent of fifth year students experienced burnout while 4% were screened positively
2 for depression. Four percent of fifth year students had thoughts about suicide.²

3 Table 2: Prevalence of Suicide Ideation among Dental Students in Pre-Clinical and Clinical Years



4 The report also provided research on the extent to which patient-specific substance use and dependence
5 education appears in current predoctoral dental curricula. At least one institution—the University of
6 California, Los Angeles (UCLA) School of Dentistry—responded to this call for education about addiction,
7 warning signs in patients, and effective treatment approaches.

8 In 2009, a comprehensive survey examined the predoctoral dental curriculum devoted to substance use
9 and dependence in the United States and Canada and specifically examined curriculum time allotted to
10 teach dental students about patients' alcohol, prescription drugs and other substance use and
11 dependence. Out of the 66 dental schools that responded, 50 schools (90.9%) reported that their
12 curriculum addressed alcohol use and dependence. The total time in contact hours spent learning about
13 alcohol use and dependence varied from 2.63 hours to 4.44 hours. Fifty two schools (94.5%) responding
14 reported that their curriculum addressed prescription drug misuse and abuse with a mean of 1.38 hours to
15 2.33 hours of teaching. Only 40 schools (72.7%) responding reported that their curriculum addressed
16 other substance use and dependence (e.g., methamphetamine, marijuana, cocaine, or inhalants). The
17 total time of contact hours on this topic ranged from 2.03 hours to 3.08 hours.³

18 Based on the DWAC report, the Council sought information from the Division of Education/Professional
19 Affairs about what role the Association might play in educating dental students on personal drug and
20 alcohol use and misuse, as well as their emotional health. The Council concluded that the ADA should
21 have formal policy encouraging dental schools to provide comprehensive resources to students on a
22 diverse range of problems related to their own alcohol and drug use and misuse and their mental health
23 with the goal of preserving the quality of life and performance, protection of their patients and their own
24 well-being.

25 While educational hours on patient focused drug abuse issues are part of the dental school curriculum,
26 there appears to be little or no emphasis on the dental student. Therefore, the Council recommends
27 adoption of the following resolution.

28 Resolution

29 **34. Resolved**, that U.S. dental schools are urged to incorporate the American Dental Association
30 Dentist Health and Wellness Program's complimentary resources on emotional health and drug and
31 alcohol misuse into the dental education curriculum to help minimize risks to dental students' health,
32 professional status and patient safety, and be it further

33 **Resolved**, that state dental societies be urged to support this effort through state-sponsored well-
34 being programs and additional resources for dental students on emotional health and drug and
35 alcohol misuse.

36 **BOARD RECOMMENDATION: Vote Yes.**

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

REFERENCES

- ¹ Barber, M.W. and Fairclough, A. (2006). "*A comparison of alcohol and drug use among dental undergraduates and a group of non-medical, professional undergraduates.*" British Dental Journal 201(9): 581-584.
- ²Galán, F., Ríos-Santos, J.V., Polo, J., Rios-Carrasco, B., Bullón, P. (2014). "*Burnout, depression and suicidal ideation in dental students.*" Medicina Oral, Patologia Oral, Cirugia Bucal19(3):e206-11.
- ³Huggett, K.N., Westerman, G.H., Lofgreen, A.S. (2011). "*Substance use dependence education in predoctoral dental curricula: Results of a survey of U.S. and Canadian dental schools.*" Journal of Dental Education 75(8): 1003-1009.

Resolution No. 62 NewReport: CDP Supplemental Report 2 Date Submitted: September 2014Submitted By: Council on Dental PracticeReference Committee: B (Dental Benefits, Practice and Related Matters)

Total Net Financial Implication:	<u>\$198,305.00</u>	Net Dues Impact:	<u>0.76</u>
			<u>\$84,200.00 (2015)</u>
Amount One-time	<u>0</u>	Amount On-going	<u>\$114,105.00 (2016)</u>
		FTE	<u>0.6</u>

ADA Strategic Plan Objective: Membership-Obj. 3: 10% increase in assessment of member value

How does this resolution increase member value: See Background

**COUNCIL ON DENTAL PRACTICE SUPPLEMENTAL REPORT 2 TO THE HOUSE OF DELEGATES:
DEVELOPMENT OF ETHICALLY BASED, VOLUNTARY PRACTICE MANAGEMENT GUIDELINES**

Background: The Council on Dental Practice (CDP) has received many inquiries regarding the availability of ADA-endorsed best practices or guidelines on practice management. One of the most compelling requests was for guidance on charging credit cards for services before they are delivered.

In response to these inquiries, the CDP convened an Ad hoc Advisory Committee (AAC) in March 2014, to assess whether the ADA should develop ethically based, voluntary practice management guidelines (Guidelines) as a resource for all members, with the expectation that guidelines would be of greatest interest to recent graduates and new dentists. Seeking a wide range of opinion, the AAC was comprised of six CDP members; one member from the Council on Access, Prevention and Interprofessional Relations (CAPIR), one from the Council on Dental Benefit Programs (CDBP), one from the New Dentist Committee (NDC), and two from the Council on Ethics, Bylaws and Judicial Affairs (CEBJA). Also participating were representatives from the Academy of Dental Management Consultants (ADMC), the American Association of Dental Office Managers (AADOM), the Association of Dental Support Organizations (ADSO), the Dental Assisting National Board (DANB), and a representative from Midwest Dental Management, Inc.

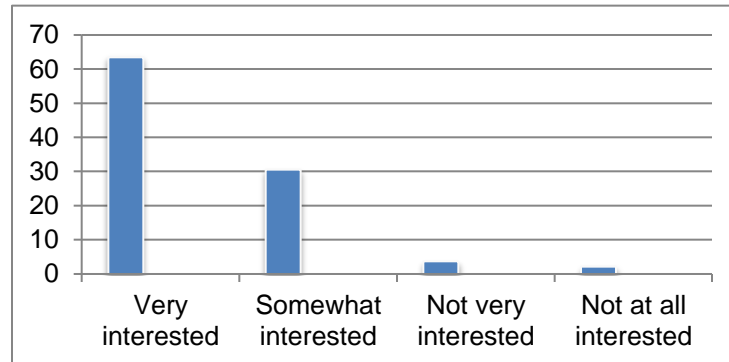
The AAC recommended the development of Guidelines in five major subject areas: patient issues; financial matters; the practice environment; managing the dental team; and technology. They also recommended the development of a free, confidential, online assessment tool that would allow members to assess their practice management expertise in each category and identify areas that could benefit from additional information or education.

A June 2014 survey of practicing dentists assessed the level of interest in the concepts of a self-assessment tool and Guidelines, to determine which topics were of most interest to dentists and whether the Guidelines would enhance the value of ADA membership. Respondents included dentists from various types of practice settings (solo practice to nonprofit) and included owners, partners, employees and contractors. ADA leaders were excluded. Survey results are outlined in Appendix 1.

The survey reveals wide interest in Guidelines, with strong interest from younger dentists (Tables 1 and 2).

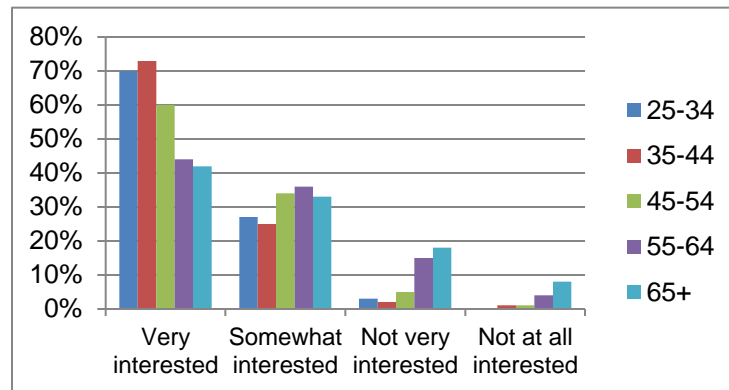
1

Table 1: Overall interest in Guidelines



2

Table 2: Overall interest in Guidelines by age

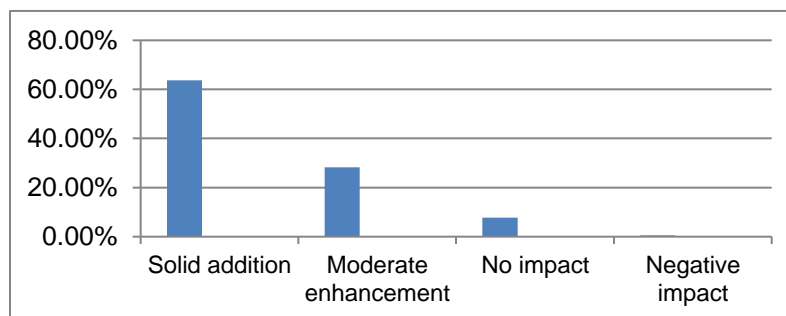


3 More than 94% of respondents report being “very” or “somewhat” interested in practice management
4 guidelines. The highest indicator of interest (very interested) was shown at higher levels by recent
5 graduates and new dentists, indicating that early career assistance in determining business practices is
6 needed.

7 Member value of this project was also evaluated in the survey (Table 3). Approximately 92% of dentists
8 who responded find the Guidelines will have a positive impact on the value of ADA membership. Nearly
9 64% of respondents report that practice management guidelines will be a “solid” addition to the value of
10 ADA membership and another 28% rank the Guidelines as a “moderate” enhancement to ADA
11 membership.

12

Table 3: Impact on ADA Membership Value



1 Additional survey results find that less than 13% of respondents rate their expertise in practice
2 management as “excellent” while only 5% of recent graduates, and 6% of new dentists, report at that
3 level.

4 **Process:** The proposed Guidelines will be developed in five subject areas; patients, the practice
5 environment, dental practice team, technology and financial matters. If funded, in Year One (2015) of the
6 project, a Steering Committee comprised of current CDP members appointed to the Advisory Committee
7 and representatives from NDC, AADOM, ADMC and ADSO will hold a one-day meeting to identify subject
8 matter experts (SMEs) in the area of patient issues, and other SMEs in financial matters. These two
9 subject areas were of high interest to the surveyed dentists, particularly with younger and female dentists.
10 Each group of SMEs would then convene for a two-day meeting to develop the guidelines within its
11 subject area. Additional work will be done electronically and via conference call. A professional writer,
12 familiar with practice management concepts and best practices, will be retained to attend each meeting
13 and draft guidelines to ensure accuracy, practicality, and consistency of style, voice and construction.

14 Once developed, the Steering Committee will distribute the draft guidelines for review and comment to
15 CDP, CAPIR, CDBP, CEBJA and NDC as well as other appropriate internal and external stakeholders
16 prior to publication, thereby ensuring review via a consensus process that involves a diverse group of
17 participants. Since nearly 56% of survey respondents indicate they prefer to access practice management
18 resources online, the final guidelines will be posted on the Center for Professional Success website.
19 Opportunities to cross-promote existing ADA salable materials or new materials developed as a result of
20 this process will be optimized; fewer than 50% of dentists surveyed prefer an option of print materials.
21 The content may also lend itself to online continuing education courses. A communications plan will be
22 developed to market the Guidelines for maximum impact using staff marketing experts. Opportunities to
23 support the launch of the Guidelines in Year One, and the rollout of additional Guidelines in Year Two, will
24 include targeted promotions to select market segments with a focus on recent graduates and new
25 dentists.

26 Year Two (2016) deliverables will include Guidelines dealing with issues that impact the practice
27 environment, matters pertaining to the dental team, and technology. The process will operate in the same
28 manner as followed in Year One, with the Steering Committee having a one-day meeting to identify SMEs
29 in the remaining three areas and with each group having two separate two-day meetings. The contracted
30 writer would be retained to attend meetings and facilitate the Guidelines development process.

31 All published Guidelines will be updated and maintained on an as-need basis by the CDP, beginning in
32 2017.

33 **Budget:** Because of the due diligence needed to develop this concept and acquire market research, this
34 project was not included in the 2015 budgeting process. The development of Guidelines is projected to
35 require two years. The budget for this project appears in Table 4. A portion of one existing, full time
36 employee (FTE) (60%) will be allocated for development of this project.

37 While the total cost to develop practice management guidelines over two years is estimated at \$198,305
38 excluding existing staff costs, the 2014 House of Delegates is asked to provide funding for Year One
39 deliverables only of \$84,200. Funding for Year Two and any subsequent maintenance funding will be
40 incorporated into the annual budgeting process, and the appropriate usage and value metrics will be used
41 to justify continued funding. Year One (2015) deliverables include the online assessment tool and
42 guidelines on patient issues and financial matters.

Table 4: Operating Budget, 2015-2016 Guidelines

Program Expense	2015 YEAR ONE	2016 YEAR TWO	Total Cost to Develop 2 Year Program
In-Person Meetings (Steering Committee, SMEs)	46,200.00	72,105.00	118,305
Professional Writer	28,000.00	42,000.00	70,000.00
IT Development	10,000.00	0	10,000.00
Marketing	15,000.00	15,000.00	30,000.00
Sponsorships	(15,000.00)	(15,000.00)	(30,000.00)
Total	84,200.00	114,105.00	198,305.00

Increased member value and high member interest in the development of ethically based, voluntary practice management guidelines, especially by new dentists has been demonstrated. Therefore, the Council on Dental Practice recommends adoption of the following resolution:

Resolution

62. Resolved, that \$84,200 be allocated in the 2015 budget to fund the first year of the development of practice management guidelines in two subject areas, patients and financial matters, by the Council on Dental Practice (CDP).

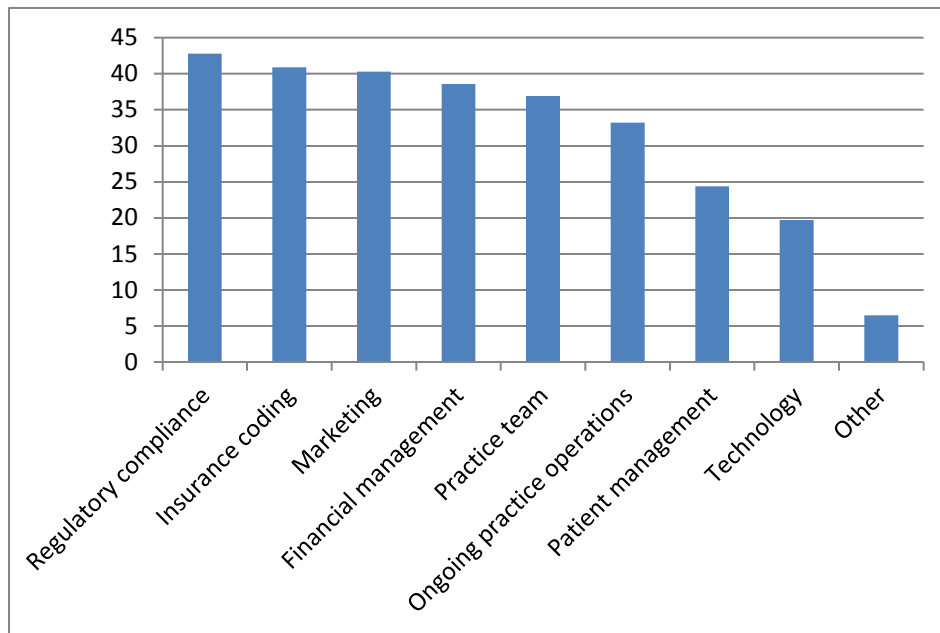
BOARD RECOMMENDATION: Vote Yes

BOARD VOTE: UNANIMOUS.

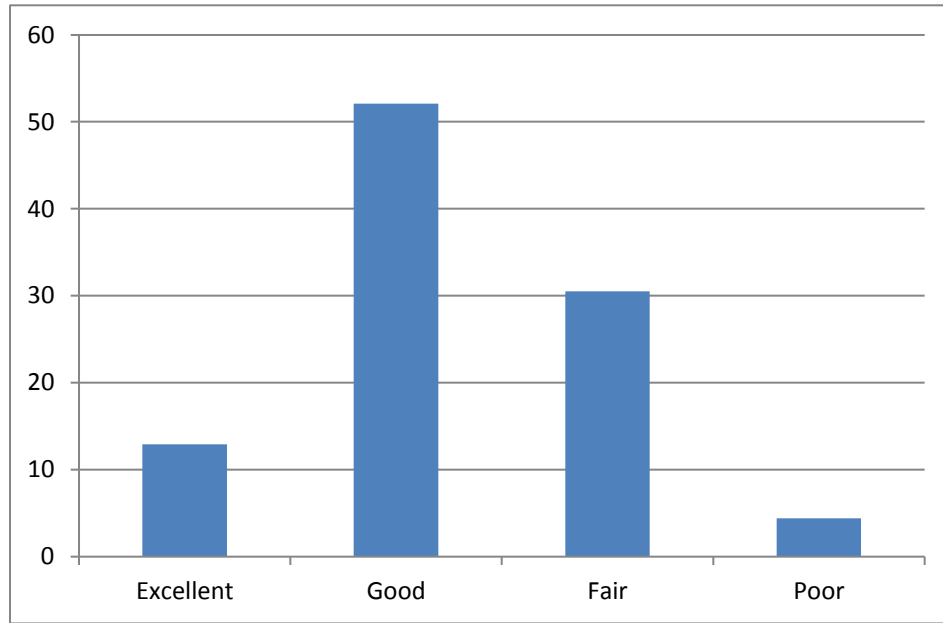
APPENDIX 1
Key Findings of the Council on Dental Practice's
2014 Practice Management Survey

A recent survey was commissioned in June 2014 by the Council on Dental Practice in which 20,000 dentists were invited to participate. Seven hundred eight member and non-member dentists responded to the survey over a two week period for a 3.5 percent response rate. Results showed a 95 percent confidence level and a margin of error of +/- 3.7 percent. The survey results are as follows:

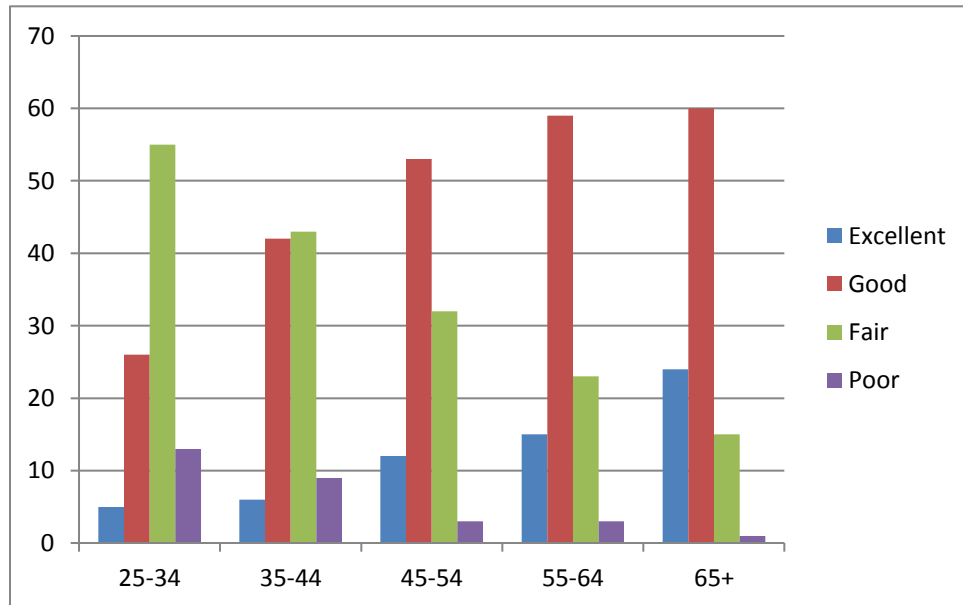
Table 1: What are your primary practice management concerns?



**Table 2: How would you assess your level of practice management expertise?
(all respondents)**



**Table 2a: How would you assess your level of practice management expertise?
(by respondent age)**



**Table 2b: How would you assess your level of practice management expertise?
(by respondent gender)**

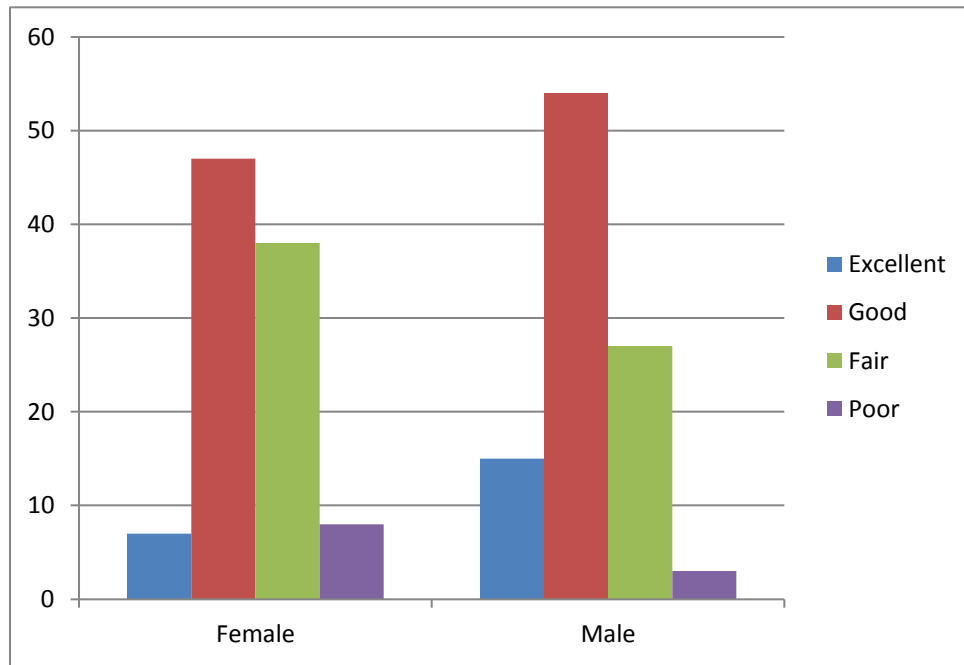


Table 3: How interested would you be in accessing free, ethically based, voluntary practice management guidelines? (all respondents)

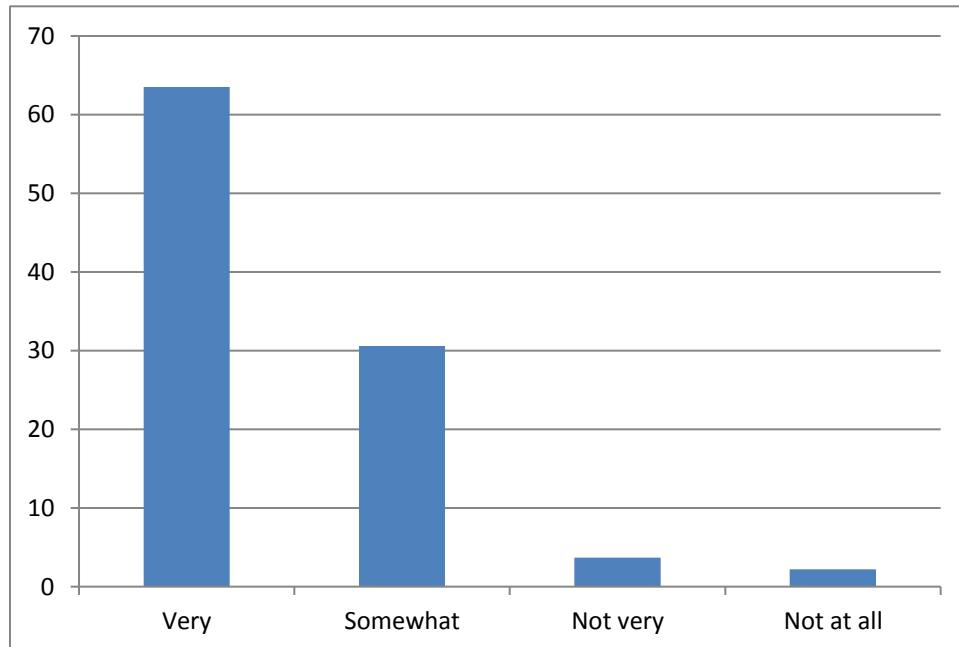


Table 3a: How interested would you be in ethically based, voluntary practice management guidelines? (by respondent age)

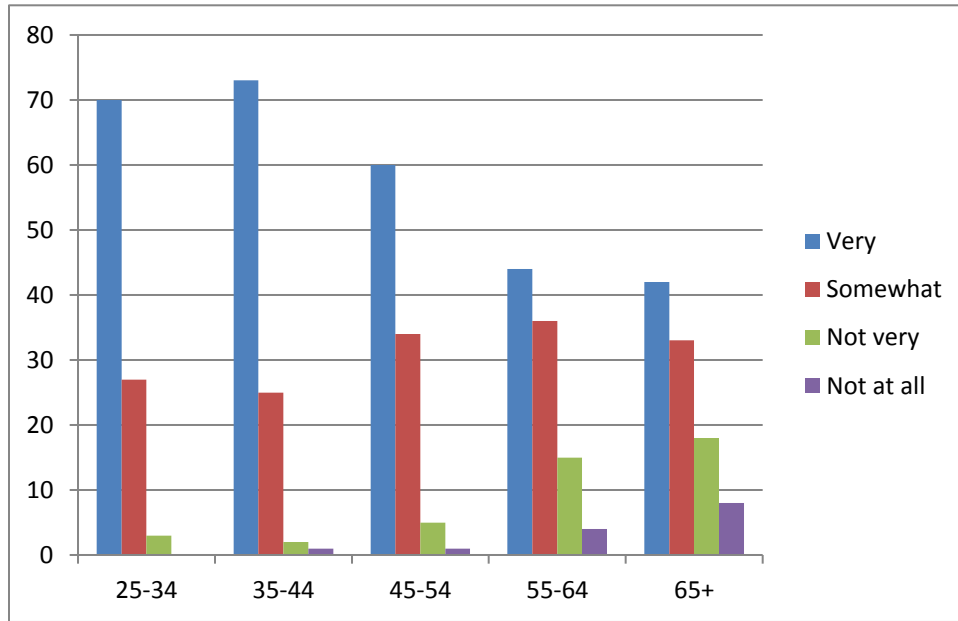


Table 4: How would free, ethically based, voluntary practice management guidelines impact the value of ADA membership?

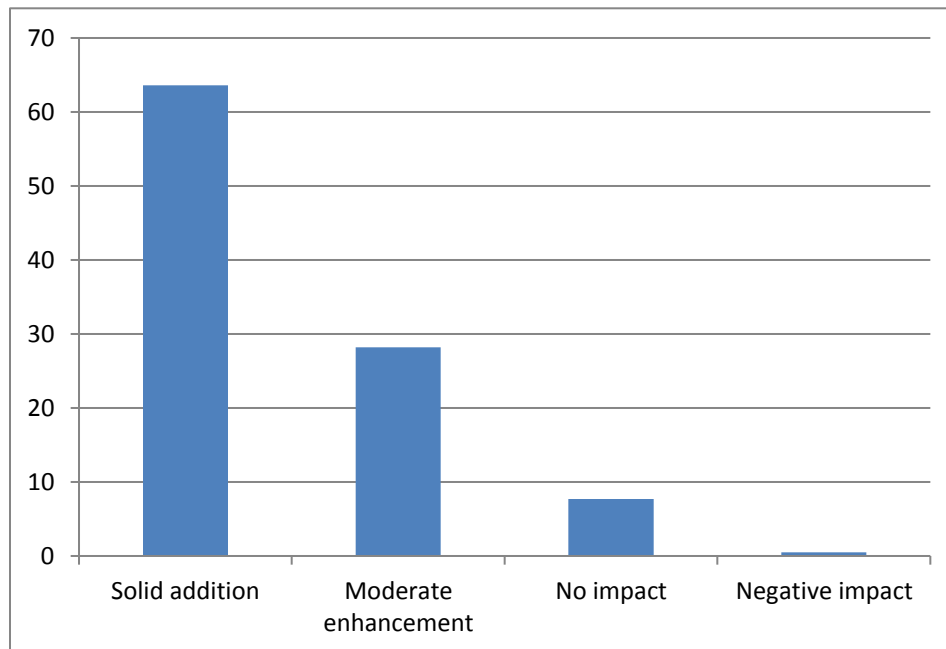


Table 5: How interested would you be in a free, personalized, confidential, online self-assessment tool that allowed you to determine practice management topics that might benefit from additional attention or education?

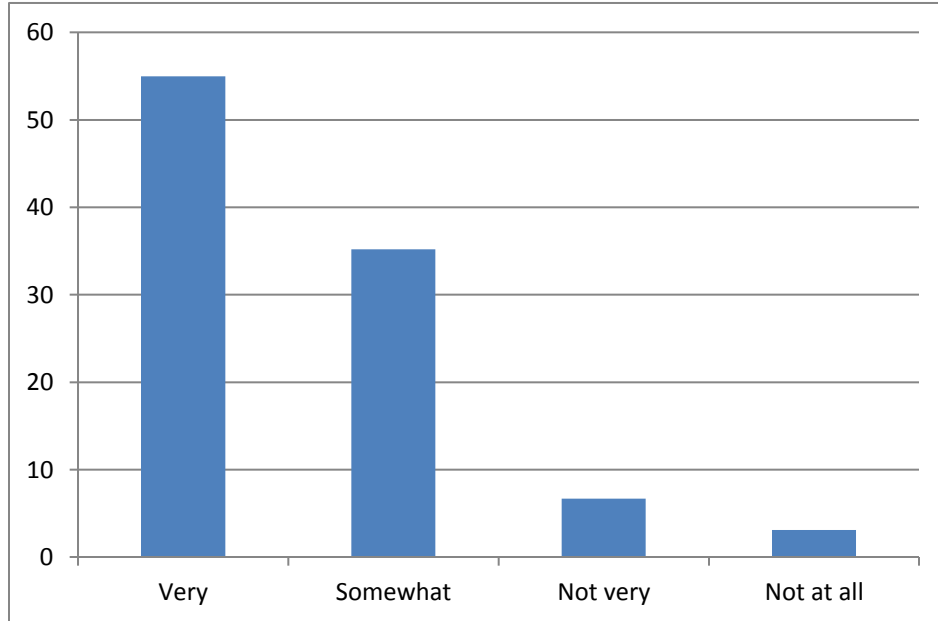
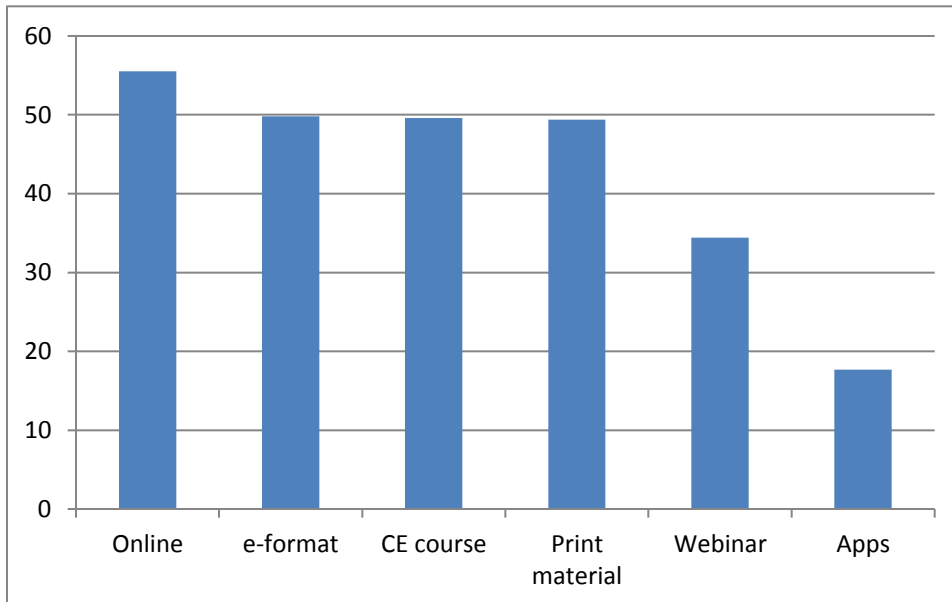
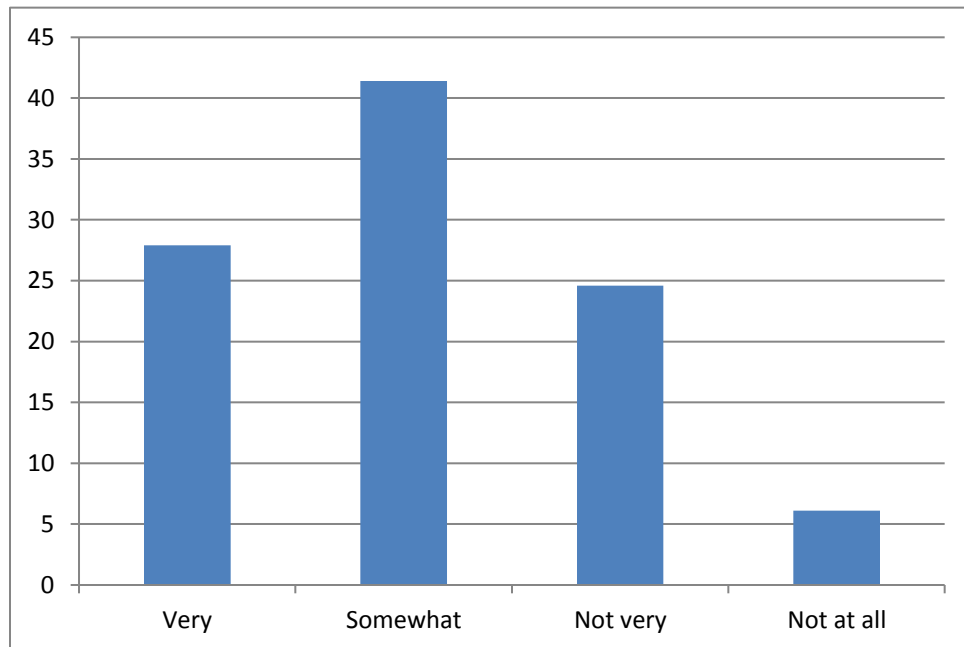


Table 6: How do you prefer to access practice management resources?



1 **Table 7: How important is CE credit when acquiring practice management information?**



Resolution No. 63 NewReport: N/A Date Submitted: August 2014Submitted By: Fourteenth Trustee DistrictReference Committee: B (Dental Benefits, Practice and Related Matters)Total Net Financial Implication: Res. 63--\$125,600; Res. 63B--\$0 Net Dues Impact: Res. 63--\$1.14Amount One-time Res. 63--\$125,600 Amount On-going 0 FTE 63B--.10

ADA Strategic Plan Objective: Membership-Obj. 1: Leaders and Advocates in Oral Health

How does this resolution increase member value: See Background

1 **CDT GUIDELINES FOR THE AFFORDABLE CARE ACT**2 The following resolution was adopted by the Fourteenth Trustee District and transmitted on August 24,
3 2014, by Dr A.J. Smith, chair, Resolutions Committee.

4 **Background:** One of the unforeseen complications of the Affordable Care Act (ACA) relates to the
5 coverage of dental Essential Health Benefits (EHB) to children under the age of 19. In many cases
6 gaining access to these benefits requires practices to file medical claims knowing that they will be denied,
7 prior to filing a dental claim. Giving dentists the tools to file complicated medical claims and giving them a
8 better idea of what to expect, will allow these practices to provide these services and access the
9 mandated benefits. As the trusted source of information for dental practice, utilizing ADA resources to
10 research and advise will benefit members across the country that find the ACA baffling and aid these
11 practices in providing access and essential services to millions of patients covered by the ACA. Some of
12 the issues that need to be addressed include:

- 13 • How do we bill for services to our young patient's medical insurance?
- 14 • How are benefits coordinated with the parent's medical insurance with two different medical
15 insurances and deductibles?
- 16 • How are fee schedules determined for dentists who are not contracted with medical insurance
17 companies?
- 18 • How is the primary coverage determined between ACA compliant medical insurances and
19 conventional dental policies?
- 20 • How do dentists contract with medical insurances when these companies must implement dental
21 EHB for ACA compliant plans?

22 Including this information in the future editions of the CDT Companion would enhance the value of the
23 publication and provide an appreciated service to our members.

24 **Resolution**

25 **63. Resolved,** that the ADA develop guidelines as they pertain to the coordination of medical and
26 dental benefits under the Affordable Care Act, and be it further

27 **Resolved,** that these guidelines be included in future editions of the CDT Companion, and be it
28 further

Resolved, that a report on these activities be presented to the 2015 House of Delegates.

BOARD COMMENT: The Board of Trustees recognizes the issues identified in the report's background, and appreciates the Fourteenth District's Resolution. As noted by the Fourteenth District, advent of "embedded products" wherein the dental benefit is embedded within a medical plan poses new administrative demands such as claim submission, and coordination of benefits. This is a fresh path to tread for most dentists.

The Board of Trustees agrees that ADA guidance on addressing these issues arising from the Affordable Care Act would be a service to members. We question, however, the wisdom of limiting dissemination of any such guidance to a single publication, the CDT Companion as specified in the second resolving clause. The Board notes successful use of *ADA News* and *CPS* to disseminate information about the ACA in late 2013 and 2014.

Further, the Board believes that there would be a significant financial implication for such a project which is yet to be determined.

The Board submits the following substitute resolution.

Resolution

63B. Resolved, that the appropriate ADA agencies determine feasibility of developing and disseminating guidance on new administrative demands such as claims submission and coordination of benefits arising from pediatric benefits embedded in medical plans sold through the Federal and State Marketplaces mandated by the Affordable Care Act, and be it further

Resolved, that a report on these activities be presented to the 2015 House of Delegates.

BOARD RECOMMENDATION: Vote Yes on the Substitute.

Board Vote: Resolution 63

BUCKENHEIMER	Yes	FEINBERG	Yes	KIESLING	Yes	STEVENS	No
COLE	Yes	GOUNARDES	Yes	KWASNY	Yes	SUMMERHAYS	Yes
CROWLEY	Yes	HAGENBRUCH	Yes	ROBERTS	Yes	YONEMOTO	Yes
DOW	Absent	ISRAELSON	Yes	SCOTT	Yes	ZENK	Yes
FAIR	Yes	JEFFERS	Yes	SHENKIN	Yes	ZUST	Yes

Resolution No. 99 NewReport: N/A Date Submitted: August 2014Submitted By: Fourteenth Trustee DistrictReference Committee: B (Dental Benefits, Practice and Related Matters)Total Net Financial Implication: None Net Dues Impact: _____Amount One-time _____ Amount On-going _____ FTE 0

ADA Strategic Plan Objective: Membership-Obj. 1: Leaders and Advocates in Oral Health

How does this resolution increase member value: See Background

DEVELOPMENT OF ADA POLICIES FOR DENTAL DISCOUNT PLANS

The following resolution was adopted by the Fourteenth Trustee District and transmitted on August 24, 2014, by Dr A.J. Smith, chair, Resolutions Committee.

Background: Discount Dental Plans present a new and difficult problem for many practices that have contracted with a particular PPO expecting reimbursement and later discover that the network has been “sold” as a plan that provides no benefit, but requires practices to accept the lower contracted fees directly from patients under the plan. Both dentists and patients often do not understand the limitations of these plans until after services have been provided. Dentists should be allowed to consider their participation before being included in plans with substantial and fundamentally different structures from those they contracted to provide. Developing policy based on thoughtful research and consideration of this emerging benefits model will aid the ADA in serving members and advocating for patients.

Resolution

99. Resolved, that the appropriate ADA agencies research the practice of contract provider plans that utilize their networks as non-reimbursing discount dental plans or include contracted dentists in other plan networks, which were originally unintended by that dentist, and be it further

Resolved, that based on that research, the appropriate ADA agencies review existing policy, and suggest definitions or recommend appropriate policy revisions related to discount dental plans and contract provisions allowing network reassignment, and be it further

Resolved, that a report on these activities be presented to the 2015 House of Delegates.

BOARD COMMENT: The Board of Trustees recognizes the issues identified in the report’s background, and appreciates the Fourteenth District’s Resolution. As noted by the Fourteenth District, “affiliated carrier clauses” that allow a carrier to “sell” the network to an affiliate are becoming commonplace. This clause is often embedded in the participating provider agreements signed by dentists. The ADA’s Contract Analysis Service specifically offers assistance to members to help identify such issues prior to signing the contract.

The ADA currently has several policies relating to both contracted and non-contracted dentists regarding this issue. These policies have either been recently reviewed or are scheduled to be reviewed per the House Resolution titled “Regular Comprehensive Policy Review” (*Trans.*2010:603; 2012:370). Given this, the Board suggests that the Fourteenth District utilize the established policy review cycles to provide specific input on existing policies, at the time of review.

1 **BOARD RECOMMENDATION: Vote No.**

2 **Board Vote: Resolution 99**

BUCKENHEIMER	No	FEINBERG	No	KIESLING	No	STEVENS	No
COLE	No	GOUNARDES	No	KWASNY	No	SUMMERHAYS	No
CROWLEY	No	HAGENBRUCH	Yes	ROBERTS	No	YONEMOTO	Yes
DOW	Absent	ISRAELSON	No	SCOTT	No	ZENK	No
FAIR	No	JEFFERS	No	SHENKIN	No	ZUST	No

3

Resolution 99

Resolution No. 103 NewReport: N/A Date Submitted: September 2014Submitted By: Sixth Trustee DistrictReference Committee: B (Dental Benefits, Practice and Related Matters)Total Net Financial Implication: None Net Dues Impact: Amount One-time Amount On-going FTE 0

ADA Strategic Plan Objective: Membership-Obj. 3: 10% increase in assessment of member value

How does this resolution increase member value: See Background

1 **STANDARDIZED EXPLANATION OF BENEFITS FORM**2 The following resolution was submitted by the Sixth Trustee District and transmitted on September 17,
3 2014 by Dr. Mark Zust, Sixth District Trustee.4 **Background:** First approved by the ADA House of Delegates in July 1967, the ADA Dental Insurance
5 Claim Form, along with the ADA CDT codes, has provided a standardized, universally accepted method
6 of submitting dental claims to dental insurers in a clear and concise manner since its inception.7 The same cannot be said for the Explanation of Benefits (EOBs) that accompanies dental benefit checks.
8 The lack of uniformity in EOBs from carrier to carrier, and the confusion created by terms such as
9 "Submitted Amount," "Accepted Amount," and "Allowed Amount," as well as numerical references to
10 policy exclusions, all combine to create the potential for errors when posting dental benefit checks and
11 calculating patient portions. Such difficulties tend to create efficiency issues as financial personnel in
12 dental practices take more time processing each claim to make sure accounts are properly credited.13 **Resolution**14 **103. Resolved,** that the Council on Dental Benefits develop a standardized Explanation of Benefits
15 form (EOB) for the reporting of dental claim adjudication that could become the industry standard,
16 and be it further17 **Resolved,** that the Council on Dental Benefits report on its progress to the 2015 House of
18 Delegates.19 **BOARD RECOMMENDATION: Vote Yes**20 **BOARD VOTE: UNANIMOUS.**

21 Resolution 103

Resolution No. 110 NewReport: N/A Date Submitted: October 2014Submitted By: Fourteenth Trustee DistrictReference Committee: B (Dental Benefits, Practice and Related Matters)Total Net Financial Implication: None Net Dues Impact: Amount One-time Amount On-going FTE 0.2

ADA Strategic Plan Objective: Membership-Obj. 1: Leaders and Advocates in Oral Health

How does this resolution increase member value: See Background

1 POLICY ON DENTIST RATING BY THIRD PARTIES

2 The following resolution was adopted by the Fourteenth Trustee District and submitted on October 10,
3 2014 by Dr. A.J. Smith, chair, Resolutions Committee.

4 **Background:** In August 2014, CIGNA Dental announced “cost effectiveness” designations for contract
5 dentist providers that they said were required by the Affordable Care Act (ACA) to provide greater
6 transparency for CIGNA patients when evaluating and selecting a dentist. They indicated that they
7 reviewed “care and cost data” on all dentists participating in their network in the process. Letters have
8 been sent to network dentists in many states informing them of their designation, which will appear on the
9 CIGNA website in the online provider directory. Information supplied by Cigna indicates that the
10 geographic area is defined by data from network providers practicing within a three digit zip code.

11 In its letter to providers, CIGNA notes that it will soon be announcing several other “transparency tools”
12 including “Dental Care Distinction”, “treatment cost estimation capabilities” and “cultural designations.”

13 Attempts by insurance carriers to create rating systems for physicians have been tried in some states,
14 including an attempt to implement ratings systems based solely on the cost of services in New York state
15 in 2007. In that case, the New York Attorney General took action against a group of insurance
16 companies alleging that the ratings systems were potentially misleading to consumers and settled the
17 matter with an enforcement action. Curiously, CIGNA was one of the subject companies that agreed to
18 the settlement. Following that action, many national medical insurance carriers signed on to an AMA
19 endorsed “Patient Charter for Physician Reporting and Tiering Programs” which contained many of the
20 provisions of the New York settlement. In 2009, the Texas Attorney General pursued action against Blue
21 Cross-Blue Shield of Texas, forcing an abandonment of their use of a “risk adjusted cost Index” which
22 determined “affordability” ratings for physicians.

23 It is also significant that cost effectiveness designations do not take into consideration the skill and
24 training of the dentist, quality of services and materials, patient population and demographics, incomes,
25 economic data, or severity of patient conditions, and do not account for dentists treating more vulnerable
26 and high risk populations.

27 Because the ADA exists to “ensure its members’ success,” protecting its members against unreasonable
28 actions from insurance carriers by initiating strong advocacy efforts and appropriate litigation on the
29 national and state level will strongly reinforce member value, and will support the ‘Power of Three’.

Resolution

110. Resolved, that the ADA believes third-party dentist ratings systems based on cost or non-validated utilization patterns are inherently flawed, unreliable, and potentially misleading to the public, and be it further,

Resolved, that the appropriate agencies of the Association will advise third parties, particularly those that publish ratings or rankings of dentists or dental practices based on selective and limited criteria, about ADA policies relating to ratings systems and encourage them not to include such ratings in their communications to the public, and be it further,

Resolved, that the ADA pursue appropriate legal, administrative and other actions to discourage and prevent third parties from developing and using such inherently flawed, unreliable, and potentially misleading dentist ratings and ranking systems, and be it further,

Resolved, that the ADA draft model legislation to discourage such objectionable dentist rating and ranking systems in federally-regulated dental benefits plans and support states in advocacy efforts to discourage such systems in state-regulated plans.

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

Resolution No. 63RCS-1 Citation for Original Resolution: Lavender:3032Submitted By: Third District Caucus Date Submitted: October 12, 2014Substitute ☒Amendment ☐Reference Committee Report On: Reference Committee B (Dental Benefits, Practice and Related Matters)

Financial Implications (if different from original resolution): _____

**SUBSTITUTE FOR RESOLUTION 63RC: COORDINATION OF MEDICAL AND DENTAL BENEFITS
UNDER THE AFFORDABLE CARE ACT**

The following substitute resolution for Resolution 63RC (Worksheet:3032) was adopted by the Third District Caucus and submitted on October 12, 2014 by Dr. Nicole Quezada, caucus secretary.

Resolution

63RCS-1. Resolved, that a concise advisory based on the best current information regarding guidelines for dentists that pertain to the coordination of medical and dental benefits under the Affordable Care Act be developed by the appropriate ADA agencies and disseminated as a member benefit, and be it further

Resolved that the appropriate ADA agencies conduct further research to determine the feasibility of developing a more comprehensive guidance on new administrative demands relating to claims submission and coordination of benefits arising from dental benefits embedded in medical plans sold through the Federal and State Marketplaces mandated by the Affordable Care Act, and be it further

Resolved, should the study confirm feasibility, that the appropriate ADA agencies will (i) develop guidance as it pertains to the coordination of medical and dental benefits under the Affordable Care Act, and (ii) use appropriate avenues of communication of these guidelines as a member benefit, and be it further

Resolved, that a report on these activities be presented to the 2015 House of Delegates.

Dental Education, Science and Related Matters

Resolution No. 1 NewReport: N/A Date Submitted: July 2014Submitted By: Commission on Dental AccreditationReference Committee: C (Dental Education, Science and Related Matters)Total Net Financial Implication: None Net Dues Impact: _____Amount One-time _____ Amount On-going _____ FTE 0

ADA Strategic Plan Objective: Organizational Capacity-Obj. 6: Role and responsibility of each element of the tripartite clearly defined and agreed upon

How does this resolution increase member value: See Background

REVISION OF THE RULES OF THE COMMISSION ON DENTAL ACCREDITATION TO REPLACE THE NAME "AMERICAN ASSOCIATION OF HOSPITAL DENTISTS" WITH "SPECIAL CARE DENTISTRY ASSOCIATION"

Background: (*Reports:38*)

Revision of the Rules of the Commission on Dental Accreditation to Replace the Name "American Association of Hospital Dentists" with "Special Care Dentistry Association": In winter 2014, the Commission directed that references made in the *Rules of the Commission on Dental Accreditation* and its Evaluation and Operational Policies and Procedures manual to the "American Association of Hospital Dentists" be changed to the "Special Care Dentistry Association" and that the American Dental Association be notified of this requested change, which is supported by the Council on Dental Education and Licensure.

The Special Care Dentistry Association had previously notified the Commission of a governance change whereby the American Association of Hospital Dentistry has been retired and now serves as the Special Care Dentistry Association's Council on Hospital Dentistry.

Resolution

1. Resolved, that the *Rules* of the Commission on Dental Accreditation be revised to replace the name "American Association of Hospital Dentists" with "Special Care Dentistry Association" as shown in Appendix 1 of the Commission's 2014 annual report.

BOARD RECOMMENDATION: Vote Yes.

BOARD VOTE: UNANIMOUS*

***Dr. Fair was absent.**

Appendix 1. Rules of the Commission on Dental Accreditation**Article I. MISSION**

The Commission on Dental Accreditation serves the oral health care needs of the public through the development and administration of standards that foster continuous quality improvement of dental and dental related educational programs.

Article II. BOARD OF COMMISSIONERS

Section I. LEGISLATIVE AND MANAGEMENT BODY: The legislative and management body of the Commission shall be the Board of Commissioners.

Section 2. COMPOSITION: The Board of Commissioners shall consist of:

Four (4) members shall be selected from nominations open to all trustee districts from the active, life or retired members of this association, no one of whom shall be a faculty member working more than one day per week of a school of dentistry or a member of a state board of dental examiners or jurisdictional dental licensing agency. These members shall be nominated by the Board of Trustees and elected by the American Dental Association House of Delegates.

Four (4) members who are active, life or retired members of the American Dental Association shall be selected by the American Association of Dental Boards from the active membership of that body, no one of whom shall be a member of a faculty of a school of dentistry.

Four (4) members who are active, life or retired members of the American Dental Association shall be selected by the American Dental Education Association from its active membership. These members shall hold positions of professorial rank in dental schools accredited by the Commission on Dental Accreditation and shall not be members of any state board of dental examiners.

The remaining Commissioners shall be selected as follows: one (1) certified dental assistant selected by the American Dental Assistants Association from its active or life membership, one (1) licensed dental hygienist selected by the American Dental Hygienists' Association, one (1) certified dental laboratory technician selected by the National Association of Dental Laboratories, one (1) student selected jointly by the American Student Dental Association and the Council of Students of the American Dental Education Association, one (1) dentist for each ADA recognized dental specialty who is board certified in the respective special area of practice and is selected by the respective specialty sponsoring organization, one (1) dentist representing postdoctoral general dentistry who is jointly appointed by the American Dental Education Association and the Special Care Dentistry Association ~~American Association of Hospital Dentists~~ and four (4) consumers who are neither dentists nor allied dental personnel nor teaching in a dental or allied dental education institution and who are selected by the Commission, based on established and publicized criteria. In the event a Commission member sponsoring organization fails to select a Commissioner, it shall be the responsibility of the Commission to select an appropriate representative to serve as a Commissioner. A member of the Standing Committee on the New Dentist (when assigned by the ADA Board of Trustees) and the Director of the Commission shall be ex-officio members of the Board without the right to vote.

Section 3. TERM OF OFFICE: The term of office of the members of the Board of Commissioners shall be one four (4) year term except that the member jointly selected by the American Dental Education Association and the American Student Dental Association shall serve only one two (2) year term.

1 Section 4. POWERS:
2

- 3 A. The Board of Commissioners shall be vested with full power to conduct all business of the
4 Commission subject to the laws of the State of Illinois, these *Rules* and the *Constitution and*
5 *Bylaws* of the American Dental Association.
- 6 B. The Board of Commissioners shall have the power to establish rules and regulations not
7 inconsistent with these *Rules* to govern its organization and procedures.

8 Section 5. DUTIES:

- 9 A. The Board of Commissioners shall prepare a budget at its winter meeting each year for
10 carrying on the activities of the Commission for the ensuing fiscal year and shall submit said
11 budget to the Board of Trustees of the American Dental Association for funding in accordance
12 with Chapter XIV of the *Bylaws* of the American Dental Association.
- 13
- 14 B. The Board of Commissioners shall submit an annual report of the Commission's activities to
15 the House of Delegates of the American Dental Association and interim reports, on request,
16 to the Board of Trustees of the American Dental Association.
- 17
- 18 C. The Board of Commissioners shall appoint special committees of the Commission for the
19 purpose of performing duties not otherwise assigned by these *Rules*.
- 20
- 21 D. The Board of Commissioners shall appoint consultants to assist in developing accreditation
22 standards and conducting accreditation evaluations, including on-site reviews of predoctoral,
23 advanced dental educational and allied dental educational programs and to assist with other
24 duties of the Commission from time to time as needed.

25 Section 6. MEETINGS:

- 26 A. REGULAR MEETINGS: There shall be two (2) regular meetings of the Board of
27 Commissioners each year.
- 28
- 29 B. SPECIAL MEETINGS: Special meetings of the Board of Commissioners may be called at any
30 time by the Chairman of the Commission. The Chairman shall call such meetings on request
31 of a majority of the voting members of the Board provided at least ten (10) days notice is
32 given to each member of the Board in advance of the meeting. No business shall be
33 considered except that provided in the call unless by unanimous consent of the members of
34 the Board present and voting.
- 35
- 36 C. LIMITATION OF ATTENDANCE DURING MEETINGS: In keeping with the confidential nature
37 of the deliberations regarding the accreditation status of individual educational programs, a
38 portion of the meetings of the Commission, and its committees shall be designated as
39 confidential, with attendance limited to members, the American Dental Association Trustee
40 Liaison, selected staff of the Commission and affiliated accreditors. During this part of the
41 meeting, only confidential accreditation actions may be considered.

42 Section 7. QUORUM: A majority of the voting members of the Board of Commissioners shall constitute a
43 quorum.
44

Article III. APPEAL BOARD

Section 1. APPEAL BOARD: The appellate body of the Commission shall be the Appeal Board which shall have the authority to hear and decide appeals filed by predoctoral and advanced dental educational and allied dental educational programs from decisions rendered by the Board of Commissioners of the Commission denying or revoking accreditation.

Section 2. COMPOSITION: The Appeal Board shall consist of four (4) permanent members. The four (4) permanent members of the Appeal Board shall be selected as follows: one (1) selected by the Board of Trustees of the American Dental Association from the active, life or retired membership of the American Dental Association giving special consideration whenever possible to former members of the Council on Dental Education and Licensure, one (1) member selected by the American Association of Dental Boards from the active membership of that body, one (1) member selected by the American Dental Education Association from the active membership of that body and one (1) consumer member who is neither a dentist nor an allied dental personnel nor teaching in a dental or allied dental educational program and who is selected by the Commission, based on established and publicized criteria. In addition, a representative from either an allied or advanced education discipline would be included on the Appeal Board depending upon the type and character of the appeal. Such special members shall be selected by the appropriate allied or specialty organization. Since there is no national organization for general practice residencies and advanced education programs in general dentistry, representatives of these areas shall be selected by the American Dental Education Association and the Special Care Dentistry Association ~~American Association of Hospital Dentists~~. One (1) member of the Appeal Board shall be appointed annually by the Chairman of the Commission to serve as the Chairman and shall preside at all meetings of the Appeal Board. If the Chairman is unable to attend any given meeting of the Appeal Board, the other members of the Appeal Board present and voting shall elect by majority vote an acting Chairman for that meeting only. The Director of the Commission shall provide assistance to the Appeal Board.

Section 3. TERM OF OFFICE: The term of office of members on the Appeal Board shall be one four (4) year term.

Section 4. MEETINGS: The Appeal Board shall meet at the call of the Director of the Commission, provided at least ten (10) days notice is given to each member of the Appeal Board in advance of the meeting. Such meetings shall be called by the Director only when an appeal to the appellate body has been duly filed by a predoctoral or advanced dental educational or allied dental educational program.

Section 5. QUORUM: A majority of the voting members of the Appeal Board shall constitute a quorum.

Section 6. VACANCIES:

A. In the event of a vacancy in the membership of the Appeal Board of the Commission, the Chairman of the Commission shall appoint a member of the same organization, or in the case of a consumer of the general public, possessing the same qualifications as established by these Rules, to fill such vacancy until a successor is selected by the respective representative organization.

B. If the term of the vacated position has less than fifty percent (50%) of a full four-year term remaining at the time the successor member is appointed, the successor member shall be eligible for a new, consecutive four-year term. If fifty percent (50%) or more of the vacated term remains to be served at the time of the appointment, the successor member shall not be eligible for another term.

Article IV. ACCREDITATION PROGRAM

Section I. ACCREDITATION STANDARDS: The Commission, acting through the Board of Commissioners, shall establish and publish specific accreditation standards for the accreditation of predoctoral and advanced dental educational and allied dental educational programs.

Section 2. EVALUATION: Predoctoral and advanced dental educational and allied dental educational programs shall be evaluated for accreditation status by the Board of Commissioners on the basis of the information and data provided on survey forms and secured by the members of, and consultants to, the Board of Commissioners during site evaluations.

If the Board of Commissioners decides to deny, for the first time, accreditation to a new educational program or to withdraw accreditation from an existing program, the Board of Commissioners shall first notify the educational program of its intent to deny or withdraw accreditation. Such notice, together with announcement of the date of the next meeting of the Board of Commissioners, shall be sent to the educational program by certified mail, return receipt requested, within fourteen (14) days following the intent to deny or withdraw decision of the Board of Commissioners. Within thirty (30) days after receipt of such notice, the educational program may, in writing, request a hearing before the Board of Commissioners at its next meeting. Within fifteen (15) days after receipt of the request, the Board of Commissioners shall schedule a hearing and notify the educational program of the date, time and place of such hearing. A request for a hearing due to the Board of Commissioner's decision to deny for the first time, accreditation to a new program, shall automatically stay the decision to deny accreditation. In the event the educational program that has been denied initial accreditation for the first time does not make a timely request for a hearing, the Board of Commissioners' findings and proposed decision to deny accreditation shall become final.

Section 3. HEARING: Upon completion of an evaluation for accreditation status, the Board of Commissioners shall notify the predoctoral, advanced or allied dental educational program (hereinafter called "educational program") of its findings and decision regarding the program's accreditation status. Two types of hearings can be held to review the appropriateness of the decision made by the Commission:

- A. CHALLENGE: This type of hearing is available to a program/institution that wishes to challenge the decision of the Commission to change its accreditation status or to a new program that wishes to challenge the decision of the Commission to deny, for the first time, initial accreditation. When an institution/program believes that the Commission has made an error in judgment, a hearing may be requested. The hearing before the Commission would be held at the next regularly scheduled meeting. Representatives of the institution/program may present arguments that the Commission, based on the information available when the decision was made, made an error in judgment in determining the accreditation status of the program. The educational program need not appear in person or by its representatives at the hearing. Legal counsel may represent the educational program at the hearing. During the hearing, the educational program may offer evidence and argument in writing or orally or both tending to refute or overcome the factual findings of the Board of Commissioners. The Director of the Board of Commissioners must receive any written evidence or argument at least thirty (30) days prior to the hearing. No new information regarding correction of the deficiencies may be presented.
- B. SUPPLEMENT: An institution/program may request a hearing in order to supplement written information, which has already been submitted to the Commission. A representative of the institution would be permitted to appear in person before the Commission to present this additional information.

When a hearing to provide supplemental information is desired, a written request is to be made to the Director of the Commission thirty (30) days prior to the meeting. The chairman and the Director of the Commission determine the disposition of the request and inform the requestor of the date, hour and amount of time which will be allocated for the hearing.

Section 4. APPEAL: In the event the final decision of the Board of Commissioners is a denial or withdrawal of accreditation, the educational program shall be informed of this decision within fourteen (14) days following the Commission meeting. Within fourteen (14) days after receipt of the final decision of the Board of Commissioners, the educational program may appeal the decision of the Board of Commissioners by filing a written appeal with the Director of the Board of Commissioners. The filing of an appeal shall automatically stay the final decision of the Board of Commissioners. The Appeal Board of the Commission shall convene and hold its hearing within sixty (60) days after the appeal is filed. The educational program filing the appeal may be represented by legal counsel and shall be given the opportunity at such hearing to offer evidence and argument in writing or orally or both tending to refute or overcome the findings and decision of the Board of Commissioners. No new information regarding correction of the deficiencies may be presented with the exception of review of new financial information if all of the following conditions are met: (i) The financial information was unavailable to the institution or program until after the decision subject to appeal was made. (ii) The financial information is significant and bears materially on the financial deficiencies identified by the Commission. The criteria of significance and materiality are determined by the Commission. (iii) The only remaining deficiency cited by the Commission in support of a final adverse action decision is the institution's or program's failure to meet the Commission's standard pertaining to finances. An institution or program may seek the review of new financial information described in this section only once and any determination by the Commission made with respect to that review does not provide a basis for an appeal. The educational program need not appear in person or by its representative at the appellate hearing. The Appeal Board may make the following decisions: to affirm, amend, remand, or reverse the adverse actions of the Commission. A decision to affirm, amend or reverse the adverse action is implemented by the Commission. In a decision to remand the adverse action for further consideration, the Appeal Board will identify specific issues that the Commission must address. The Commission must act in a manner consistent with the Appeal Board's decisions or instructions. The Appeal Board shall advise the appellant educational program of the Appeal Board's decision in writing by registered or certified mail. The decision rendered by the Appeal Board shall be final and binding. In the event the educational program does not file a timely appeal of the Board of Commissioners' findings and decision, the Board of Commissioners' decision shall become final.

Section 5. HEARING AND APPEAL COSTS: If a hearing is held before the Board of Commissioners, the costs of the Commission respecting such hearing shall be borne by the Commission. If an appeal is heard by the Appeal Board, the costs of the Commission respecting such appeal shall be shared equally by the Commission and the appellant educational program filing the appeal except in those instances where equal sharing would cause a financial hardship to the appellant. However, each educational program shall bear the cost of its representatives for any such hearing or appeal.

Article V. OFFICERS

Section I. OFFICERS: The officers of the Commission shall be a Chair, Vice-Chair and a Director and such other officers as the Board of Commissioners may authorize. The Chair and Vice-Chair shall be elected by the members of the Commission. The Chair and Vice-Chair shall be active, life or retired member of the American Dental Association.

Section 2. DUTIES: The duties of the officers are as follows:

A. CHAIR: The Chair shall preside at all meetings of the Board of Commissioners.

B. VICE-CHAIR: If the Chair is unable to attend any given meeting of the Board of Commissioners, the Vice-Chair shall preside at the meeting. If the Vice-chair is unable to attend the meeting, the other members of the Board of Commissioners present and voting

1 shall elect by majority vote an acting chair for the purpose of presiding at that meeting only.

- 2 C. DIRECTOR: The Director shall keep the minutes of the meetings of the Board of
3 Commissioners, prepare an agenda for each meeting, see that all notices are duly given in
4 accordance with the provisions of these *Rules* or as required by law, be the custodian of the
5 Commission's records, and in general shall perform all duties incident to the office of Director.

6 Article VI. MISCELLANEOUS

7 The rules contained in the current edition of "Sturgis Standard Code of Parliamentary Procedures" shall
8 govern the deliberations of the Board of Commissioners and Appeal Board in all instances where they are
9 applicable and not in conflict with the *Rules* or the previously established rules and regulations of the
10 Board of Commissioners.

11 Article VII. AMENDMENTS

12 These *Rules* may be amended at any meeting of the Board of Commissioners by majority vote of the
13 members of the Board present and voting subject to the subsequent approval of the House of Delegates
14 of the American Dental Association.

15 Reaffirmed: 8/12; Revised: 8/10, 10/02, 10/97, 10/87, 11/82

16
17 Adopted by the Commission on Dental Accreditation, February 1, 2002. Approved by the ADA House of
18 Delegates, October 2002. Revisions adopted by the Commission on Dental Accreditation, August 2010.
19 Approved by the ADA House of Delegates, October 2010. Revision of Mission Statement adopted by the
20 Commission on Dental Accreditation, August 2012. Approved by the ADA House of Delegates, October
21 2012.

Resolution No. 2 NewReport: N/A Date Submitted: July 2014Submitted By: Commission on Dental AccreditationReference Committee: C (Dental Education, Science and Related Matters)Total Net Financial Implication: None Net Dues Impact: _____Amount One-time _____ Amount On-going _____ FTE 0

ADA Strategic Plan Objective: Organizational Capacity-Obj. 6: Role and responsibility of each element of the tripartite clearly defined and agreed upon

How does this resolution increase member value: See Background

AMENDMENT OF THE ADA BYLAWS REGARDING THE DUTIES OF THE COMMISSION ON DENTAL ACCREDITATION

Background: (*Reports:41*)

Amendment of the ADA Bylaws Regarding the Duties of the Commission on Dental Accreditation:

In accord with Resolution 1H-2013 (*Trans.2013:339*), the Commission on Dental Accreditation reviewed each of the six areas of the self-assessment, which included threshold issues, structure, efficiencies, areas of responsibility, agenda review, and strategic direction. The Commission made the following conclusions as a result of the self-assessment:

- As the only nationally recognized accrediting agency for dental and dental related education programs, there would be a profound impact on the profession and dental education if the Commission on Dental Accreditation ceased to exist.
- The duties of the Commission should be revised to reflect contemporary terminology for dental and dental related professions (see Resolution 2).
- The Commission should have authority to make editorial changes to its *Rules*, which do not alter its context or meaning (see Resolution 3).
- The Commission continues to offer a strong accreditation program, as evidenced through continued compliance with the United States Department of Education criteria for recognition and continuous benchmarking of the Commission against similar accreditors.
- The Commission's agenda enables strategic discussion; however, two areas for improvement are: 1) enhancing the level of trust between the Commission and its committees, and 2) addressing the increased workload and complexity of issues which come before the Commission by considering other meeting structures.
- The number of staff dedicated to this agency is insufficient to support long-term growth and sustainability of this agency.
- Responsibilities of the Commission on Dental Accreditation cannot be placed with another agency or discontinued, nor can the responsibilities of the Commission be consolidated beyond the current structure of the Board of Commissioners, its committees, appeal board, and staff support.

As a result of the assessment the Commission presents the following resolution to the House of Delegates:

Resolution

2. Resolved, that Chapter XV. COMMISSIONS, *Section 130. DUTIES*, Subsection A. COMMISSION ON DENTAL ACCREDITATION, of the ADA *Bylaws*, be amended as follows (additions are underscored; deletions are ~~stricken~~):

Section 130. DUTIES:

A. COMMISSION ON DENTAL ACCREDITATION. The duties of the Commission on Dental Accreditation shall be to:

- a. Formulate and adopt requirements and guidelines for the accreditation of dental, advanced dental ~~educational~~ and ~~dental auxiliary~~ allied dental educational programs.
- b. Accredit dental, advanced dental, ~~educational~~ and ~~dental auxiliary~~ allied dental educational programs.
- c. Provide a means for appeal from an adverse decision of the accrediting body of the Commission to a separate and distinct body of the Commission whose membership shall be totally different from that of the accrediting body of the Commission.
- d. Submit an annual report to the House of Delegates of this Association and interim reports, on request, and the Commission's annual budget to the Board of Trustees of the Association.
- e. Submit the Commission's articles of incorporation and rules and amendments thereto to this Association's House of Delegates for approval by majority vote either through or in cooperation with the Council on Dental Education and Licensure.

BOARD RECOMMENDATION: Vote Yes.

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

***Dr. Fair was absent.**

Resolution No. 3 NewReport: N/A Date Submitted: July 2014Submitted By: Commission on Dental AccreditationReference Committee: C (Dental Education, Science and Related Matters)Total Net Financial Implication: None Net Dues Impact: _____Amount One-time _____ Amount On-going _____ FTE 0

ADA Strategic Plan Objective: Organizational Capacity-Obj. 6: Role and responsibility of each element of the tripartite clearly defined and agreed upon

How does this resolution increase member value: See Background

**AMENDMENT OF THE ADA BYLAWS TO GIVE THE COMMISSION ON DENTAL ACCREDITATION
AUTHORITY TO MAKE EDITORIAL CORRECTIONS TO ITS RULES**

Background: (*Reports:42*)

The Amendment of the ADA Bylaws to Give the Commission on Dental Accreditation Authority to Make Editorial Corrections to its Rules: In accord with Resolution 1H-2013 (*Trans.2013:339*), the Commission on Dental Accreditation reviewed each of the six areas of the self-assessment, which included threshold issues, structure, efficiencies, areas of responsibility, agenda review, and strategic direction. The Commission made the following conclusions as a result of the self-assessment:

- As the only nationally recognized accrediting agency for dental and dental related education programs, there would be a profound impact on the profession and dental education if the Commission on Dental Accreditation ceased to exist.
- The duties of the Commission should be revised to reflect contemporary terminology for dental and dental related professions (see Resolution 2).
- The Commission should have authority to make editorial changes to its *Rules*, which do not alter its context or meaning (see Resolution 3).
- The Commission continues to offer a strong accreditation program, as evidenced through continued compliance with the United States Department of Education criteria for recognition and continuous benchmarking of the Commission against similar accreditors.
- The Commission's agenda enables strategic discussion; however, two areas for improvement are: 1) enhancing the level of trust between the Commission and its committees, and 2) addressing the increased workload and complexity of issues which come before the Commission by considering other meeting structures.
- The number of staff dedicated to this agency is insufficient to support long-term growth and sustainability of this agency.
- Responsibilities of the Commission on Dental Accreditation cannot be placed with another agency or discontinued, nor can the responsibilities of the Commission be consolidated beyond the current structure of the Board of Commissioners, its committees, appeal board, and staff support.

As a result of the assessment the Commission presents the following resolution to the House of Delegates:

Resolution

3. Resolved, that Chapter XV. COMMISSIONS, *Section 120. POWER TO ADOPT RULES*, of the ADA *Bylaws*, be amended as follows (additions are underscored):

Section 120.

POWER TO ADOPT RULES: Any commission of this Association shall have the power to adopt rules for such commission and amendments thereto, provided such rules and amendments thereto do not conflict with or limit the *Constitution and Bylaws* of this Association. Rules and amendments thereto, adopted by any commission of this Association, shall not be effective until submitted in writing to and approved by majority vote of the House of Delegates of this Association, except the Joint Commission on National Dental Examinations shall have such bylaws and amendments thereto as the House of Delegates of this Association may adopt by majority vote for the conduct of the purposes and management of the Joint Commission on National Dental Examinations. The Commission on Dental Accreditation shall have the authority to make corrections in punctuation, grammar, spelling, name changes, gender references, and similar editorial corrections to the *Rules* of the Commission on Dental Accreditation which do not alter its context or meaning without the need to submit such editorial corrections to the House of Delegates. Such corrections shall be made only by a unanimous vote of the Commission on Dental Accreditation members present and voting.

BOARD RECOMMENDATION: Vote Yes.

Vote: Resolution 3

BUCKENHEIMER	Yes	FEINBERG	Yes	KIESLING	Yes	STEVENS	No
COLE	Yes	GOUNARDES	Yes	KWASNY	Yes	SUMMERHAYS	Yes
CROWLEY	Yes	HAGENBRUCH	Yes	ROBERTS	No	YONEMOTO	Yes
DOW	Yes	ISRAELSON	Yes	SCOTT	Yes	ZENK	Yes
FAIR	Absent	JEFFERS	Yes	SHENKIN	Yes	ZUST	Yes

Resolution No. 6 SubstituteReport: N/A Date Submitted: July 2014Submitted By: Council on Dental Education and LicensureReference Committee: C (Dental Education, Science and Related Matters)Total Net Financial Implication: None Net Dues Impact: Amount One-time Amount On-going FTE 0

ADA Strategic Plan Objective: Organizational Capacity-Obj. 6: Role and responsibility of each element of the tripartite clearly defined and agreed upon

How does this resolution increase member value: See Background

**AMENDMENT OF THE BYLAWS TO ESTABLISH THE COMMISSION FOR CONTINUING
EDUCATION PROVIDER AND APPROVAL OF THE RULES OF THE ADA COMMISSION FOR
CONTINUING EDUCATION PROVIDER RECOGNITION**

Background: (*Reports:103*)

**Amendment of the Bylaws to Establish the Commission for Continuing Education Provider and
Approval of the Rules of the ADA Commission for Continuing Education Provider Recognition:**

Resolution 82H-1996, Proposed Organizational Restructure of the ADA CERP Committee (*Trans.1996:706*), charged the Council on Dental Education (now known as CDEL) with oversight responsibility for the Continuing Education Recognition Program, established the responsibilities of CERP, and defined the composition of the CERP Committee. Resolution 5H-2007, Composition of the ADA CERP Committee (*Trans.2007:393*), amended 82H-1996 to specify the names of the organizations appointing CERP Committee members and stipulate that all dentists nominated to serve must be members of the ADA.

During the past three years, the Council and CERP Committee have assessed the effectiveness of this structure and explored options to restructure CERP as an ADA agency separate from the Council to better support the program's mission, enhance its impartiality and objectivity, and minimize internal conflicts of interest. The Council is proposing the establishment of the ADA Commission for Continuing Education Provider Recognition to oversee the program. Proposed revisions to the ADA *Bylaws* and draft rules for the proposed agency (similar to those of other ADA commissions) were circulated to the communities of interest and the Board of Trustees for comment in 2013.

- In developing this proposal, the Council and CERP Committee noted that CERP's current placement under the Council can potentially create internal conflicts of interest which may be detrimental to the credibility of both the ADA and its Continuing Education Recognition Program. Under the existing structure, the ADA approves its own CE program. In the event of an adverse action by CERP against the ADA, the Council would also adjudicate the ADA's appeal.
- The Council emphasizes that the proposal represents a shift in governance from one ADA agency to another. CERP will continue to operate under ADA *Bylaws*.
- The proposed commission's rules and annual operating budget would be subject to approval by the ADA House of Delegates.
- Financial impact on the ADA is anticipated to be minimal, as the proposed commission would be supported by existing staffing and financial structures. Currently, 68% of the program's direct and

indirect operating costs are covered by participating provider fees (\$262,250 budgeted revenue for 2014); the remainder is supported by the ADA.

- Initially, the new Board of Commissioners will be composed of the incumbent members of the CERP Committee and any new appointees to the CERP Committee selected by the American Association of Dental Boards, American Dental Education Association, American Society of Constituent Dental Executives and/or a sponsoring organization of any ADA recognized dental specialty. These inaugural Commission members shall serve for terms that are equal in time to their unfinished terms on the retired CERP Committee. To the extent that there exists an unfilled position on the Commission for Continuing Education Provider Recognition for an ADA appointee when the Commission is created, that position shall be treated as a vacancy and filled in accordance with the procedure set forth in CHAPTER XV. COMMISSIONS, SECTION 70 of the ADA *Bylaws*.
- The proposed commission would have the authority to approve CE providers, adopt standards and policies and manage administration of the program.
- The recognition status of CE providers approved by CERP would be maintained in accordance with CERP Recognition Standards and Procedures.

A majority of stakeholders submitting comments, including the ADA Board of Trustees, were supportive of the concept, agreeing that the proposal to create a commission to oversee CERP:

- Reflects a best practice for recognition and accreditation programs by establishing a governance structure that minimizes the possibility of direct conflicts of interest;
- Enhances an ADA program that sets standards designed to help dentists excel throughout their careers; and
- Involves representatives from all disciplines of dentistry in program oversight.

The Council believes that a strength of the program is the broad representation of stakeholder groups on the CERP Committee. In light of feedback from the communities of interest and in order to ensure that general dentists are represented on the board of the proposed new commission, the Council modified its original proposal to stipulate that at least two of the ADA's four appointments to the board must be general dentists. The Council also modified the name of the commission from the original proposal to better reflect its function. Proposed amendments to ADA *Bylaws* establishing the commission and proposed rules for the commission are attached as Appendices 1 and 2. In establishing the Commission for Continuing Education Provider Recognition, the House of Delegates is empowered to approve the Rules of that commission. Thus, the Council on Dental Education and Licensure recommends that the following resolution be adopted by the 2014 House of Delegates:

Resolution

6. Resolved, that ADA *Bylaws* be amended as shown in Appendix 1 of the Council on Dental Education and Licensure's 2014 annual report, establishing the Commission for Continuing Education Provider Recognition, and be it further

Resolved, that the Rules of the ADA Commission for Continuing Education Provider Recognition as shown in Appendix 2 of the Council on Dental Education and Licensure's 2014 annual report be approved, and be it further

Resolved, that Resolution 82H-1996 and Resolution 5H-2007 be rescinded.

BOARD COMMENT: The Board believes that provisions should be put in place to review the effectiveness of this new ADA agency to ensure that the Commission for Continuing Education Provider Recognition is periodically assessed, like all ADA Councils and Commissions per Resolution 1H-2013. The Board recommends that the first assessment of the Commission for Continuing Education Provider

Recognition be conducted in five years and that the results of that assessment be provided to the 2019 House of Delegates. Accordingly, the Board urges adoption of the following substitute resolution:

6B. Resolved, that ADA *Bylaws* be amended as shown in Appendix 1 of the Council on Dental Education and Licensure's 2014 annual report (Reports:114 and Worksheet:4015) establishing the Commission for Continuing Education Provider Recognition, and be it further

Resolved, that the Rules of the ADA Commission for Continuing Education Provider Recognition as shown in Appendix 2 of the Council on Dental Education and Licensure's 2014 annual report (Reports:119 and Worksheet:4020) be approved, and be it further

Resolved, that the Board of Trustees conduct a review of the ADA Commission for Continuing Education Provider Recognition in 2019 assessing its effectiveness and report findings to the 2019 House of Delegates, and be it further

Resolved, that Resolution 82H-1996 and Resolution 5H-2007 be rescinded (Worksheet:4014).

BOARD RECOMMENDATION: Vote Yes on the Substitute.

Vote: Resolution 6B

BUCKENHEIMER	Yes	FEINBERG	Abstain	KIESLING	Yes	STEVENS	No
COLE	No	GOUNARDES	Yes	KWASNY	Yes	SUMMERHAYS	Yes
CROWLEY	Yes	HAGENBRUCH	Yes	ROBERTS	No	YONEMOTO	Yes
DOW	Yes	ISRAELSON	Yes	SCOTT	Yes	ZENK	Yes
FAIR	Absent	JEFFERS	Yes	SHENKIN	Yes	ZUST	Yes

**WORKSHEET ADDENDUM
COUNCIL ON DENTAL EDUCATION AND LICENSURE**

ADA POLICIES TO BE RESCINDED

Organizational Restructure of the ADA CERP Committee (*Trans.1996:706*)

82H-1996. Resolved, that responsibility for the conduct of the American Dental Association's Continuing Education Recognition Program (ADA CERP) be transferred from the existing ADA CERP Policy Board to the Council on Dental Education, and be it further

Resolved, that a continuing education subcommittee of the Council be created to facilitate the conduct of the ADA CERP by developing expertise and making recommendations regarding continuing education provider recognition for consideration by the Council, and be it further

Resolved, that the continuing education subcommittee shall have the following composition: one representative each representing the dental education community, the dental licensure community, the parent organizations of the ADA-recognized dental specialties, the dental profession in Canada, and four general dentists, and be it further

Resolved, that all representatives be members of the American Dental Association or the Canadian Dental Association, and be it further

Resolved, that the CERP Standards and Criteria for Recognition and related program documents be revised to reflect this change in program governance.

Organizational Restructure of the ADA CERP Committee (*Trans.2007:393*)

5H-2007. Resolved, that the ADA policy on Organizational Restructure of the ADA CERP Committees be amended as follows:

Resolved, that responsibility for the conduct of the American Dental Association's Continuing Education Recognition Program (ADA CERP) be transferred from the existing ADA CERP Policy Board to the Council on Dental Education, and be it further

Resolved, that a continuing education subcommittee of the Council be created to facilitate the conduct of the ADA CERP by developing expertise and making recommendations regarding continuing education provider recognition for consideration by the Council, and be it further

Resolved, that the continuing education subcommittee shall have the following composition: one representative each representing the American Dental Education Association; the American Association of Dental Examiners, the parent organizations of the ADA-recognized dental specialties, the Canadian Dental Association, the American Society of Constituent Dental Executives and four American Dental Association general dentists, and be it further

Resolved, that all representatives who are dentists be members of the American Dental Association or the Canadian Dental Association, and be it further

Resolved, that the ADA CERP Standards and Criteria for Recognition and related program documents be revised to reflect this change in program governance.

Appendix 1.

ADA BYLAWS

(additions are underscored; deletions are ~~stricken~~):

CHAPTER XV • COMMISSIONS

Section 10. NAME: The commissions of this Association shall be:

Commission on Dental Accreditation

Joint Commission on National Dental Examinations

Commission for Continuing Education Provider Recognition

Section 20. MEMBERS, SELECTIONS, NOMINATIONS AND ELECTIONS:

A. COMMISSION ON DENTAL ACCREDITATION. The number of members and the method of selection of the members of the Commission on Dental Accreditation shall be governed by the *Rules of the Commission on Dental Accreditation* and these *Bylaws*.

Twelve (12) of the members of the Commission on Dental Accreditation shall be selected as follows:

(1) Four (4) members shall be selected from nominations open to all trustee districts from the active, life or retired members of this Association, no one of whom shall be a faculty member working for a school of dentistry more than one day per week or a member of a state board of dental examiners or jurisdictional dental licensing agency. These members shall be nominated by the Board of Trustees and elected by the House of Delegates.

(2) Four (4) members who are active, life or retired members of this Association shall be selected by the American Association of Dental Boards from the active membership of that body, no one of whom shall be a member of a faculty of a school of dentistry.

(3) Four (4) members who are active, life or retired members of this Association shall be selected by the American Dental Education Association from its active membership. These members shall hold positions of professorial rank in dental schools accredited by the Commission on Dental Accreditation and shall not be members of any state board of dental examiners or jurisdictional dental licensing agency.

B. JOINT COMMISSION ON NATIONAL DENTAL EXAMINATIONS. The Joint Commission on National Dental Examinations shall be composed of fifteen (15) members selected as follows:

a. Three (3) members shall be nominated by the Board of Trustees from the active, life or retired members of this Association and additional nominations may be made by the House of Delegates but no one of such nominees shall be a member of a faculty of a school of dentistry or a member of a state board of dental examiners or jurisdictional dental licensing agency. The House of Delegates shall elect the three (3) members from those nominated by the Board of Trustees and the House of Delegates.

b. Six (6) members who are active, life or retired members of this Association shall be selected by the American Association of Dental Boards from the active membership of that body, no one of whom shall be a member of a faculty of a dental school.

c. Three (3) members who are active, life or retired members of this Association shall be selected by the American Dental Education Association from its active membership. These members shall hold positions of professorial rank in the dental schools accredited by this Association and shall not be members of any state board of dental examiners or jurisdictional dental licensing agency.

d. One (1) member who is a dental hygienist shall be selected by the American Dental Hygienists' Association.

e. One (1) member who is a public representative shall be selected by the Joint Commission on National Dental Examinations.

f. One (1) member who is a dental student shall be selected annually by the American Student Dental Association.

C. COMMISSION FOR CONTINUING EDUCATION PROVIDER RECOGNITION. The Commission for Continuing Education Provider Recognition shall be composed of members selected as follows:

a. Four (4) members, at least two of whom shall be general dentists, shall be selected from nominations open to all trustee districts from the active, life or retired members of this Association. These members shall be nominated by the Board of Trustees and elected by the House of Delegates.

b. One (1) member who is an active, life or retired member of this Association (if eligible) shall be selected by the American Association of Dental Boards from the active membership of that body.

c. One (1) member who is an active, life or retired member of this Association (if eligible) shall be selected by the American Dental Education Association from its active membership.

d. One (1) member who is an active, life or retired member of this Association (if eligible) shall be selected by the American Society of Constituent Dental Executives from its active membership.

e. One (1) member who is an active, life or retired member of this Association shall be selected by each sponsoring organization of the ADA recognized dental specialties.*

*The Commission for Continuing Education Provider Recognition initially shall be composed of the incumbent members of the CERP Committee of the Council on Dental Education and Licensure that was retired by the 2014 House of Delegates and any new appointees to the CERP Committee of the Council on Dental Education and Licensure selected by the American Association of Dental Boards, American Dental Education Association, American Society of Constituent Dental Executives and/or a sponsoring organization of any ADA recognized dental specialty. To the extent that there exists an unfilled position on the Commission for Continuing Education Provider Recognition for an ADA appointee when the Commission is created, that position shall be treated as a vacancy and filled in accordance with the procedure set forth in CHAPTER XV. COMMISSIONS, SECTION 70 of these ADA *Bylaws*. These inaugural Commission members shall serve for terms that are equal in time to their unfinished terms on the retired CERP Committee. This footnote shall expire at adjournment sine die of the 2018 House of Delegates.

Section 30. REMOVAL FOR CAUSE: The Board of Trustees may remove a commission member for cause in accordance with procedures established by the Board of Trustees, which procedures shall provide for notice of the charges, including allegations of the conduct purported to constitute each violation, and a decision in writing which shall specify the findings of fact which substantiate any and all of the charges, and that prior to issuance of the decision of the Board of Trustees, no commission member shall be excused from attending any meeting of a commission unless there is an opportunity to be heard or compelling reasons exist which are specified in writing by the Board of Trustees.

1
2 *Section 40. ELIGIBILITY:*

3 A. All members of commissions who are dentists must be active, life or retired members in good standing
4 of this Association except as otherwise provided in these *Bylaws*.

5 B. A member of the Joint Commission on National Dental Examinations, who was selected by the
6 American Association of Dental Boards and who is no longer an active member of that Association, may
7 continue as a member of the Commission for the balance of that member's term.

8 C. When a member of the Joint Commission on National Dental Examinations, who was selected by the
9 American Dental Education Association, shall cease to be a member of the faculty of a member school of
10 that Association, such membership on the Commission shall terminate, and the President of the
11 American Dental Association shall declare the position vacant.

12 D. Any organizations that select members to serve on the Commission for Continuing Education Provider
13 Recognition and offer continuing dental education courses shall be continuing education providers
14 currently approved by that Commission.

15 ~~D~~E. No member of a commission may serve concurrently as a member of a council or another
16 commission.

17 ~~E~~F. The Commissions of this Association shall elect their own chairs who shall be active, life or retired
18 members of this Association.

19
20 *Section 50. CONSULTANTS, ADVISERS AND STAFF:*

21 A. CONSULTANTS AND ADVISERS. Each commission shall have the authority to nominate consultants
22 and advisers in conformity with rules and regulations established by the Board of Trustees except as
23 otherwise provided in these *Bylaws*. The Joint Commission on National Dental Examinations also shall
24 select consultants to serve on the Commission's test construction committees. The Commission on
25 Dental Accreditation shall have the power to appoint consultants to assist in developing requirements and
26 guidelines for the conducting of accreditation evaluations, including site visitations, of predoctoral,
27 advanced dental educational, and dental auxiliary educational programs. The Commission for Continuing
28 Education Provider Recognition shall have the power to appoint consultants to assist in developing
29 standards and procedures, conducting recognition reviews and conducting appeals.

30 B. STAFF. The Executive Director shall employ the staff of Commissions, in the event they are
31 employees, and shall select the titles for commission staff positions.

32
33 *Section 60. TERM OF OFFICE:* The term of office of members of the commissions shall be four (4) years
34 except that (a) the term of office of members of the Commission on Dental Accreditation selected
35 pursuant to the *Rules of the Commission on Dental Accreditation* shall be governed by those *Rules* and
36 (b) the term of office of the dental student selected by the American Student Dental Association for
37 membership on the Joint Commission on National Dental Examinations shall be one (1) year.

38 The tenure of a member of a commission shall be limited to one (1) term of four (4) years except that (a)
39 the consecutive tenure of members of the Commission on Dental Accreditation selected pursuant to the
40 *Rules of the Commission on Dental Accreditation* shall be governed by those *Rules* and (b) tenure in
41 office of the dental student selected by the American Student Dental Association for membership on the
42 Joint Commission on National Dental Examinations shall be one (1) term. A member shall not be eligible
43 for appointment to another commission or council for a period of two (2) years after completing a previous
44 commission appointment.

45
46 *Section 70. VACANCY:* In the event of a vacancy in the office of a commissioner, the following procedure
47 shall be followed:

1 A. In the event the member of a commission, whose office is vacant, is or was a member of and was
2 appointed or elected by this Association, the President of this Association shall appoint a member of this
3 Association possessing the same qualifications as established by these *Bylaws* for the previous member,
4 to fill such vacancy until a successor is elected by the next House of Delegates of this Association for the
5 remainder of the unexpired term.

6 B. In the event the member of a commission whose office is vacant was selected by an organization other
7 than this Association, such other organization shall appoint a successor possessing the same
8 qualifications as those possessed by the previous member of the commission.

9 C. In the event such vacancy involves the chair of the commission, the President of this Association shall
10 have the power to appoint an *ad interim* chair, except as otherwise provided in these *Bylaws*.

11 D. If the term of the vacated commission position has less than fifty percent (50%) of a full four-year term
12 remaining at the time the successor member is appointed or elected, the successor member shall be
13 eligible for election to a new, consecutive four-year term. If fifty percent (50%) or more of the vacated term
14 remains to be served at the time of the appointment or election, the successor member shall not be
15 eligible for another term.

16
17 *Section 80. MEETINGS OF COMMISSIONS:* Each commission shall hold at least one regular meeting
18 annually, provided that funds are available in the budget for that purpose and unless otherwise directed
19 by the Board of Trustees. Meetings may be held at the Headquarters Building, the Washington Office or
20 from multiple remote locations through the use of a conference telephone or other communications
21 equipment by means of which all members can communicate with each other. Such meetings shall be
22 conducted in accordance with rules and procedures established by the Board of Trustees.

23
24 *Section 90. QUORUM:* A majority of the members of any commission shall constitute a quorum.

25
26 *Section 100. PRIVILEGE OF THE FLOOR:* Chairs and members of the commissions who are not
27 members of the House of Delegates shall have the right to participate in the debate on their respective
28 reports but shall not have the right to vote.

29
30 *Section 110. ANNUAL REPORT AND BUDGET:*

31 A. ANNUAL REPORT. Each commission shall submit, through the Executive Director, an annual report to
32 the House of Delegates and a copy thereof to the Board of Trustees.

33 B. PROPOSED BUDGET. Each commission shall submit to the Board of Trustees, through the Executive
34 Director, a proposed itemized budget for the ensuing fiscal year.

35
36 *Section 120. POWER TO ADOPT RULES:* Any commission of this Association shall have the power to
37 adopt rules for such commission and amendments thereto, provided such rules and amendments thereto
38 do not conflict with or limit the *Constitution and Bylaws* of this Association. Rules and amendments
39 thereto, adopted by any commission of this Association, shall not be effective until submitted in writing to
40 and approved by majority vote of the House of Delegates of this Association, except the Joint
41 Commission on National Dental Examinations shall have such bylaws and amendments thereto as the
42 House of Delegates of this Association may adopt by majority vote for the conduct of the purposes and
43 management of the Joint Commission on National Dental Examinations.

44
45 *Section 130. DUTIES:*

46 A. COMMISSION ON DENTAL ACCREDITATION. The duties of the Commission on Dental Accreditation
47 shall be to:

1 a. Formulate and adopt requirements and guidelines for the accreditation of dental educational and dental
2 auxiliary educational programs.

3 b. Accredite dental educational and dental auxiliary educational programs.

4 c. Provide a means for appeal from an adverse decision of the accrediting body of the Commission to a
5 separate and distinct body of the Commission whose membership shall be totally different from that of the
6 accrediting body of the Commission.

7 d. Submit an annual report to the House of Delegates of this Association and interim reports, on request,
8 and the Commission's annual budget to the Board of Trustees of the Association.

9 e. Submit the Commission's articles of incorporation and rules and amendments thereto to this
10 Association's House of Delegates for approval by majority vote either through or in cooperation with the
11 Council on Dental Education and Licensure.

12 B. JOINT COMMISSION ON NATIONAL DENTAL EXAMINATIONS. The duties of the Joint Commission
13 on National Dental Examinations shall be to:

14 a. Provide and conduct written examinations, exclusive of clinical demonstrations for the purpose of
15 assisting state boards of dental examiners in determining qualifications of dentists who seek license to
16 practice in any state or other jurisdiction of the United States. Dental licensure is subject to the laws of the
17 state or other jurisdiction of the United States and the conduct of all clinical examinations for licensure is
18 reserved to the individual board of dental examiners.

19 b. Provide and conduct written examinations, exclusive of clinical demonstrations for the purpose of
20 assisting state boards of dental examiners in determining qualifications of dental hygienists who seek
21 license to practice in any state or other jurisdiction of the United States. Dental hygiene licensure is
22 subject to the laws of the state or other jurisdiction of the United States and the conduct of all clinical
23 examinations for licensure is reserved to the individual board of dental examiners.

24 c. Make rules and regulations for the conduct of examinations and the certification of successful
25 candidates.

26 d. Serve as a resource of the dental profession in the development of written examinations.

27 C. COMMISSION FOR CONTINUING EDUCATION PROVIDER RECOGNITION. The duties of the
28 Commission for Continuing Education Provider Recognition shall be to:

29 a. Formulate and adopt requirements, guidelines and procedures for the recognition of continuing dental
30 education providers.

31 b. Approve providers of continuing dental education programs and activities.

32 c. Provide a means for continuing dental education providers to appeal adverse recognition decisions.

33 d. Submit an annual report to the House of Delegates of this Association and interim reports, on request,
34 and the Commission's annual budget to the Board of Trustees of the Association.

35 e. Submit the Commission's rules and amendments thereto to this Association's House of Delegates for
36 approval by majority vote either through or in cooperation with the Council on Dental Education and
37 Licensure.

1 **Appendix 2.**

2 **Proposed Rules of the ADA Commission for**
3 **Continuing Education Provider Recognition**

4 *PROPOSED*

5 RULES OF THE ADA COMMISSION FOR CONTINUING EDUCATION PROVIDER RECOGNITION

6 *Article I. BOARD OF COMMISSIONERS*

7 Section I. MANAGEMENT BODY: The management body of the Commission shall be the Board of
8 Commissioners.

9 Section 2. COMPOSITION: The Board of Commissioners shall be as defined in Chapter XV, Section
10 20.C of the ADA *Bylaws*.

11 Section 3. TERM OF OFFICE: The term of office of the members of the Board of Commissioners shall be
12 as defined in Chapter XV, Section 60 of the ADA *Bylaws*.

13 Section 4. POWERS:

14 A. The Board of Commissioners shall be vested with full power to conduct all business of the Commission
15 subject to the laws of the State of Illinois, these *Rules* and the *Constitution and Bylaws* of the American
16 Dental Association.

17 B. The Board of Commissioners shall have the power to establish rules and regulations not inconsistent
18 with these *Rules* to govern its organization and procedures.

19 Section 5. DUTIES: The duties of the Board of Commissioners are as set forth in Chapter XV. Sections
20 50.A and 130 of the ADA *Bylaws*, and in addition the Board of Commissioners may appoint special
21 committees of the Commission for the purpose of performing duties not otherwise assigned by these
22 *Rules*.

23 Section 6. MEETINGS:

24 A. REGULAR MEETINGS: There shall be at least two (2) regular meetings of the Board of
25 Commissioners each year.

26 B. SPECIAL MEETINGS: Special meetings of the Board of Commissioners may be called at any time by
27 the Chairman of the Commission. The Chairman shall call such meetings on request of a majority of the
28 voting members of the Board provided at least ten (10) days' notice is given to each member of the Board
29 in advance of the meeting. No business shall be considered except that provided in the call unless by
30 unanimous consent of the members of the Board present and voting.

31 Section 7. QUORUM: A quorum of the Board shall be defined as defined in Chapter XV, Section 90 of
32 the ADA *Bylaws*.

33 *Article II. OFFICERS*

34 Section I. OFFICERS: The officers of the Commission shall be a Chair and Vice-Chair and such other
35 officers as the Board of Commissioners may authorize. The Chair and Vice-Chair shall be elected by the
36 members of the Commission. The Chair and Vice-Chair shall be active, life or retired member of the
37 American Dental Association.

38 Section 2. DUTIES: The duties of the officers are as follows:

1 A. CHAIR: The Chair shall preside at all meetings of the Board of Commissioners.

2 B. VICE-CHAIR: If the Chair is unable to attend any given meeting of the Board of Commissioners, the
3 Vice-Chair shall preside at the meeting. If the Vice-chair is unable to attend the meeting, the other
4 members of the Board of Commissioners present and voting shall elect by majority vote an acting chair
5 for the purpose of presiding at that meeting only.

6 Article III. APPEAL BOARD

7 Section 1. APPEAL BOARD: The appellate body of the Commission shall be the Appeal Board which
8 shall have the authority to hear and decide appeals filed by continuing education providers from decisions
9 rendered by the Board of Commissioners of the Commission denying or revoking recognition.

10 Section 2. COMPOSITION: The Appeal Board consists of one representative selected by each of the
11 organizations represented on the Board of Commissioners who has previously served on the Board of
12 Commissioners. When an appeal is initiated, the Director selects three (3) individuals from the pool of
13 available Appeal Board Members to hear the appeal.

14 Section 3. TERM OF OFFICE: The term of office of members on the Appeal Board shall be one four (4)
15 year term.

16 Section 4. MEETINGS: The Appeal Board shall meet at the call of the Director of the Commission,
17 provided at least ten (10) days' notice is given to each member of the Appeal Board in advance of the
18 meeting. Such meetings shall be called by the Director only when an appeal to the appellate body has
19 been duly filed by a continuing education provider.

20 Section 5. QUORUM: A majority of the voting members of the Appeal Board shall constitute a quorum.

21 Section 6. VACANCIES:

22 A. In the event of a vacancy in the membership of the Appeal Board, the Chair of the Commission shall
23 appoint a member of the same organization to fill such vacancy until a successor is selected by the
24 respective representative organization.

25 B. If the term of the vacated position has less than fifty percent (50%) of a full four-year term remaining at
26 the time the successor member is appointed, the successor member shall be eligible for a new,
27 consecutive four-year term. If fifty percent (50%) or more of the vacated term remains to be served at the
28 time of the appointment, the successor member shall not be eligible for another term.

29 Article IV. CONTINUING EDUCATION RECOGNITION PROGRAM

30 Section I. RECOGNITION STANDARDS AND PROCEDURES: The Commission, acting through the
31 Board of Commissioners, shall establish and publish specific Standards and Procedures for the
32 recognition of providers of continuing dental education programs.

33 Section 2. PROCEDURES FOR EVALUATING INITIAL AND RENEWAL APPLICATIONS FOR
34 RECOGNITION: Providers of continuing dental education activities shall be evaluated for compliance
35 with the Standards and Procedures and recognition status conferred by the Board of Commissioners on
36 the basis of the information and data provided on survey forms and reports and secured by the members
37 of, and consultants to, the Board of Commissioners, as set forth in the Standards and Procedures and in
38 the Procedures for an Adverse Action Against a Continuing Education Provider.

39 Article V. MISCELLANEOUS

40 The operating procedures of the Commission shall be governed by the *Rules* except where they are in
41 conflict with the ADA *Bylaws* and the Standing Rules of Councils and Commissions.

Resolution No. 7 NewReport: N/A Date Submitted: July 2014Submitted By: Council on Dental Education and LicensureReference Committee: C (Dental Education, Science and Related Matters)Total Net Financial Implication: None Net Dues Impact: Amount One-time Amount On-going FTE 0

ADA Strategic Plan Objective: Organizational Capacity-Obj. 6: Role and responsibility of each element of the tripartite clearly defined and agreed upon

How does this resolution increase member value: See Background

AMENDMENT OF THE BYLAWS DUTIES OF THE COUNCIL ON DENTAL EDUCATION AND LICENSURE

Background: (*Reports:107*)

Amendment of the Bylaws Duties of the Council on Dental Education and Licensure: In accord with Resolution 1H-2013 (*Trans.2013:339*), the Council reviewed each of the six areas of the self-assessment, which included threshold issues, structure, efficiencies, areas of responsibility, agenda review, and strategic direction and made the following conclusions. The complete assessment is presented as Appendix 3 in the Council's annual report.

The Council came to the following conclusions as a result of the self-assessment:

- The current ADA/ADEA/AADB structure of the Council supports the Association and members, providing broad-based volunteer oversight, expertise and input in matters which are paramount to a learned profession. The composition of the Council and its standing committees should remain as is. The Council's unique structure of private practitioners, dental educators and dental examiners is important and necessary to address the myriad of responsibilities assigned to this agency. The Council carries out assignments and activities related to all areas of its assigned duties. Additionally, the Council receives assignments from the House of Delegates related to its assigned duties. The Council's work assignments often require input from a variety of internal and external agencies, and the Council requests the appointment of interagency committees when collaboration is required to carry out its assignments.
- The Council operates efficiently, meeting in-person twice annually and conducting business electronically and via conference calls throughout the year. When appropriate, the chair assigns business to the subject-matter standing committees for consideration and recommendation to the Council. Business conducted electronically and via teleconferencing provides more opportunity for the Council to use in-person meeting time focused on strategic discussions on dental education, licensure and recognition matters critical to the membership and the profession. Professional and administrative staff support for this agency is adequate and appropriate.
- With regard to the Council's *Bylaws* responsibilities, the Council's duties should be amended to include its responsibility for dental anesthesiology policy matters as well as governance oversight for dental admission testing (see resolution below).

Based on the conclusions of the self-assessment, the Council presents the following resolution to the House of Delegates:

Resolution

7. Resolved, that CHAPTER X, COUNCILS; *Section 120. DUTIES*, Subsection E. COUNCIL ON DENTAL EDUCATION AND LICENSURE of the ADA *Bylaws* be amended as follows (proposed additions are underlined):

The duties of the Council shall be to:

- a. Act as the agency of the Association in matters related to the evaluation and accreditation of all dental educational, allied dental educational and associated subjects.
- b. Study and make recommendations including the formulation and recommendation of policy on:
 - 1) Dental education, continuing dental education and allied dental education.
 - 2) The recognition of dental specialties.
 - 3) The recognition of interest areas in general dentistry, excluding ADA recognized specialties.
 - 4) The recognition of categories of allied dental personnel.
 - 5) The approval or disapproval of national certifying boards for dental specialties and for allied dental personnel.
 - 6) The educational and administrative standards of the certifying boards for dental specialties and for allied dental personnel.
 - 7) Associated subjects that affect all dental, allied dental and related education.
 - 8) Dental licensure and allied dental personnel credentialing
 - 9) Dental anesthesiology, sedation and related matters.
- c. Act on behalf of this Association in maintaining effective liaison with certifying boards and related agencies for dental specialties and for allied dental personnel.
- d. Monitor and disseminate information on continuing dental education and to encourage the provision of and participation in continuing dental education.
- e. Monitor and disseminate information on careers in dentistry.
- f. Act on behalf of this Association in matters related to dental admission testing.

BOARD RECOMMENDATION: Vote Yes.

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

***Dr. Fair was absent.**

Resolution No. 8 NewReport: N/A Date Submitted: July 2014Submitted By: Council on Dental Education and LicensureReference Committee: C (Dental Education, Science and Related Matters)Total Net Financial Implication: None Net Dues Impact: _____Amount One-time _____ Amount On-going _____ FTE 0

ADA Strategic Plan Objective: Membership-Obj. 1: Leaders and Advocates in Oral Health

How does this resolution increase member value: See Background

1 **AMENDMENT OF THE POLICY, DEVELOPMENT OF ALTERNATE PATHWAYS FOR DENTAL**
2 **HYGIENE TRAINING**

3 **Background:** (*Reports:109*)
4

5 **Amendment of the Policy, Development of Alternate Pathways for Dental Hygiene Training:** The
6 Council believes that the policy "Development of Alternate Pathways for Dental Hygiene Training" should
7 be amended to delete the phrase, "as an educational opportunity that satisfies the criteria of 42H-1997,
8 and that constituent dental societies be notified of this support" because this part of the statement was a
9 directive in 1997 related to the Comprehensive Policy on Dental Auxiliary Personnel, which subsequently
10 was revised.

11 **Resolution**

12 **8. Resolved,** that the ADA policy on Development of Alternative Pathways for Dental Hygiene
13 Training (*Trans.1998:714*) be amended by deletion of the phrase, "as an educational opportunity that
14 satisfies the criteria of 42H-1997, and that constituent dental societies be notified of this support", so
15 that the amended policy reads as follows (deletions are ~~striketroughs~~):

16 **Development of Alternate Pathways for Dental Hygiene Training (*Trans.1998:714*)**

17 **Resolved,** the American Dental Association supports the alternate pathway model of the Dental
18 Hygiene Education as used in Alabama ~~as an educational opportunity that satisfies the criteria of~~
19 ~~42H-1997, and that constituent dental societies be notified of this support.~~

20
21 **BOARD RECOMMENDATION: Vote Yes.**

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

24 ***Dr. Fair was absent.**

Resolution No. 9 NewReport: N/A Date Submitted: July 2014Submitted By: Council on Dental Education and LicensureReference Committee: C (Dental Education, Science and Related Matters)Total Net Financial Implication: None Net Dues Impact: _____Amount One-time _____ Amount On-going _____ FTE 0

ADA Strategic Plan Objective: Membership-Obj. 1: Leaders and Advocates in Oral Health

How does this resolution increase member value: See Background

AMENDMENT OF THE POLICY, RECOGNITION OF CERTIFICATION BOARD FOR DENTAL ASSISTANTS**Background:** (*Reports: 109*)**Amendment of the Policy, Recognition of Certification Board for Dental Assistants:** The Council believes that the policy, "Recognition of Certification Board for Dental Assistants" should be amended in an effort to establish standardized declarative policy statements for approved certifying boards.**Resolution****9. Resolved**, that the ADA policy, Recognition of Certification Board for Dental Assistants (*Trans.1990:551*) be amended as follows (additions are underscored; deletions are ~~strike throughs~~):~~**Recognition of Certification**~~ **Certifying Board for in Dental Assistants Assisting****Resolved**, that the American Dental Association approves the Dental Assisting National Board, Inc.'s ~~request for recognition as the certification board for dental assistants~~ as the national certifying board for dental assisting.**BOARD RECOMMENDATION: Vote Yes.****BOARD VOTE: UNANIMOUS*. (BOARD OF TRUSTEES CONSENT CALENDAR ACTION—NO BOARD DISCUSSION)*****Dr. Fair was absent.**

Resolution No. 10 NewReport: N/A Date Submitted: July 2014Submitted By: Council on Dental Education and LicensureReference Committee: C (Dental Education, Science and Related Matters)Total Net Financial Implication: None Net Dues Impact: _____Amount One-time _____ Amount On-going _____ FTE 0

ADA Strategic Plan Objective: Membership-Obj. 1: Leaders and Advocates in Oral Health

How does this resolution increase member value: See Background

1 **AMENDMENT OF THE POLICY, NATIONAL BOARD FOR CERTIFICATION OF DENTAL**
 2 **LABORATORY TECHNICIANS' CONTINUED RECOGNITION**

3
 4 **Background:** (*Reports:109*)

5
 6 **Amendment of the Policy, National Board For Certification of Dental Laboratory Technicians'**
 7 **Continued Recognition:** The Council believes that the policy "National Board for Certification of Dental
 8 Laboratory Technicians' Continued Recognition" should be amended in an effort to establish standardized
 9 declarative policy statements for approved certifying boards.

10 **Resolution**

11 **10. Resolved,** that the ADA policy National Board for Certification of Dental Laboratory Technicians'
 12 Continued Recognition (Trans. 2002:440) be amended as follows (additions are underscored;
 13 deletions are ~~strike throughs~~):

14 ~~National Board for Certification of~~ Certifying Board in Dental Laboratory Technicians'
 15 ~~Continued Recognition~~ Technology

16 **Resolved,** that the American Dental Association approves the National Board for Certification of
 17 ~~in Dental Laboratory Technicians' request for continued recognition as the certification board for~~
 18 ~~dental laboratory technicians be approved~~ Technology as the national certifying board for dental
 19 laboratory technology.

20
 21 **BOARD RECOMMENDATION: Vote Yes.**

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

24 ***Dr. Fair was absent.**

Resolution No. 11 NewReport: N/A Date Submitted: July 2014Submitted By: Council on Dental Education and LicensureReference Committee: C (Dental Education, Science and Related Matters)Total Net Financial Implication: None Net Dues Impact: _____Amount One-time _____ Amount On-going _____ FTE 0

ADA Strategic Plan Objective: Membership-Obj. 1: Leaders and Advocates in Oral Health

How does this resolution increase member value: See Background

AMENDMENT OF THE CRITERIA FOR RECOGNITION OF A CERTIFICATION BOARD FOR DENTAL ASSISTANTS**Background:** (*Reports:109*)

Amendment of the Criteria for Recognition of a Certification Board for Dental Assistants: The Council believes that the policy, "Criteria for Recognition of a Certification Board for Dental Assistants" should be amended as a housekeeping measure to reflect consistent clarifying language and contemporary style.

Resolution

11. Resolved, that the policy Criteria for Recognition of a Certification Board for Dental Assistants (*Trans.1989:520*) be amended as follows (additions are underscored; deletions are ~~strike throughs~~):

Criteria for Recognition of a Certification Board for Dental Assistants

Introduction: ~~Duties~~ A duty of the Council on Dental Education and Licensure as indicated in the *Bylaws* of the American Dental Association ~~include acting as the agency of the Association in matters related to the evaluation and accreditation of all dental and dental auxiliary education programs and to approve or disapprove~~ is to study and make recommendations on policy related to the approval or disapproval of national certifying boards for ~~special areas of dental practice and for dental auxiliaries~~ allied dental personnel.

~~It is the opinion of the Council on Dental Education and Licensure that a~~ A mechanism should be made available for providing evidence that a dental assistant has acquired the knowledge and ability that is expected of an individual employed as a dental assistant through a program of certification. Such a certification program should be based on the educational requirements for dental assistants approved by the Commission on Dental Accreditation.

~~The Association has already indicated its approval of certification programs for the eight recognized dental specialties and for dental laboratory technicians; the House of Delegates has approved basic requirements under which these certification programs are conducted. Such a program of certification that has been approved as meeting these basic requirements has therefore earned the approval of the dental profession even though the program itself is not conducted or operated by the American Dental Association.~~

The dental profession is committed to assuring appropriate education and training of all personnel who participate in the provision of oral health care to the public. The following basic requirements are prescribed by the Council on Dental Education and Licensure for the evaluation of an agency which seeks approval of the American Dental Association for a program to certify dental assistants on the basis of educational standards approved by the dental profession.

I. Organization

1. The Board shall have no less than five nor more than nine voting members designated on a rotation basis in accordance with a method approved by the Council on Dental Education and Licensure. The following organizations/interests shall be represented on the Board:

- a. American Dental Assistants Association
- b. American Dental Association
- c. American Dental Education Association
- d. American Association of Dental ~~Examiners~~ Boards
- e. Public
- f. The at-large population of Board Certificants

All dental assistant members shall be currently certified by the Board.

2. The Board shall submit to the Council on Dental Education and Licensure evidence of adequate financial support to conduct its program of certification.

3. The Board may select suitable consultants or agencies to assist in its operations, such as the preparation and administration of examinations and the evaluation of records and examinations of candidates. Dental assistant consultants should be certified by the board.

4. The Board shall submit in writing to the Council on Dental Education and Licensure a program sufficiently comprehensive in scope to meet the requirements established by the American Dental Association for the operation of a certifying board for dental assistants. This statement should include evidence that the Board has the support of the American Dental Assistants Association, the organization representative of dental assistants, as well as other groups within the communities of interests represented by the Board.

II. Operation of Board

1. The Board shall ~~issue certificates~~ grant certification to individuals who have provided evidence of competence in dental assisting.

2. The Board shall submit in writing to the Council on Dental Education and Licensure a plan for renewal of certificate currently held by certified persons.

3. The Board shall submit annually to the Council on Dental Education and Licensure data relative to its financial operations, applicant eligibility criteria, examination procedures and results of its certifying examination.

4. The Board shall ~~conduct at least two~~ administer the certification examinations at least twice each calendar year ~~which shall be~~ with administrations publicized at least six months prior to the examination.

5. The Board shall maintain and make available a current list of all persons certified.

6. The Board shall have authority to conduct the certification program; i.e., the Board shall be responsible for evaluating qualifications and competencies of persons certified and for

maintaining adequate standards for the annual renewal of certificates. However, proposals for important changes in the examination eligibility criteria or the Board procedures and policies must be circulated reasonably well in advance of consideration to affected communities of interest for review and comment. Proposed changes must have the approval of the Council on Dental Education and Licensure.

7. The Board shall maintain close liaison with the organizations represented on the Board. The Board shall report on its program annually to the organizations represented on the Board.

III. Granting Certificates

1. In the evaluation of its candidates for certification, the Board shall use standards of education and clinical experience approved by the Commission on Dental Accreditation. The Board shall require for eligibility for certification the successful completion of a dental assisting education program accredited by the Commission on Dental Accreditation, and satisfactory performance on an examination prescribed by the Board.

2. The Board shall ~~issue certificates~~ grant certification or recertification annually to those who qualify for certification.

The Board may require an annual certificate renewal fee to enable it to carry on its program.

IV. Waivers

It is a basic view of the Council that all persons seeking certification shall qualify for certification by completing satisfactorily a minimum period of approved training and experience and by passing an examination. However, the Council realizes that there may be need for a provision to recognize candidates who do not meet the established eligibility criteria on educational training. Therefore, the Board may make formal requests to the Council on Dental Education and Licensure regarding specific types of waivers which it believes essential for certification and/or certificate renewal. Such requests shall be substantiated and justified to and supported by the organizations represented on the Board; only waivers approved by the Council on Dental Education and Licensure may be used.

BOARD RECOMMENDATION: Vote Yes.

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

***Dr. Fair was absent.**

Resolution No. 12 NewReport: N/A Date Submitted: July 2014Submitted By: Council for Dental Education and LicensureReference Committee: C (Dental Education, Science and Related Matters)Total Net Financial Implication: None Net Dues Impact: _____Amount One-time _____ Amount On-going _____ FTE 0

ADA Strategic Plan Objective: Membership-Obj. 1: Leaders and Advocates in Oral Health

How does this resolution increase member value: See Background

**AMENDMENT OF THE CRITERIA FOR APPROVAL OF A CERTIFICATION BOARD FOR DENTAL
LABORATORY TECHNICIANS****Background:** (*Reports:113*)**Amendment of the Criteria for Approval of a Certification Board for Dental Laboratory****Technicians:** The Council believes that the policy "Criteria for Approval of a Certification Board for Dental Laboratory Technicians" should be amended as a housekeeping measure to reflect consistent clarifying language and contemporary style.**Resolution****12. Resolved**, that the policy "Criteria for Approval of a Certification Board for Dental Laboratory Technicians (*Trans.*1998:92, 713) be amended as follows (additions are underscored; deletions are ~~strikethroughs~~):**Criteria for ~~Approval~~ Recognition of a Certification Board for Dental Laboratory Technicians**

~~One of the duties~~ A duty of the Council on Dental Education and Licensure as indicated in the *Bylaws* of the American Dental Association is to study and make recommendations ~~including the formulation and recommendation of on policy on:~~ (4) The related to the approval or disapproval of national certifying boards for allied dental personnel~~special areas of dental practice and for dental auxiliaries~~ (5) ~~The educational and administrative standards of the certifying boards for special areas of dental practice and for dental auxiliaries. The Council on Dental Education and Licensure believes that~~ A mechanism for the examination and certification of dental laboratory technicians is necessary to provide the dental profession with an indication of those persons who have demonstrated their ability to fulfill the dental laboratory work authorization. Such a certification program should be based on the educational requirements for dental laboratory technicians approved by the Commission on Dental Accreditation.

The following basic requirements are prescribed by the Council on Dental Education and Licensure for the evaluation of an agency which seeks approval of the American Dental Association for a program to certify dental laboratory technicians on the basis of educational standards approved by the dental profession.

- I. Organization:** An agency that seeks approval as a Certification Board for Dental Laboratory Technicians should be representative of or affiliated with a national organization of the dental

laboratory industry and have authority to speak officially for that organization. It is required that each dental laboratory technician member of the Certification Board hold a certificate in one of the areas of the dental laboratory technology.

II. Authority and Purpose: The rules and regulations established by the Certification Board of Dental Laboratory Technicians will be considered for approval by the Council on Dental Education and Licensure on the basis of these requirements. Changes that are planned in the rules and regulations of the Certification Board should be reported to the Council before they are put into effect. The Board shall submit data annually to the Council on Dental Education and Licensure relative to its financial operations, applicant admission and examination procedures, and results thereof.

The principal functions of the Certification Board shall be:

- a. to determine the levels of education and experience of candidates applying for certification examination within the requirements for education established by the Commission on Dental Accreditation;
- b. to prepare and administer comprehensive examinations to determine the qualifications of those persons who apply for certification; and
- c. to issue certificates to those persons who qualify for certification and to prepare and maintain a roster of ~~certifees~~ certificants.

III. Qualifications of Candidates: It will be expected that the minimum requirements established by the Certification Board for the issuance of a certificate will include the following:

- a. satisfactory legal and ethical standing in the dental laboratory industry;
- b. graduation from high school or an equivalent acceptable to the Certification Board;
- c. a period of study and training as outlined in the Accreditation Standards for Dental Laboratory Technology Education Programs, plus an additional period of at least two years of working experience as a dental laboratory technician; or, five years of education and/or experience in dental technology; and
- d. satisfactory performance on examination(s) prescribed by the Certification Board.

BOARD RECOMMENDATION: Vote Yes.

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

***Dr. Fair was absent.**

Resolution No. 13 NewReport: N/A Date Submitted: July 2014Submitted By: Council on Dental Education and LicensureReference Committee: C (Dental Education, Science and Related Matters)Total Net Financial Implication: None Net Dues Impact: _____Amount One-time _____ Amount On-going _____ FTE 0

ADA Strategic Plan Objective: Membership-Obj. 1: Leaders and Advocates in Oral Health

How does this resolution increase member value: See Background

AMENDMENT OF THE POLICY, TITLES AND DESCRIPTIONS OF DENTAL HYGIENE CONTINUING EDUCATION COURSES**Background:** (*Reports:113*)**Amendment of the Policy, Titles and Descriptions of Dental Hygiene Continuing Education****Courses:** The Council believes that the policy "Titles and Descriptions of Dental Hygiene Continuing Education Courses" should be amended in an effort to broaden the policy to all allied personnel and to delete the resolving clauses that were directives for implementation at the time the policy was adopted.**Resolution****13. Resolved**, that the policy Titles and Descriptions of Dental Hygiene Continuing Education Courses (*Trans.1992:618*) be amended as follows (additions are underscored; deletions are ~~strikethroughs~~):**Titles and Descriptions of ~~Dental Hygiene~~ Continuing Education Courses****Resolved**, that the American Dental Association supports the ~~opposes~~ use of the terms "diagnosis" and "treatment planning" solely in the titles and descriptions of continuing education courses for dentists. The use of these terms in continuing education activities for allied dental personnel dental hygienists and descriptions of these courses that inappropriately imply implies that the continuing education program content or prior educational level of allied dental personnel dental hygienists is sufficient to make the dental hygienist competent for them to render diagnosis of dental disease or to develop treatment plans planning for dental patients, and be it further**Resolved**, that the ADA communicate its position on this issue to the American Dental Education Association and the American Association of Dental Examiners, ~~and be it further~~**Resolved**, that constituent and component dental societies be asked to work with sponsors of continuing education and boards of dentistry to maintain appropriate use of terminology in continuing education program literature.

BOARD RECOMMENDATION: Vote Yes.

- 1 **BOARD VOTE: UNANIMOUS*. (BOARD OF TRUSTEES CONSENT CALENDAR ACTION—NO**
- 2 **BOARD DISCUSSION)**
- 3 ***Dr. Fair was absent.**

Resolution No. 20 NewReport: N/A Date Submitted: July 2014Submitted By: Joint Commission on National Dental ExaminationsReference Committee: C (Dental Education, Science and Related Matters)Total Net Financial Implication: None Net Dues Impact: _____Amount One-time _____ Amount On-going _____ FTE 0

ADA Strategic Plan Objective: Membership-Obj. 1: Leaders and Advocates in Oral Health

How does this resolution increase member value: See Background

REVISIONS TO STANDING RULES OF THE JOINT COMMISSION ON NATIONAL DENTAL EXAMINATIONS

Background: (Reports:212)

Revisions to Standing Rules of the Joint Commission on National Dental Examinations: In conducting its self-assessment, the Joint Commission considered its mission and how its activities and operations were aligned with that mission. One area that received special attention involved the process by which criteria are established for selecting new members into each of the Joint Commission's 24 Test Construction Committees (TCCs). In considering this matter, it was realized that TCC member qualifications represent an operational matter that should likely be removed from the Joint Commission's *Standing Rules* and placed in a separate document that would be subject to approval by the Joint Commission. The Joint Commission's *Standing Rules* require approval by the House of Delegates, which has introduced delays that slow progress. An example of the inefficiency brought about by this structure is that it required approximately 1½ years to move between the idea and implementation phases when the Joint Commission identified the need to add the word 'preferably' to the qualifications listed for TCC members serving on the Clinical Dental Hygiene TCC. As the Joint Commission works to construct an integrated examination to replace National Board Dental Examination Parts I and II, greater flexibility is needed so the Joint Commission can work quickly to make adjustment to TCC membership and structure, in alignment with the Joint Commission's mission.

In consideration of the above issues and to provide more timely review and revision of the qualifications for TCC members, in April of 2014 the Joint Commission adopted changes to its *Standing Rules* that included the removal of Test Constructor Qualifications from the document. Qualification requirements would be placed in a new document entitled "Qualification Requirements for National Board Dental and Dental Hygiene Test Constructors." Additional noteworthy changes to the *Standing Rules* include the following:

- Editorial modifications to clarify language within the document and align language more closely with prior Joint Commission decisions (e.g., the move to pass/fail results reporting).
- The Joint Commission affirmed that the predominant consideration with respect to candidate appeals decisions concerns the validity of examination results.

As noted previously, the preceding changes to the Joint Commission's *Standing Rules* require approval by the House of Delegates before they can take effect.

1 **Resolution**

2 **20. Resolved**, that the *Standing Rules of the Joint Commission on National Dental Examinations* be
3 approved as revised in the Joint Commission's 2014 annual report.

4

5 **BOARD RECOMMENDATION: Vote Yes.**

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

8 ***Dr. Fair was absent.**

9

**Appendix 1. Revisions to Standing Rules of the Joint Commission on National Dental
Examinations**

STANDING RULES

PROPOSED CHANGES TO DOCUMENT

Underline indicates text that has been inserted.
~~Strikeout~~ indicates text that has been deleted.

April ~~2013~~2014

A publication of the Joint Commission on National Dental Examinations
American Dental Association Building
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Chicago, Illinois 60611-2637

1 The Joint Commission on National Dental Examinations operates within the limits imposed by
2 three documents, listed here in order of precedence:
3

- 4 1. Bylaws of the American Dental Association
 - 5 2. Bylaws of the Joint Commission on National Dental Examinations
 - 6 3. Standing Rules for Councils and Commissions
- 7

8 Subject to constraints defined in these documents, the Joint Commission is free to establish its
9 own policies and procedures for the conduct of its business. Such policies and procedures as
10 have been adopted are compiled here.
11
12

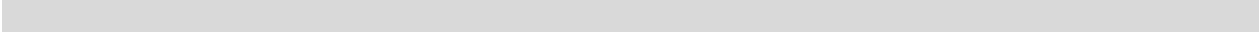


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ELECTION OF A PUBLIC MEMBER

The Joint Commission is charged with electing a public member to serve as a commissioner. Policies relating to election are as follows:

Qualifications

The public member shall not be a(n):

- a. Dentist
- b. Dental hygienist
- c. Dental student
- d. Dental hygiene student
- e. Faculty member of an accredited dental school or dental hygiene program
- f. Employee of the Joint Commission
- g. Member of another health profession
- h. Professional who has represented the Joint Commission, dental profession, or dental hygiene profession for a fee in the last five years
- i. Spouse of any of the above

Not more than five percent of the public member's income shall be derived from the Joint Commission, dentistry, or dental hygiene.

It is suggested that the public member not be employed by a firm with a substantial interest in dentistry or dental hygiene, and that the public member be experienced in health issues, testing, credentialing, or advocating the interest of the public and/or advocating for the interests of the public. Individuals wishing to serve as the public member must disclose in their application materials any financial benefits they may be receiving from the Joint Commission's examination programs.

Term

The public member will serve a single four-year term.

Identification of Nominees

When a new public member is needed, nominations will be requested from appropriate agencies, such as state boards of dentistry and public service organizations. Each nominee will be requested to supply a summary of his or her qualifications. At least two qualified nominees will be identified prior to conducting of an election.

ROLES OF COMMITTEES

~~Four~~ The following four Joint Commission standing committees meet in conjunction with the annual meeting of the Joint Commission. ~~They are:~~

- a. Committee on Administration
- b. Committee on Dental Hygiene

- c. Committee on Examination Development
- d. Committee on Research and Development

Each committee is assigned a portion of the materials to be considered by the Joint Commission, and is responsible for formulating specific recommendations for Joint Commission action.

Assignments

Assignment of topics to specific committees is the responsibility of the Joint Commission Chair, but this responsibility may be delegated in part or in total to the Secretary. Listed and discussed below are examples of topics that are typically assigned to each committee.

A topic may be assigned to more than one committee. In addition, provided that it completes its assigned items, a committee may consider a topic assigned to a different committee.

Committee on Administration

This committee's responsibility relates to both National Board Dental Examinations and the National Board Dental Hygiene Examination. The committee deals with operations. Specific topics to be considered include:

- a. Examination security, including procedures for examination administration
- b. Examination regulations
- c. Joint Commission Bylaws and Standing Rules
- d. Finances, including an annual comparison of income and expenses

Committee on Dental Hygiene

This committee's responsibility relates primarily to the National Board Dental Hygiene Examination. Specific topics to be considered include:

- a. Examination content and specifications
- b. Test construction procedures, including nomination of test constructors and establishment of qualification requirements
- c. Information circulated to publicize or explain the testing program
- d. Portions of Examination Regulations that affect dental hygiene candidates
- e. Matters pertaining to finances, ADA and Joint Commission Bylaws, and Joint Commission Standing Rules that affect the National Board Dental Hygiene Examination

Committee on Examination Development

This committee's responsibility relates primarily to the National Board Dental Examinations. Specific topics to be considered include:

- a. Examination content and specifications
- b. Test construction procedures, including nomination of test constructors and establishment of qualification requirements

- c. Information circulated to publicize or explain the testing program
- d. Portions of Examination Regulations that affect dental candidates
- e. Matters pertaining to finances, ADA and Joint Commission Bylaws, and Joint Commission Standing Rules that affect the National Board Dental Examinations

Committee on Research and Development

This committee's responsibility relates to both the National Board Dental Examinations and the National Board Dental Hygiene Examination. Topics considered by this Committee include any research ~~or~~ and developmental activities related to the ~~E~~examinations.

Committee Actions

A committee is expected to consider and report on all assigned topics. For most topics, committee actions are to be presented in the form of recommendations for Joint Commission action. ~~The F~~Following are three exceptions:

- a. A decision about the manner in which a committee approaches its assignment ~~for~~For example, a change in the personal data form for potential test constructors— need not be reported.
- b. Identification of background materials requested ~~for~~to inform future deliberations may be reported as informational without an accompanying recommendation. If compilation of needed background materials requires substantial resources, however, a specific recommendation for action is appropriate.
- c. A decision not to act may be reported as an informational item. If the topic has generated substantial outside interest, however, a recommendation not to act is appropriate so as to allow the Joint Commission to affirm the committee's decision.

Reporting

Background information prepared for Committee deliberations is circulated to all Commissioners and all Committee members. Exceptions are: as follows: 1) information about a nominee to a test construction committee is provided only to the committee charged with screening nominees and 2) technical reports provided as background for the Committee on Research and Development.

Committee reports are provided to the Joint Commission in written or electronic form. Topics are discussed in the order they are listed on the Joint Commission's agenda, and background information related to each topic is identified. For each recommendation, a~~the~~ report should include a brief summary or rationale. An exception is made in that no rationale is expected for appointment of a test constructor. Instead, an alternate is named for each newly proposed test constructor.

Preparation and presentation of a committee's report is the responsibility of each committee's Chair. Preparation may be delegated to a staff ~~secretary~~member assigned to the committee. If

the committee Chair is not a commissioner or if, for some other reason, the committee Chair is not present at the Joint Commission's annual meeting, responsibility for presenting the report may be delegated to a commissioner who has served on that committee.

Committee reports are presented orally, stopping for action as needed. At each stop for action, the presenter represents the committee's views through his or her answers to questions. Only after ensuring that the committee's views have been represented adequately may the presenter impart any personal views.

TEST CONSTRUCTOR SELECTION CRITERIA FOR DENTAL TEST CONSTRUCTORS

The Joint Commission selects consultants to serve on its Dental and Dental Hygiene Test Construction Committees. A test constructor is appointed for a one-year term and may be reappointed to four consecutive terms. To be considered for appointment, ~~a person~~ candidates must possess appropriate qualifications and must submit a completed personal data form. ~~Someone~~ Test constructor qualifications are published in the Joint Commission's *Qualification Requirements for National Board Dental and Dental Hygiene Test Constructors*. Test Constructors who have completed five years of service on a committee will not be considered for reappointment to the same committee.

~~The following are the criteria for test constructors on Anatomic Sciences, Biochemistry-Physiology, Microbiology-Pathology, Dental Materials, Pharmacology, Patient Management, and Testlet Development Committees:~~

- ~~a. Dentist with a master's degree in that biomedical science OR a professional with a doctoral degree in that biomedical science.~~
- ~~b. Three years of experience within the last five years teaching or in research in that biomedical science.~~

~~The following are the criteria for test constructors on Dental Anatomy and Occlusion, Operative Dentistry, Prosthodontics, Oral and Maxillofacial Surgery-Pain Control, Orthodontics-Pediatric Dentistry, Endodontics, Periodontics, and Oral Diagnosis Committees:~~

- ~~a. Dentist~~
- ~~b. In the case of special areas of dentistry, graduation from an accredited advanced education program in that specialty.~~

Part I (Component A) Test Construction Committees

Anatomic Sciences

~~This five member committee includes the following. At least one of the four subject-matter experts must be a dentist.~~

- ~~a. Gross anatomists (2)~~
- ~~b. Histologists (2); including one whose expertise is embryology and one whose expertise is neuroanatomy~~
- ~~c. Full-time practitioner (1)~~

Biochemistry/Physiology

~~This five member committee includes the following. At least one of the four subject-matter experts must be a dentist.~~

- ~~a. Biochemists (2)~~
- ~~b. Physiologists (1)~~
- ~~c. Full-time practitioner (1)~~

Microbiology/Pathology

~~This five member committee includes the following. At least one of the four subject-matter experts must be a dentist.~~

- ~~a. Microbiologists (2); including one whose expertise is immunology~~
- ~~b. Pathologists (2)~~
- ~~c. Full-time practitioner (1)~~

Dental Anatomy and Occlusion

~~This four member committee consists of 4 dentists who are:~~

- ~~a. Dental anatomists (3)~~
- ~~b. Full-time practitioner (1)~~

Part I (Component B) Test Construction Committees**Testlet Development**

~~This nine member committee consists of:~~

- ~~_____ a. Dental educators representing the various discipline areas, and all of who should already have served on a Part I discipline-based committee. (5)~~
- ~~_____ b. Dental practitioners representing each of the discipline-based Part I committees. (4)~~

Consultant Review

~~This committee is responsible for reviewing the discipline-based (Component A) and testlet-based (Component B) components of the Comprehensive Part I examinations to ensure the examinations adhere to test specifications and item guidelines outlined by the Joint Commission. The composition of this two member committee varies between the dental discipline experts and practitioners. Members of this committee should already have served on a Component A committee.~~

Part II (Component A) Test Construction Committees**Operative Dentistry**

1 This five member committee consists of:

- 2
3 a. ~~Restorative/operative dentists (3)~~
4 b. ~~Expert in dental materials (1)~~
5 c. ~~Full-time practitioner (1)~~
6

7 **Pharmacology**

8
9 This four member committee consists of:

- 10
11 a. ~~Pharmacologists (3), one who is a dentist~~
12 b. ~~Full-time practitioner (1)~~
13

14 **Prosthodontics**

15
16 This six member committee consists of:

- 17
18 a. ~~Prosthodontists (4), two with expertise in fixed prosthodontics and two with expertise~~
19 ~~in removable partial/complete prosthodontics~~
20 b. ~~Expert in dental materials (1)~~
21 c. ~~Full-time practitioner (1)~~
22

23 **Oral and Maxillofacial Surgery/Pain Control**

24
25 This four member committee consists of:

- 26
27 a. ~~Oral and maxillofacial surgeons (3), at least one with expertise in pain control~~
28 b. ~~Full-time practitioner (1)~~
29

30 **Orthodontics/Pediatric Dentistry**

31
32 This six member committee consists of:

- 33 a. ~~Orthodontists (3)~~
34 b. ~~Pediatric dentists (2)~~
35 c. ~~Full-time practitioner (1)~~
36

37 **Endodontics**

38
39 This four member committee consists of:

- 40
41 a. ~~Endodontists (3)~~
42 b. ~~Full-time practitioner (1)~~
43

44 **Periodontics**

45
46 This four member committee consists of:

- 47
48 a. ~~Periodontists (3)~~
49 b. ~~Full-time practitioner (1)~~

Oral Diagnosis

This six member committee consists of:

- a. Oral pathologists (2)
- b. Oral and maxillofacial radiologists (2)
- c. Dentist with advanced education in oral diagnosis (1)
- d. Full-time practitioner (1)

Patient Management

This eight member committee consists of:

- a. Dental public health specialists (2)
- b. Dentist with advanced education in special needs (1)
- c. Behavioral scientists (3), at least one who must be a dentist
- d. Full-time practitioners (2)

Full-time Practitioners

A full-time practitioner is a currently licensed dentist (not necessarily a specialist) in the United States, practicing dentistry full-time (30 to 40 hours per week) for at least 10 years.

Part II (Component B) Test Construction Committee**—Component B**

This committee develops the case-based items for the Comprehensive Part II examination. This thirteen member committee consists of:

- a. Members representing the dental disciplines, all of who have served on a Part II Component A committee (10)
- b. General practitioners with experience in preparing educational or licensure examinations (2)
- c. Behavioral scientist (1)

Case Selection

As an adjunct to the Component B committee, this committee does the preliminary work of screening new patient cases, and identifying suitable cases. This committee drafts and reviews the patient histories, dental charts, and treatment plans associated with the cases. The composition of this 4-member committee varies between dental discipline experts and practitioners.

Consultant Review

This committee is responsible for reviewing the discipline-based (Component A) and case-based (Component B) components of the Comprehensive Part II examinations to ensure

the examinations adhere to test specifications and item guidelines outlined by the Joint Commission. The composition of this two member committee varies between the dental discipline experts and practitioners. Members of this committee should already have served on a Component A committee.

CRITERIA FOR DENTAL HYGIENE TEST CONSTRUCTORS

The National Board Dental Hygiene Examination is constructed by committees of consultants with subject matter expertise in the following eight areas.

Basic Sciences

The basic sciences include anatomy, histology, biochemistry and nutrition, physiology, microbiology and immunology, pathology, pharmacology, and oral biology.

- a. Doctoral degree in a biomedical science, or a dentist or dental hygienist with an advanced degree in a biomedical or dental science.
- b. At least three years' experience within the last five years teaching a biomedical or dental science to dental hygiene students.

Radiology

- a. Dentist or dental hygienist with a baccalaureate degree from an accredited program.
- b. An oral and maxillofacial radiologist or a dental hygienist with formal education in dental radiology beyond what was provided in dental hygiene program.
- c. At least three years' experience within the last five years teaching radiology.

Periodontics

- a. Graduate of an accredited dental or dental hygiene program with advanced formal education or training in periodontics.
- b. At least three years' experience within the last five years teaching or practicing periodontics.

Oral Medicine/Oral Diagnosis

- a. Dentist with advanced clinical training.
- b. At least three years of experience within the last five years teaching oral medicine/oral diagnosis.

Special Needs Professional

- a. Dentist or dental hygienist with advanced clinical training.
- b. At least three years of experience within the last five years teaching a clinical science.

Dental Hygiene Curriculum

- a. Dental hygienist who has graduated from an accredited program.

- b. ~~Advanced degree, preferably in dental hygiene.~~
- c. ~~Experience in curriculum design as a dental hygiene program director, member of a dental hygiene curriculum committee, or accreditation consultant for dental hygiene.~~
- d. ~~At least three years' experience within the last five years teaching to dental hygiene students.~~

Clinical Dental Hygiene

- a. ~~Dental hygienist who has graduated from an accredited program.~~
- b. ~~Baccalaureate degree in dental hygiene, education, or a biomedical science.~~
- c. ~~At least three years' experience, preferably within the last five years, teaching and practicing clinical dental hygiene; full-time or part-time in private practice or faculty practice.~~

Community Dental Health

- a. ~~Dentist or dental hygienist who has graduated from an accredited program.~~
- b. ~~Advanced degree in public health or related field.~~
- c. ~~At least three years' experience within the last five years in a public health position or teaching community and public health courses to dental or dental hygiene students.~~

Dental Hygiene Test Construction Committees

Three dental hygiene Component A committees (total of 15 members) and a dental hygiene Component B committee (8 members) construct the National Board Dental Hygiene Examination.

Component A Committees

—— Dental Hygiene I

- a. ~~Basic science experts (3) ——~~
- b. ~~Dental hygiene curriculum expert (1)~~

Dental Hygiene II ——

- a. ~~Periodontists (3), at least one who must be a dentist~~
- b. ~~Dental hygiene curriculum expert (1)~~
- c. ~~Clinical dental hygiene experts (2)~~
- d. ~~Oral and Maxillofacial Radiologist or dental hygienist with formal education in radiology (1)~~

—— Dental Hygiene III ——

- a. ~~Dental Hygiene Curriculum expert (1)~~
- b. ~~Clinical Dental Hygiene expert (1)~~
- c. ~~Community Dental Health experts (2)~~

Component B Committees~~Component B~~

- ~~a. Basic science expert (1)~~
- ~~b. Dental hygiene curriculum expert (1)~~
- ~~c. Clinical dental hygiene expert (1)~~
- ~~d. Community dental health expert (1)~~
- ~~e. Oral medicine/oral diagnosis expert (1)~~
- ~~f. Periodontist (1)~~
- ~~g. Oral and Maxillofacial radiologist or dental hygienist with formal education in radiology (1)~~
- ~~h. Special needs expert (1)~~

Case Selection

~~Members from various dental hygiene disciplines (4)~~

Consultant Review

~~Members from the various dental hygiene disciplines, one of which must be a dentist (4)~~

~~Members on these Component B committees should have already served on a Dental Hygiene Component A committee.~~

DETECTION OF IRREGULARITIES BASED ON FORENSIC ANALYSES**Definitions**

~~The Joint Commission is responsible for protecting the integrity of National Board Examination scores~~results. ~~One method used is to withhold scores that reflect unrealistic response patterns. Procedures for withholding scores are listed in the Examination Regulations for National Board Examinations.~~

~~Statistical criteria for withholding scores are based on the response patterns~~involves forensic analyses of candidates or the performance of candidates on the overall examination. Potential to detect irregularities and aberrant response patterns. ~~may include, but are not limited to, the following:~~

~~Aberrant results:~~ ~~Inconsistent response patterns as measured by response aberrance index (e.g., answering difficult questions correctly and missing easy questions).~~

~~Latency aberrance:~~ ~~Candidates with inconsistent or inappropriate use of time in responding to items.~~

~~Perfect tests:~~ ~~Two or more candidates with identical test results or perfect tests.~~

Unrealistic similarity: ~~Two or more candidates who have more identical wrong answers than different wrong answers.~~

Unusual gain in scores: ~~Candidates with unusual or artificial gains in scores in comparison to previous testing attempts.~~

Criteria for Withholding Scores

Candidate's ~~scores~~results may be withheld or, as circumstances may warrant, reported when 1) aberrant response patterns or aberrant examination performance is detected through forensic analyses or 2) ~~other information~~evidence comes to light that supports the possibility that the candidate has given or received confidential information concerning examination content during or prior to the examination. Similarly, ~~scores~~results may be withheld or reported if compelling information is available that suggests that the candidate was not testing for the intended purpose.

LIMITED RIGHT OF APPEALS FOR EXAMINATION CANDIDATES

The Joint Commission on National Dental Examinations (JCNDE) recognizes that strict application of the Examination Regulations for National Board Examinations may, because of unusual circumstances, impose an unusual burden on one or more candidates. In these situations, the ~~Joint Commission~~JCNDE may consider an appeal ~~for special consideration~~.

Requests for an appeal pertaining to test results must be initiated within 30 days of receiving test results or, in the case of withheld ~~scores~~results, within 30 days of receiving written notice that ~~scores~~results are being withheld. In the event that the ~~Joint Commission~~JCNDE has given notice that previously released ~~scores~~results are to be invalidated or voided, the request for appeal must be submitted within 30 days of that notice. In this case, a request for appeal will stay the action to invalidate or void the ~~scores~~results until such time as the appeal is decided or the time for submitting a request for appeal has expired. A request for an appeal must be submitted in writing and must include adequate supporting documentation. The request for an appeal must indicate the specific relief requested.

A request for an appeal will first be screened by the Chair in consultation with the secretary. The Chair, ~~in~~at his/her sole discretion, may 1) ~~allow~~grant the appeal ~~(if,~~2) deny the appeal, or 3) ~~forward the appeal to the full Joint Commission for its consideration~~. If during the Joint Commission's deliberations credible information becomes available indicating an error was made in the decision to withhold scores, the Chair believes that there is a reasonable basis for the review in consultation with the secretary may end the deliberations and grant the appeal. At his or her discretion, the Chair may delegate the screening of the facts ~~appeals to another member of the case and the procedures applied thereto), 2) deny an appeal, or 3) recommend, in consultation with the secretary, to release scores~~ Joint Commission.

~~When considering an appeal, the Joint Commission will strive to ensure that the candidates have an opportunity to gain National Board certification equal to, but not greater than, the opportunity provided other candidates.~~

In rendering a decision with respect to appeals—and particularly in situations where results have been withheld—the touchstone and foremost consideration is the validity of examination results, in alignment with the purpose of the examination. The Joint Commission strives to be fair and objective in its decision making process, as it remains true to its mission. When considering appeals, the JCNDE avoids favoritism and strives to ensure that all candidates are treated equally and fairly.

If the issue presented in an appeal is likely to recur, the ~~Joint Commission~~JCNDE may consider a change in ~~regulations. Granting its Examination Regulations.~~ The granting of an appeal will be considered a precedent only if a change in regulations is also adopted. The candidate will be notified of the ~~Joint Commission~~JCNDE action within 60 days after receipt of the written request for the an appeal.

~~The Chair of the JCNDE, in consultation with the secretary of the JCNDE, may grant an appeal when additional, convincing information becomes available early in the appeal process that indicates an error was made in the decision to withhold scores.~~

CONFLICT OF INTEREST POLICY

Policies and procedures used in National Board testing programs should provide for fairness and impartiality in the conduct of examinations and treatment of all candidates. Central to the fairness of the JCNDE's operations and the impartiality of its decision-making process is an organizational and personal duty to avoid real or perceived conflicts of interest. The potential for a conflict of interest arises when one's duty to make decisions in the public's interest is compromised by competing interests of a personal or private nature, including but not limited to pecuniary interests. Conflicts of interest can result in a partiality or bias which might interfere with objectivity in decision-making with respect to policy, or the evaluation of candidate appeals.

Conflict of interest is considered to be:

- ~~1) Any relationship with a candidate for National Board certification, or~~
- ~~2) A partiality or bias which might interfere with objectivity in the decision-making with respect to policy or the evaluation of individual appeals to the Joint Commission.~~

The Joint Commission strives to avoid conflicts of interest ~~or~~and the appearance of a ~~conflicts~~ in decisions regarding examination policy or individual candidate appeals. Potential conflicts of interest ~~effor~~or Commissioners include, but are not limited to:

- A professional or personal relationship or an affiliation with the individual or an organization that may create a conflict or the appearance of a conflict.
- Being an officer or administrator in a dental education program, testing agency, or board of dentistry with related decision-making influence regarding a candidate for National Board certification.

To safeguard the objectivity of the Joint Commission, it is the responsibility of any

1 Commissioner to disclose any potential conflicts. Any member with a direct conflict of interest
2 must recuse himself/herself from the decision-making process regarding candidate appeals, or
3 from discussions involving policies that impact the fairness and impartiality of the JCNDE's
4 examination programs.

5 **ASSISTANCE TO OTHER AGENCIES**

7
8 One of the duties of the Joint Commission is to serve as a resource for the dental profession in
9 the area of developing written examinations for licensure. ~~The~~This charge is fulfilled by
10 providing assistance to state boards of dentistry and to national and international dental
11 organizations. This policy statement describes limitations on availability.

12 **Availability**

13
14
15 Operation of the National Board ~~e~~Examinations is the Joint Commission's primary charge.
16 Assistance is provided to ~~a~~-state boards of dentistry or national dental organizations only upon
17 request and only if the Joint Commission possesses the resources to fulfill the request.

18
19 If the Joint Commission is forced to select agencies to receive assistance, highest priority will be
20 given to state boards of dentistry that accept National Board scores. For dental organizations in
21 the U.S. and its territories, assistance is limited to consultation and sharing general information
22 about Joint Commission policies and procedures. Requests for testing services will be referred
23 to the ADA Department of Testing Services or other organizations or individuals that provide
24 such services.

Resolution No. 35 NewReport: CDEL Supplemental Report 1 Date Submitted: September 2014Submitted By: Council on Dental Education and LicensureReference Committee: C (Dental Education, Science and Related Matters)Total Net Financial Implication: \$280,000 Net Dues Impact: \$2.53Amount One-time \$280,000 Amount On-going FTE .75

ADA Strategic Plan Objective: Membership-Obj. 1: Leaders and Advocates in Oral Health

How does this resolution increase member value: See Background

**COUNCIL ON DENTAL EDUCATION AND LICENSURE SUPPLEMENTAL REPORT 1 TO THE
HOUSE OF DELEGATES: A COMPREHENSIVE STUDY OF THE CURRENT DENTAL EDUCATION
MODELS**

Response to Resolution 56H-2013: The 2013 House of Delegates considered several resolutions related to Report 13 of the Board of Trustees to the House of Delegates: Response to Resolutions 66H-2011, 91H-2011, B-204-2011, and 113H-2012 Deflating the Dental Education Bubble and the Report of the ADA Taskforce on Dental Education Economics and Student Debt (*Reports: 3036*). This report focuses specifically on Resolution 56H-2013, which was assigned to the Council on Dental Education and Licensure for consideration with a directive to report to the 2014 House of Delegates.

56H-2013. Resolved, that the ADA seek collaboration with broad communities of interest, including dental educators, students, practicing dentists, health economists, and others with appropriate expertise to define the scope and specific aims of a comprehensive study of current dental education models, to include:

1. Evaluation of the long-term sustainability of dental schools.
2. Evaluation of the efficiency of the current dental school curricula and delivery methods.
3. Analysis of the impact of student debt on dentistry as a career choice and subsequent practice choices.
4. A determination of whether dental schools are meeting the appropriate level of scholarship to ensure that dentistry continues to be a learned profession;

and be it further

Resolved, that the ADA's financial implication for this resolution shall not exceed \$80,000, to be used to define the scope and specific aims of the study, to determine the estimated cost of the study, to identify potential funding sources for the study, and to report to the 2014 ADA House of Delegates.

Key Issues presented in the 2013 Report of the Taskforce on Dental Education Economic and Student Debt: To begin its consideration of Resolution 56H-2013, the Council first reviewed the research questions and main findings presented in the Taskforce's 2013 Report:

- What are the trends in dental student debt? How does this compare to higher education in general?
- Dentistry is experiencing the same trends in student loan debt as most other high-income professions. Dental school debt has increased over time due to increases in the cost of attending dental school. The rates of increase are in line with those experienced by other professional students

(e.g., physicians, veterinarians). The debt-to-income ratio for dentists has increased over time, as it has for most occupations/degrees.

- What are the operating costs of a dental school? Does institutional setting matter? How are the operating costs financed (e.g., tuition, government) and how has the financing pattern changed over time?

There is great variation in operating costs among schools, which can be attributed mostly to expenses associated with the number of full-time faculty and staff. As long as the “return on investment” allows students to pay off educational debt in a “reasonable” amount of time, the profession will continue to attract a large number of qualified applicants to fill the total number of available positions. Institutional setting (public versus private) does not seem to matter as a driver of overall revenue and overall expenses, particularly in recent years when financial support from states to their public universities has diminished.

- What innovations have dental schools pursued to reduce operating costs?

There have not been significant innovations in dental school models that significantly reduce operating costs. The increased number and quality of applicants over the past 15 years has allowed dental schools to increase tuition without adversely affecting enrollment. In addition, dental schools have been able to increase enrollment without substantially increasing expenses. Overall, dental schools are currently financially sound.

- What is the role of educational institutions, students, residents and new graduates in the dental “safety net” and what innovations are there in recent years?

Due to the limited number of students and residents available to provide treatment, compared to the estimated total number of underserved patients, dental schools cannot solely solve the access-to-care problem. In addition, students/residents are not as efficient in providing treatment compared to an experienced private practitioner. Innovations have centered around sending students to off-campus clinical sites such as Federally Qualified Health Centers (FQHC) for a portion of their clinical education.

- What impact does student debt have on graduates’ employment choices?

Debt appears to have a small effect on some of dentists’ career decisions. The magnitude of the effect is very small compared to other factors such as gender and race. In regression models, students graduating with relatively large amounts of debt are more likely to plan on entering private practice, less likely to plan on completing advanced education, and less likely to plan on pursuing a government position. Debt levels do not have an impact on the likelihood of owning a practice.

- How many loan forgiveness programs are available to dental students? How effective are these programs in reducing student debt and improving access to care for the underserved?

As of May 2013, there are a total of 1,732 dentists participating in loan repayment programs across the country, excluding active-duty military and the Army National Guard. The majority of programs (92.3%) do not have debt level requirements for participation, but 41.2% of programs consider debt level when determining the amount of support provided. The majority of programs have specific practice location requirements (e.g., federal or state HPSA, rural, etc.; 81.8%). Additionally, most programs require treatment of specific populations (e.g., Medicaid; 76.8%). There are more applications for positions than there are positions available. The programs seem to be effective in improving access to care; however, the improvement is limited by the small number of positions available.

- What are dental schools doing in regards to teaching debt management and student loans?

Eighty percent of surveyed dental school deans reported that the dental school offers student debt or personal financial management information. In addition, the majority of dental school deans reported that student debt or personal financial management information is part of the dental school

curriculum. This was closely correlated with survey results of recent graduates. More than 70% of surveyed recent graduates and current students believe that the dental school should provide more student debt or personal financial management information than is currently offered.

- What innovations could dental schools do in collaboration with the American Dental Association to reduce student debt?

The Taskforce came to the conclusion that the ADA can be most effective in addressing the student debt issue through a defined program of advocacy at the federal level and through development of a robust information portal to help current and prospective students be fully informed, financially literate consumers about a career in dentistry, including workforce forecasting reports, student debt, expected income, and life-long financial planning.

June 2014 Stakeholder Meeting: The Council's Dental Education Committee then hosted a meeting of stakeholders on June 19-20, 2014 to receive broad-based input regarding the costs of dental education and Resolution 56H-2013. Specifically the Council sought input from participants on how the Association might define the scope and specific aims of a comprehensive study of current dental education models. A summary report of the Stakeholder Meeting, including an extensive list of proposed questions for a comprehensive study of the current dental education models, is provided in Appendix 1.

Recommended Research Questions for a Study: After careful review of the list of questions generated based on feedback from the Stakeholder Meeting participants, the research questions were narrowed to more clearly and succinctly support the four domains of a study as outlined and requested in Resolution 56H-2013:

Domain 1: Long-Term Sustainability of Dental Schools

Summary Points:

- ✓ There is no "single model" of dental education.
- ✓ Each dental school is different as it is shaped by the specific mission of the university/school, its educational delivery model, and market conditions.
- ✓ As each school is different, it is challenging to draw universal conclusions about the long-term sustainability of US dental schools. Each school requires its own model for sustainability.
- ✓ A key threat to the long-term financial sustainability of public and state-related schools is the significant reductions in state support.
- ✓ The development of new or enhanced revenue sources, including increased clinical revenue and private philanthropy are key opportunities for additional funding.
- ✓ The current models of dental education remain sustainable at the current level, however, further increases in tuition, combined with a flattening of dentists' income, could make dental education less attractive in the future educational marketplace.

Domain 1 Research Questions for a Study:

1. What are the major revenue and expense drivers for dental education, and how do these differ across schools?
2. What opportunities exist to increase revenue for dental schools other than increases in tuition and fees (for example, increased reimbursement for clinical care, increased net clinical income, private philanthropy, intellectual property and technology transfer, and increased federal and state funding)?
3. What opportunities exist to reduce the cost of dental education (for example, sharing of faculty and educational resources, increasing the productivity of clinical faculty, use of technology, addressing the financial impact of accreditation standards and state regulations)?

Domain 2: Efficiency of the Current Dental School Curricula and Delivery Methods

Summary points:

- ✓ Numerous factors influence the dental curriculum models with many of these factors being outside of the dental school, including the mission of the parent institution.
- ✓ There are, at least, 8 different curricular approaches.
- ✓ There are no agreed-upon measures for assessing the “efficiency” of dental school curricula and delivery methods.
- ✓ Multiple methods for dental education all seem to work well in different ways and in different situations.
- ✓ Not all curricular methods are appropriate for all schools.
- ✓ Common methods of financial efficiency can be challenging to develop, given the different financial models used by universities and/or dental schools (e.g., whether costs are centralized or decentralized, contributions of the parent institution, scope and depth of the research program, amount of free or subsidized care provided).

Domain 2 Research Question for a Study:

1. Which dental schools are utilizing each of the curricular models and what is the financial model that supports each approach?

Domain 3: Impact of Student Debt on Dentistry as a Career Choice and Subsequent Practice Choices

Summary points:

- ✓ Educational debt has some impact on career choices, but the “magnitude of (debt) is fairly small, especially when compared to the impact of personal characteristics like gender, race and whether a parent is a dentist.”
- ✓ Demographic enrollment trends appear to be more important in determining the future dental labor market.
- ✓ Characteristics of the student body may be a better avenue for understanding employment after graduation.
- ✓ The potential implications of a perceived decrease in the return-on-investment (ROI) include decrease in applications, a focus on practice opportunities over other career options such as public service or academia, and decisions to pursue post-graduate and dental specialty programs.
- ✓ There is a need to renew and enhance efforts and commitments for lowering dental education costs and reducing student borrowing, (e.g., promoting financial literacy and quality financial aid services, pursuing funding for scholarships, increasing philanthropic support to dental schools, and advocating for loan repayment and forgiveness programs and increased reimbursement for safety-net clinical care).

Domain 3 Research Questions for a Study:

1. How does the cost of dental education and/or level of student borrowing influence students’ decisions to enter dental education and their future career choices?
2. Do higher levels of educational debt have a greater impact on career choices?
3. What is the critical point at which the perceived return on investment means that dentistry is no longer seen as a desired profession?
4. Are there differences in the perceived return on investment for specific subsets of dental careers?
5. At what income/debt ratio are specific labor force choices impacted (disaggregating the data to determine impact on generalist, specialist, public health, Medicaid providers, etc.)
6. How long does it actually take for dentists to pay off their educational debt?
7. What is the impact of new loan repayment programs/options on student debt?

8. Are there other strategies we can use to reduce the cost to students and/or students' educational debt (e.g., subsidizing loans, level of clinical production while in school, alternative investment pools, philanthropy, and planned giving)?
9. What is the impact of educational debt on graduates' decisions to enter subsets of practice such as solo practice, small group practice and large group practice, and to be a practice owner or an employed dentist?
10. Does educational debt primarily have a short-term impact on practice choices (i.e., decisions upon graduation or in the first few years of practice) or does it impact longer-term practice choices?

Domain 4: Appropriate Level of Scholarship to Ensure that Dentistry Continues to Be a Learned Profession

Summary points:

- ✓ A strong commitment to research is the foundation of a learned profession.
- ✓ Most dental education is based on an experiential learning model, thus students need experiences utilizing the scientific method while in dental school in order to develop the critical thinking skills that will prepare graduates for the future.
- ✓ The percentage of the NIDCR extramural research budget going to dental schools is decreasing.
- ✓ The number of dentist-scientists (DDS or DMD/PhD) is underrepresented compared to other health professions.
- ✓ Almost all MD/PhD students "made a decision to enter a research career well before they entered medical school."
- ✓ Research and scholarship activities extend "beyond the lab." Thus there is room for all dental schools to more vigorously pursue research and scholarship opportunities in order to continue to position dentistry as a learned profession.

Domain 4 Research Questions for a Study:

1. Is the profession attracting and retaining the highest quality faculty who can lead the research enterprise?
2. How can the dental community provide more effective advocacy for research support?

Estimated Costs of a Study: Resolution 56H-2013 called for the ADA to determine the estimated cost of a study on the dental education curriculum models and to identify potential funding sources for the study. The costs of the proposed study are dependent upon a number of factors including the size and scale of the undertaking, and whether the ADA wishes to conduct or commission the study itself, or request that an independent organization, such as the Institutes of Medicine, undertake the study.

The estimated cost for a comprehensive study of the current dental education models that would address most, if not all, of the questions outlined in the Stakeholder Summary Report (Appendix 1) and be conducted by an external research organization (whether commissioned by the ADA or independently) range from \$1.5M to \$2.5M.

However, the Council believes that a more focused approach, using the research questions noted above in this report should be pursued. Estimated costs related to studying the questions in each of the four domains are as follows:

Domain 1: Long-Term Sustainability of Dental Schools
Financial Implication: \$100,000

Domain 2: Efficiency of the Current Dental School Curricula and Delivery Methods
Financial Implication: \$100,000

Domain 3: Impact of Student Debt on Dentistry as a Career Choice and Subsequent Practice Choices
Financial Implication: \$50,000

Domain 4: Appropriate Level of Scholarship to Ensure that Dentistry Continues to Be a Learned Profession
Financial Implication: \$30,000

Total: Assuming that all of the proposed questions in the four domains are researched, the total estimated cost for the study is \$280,000.

Once the research questions have been agreed upon and the scope of the study confirmed, potential funders such as the National Institutes of Health, the National Institute of Dental and Craniofacial Research and select national foundations such as the Josiah Macy Jr. Foundation and the Robert Wood Johnson Foundation could be approached via a request for proposals. However, it is the opinion of the Council that funding by these organizations is not likely. If the Association believes that the conduct of this study supports the Members First 2020 Strategic Plan, the Association may wish to assume the responsibility to fund the study. Accordingly, the Council recommends that the ADA pursue a focused study of the current dental education models using the research questions as outlined in this report and report the results to the 2016 House of Delegates. The Council's resolution on this matter is presented at the end of this report.

Additional Considerations: The Council believed that the very comprehensive list of research questions as presented in Appendix 1 raises important long-term issues and concepts for dental education and the profession. The most critical questions have been identified for a focused research study now, but the Association and its appropriate agencies should continue to monitor these critical matters. The Council concluded that the Health Policy Institute should be encouraged to evaluate the questions that can be monitored using existing ADA data sources, revised ADA data sources, and data sources from other organizations such as the American Dental Education Association. The Council directed the chair to transmit the list of research questions outlined in the Stakeholder Summary Report (Appendix 1) to the Health Policy Institute for further consideration and ongoing monitoring.

During the Stakeholder Meeting, a secondary discussion focused on the need for a new study on the future for dentistry, exploring the long-term trends and changes in the health care environment that will impact the future of dental practice. For example:

- The shifting demand for dental services, particularly among the adult population;
- The implications of Medicaid expansion, particularly in terms of the growth in pediatric and older adult populations;
- The transition from "volume-based" to "value-based" payment models;
- The increase in care coordination and growth of Accountable Care Organizations, and the opportunities this presents for the dental profession; and
- The growth of large group practices and dental support organizations, and the implications for the future of dental practice and the skill sets expected of dental school graduates.

Participants asked what would the shift to a value-based model in which dentistry is embedded into the health system mean for the future of dentistry over the next 25 years. What would be the role of the dentist? What would dental practice look like? What would be the composition of the dental team?

The potential impact of these shifts in dental practice and dental education are, as yet, unclear. As such, it was not possible to develop more specific questions to investigate. However, the Stakeholder Group felt, and the Council concurred, that there would be significant value in more deeply investigating these trends so that organized dentistry can play a proactive role in shaping and adapting to these likely new realities of the future of dental practice. Participants at the Stakeholder Meeting and members of the Council believe that a study of the "new future for dentistry and its implications for dental education" would likely provide a significant long-term return on investment for the ADA and its members and should be considered by the ADA Board of Trustees for further exploration and action. Recognizing that such a comprehensive costly study (estimates range from \$250,000 to \$1 million) is beyond the Council's charge in responding to Resolution 56H-2013, the Council urged the ADA Board of Trustees to explore with appropriate ADA agencies, the need for a "Future of Dentistry" study by 2020 to analyze dentistry's role in

the future health system, including implications for the role of dentists and allied dental personnel, dental practice models, and dental education models.

Summary: This report is the Council's response to Resolution 56H-2013 *A Comprehensive Study of the Current Dental Education Models*. The Council has concluded that a focused study of the current dental education models should be conducted and presents the following resolution to the 2014 House of Delegates:

Resolution

35. Resolved, that the ADA pursue a focused study of the current dental education models using the following research questions:

Domain 1: Long-Term Sustainability of Dental Schools

1. What are the major revenue and expense drivers for dental education, and how do these differ across schools?
2. What opportunities exist to increase revenue for dental schools other than increases in tuition and fees (for example, increased reimbursement for clinical care, increased net clinical income, private philanthropy, intellectual property and technology transfer, and increased federal and state funding)?
3. What opportunities exist to reduce the cost of dental education (for example, sharing of faculty and educational resources, increasing the productivity of clinical faculty, use of technology, addressing the financial impact of accreditation standards and state regulations)?

Domain 2: Efficiency of the Current Dental School Curricula and Delivery Methods

1. Which dental schools are utilizing each of the curricular models and what is the financial model that supports each approach?

Domain 3: Impact of Student Debt on Dentistry as a Career Choice and Subsequent Practice Choices

1. How does the cost of dental education and/or level of student borrowing influence students' decisions to enter dental education and their future career choices?
2. Do higher levels of educational debt have a greater impact on career choices?
3. What is the critical point at which the perceived return on investment means that dentistry is no longer seen as a desired profession?
4. Are there differences in the perceived return on investment for specific subsets of dental careers?
5. At what income/debt ratio are specific labor force choices impacted (disaggregating the data to determine impact on generalist, specialist, public health, Medicaid providers, etc.)
6. How long does it actually take for dentists to pay off their educational debt?
7. What is the impact of new loan repayment programs/options on student debt?
8. Are there other strategies we can use to reduce the cost to students and/or students' educational debt (e.g., subsidizing loans, level of clinical production while in school, alternative investment pools, philanthropy, and planned giving)?
9. What is the impact of educational debt on graduates' decisions to enter subsets of practice such as solo practice, small group practice and large group practice, and to be a practice owner or an employed dentist?
10. Does educational debt primarily have a short-term impact on practice choices (i.e., decisions upon graduation or in the first few years of practice) or does it impact longer-term practice choices?

Domain 4: Appropriate Level of Scholarship to Ensure that Dentistry Continues to Be a Learned Profession

1. Is the profession attracting and retaining the highest quality faculty who can lead the research enterprise?
2. How can the dental community provide more effective advocacy for research support?

and be it further

Resolved, that the study results be reported to the 2016 House of Delegates.

BOARD COMMENT: The Board believes the questions raised in each domain are important to the membership and there was a lengthy discussion on whether the ADA can gain cooperation from the relevant entities should it pursue the questions contained within each domain, as outlined in Resolution 35. The Board understands that a cooperative effort in obtaining information from dental schools is a key to completely and accurately answering the questions in domains 1, 2 and 4. Further, the Board is aware that financial information is highly sensitive and may be difficult to acquire. The Board believes it is vitally important to build coalitions with other relevant groups in order to conduct future studies. Finally, the Board noted the financial implications for each domain are as follows:

- Domain 1: Long-Term Sustainability of Dental Schools; Financial Implication: \$100,000
- Domain 2: Efficiency of the Current Dental School Curricula and Delivery Methods; Financial Implication: \$100,000
- Domain 3: Impact of Student Debt on Dentistry as a Career Choice and Subsequent Practice Choices; Financial Implication: \$50,000
- Domain 4: Appropriate Level of Scholarship to Ensure that Dentistry Continues to Be a Learned Profession, Financial Implication: \$30,000

Accordingly, the Board urges adoption of the following substitute resolution:

35B. Resolved, that the ADA conduct a focused study relative to the following:

Domain 3: Impact of Student Debt on Dentistry as a Career Choice and Subsequent Practice Choices

1. How does the cost of dental education and/or level of student borrowing influence students' decisions to enter dental education and their future career choices?
2. Do higher levels of educational debt have a greater impact on career choices?
3. What is the critical point at which the perceived return on investment means that dentistry is no longer seen as a desired profession?
4. Are there differences in the perceived return on investment for specific subsets of dental careers?
5. At what income/debt ratio are specific labor force choices impacted (disaggregating the data to determine impact on generalist, specialist, public health, Medicaid providers, etc.)
6. How long does it actually take for dentists to pay off their educational debt?
7. What is the impact of new loan repayment programs/options on student debt?
8. Are there other strategies we can use to reduce the cost to students and/or students' educational debt (e.g., subsidizing loans, level of clinical production while in school, alternative investment pools, philanthropy, and planned giving)?
9. What is the impact of educational debt on graduates' decisions to enter subsets of practice such as solo practice, small group practice and large group practice, and to be a practice owner or an employed dentist?
10. Does educational debt primarily have a short-term impact on practice choices (i.e., decisions upon graduation or in the first few years of practice) or does it impact longer-term practice choices?

and be it further

Resolved, that the ADA pursue a focused study relative to the following:

Domain 1: Long-Term Sustainability of Dental Schools

1. What are the major revenue and expense drivers for dental education, and how do these differ across schools?
2. What opportunities exist to increase revenue for dental schools other than increases in tuition and fees (for example, increased reimbursement for clinical care, increased net

clinical income, private philanthropy, intellectual property and technology transfer, and increased federal and state funding)?

3. What opportunities exist to reduce the cost of dental education (for example, sharing of faculty and educational resources, increasing the productivity of clinical faculty, use of technology, addressing the financial impact of accreditation standards and state regulations)?

Domain 2: Efficiency of the Current Dental School Curricula and Delivery Methods

1. Which dental schools are utilizing each of the curricular models and what is the financial model that supports each approach?

Domain 4: Appropriate Level of Scholarship to Ensure that Dentistry Continues to Be a Learned Profession

1. Is the profession attracting and retaining the highest quality faculty who can lead the research enterprise?
2. How can the dental community provide more effective advocacy for research support?

and be it further

Resolved, that the study results be reported to the 2016 House of Delegates.

Note: The Summary Report of the Stakeholder Meeting is available for review in Appendix 1.

BOARD RECOMMENDATION: Vote Yes on the Substitute.

Vote: Resolution 35B

BUCKENHEIMER	Yes	FEINBERG	Yes	KIESLING	Yes	STEVENS	Yes
COLE	Yes	GOUNARDES	Yes	KWASNY	Yes	SUMMERHAYS	Yes
CROWLEY	Yes	HAGENBRUCH	Yes	ROBERTS	Yes	YONEMOTO	Yes
DOW	Absent	ISRAELSON	Yes	SCOTT	Yes	ZENK	Yes
FAIR	Yes	JEFFERS	Yes	SHENKIN	Yes	ZUST	Absent

REPORT FROM THE ADA STAKEHOLDER MEETING (June 19 – 20, 2014)

Defining the Scope and Aims of a Proposed Comprehensive Study of Current Dental Education Models

BACKGROUND

The 2013 House of Delegates considered several resolutions related to Report 13 of the Board of Trustees to the House of Delegates: Response to Resolutions 66H-2011, 91H-2011, B-204-2011, and 113H-2012 Deflating the Dental Education Bubble and the Report of the ADA Taskforce on Dental Education Economics and Student Debt (*Reports:3036*).

In response to these resolutions and subsequent discussions by the House of Delegates, Resolution 56H-2013 was approved, calling upon the ADA to convene a meeting of key stakeholders to define the scope and specific aims of a proposed comprehensive study of current dental education models. Specifically, the resolution read:

56H-2013. Resolved, that the ADA seek collaboration with broad communities of interest, including dental educators, students, practicing dentists, health economists, and others with appropriate expertise to define the scope and specific aims of a comprehensive study of current dental education models, to include:

1. Evaluation of the long-term sustainability of dental schools.
2. Evaluation of the efficiency of the current dental school curricula and delivery methods.
3. Analysis of the impact of student debt on dentistry as a career choice and subsequent practice choices.
4. A determination of whether dental schools are meeting the appropriate level of scholarship to ensure that dentistry continues to be a learned profession;

and be it further

Resolved, that the ADA's financial implication for this resolution shall not exceed \$80,000, to be used to define the scope and specific aims of the study, to determine the estimated cost of the study, to identify potential funding sources for the study, and to report to the 2014 ADA House of Delegates.

Resolution 56H-2013 was assigned to the Council on Dental Education and Licensure for consideration with a directive to report to the 2014 House of Delegates. Dr. Teresa (Terri) A. Dolan, Chair of the Council on Dental Education and Licensure assigned the CDEL Dental Education Committee, chaired by Dr. Cecile A. Feldman, with oversight for the study and requested that the Dental Education Committee report its findings and recommendations back to the full Council for consideration.

The CDEL Dental Education Committee planned and convened a Stakeholder Meeting which was held at the ADA Headquarters on June 19 – 20, 2014. Approximately 40 individuals representing practicing dentists, dental educators, students, dental organizations, and health economists participated in the meeting. The goal of the Stakeholder Meeting was to review extant information in each of the four domains defined by the resolution, to identify gaps in the existing knowledge that would merit further study, and then to define potential questions that a comprehensive study of the current dental education models could explore in order to fill these gaps in knowledge and information. Following the

Stakeholder Meeting the Council leadership, supported by ADA staff, investigated the estimated costs of the proposed study and identified potential sources of funding to support the study.

The following report summarizes the Stakeholder Meeting and proposes questions that could be asked in a comprehensive study of dental education.

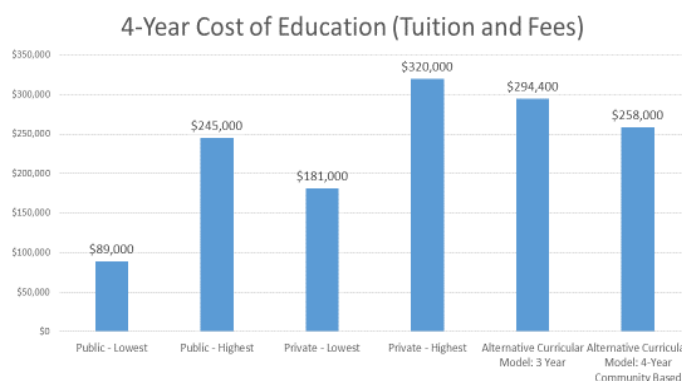
THE ROLE AND POSITIONING OF THE DENTAL SCHOOL IN THE UNIVERSITY ENVIRONMENT

Dr. Jerold S. Goldberg, Dean of the Case Western Reserve University School of Dental Medicine provided a brief framing presentation to set the context for the Stakeholder Meeting. In addition to his role as dean, Dr. Goldberg has served as interim dean of the School of Medicine and interim provost of Case Western Reserve University, giving him a unique perspective on the positioning of the dental school within the larger university. Dr. Goldberg's advice to the group was that it is important for the dental school to "be needed" by aligning the work of the dental school with the advancement of the university's priorities: ensuring the quality of education, creating new and impactful knowledge, strengthening the reputation and visibility of the university, providing societal value through interprofessional and community impact, and contributing to the financial sustainability of the university. He also stressed the importance of advancing the tripartite mission of the university: education, research and service/patient care. There was consensus among the group that dental schools are well aligned with these priority areas and are making significant contributions to their advancement.

DOMAIN 1: EVALUATION OF THE LONG-TERM SUSTAINABILITY OF DENTAL SCHOOLS

As a starting point for the group's identification of potential questions to be explored about the long-term sustainability of dental schools, two framing presentations were provided. The first, by Dr. David A. Asch of the Wharton Health Care Management Department at the University of Pennsylvania, focused on the "Business Model for Dental Schools and Dental Education." The second presentation, by Dr. William W. Dodge, Dean of the Dental School at the University of Texas Health Science Center at San Antonio, focused on the key costs and revenue drivers of the "traditional" model of dental education. Both Drs. Asch and Dodge noted that there is no "single model" of dental education. Rather, the educational model of each dental school is slightly different as it is shaped by the specific mission of the university/school, its educational delivery model, and market conditions. As such, it is challenging to draw universal conclusions about the long-term sustainability of US dental schools. Each school requires its own model for sustainability.

Efforts to reduce the cost of dental education and increase non-tuition sources of revenue are ongoing. There was general agreement that dental education, a clinically focused enterprise dependent upon a highly skilled workforce and requiring significant investments in technology and research, is an inherently expensive undertaking. New models for the delivery of dental



Source: 2012-13 ADA Survey of Dental Education

Figure 1 Source: 2012-13 ADA Survey of Dental Education

education have been developed and are being implemented in several dental schools; however the overall financial impact of these different approaches does not appear to vary significantly from the “traditional model” (two years of didactic education followed by two years of clinical education).

A key threat to the long-term financial sustainability of public and private-state related dental schools over the past decade has been the significant reductions in state support. These cuts have been offset by an increased dependence on clinical income and rising tuition, however there was general agreement that further increases in tuition will be challenging from both an economic and political perspective. The development of new or enhanced revenue sources, including increased clinical revenue and private philanthropy are seen as key opportunities for additional funding.

There was a general consensus among the group that current models of dental education, with their focus on education, patient care, research and scholarship, and community service remains sustainable at the current level, however further increases in tuition, combined with a flattening of dentists’ income, could make dental education less attractive in the future educational marketplace.

Specific questions about the long-term sustainability of dental schools that could be explored as part of a comprehensive study of dental education include:

1. What are the major revenue and expense drivers for dental education, and how do these differ across schools?
2. What opportunities exist to increase revenue for dental schools other than increases to tuition and fees (for example, increased reimbursement for clinical care, increased net clinical income, private philanthropy, intellectual property and technology transfer, and increased federal and state funding)? What can be learned from dental schools that have been highly effective enhancing revenue using one or more of these strategies?
3. What opportunities exist to reduce the cost of dental education (for example, sharing of faculty and educational resources, increasing the productivity of clinical faculty, use of technology, addressing the financial impact of accreditation standards and state regulations)? Would these cost reductions help to reduce tuition, or would the savings be reinvested in other areas?
4. What would be the impact to the business model for dental schools if dental education became less attractive in the educational marketplace, leading to a decline in the number of qualified applicants? How would dental schools respond? How would a decline in the number of qualified dental school applicants impact the dental workforce and the ADA membership?

DOMAIN 2: EVALUATION OF THE EFFICIENCY OF THE CURRENT DENTAL SCHOOL CURRICULA AND DELIVERY METHODS

Dr. Denise K. Kassebaum, Dean of the School of Dental Medicine at the University of Colorado Denver provided an overview of the various curricular and delivery models being employed by dental schools. She noted that there are numerous factors that influence the dental curriculum models, many of which are outside the control of the dental school, including the mission of the parent institution, state and local factors, accreditation standards, national board dental examinations, regional board and state

licensing requirements, and the wide array of curricular initiatives advanced by professional associations and national foundations.

In addition to these drivers of curricular changes, there have also been significant changes to the methods of instruction which have been impacted by faculty staffing models (availability and roles), technology (including simulation, distributed learning and e-learning), a shift toward interprofessional education, the location of clinical education (on-site clinics, off-site “school-owned” clinics, off-site community clinics owned by safety-net providers and/or federally qualified health centers), and patient availability.

Dr. Kassebaum shared brief descriptions and the pros and cons of 8 different curricular approaches including the “traditional model”, systems-based or integrated, problem-based learning, community-based dental education (version 1), case-based and community-based dental education (version 2), block curriculum, hybrid models and interprofessional education influenced models. In the ensuing discussion it became clear that each model has relative advantages and disadvantages, that not all models are appropriate for all geographic locations, and that there does not appear to be a clear connection between the various models and the cost of tuition, with tuition at some of the schools utilizing alternative curricular models equal to or greater than some schools with a “Traditional (2+2)” model.

Traditional 2 + 2	Systems-Based or Integrated	PBL – Problem-based Learning
<p>Basic sciences and preclinical courses</p> <ul style="list-style-type: none"> • 2 years of distinct basic science courses and preclinical courses • Curriculum divided into pre-clinical and clinical activities • Faculty-driven student learning <p>Clinical activities</p> <ul style="list-style-type: none"> • Possible structures - discipline-based years 3 and 4, or discipline-based in year 3 + general practice year 4, or Comp care teams year 3 and 4 • School owned & operated clinics <p>Pros</p> <ul style="list-style-type: none"> • Faculty calibration easier • Patient care continuity <p>Cons</p> <ul style="list-style-type: none"> • Student-centered care delivery • Clinical operation expenses • Low fees and long appointments 	<p>Basic sciences and preclinical</p> <ul style="list-style-type: none"> • Integrated basic sciences around strands, body systems or themes • Small-group, case-based learning • Ground rounds case conferences • Integrated clinical sciences <p>Clinical activities</p> <ul style="list-style-type: none"> • Early clinical activities in year 2 • Clinical practice in care teams • School owned & operated clinics <p>Pros</p> <ul style="list-style-type: none"> • Improved sequencing of content • Fosters critical thinking • Evidenced-based approach to clinical decision-making <p>Cons</p> <ul style="list-style-type: none"> • Student-centered care delivery • Clinical operation expenses • Low fees and long appointments 	<p>Basic sciences and preclinical</p> <ul style="list-style-type: none"> • Student determines learning objectives • Small group, active learning • Faculty serve as tutors/guides <p>Clinical activities</p> <ul style="list-style-type: none"> • May conduct usual year 3 & 4 traditional team care, or • Can employ “clinical PBL” – i.e., Pre-session and Research-Phase clinical treatment activities • School owned & operated clinics <p>Pros</p> <ul style="list-style-type: none"> • Foster enhanced critical thinking • Teaches lifelong learning skills • Evidence-based dentistry <p>Cons</p> <ul style="list-style-type: none"> • Clinical operation expenses • Appointment length • Low fees and long appointments

Figure 2 Curricular Models 1

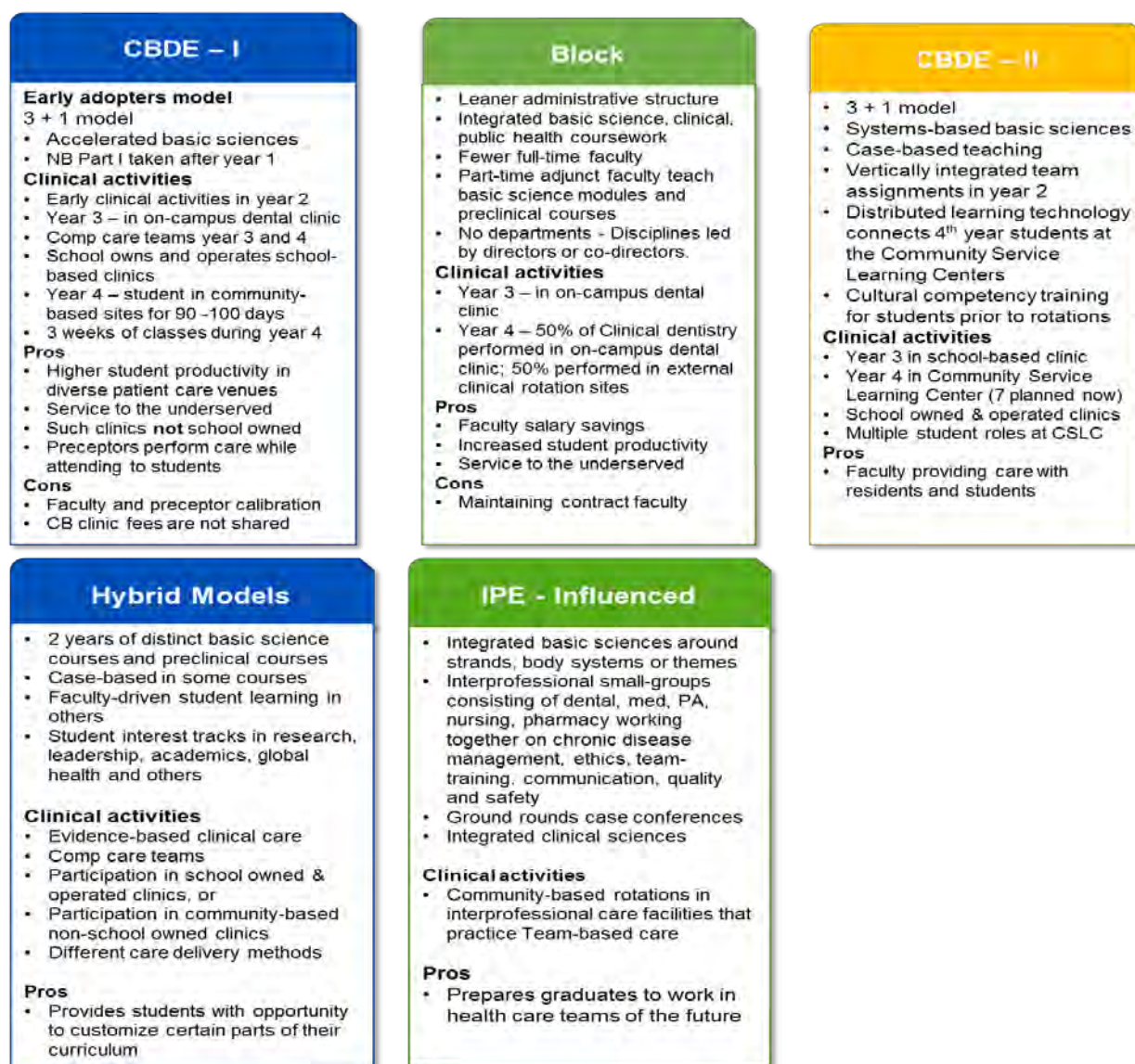


Figure 3 Curricular Models 2

The participants also noted that there are no agreed upon measures for assessing the “efficiency” of the dental school curricula and delivery methods. Potential measures could include financial efficiency, graduation or attrition rates, likelihood of graduates entering dental-related activities upon graduation, amount of clinical care provided or patients treated.

The group noted that there are multiple models for dental education and that all seem to work well in different ways and in different situations. There was little discussion of changes to the length of dental education, but recognition that expanding the length of study would have implications for the total cost of education and student debt. Only one school in the United States currently offers a four-year curriculum, delivered in three years, leading to a DDS degree. Participants cautioned that not all of the curricular models are appropriate for all schools, and that common measures of financial efficiency can be challenging to develop given the different financial models used across the schools (e.g., whether costs are centralized or decentralized, the contribution of the parent institution, the level of research conducted, the amount of free or subsidized care provided). As such, holding a single model out as being

most cost-efficient without factoring in these costs could have unintended consequences for the future of dental education.

Specific questions about the efficiency of the current dental school curricula and delivery methods that could be explored as part of a comprehensive study of dental education include:

1. Which dental schools are utilizing each of the curricular models, and what is the financial model that supports each approach?
2. What are appropriate measures for assessing the efficiency of the dental school curricula that can be commonly assessed across institutions? Based on these measures, how do the various curricular delivery models compare?
3. Can technology be used to support resource sharing among dental education on some curricular topics? Is regionalization of dental schools feasible and would it reduce costs? Should the European model of dental education be considered (six years post high school) and, if so, what would be the impact on costs?
4. Do differences in setting or curricular delivery model impact educational outcomes? Health care outcomes? Decisions for where graduates practice?

DOMAIN 3: ANALYSIS OF THE IMPACT OF STUDENT DEBT ON DENTISTRY AS A CAREER CHOICE AND SUBSEQUENT PRACTICE CHOICES

The discussion of the impact of student debt on dentistry as a career choice began with framing presentations by Dr. Marko Vujcic, Chief Economist and Vice President of the ADA Health Policy Institute, and Dr. Cecile A. Feldman, Dean of the Rutgers School of Dental Medicine. Their presentations provided insight into the complexity of dental education finances, dental student expenses, the growth in tuition and fees, the associated increase in student debt, and the impact of educational debt and other personal factors on the decision to enter private practice.

The ADA's Health Policy Institute analysis has shown that educational debt has some impact on career choices, but that the "magnitude of (debt) is fairly small, especially when compared to the impact of personal characteristics like gender, race and whether a parent is a dentist."

In the study, the focus was on the relative importance of educational debt on dental school seniors' intended employment after graduation. The study controlled for a variety of characteristics and found that although educational debt was significant, the magnitude of its effect

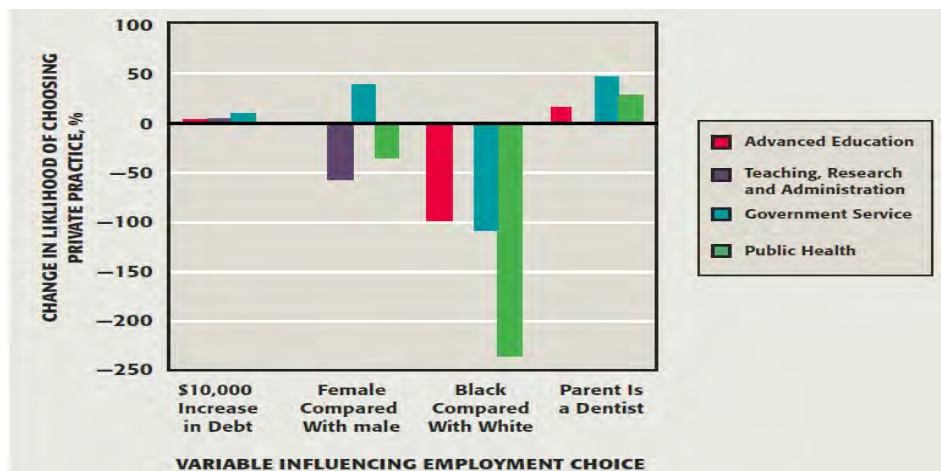


Figure 4 Source: Educational Debt and Intended Employment Choice Among Dental School Seniors; JADA 145(5); May 2014

was relatively small compared with other characteristics.

Despite educational debt receiving a lot of attention, demographic enrollment trends appeared to be more important in determining the future dental labor market. Findings suggest that focusing on the characteristics of the student body may be a better avenue for understanding employment after graduation. There are important shortcomings. Future research needs to examine the relationship between intended and actual employment, long-term career earnings and flexibility in moving between employment sectors in the dental labor market. The findings nonetheless, can help dentistry gain a better understanding of the factors that influence students' employment decisions.

The presenters also explored the confluence of increasing student debt and the flattening of dentists' income, and the impact that may have on the perceived return on

investment in dental education. One benchmark of "manageable student debt" is that total educational debt at graduation not exceed total annual salary. Based on the 2012 ADA Health Policy Institute Survey of Dental Practice and the American Dental Education Association Survey of Dental School Seniors, dental education has already exceeded that benchmark for students attending private schools, with public schools are quickly approaching the benchmark as well.

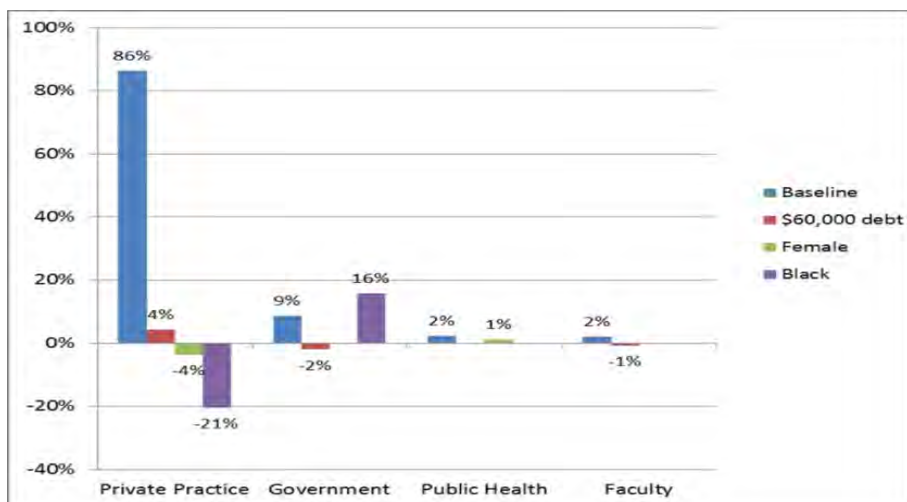


Figure 5 Impact of \$60,000 increase in debt versus other variables on decision to enter private practice; ADA Health Policy Institute.

2012 Average Educational Debt Among Graduating Students with Debt by Type of School and as a Percentage of Total Salary



Figure 6 Source: 2012 ADA Health Policy Institute Survey of Dental Practice and ADEA Survey of Dental School Seniors.

The group discussed the potential implications of a perceived decrease in the “Return on Investment” (ROI) for dental education, such as a decrease in applications, an impact on the quality of applicants, a focus on practice opportunities over other career options such as public service or academia, and decisions to pursue post-graduate and dental specialty programs. In addition, the group discussed the ratio of debt to income for dentistry versus other occupations.

The presenters emphasized the need to renew and enhance efforts and commitments for lowering dental education costs and reducing student borrowing, including promotion of financial literacy and quality financial aid services, pursuing funding for scholarships and increasing philanthropic support to dental schools, and advocating for loan repayment and forgiveness programs and increased reimbursement for clinical care, particularly for care provided for safety-net patients.

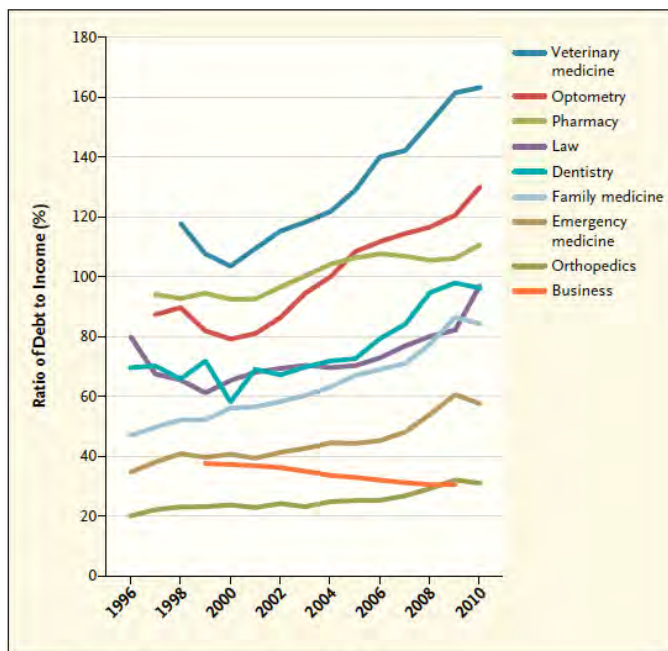


Figure 7 Source: ADA Health Policy Institute

Specific questions about the impact of student debt on dentistry as a career choice and subsequent practice choices that could be explored as part of a comprehensive study of dental education include:

1. How does the cost of dental education and/or level of student borrowing influence students' decisions to enter dental education and their future career choices? Do higher levels of educational debt have a greater impact on career choices? What is the critical point at which the perceived return on investment means that dentistry is no longer seen as a desired profession? Are there differences in the perceived return on investment for specific subsets of dental careers? At what income/debt ratio are specific labor force choices impacted (disaggregating the data to determine impact on generalist, specialist, public health, Medicaid providers, etc.)?
2. How long does it actually take for dentists to pay off their educational debt? What is the default rate for dentists' education debt? What is the impact of new loan repayment programs/options on student debt? Are there other strategies we can use to reduce the cost to students and/or students' educational debt (e.g., subsidizing loans, level of clinical production while in school, alternative investment pools, philanthropy and planned giving)?
3. Who chooses dentistry as a career? What accounts for the variability of the number of applications to dentistry over time (versus medicine which has remained stable over the same time period)? To what extent is it cost or debt related versus other factors? What is the impact of an individual's socio-economic background on their career choice?
4. As the environment for private practice dentistry continues to evolve, the “catch-all” category of private practice may no longer provide the level of detail useful for tracking career choices. What is the impact of educational debt on graduates decisions to enter specific subsets of

private practice such as solo practice, small group practice and large group practice, and the decision on whether to be a practice owner or an employed dentist? And what are the implications of the shifting environment for private practice dentistry mean for the dental education curriculum?

5. Does educational debt primarily have a short-term impact on practice choices (i.e., decisions upon graduation or in the first few years of practice) or does it impact longer-term practice choices? Are there differences in graduates' intended practice choices (as identified in the ADEA Survey of Dental School Seniors) versus their actual choices after graduation?
6. Does educational debt have an impact on ethical decision making while in school? While in practice? Does it impact a dentist's willingness to treat low-income, underserved patients?

DOMAIN 4: DETERMINATION OF WHETHER DENTAL SCHOOLS ARE MEETING THE APPROPRIATE LEVEL OF SCHOLARSHIP TO ENSURE THAT DENTISTRY CONTINUES TO BE A LEARNED PROFESSION

Dr. Laurie McCauley, Dean of the University of Michigan School of Dentistry provided a framing presentation on the current status of research and scholarship activities of dental schools and recent National Institutes of Health funding trends for dental and craniofacial research. Dr. McCauley shared her perspective that a strong commitment to research is the foundation of a learned profession, a view shared by the participants at the Stakeholder Meeting. Noting that most of dental education is based on an experiential learning model, Dr. McCauley offered that students need experiences utilizing the scientific method while in dental school in order to develop the critical thinking skills that will prepare graduates for the future.

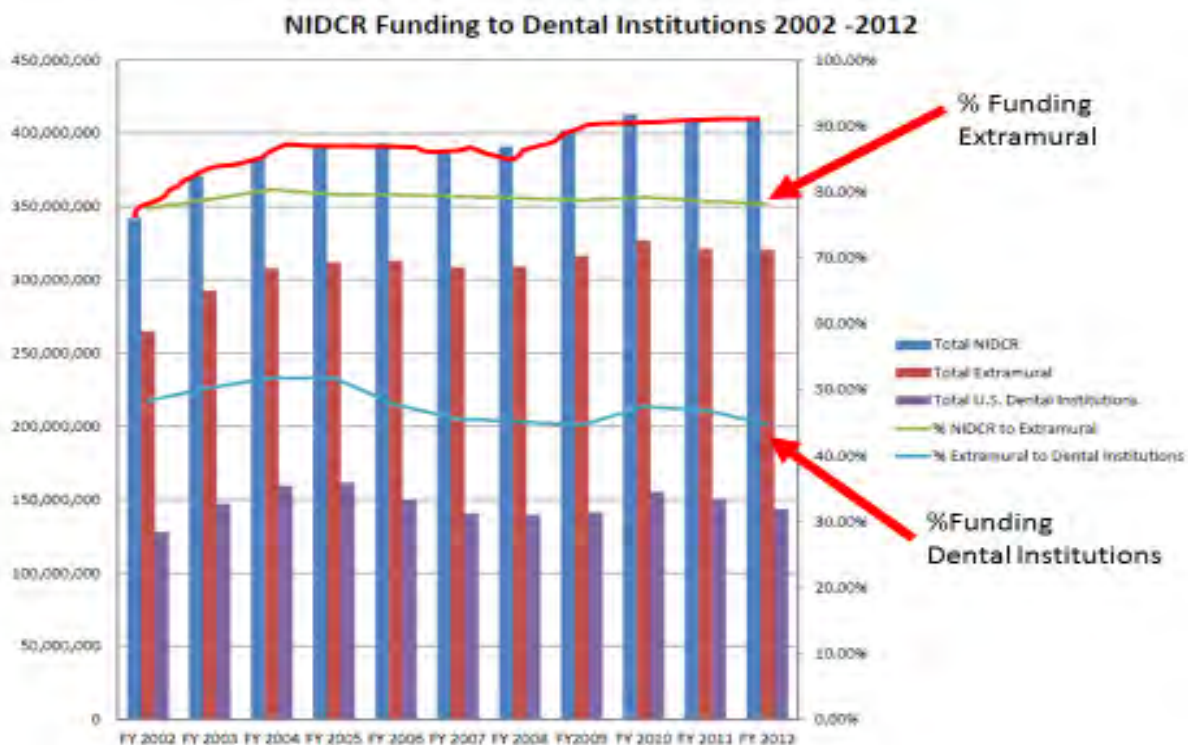


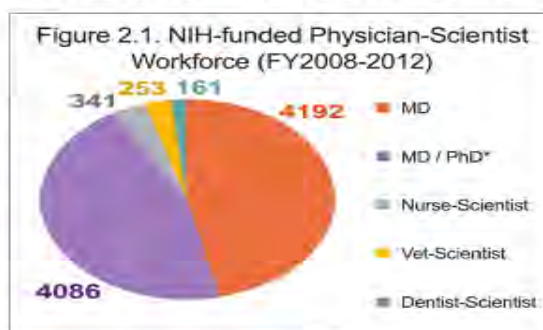
Figure 8 Source: National Institute of Dental and Craniofacial Research

While the National Institute of Dental and Craniofacial Research (NIDCR) appropriations have increased over the past decade in current dollars, the actual purchasing power of those funds has decreased 22% in constant dollars over the past 10 years. In addition, while total extramural funding has remained relatively flat since FY2002, the percentage of extramural funding going to dental schools has decreased over that time period.

While some of this shift in funding from dental schools can be attributed to advancements in team science and cross-institutional collaboration (e.g., dental school faculty may be involved in research activities in which the principle investigator is in the medical school), this trend may also reflect a shift in research priorities from areas that were historic strengths of the dental school (e.g., dental and biomaterials, clinical trials) to new areas of science (e.g., tissue engineering and regenerative medicine, developmental biology and genetics) in which other departments of the university may be more competitive than dental schools for funding.

Also discussed was the training pipeline for new dentist-scientists, and the importance of increasing the number of dentist-scientists (DDS or DMD/PhD) who are underrepresented compared to other health professions. NIDCR supports a full spectrum of research training and career development awards, and it is unclear if

Dentist-Scientists: A Small Piece of the Pie



NIH Physician-Scientist workforce working group report June 2014

Figure 9 Source: NIH Physician-Scientist workforce working group report June 2014

dental schools are maximizing these opportunities. A recent National Institutes of Health (NIH) Physician-Scientist Workforce Working Group Report found that almost all MD/PhD students “made a decision to enter a research career well before they entered medical school,” which raises a question for the dental education community – “should we be admitting students who want to be clinicians and convince them to do research or should we identify students who want to do research and convince them to be clinicians?”

Finally, the group discussed that research and scholarship activities extend “beyond the wet lab” and are inclusive of other forms of research including pedagogical research, practice-based research, translational research, behavioral and health sciences research, among others. Given this broad definition of research activities, the group felt that there was room for all dental schools to more vigorously pursue research and scholarship opportunities in order to continue to position dentistry as a learned profession.

Specific questions about the appropriate level of scholarship to ensure that dentistry continues to be a learned profession that could be explored as part of a comprehensive study of dental education include:

1. As funding sources change and the spectrum of research activities expands, how should we measure the success of research and scholarship activities beyond the metric of NIH/NIDCR

funds received? How should the “appropriate level of scholarship to ensure that dentistry continues to be a learned profession” be determined, and how might it be incorporated into Standard 6 on Research of the Commission on Dental Accreditation’s Accreditation Standards for Dental Education Programs?

2. What is the impact of who we admit to dental schools on the development of dentist-scientists? Should students be required to undertake more research and scholarly activity in dental school in order to develop critical thinking skills?
3. How can we more effectively prepare dentist-scientists? What is the impact of the shift in faculty profile (mix of full time / part time) and increased clinical teaching expectations for junior faculty mean for faculty’s ability to have adequate time for scholarship? Are we attracting and retaining the highest quality faculty who can lead the research enterprise? What is the impact of tenure on research productivity?
4. What are the resource implications of a robust research enterprise? Particularly in light of concerns about the high cost of dental education, how can we maintain research efforts within dental schools during a time of decreasing funding for research? How can we quantify the cost benefit of improved oral health outcomes versus the amount of funding dental schools receive from NIH as the basis for advocacy effort to increase research funding? How can the dental community provide more effective advocacy for research support?

A NEW FUTURE FOR DENTISTRY?

Throughout the Stakeholder Meeting, two different frameworks for a comprehensive study of dental education emerged. The first, which more directly responds to the issues articulated by the House of Delegates in Resolution 56H-2013, focuses on the efficiency and

sustainability of the current models of dental education (e.g., costs and revenue). The potential questions for exploration in such a study are listed in the prior sections of this report.

The second framework focuses on a potential new future for dentistry, exploring the long-term trends and changes in the health care environment that will impact the future of dental practice. For example:

- The shifting demand for dental services, particularly among the adult population;

Shift in Demand for Dental Care

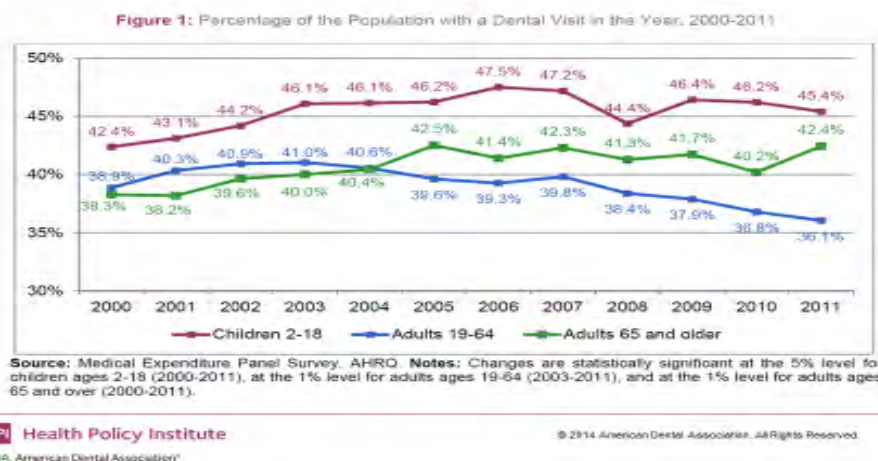


Figure 10 Source: 2012-13 ADA Health Policy Institute

- The implications of Medicaid expansion, particularly in terms of the growth in pediatric and older adult populations;
- The transition from “volume-based” to “value-based” payment models;
- The increase in care coordination and growth of Accountable Care Organizations, and the opportunities this presents for the dental profession; and
- The growth of large group practices and dental support organizations, and the implications for the future of dental practice and the skill sets expected of dental school graduates.

Over the next 25+ years, what would the shift to a value-based model in which dentistry is embedded into the health system mean for the future of dentistry? What would be the role of the dentist? What would dental practice look like? What would be the composition of the dental team?

The potential impact of these shifts on dental practice and dental education are, as yet, unclear. As such, it was not possible to develop more specific questions to investigate. However, the Stakeholder Group felt that there would be significant value in more deeply investigating these trends so that organized dentistry can play a proactive role in shaping and adapting to these likely new realities of the future of dental practice.

A majority of the participants at the Stakeholder Meeting noted that a study of the “new future for dentistry and its implications for dental education” would likely provide a significant long-term return on investment for the ADA and its members and should be considered by the ADA Board of Trustees for further exploration and action.

ESTIMATED COST OF THE STUDY ON THE CURRENT DENTAL EDUCATION MODELS AND IDENTIFICATION OF POTENTIAL FUNDING SOURCES

The second part of Resolution 56H-2013 called upon the ADA to “determine the estimated cost of the study, to identify funding sources for the study, and to report to the 2014 ADA House of Delegates.”

The costs of the proposed study on the current dental education models are dependent upon a number of factors including the size and scale of the undertaking, and whether the ADA wishes to conduct or commission the study itself, or request that an independent organization, such as the Institutes of Medicine, undertake the study.

The estimated cost for the proposed comprehensive study of the current dental education models that would address most, if not all, of the issues identified in this report and be conducted by an external research organization (whether commissioned by the ADA or independently) range from \$1.5M to \$2.5M. As some of the questions identified by the Stakeholder Meeting participants have been investigated in the past, it may be possible to conduct a more targeted study of a subset of the issues at a cost of \$500,000 to \$750,000. A highly targeted study of a single research question is estimated to cost \$50,000 to \$150,000.

The estimated cost for a proposed study on the future of dentistry that would be conducted by an external research organization would range from \$250,000 to \$1 million.

Potential funders for a comprehensive study of the current education models or a study on the future of dentistry include the National Institutes of Health, the National Institute of Dental and Craniofacial Research and select national foundations such as the Josiah Macy Jr. Foundation and the Robert Wood Johnson Foundation.

APPENDICES

- A. Agenda from the ADA CDEL Stakeholder Meeting (June 19 – 20, 2014)
- B. ADA Stakeholder Meeting Participant List
- C. List of Resources for ADA Stakeholder Meeting
- D. PowerPoint Presentations

**ADA STAKEHOLDER MEETING
DEFINING THE SCOPE AND AIMS OF A PROPOSED COMPREHENSIVE STUDY OF
CURRENT DENTAL EDUCATION MODELS**

June 19-20, 2014

ADA Headquarters Auditorium; Chicago, IL

GOAL FOR THE SESSION

To more clearly define the questions that a comprehensive study of the current dental education model should address and explore how such a study could be conducted.

The findings and outcomes of the Stakeholder Meeting will be submitted to the Council on Dental Education and Licensure to help inform their recommendation via the Board of Trustees to the 2014 House of Delegates on whether and how to pursue the funding to support a comprehensive study.

AGENDA

Thursday, June 19, 2014

1:00 p.m. Opening, Welcome and Introductions: Teresa A. Dolan, DDS, MPH
Overview of the Stakeholder Meeting: Joshua S. Mintz, MS

**1:15 p.m. The Role and Positioning of the Dental School in the University
Environment:**

Presenter: James J. Koelbl, DDS, MS, MJ

Respondent: Jerold S. Goldberg, DDS

2:15 p.m. Issue 1: The Long-Term Financial Sustainability of Dental Schools

**What We Do and Don't Know about the Sustainability of the
"Business Model" for Medical and Dental Schools:**

Presenter: David A. Asch, MD, MBA

Respondent: William Dodge, DDS

3:30 p.m. Break

**3:45 p.m. Issue 2: Efficiency of Current Dental School Curricula & Delivery
Methods**

**What We Do and Don't Know about the Efficiency of Different
Curricular Models:**

Presenter: Denise K. Kassebaum, DDS, MS

4:55 p.m. Wrap Up and Preview of Day Two

5:00 p.m. Reception

Friday, June 20, 2014

8:00 a.m. Breakfast

8:30 a.m. **Issue 3: Impact of Student Debt on Career and Practice Choices**

What We Do and Don't Know About the Impact of Debt on Career and Practice Choices:

Presenter: Marko Vujicic, PhD

Respondent: Cecile A. Feldman, DMD, MBA

9:45 a.m. Break

10:00 a.m. **Issue 4: The Appropriate Level of Scholarship within Dental Schools to Ensure that Dentistry Continues to be a Learned Profession**

What We Do and Don't Know about the Research and Scholarship Activities of Dental Schools and the Changes in Dental Research:

Presenter: Laurie McCauley, DDS, MS, PhD

11:15 a.m. **Group Discussion**

12:00 p.m. **Lunch**

1:00 p.m. **Identifying the Most Critical Questions**

2:00 p.m. **Update on Advancing Dental Education: Gies in the 21st Century:**
Allan J. Formicola, DDS, MS and Howard Bailit, DMD, PhD

2:15 p.m. **Summary of Considerations and Next Steps:** Dr. Teresa A. Dolan

3:00 p.m. **Adjourn**

Attachments:

- Participant List
- Resolution 56H – 2013 Comprehensive Study of the Current Dental Education Model
- ADA Stakeholder Survey Responses
- Resource Materials List
- BOT Report 13 and Report of the ADA Taskforce on Dental Education Economics and Student Debt
- A Report of The ADEA Presidential Task Force on the Cost of Higher Education and Student Borrowing
- Educational debt and intended employment choice among dental school seniors

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**ADA STAKEHOLDER MEETING:
DEFINING THE SCOPE AND AIMS OF A PROPOSED COMPREHENSIVE
STUDY OF CURRENT DENTAL EDUCATION MODELS
June 19-20, 2014**

Resource Materials

1. Report of the ADA Taskforce on Dental Education Economics and Student Debt; ADA; August 2013, including Resolution 56H-2013 as amended and adopted by the ADA House of Delegates
2. A Report of the ADEA Presidential Task Force on the Cost of Higher Education and Student Borrowing; ADEA, March 2013; does not require member login:
<http://www.adea.org/costandborrowing/>
3. Educational Debt and Intended Employment Choice Among Dental School Seniors; JADA 145(5); May 2014
4. ADEA Survey of Dental School Seniors, 2013 Graduating Class Tables Report;
<http://www.adea.org/surveys-and-reports/>
5. Dental Education at the Crossroads – Challenges and Change; Division of Health Care Services; Institute of Medicine; National Academy Press, Washington, DC, 1995;
<http://www.iom.edu/reports/1995/dental-education-at-the-crossroads-challenges-and-changes.aspx>
6. Beyond the Crossroads: Change and Innovation in Dental Education; ADEA Commission on Change and Innovation in Dental Education; American Dental Education Association, Washington, DC, 2009; free downloadable pdf at: <http://www.adea.org/beyondthecrossroads/>
7. American Dental Association. *Future of Dentistry: Today's Vision Tomorrow's Reality*, Chicago, ADA, Health Policy Resources Center: 2001;
<http://ebusiness.ada.org/productcatalog/product.aspx?ID=1037>
8. New Models of Dental Education, The Macy Study Report; American Dental Education Association, Washington, DC, February 2008 supplement; requires member login:
<http://www.adea.org/publications/jde/Pages/default.aspx>
9. Frank W. Licari and David W. Chambers; Some Paradoxes in Competency-Based Dental Education; J Dent Educ 2008 72:8-18
10. ADEA Official Guide to Dental Schools; Chapter 4 Financing a Dental Education;
<http://www.adea.org/publications/Pages/OfficialGuide.aspx>
11. Christine Hryhorczuk, Aljernon J. Bolden, G. William Knight, Indru Punwani, Daniel M. Mulvihill, Khatija Noorullah, and Caswell A. Evans; A Model for Selection and Assessment of Community-Based Sites for Dental Students' Extramural Clinical Experiences; J Dent Educ 2008 72:153-171
12. Jeanette E. DeCastro, M.Ed.; David Bolger, DMD; Cecile A. Feldman, DMD, MBA; Clinical Competence of Graduates of Community-Based and Traditional Curricula; J Dent Educ 2005 69: 1324-1331
13. Oscar Arevalo, DDS., ScD, MBA, MS; Daniel M. Saman, MPH; Victoria Rohall, BS; Measuring Clinical Productivity in Community-Based Dental Education Programs; J Dent Educ 2011 75: 1200-1207

Resolution No. 53-57 New

Report: Board Report 13 Date Submitted: August 2013

Submitted By: Board of Trustees

Reference Committee: Dental Education, Science and Related Matters

Total Net Financial Implication: See Individual Resolution Worksheets Net Dues Impact: _____

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

ADA Strategic Plan Goal: Members (Required)

REPORT 13 OF THE BOARD OF TRUSTEES TO THE HOUSE OF DELEGATES: RESPONSE TO RESOLUTIONS 66H-2011, 91H-2011, B-204-2011, AND 113H-2012 DEFLATING THE DENTAL EDUCATION BUBBLE

Background: In response to resolutions 66H-2011, 91H-2011, and B-204-2011, Dr. William R. Calnon, ADA president, appointed members to a workgroup on dental education as follows: Dr. Ken Rich, chair (6th district), Dr. Maxine Feinberg (4th district), Dr. Gary S. Yonemoto (14th district), Dr. James M. Boyle (CDEL Representative); Dr. Teresa A. Dolan (CDEL Representative); and Dr. Brian M. Schwab (New Dentist Committee Representative). Due to the complexity of the research requested by the House of Delegates, and the need to generate data not currently collected by the ADA through the HPRC, the project was extended into 2013 for a report to the 2013 House of Delegates (Resolution 113H-2012). Subsequently, ADA President Dr. Robert Faiella appointed Dr. Feinberg to replace Dr. Rich as chair, while Dr. Julian (Hal) Fair III (16th District) was appointed to serve on the Taskforce. In addition, the Taskforce invited a representative from the American Student Dental Association (ASDA), Mr. Martin Smallidge, to attend the meetings held in April 2013.

The Taskforce learned that student debt is perceived as a national higher education problem at all levels; however, the existing data on the issue of student debt is sparse, making analysis of trends and implications for the dental profession difficult to determine. At the April 2012 meeting, the Taskforce developed eight research foci to serve as a basis for data collection and analysis on the current financial state of dental schools; the rapidly increasing average debt load that dental students incur throughout their education; the potential impact dental student debt has on the way dentistry is commonly practiced in the United States; and the potential impact all these factors have on access to care in underserved communities. Two outside consultants were hired with expertise in the field of higher education financing: Howard Bailit, DDS, PhD, professor emeritus, University of Connecticut School of Medicine and Director, University of Connecticut Health Center Health Policy & Primary Care Research Center (1996-2005); and Sean Nicholson, PhD, professor, Cornell University, Department of Policy Analysis and Management (PAM) and a research associate at the National Bureau of Economic Research. The research questions generated by the Taskforce and the subsequent analysis of the data have resulted in the most comprehensive information available, to date, on dental student debt, dental school finances, and the dental "safety net."

Key Issues: The research questions and main findings are summarized as follows:

- What are the trends in dental student debt? How does this compare to higher education in general?
Dentistry is experiencing the same trends in student loan debt as most other high-income professions. Dental school debt has increased over time due to increases in the cost of attending dental school. The rates of increase are in line with those experienced by other professional

1 students (e.g., physicians, veterinarians). The debt-to-income ratio for dentists has increased
2 over time, as it has for most occupations/degrees.

- 3
4 • What are the operating costs of a dental school? Does institutional setting matter? How are the
5 operating costs financed (e.g., tuition, government) and how has the financing pattern changed
6 over time?

7
8 There is great variation in operating costs among schools, which can be attributed mostly to
9 expenses associated with the number of full-time faculty and staff. As long as the “return on
10 investment” allows students to pay off educational debt in a “reasonable” amount of time, the
11 profession will continue to attract a large number of qualified applicants to fill the total number of
12 available positions. Institutional setting (public versus private) does not seem to matter as a driver
13 of overall revenue and overall expenses, particularly in recent years when financial support from
14 states to their public universities has diminished.

- 15
16 • What innovations have dental schools pursued to reduce operating costs?

17
18 There have not been significant innovations in dental school models that significantly reduce
19 operating costs. The increased number and quality of applicants over the past 15 years has
20 allowed dental schools to increase tuition without adversely affecting enrollment. In addition,
21 dental schools have been able to increase enrollment without substantially increasing expenses.
22 Overall, dental schools are currently financially sound.

- 23
24 • What is the role of educational institutions, students, residents and new graduates in the dental
25 “safety net” and what innovations are there in recent years?

26
27 Due to the limited number of students and residents available to provide treatment, compared to
28 the estimated total number of underserved patients, dental schools cannot solely solve the
29 access-to-care problem. In addition, students/residents are not as efficient in providing treatment
30 compared to an experienced private practitioner. Innovations have centered around sending
31 students to off-campus clinical sites such as Federally Qualified Health Centers (FQHC) for a
32 portion of their clinical education.

- 33
34 • What impact does student debt have on graduates’ employment choices?

35
36 Debt appears to have a small effect on some of dentists’ career decisions. The magnitude of the
37 effect is very small compared to other factors such as gender and race. In regression models,
38 students graduating with relatively large amounts of debt are more likely to plan on entering
39 private practice, less likely to plan on completing advanced education, and less likely to plan on
40 pursuing a government position. Debt levels do not have an impact on the likelihood of owning a
41 practice.

- 42
43 • How many loan forgiveness programs are available to dental students? How effective are these
44 programs in reducing student debt and improving access to care for the underserved?

45
46 As of May 2013, there are a total of 1,732 dentists participating in loan repayment programs
47 across the country, excluding active-duty military and the Army National Guard. The majority of
48 programs (92.3%) do not have debt level requirements for participation, but 41.2% of programs
49 consider debt level when determining the amount of support provided. The majority of programs
50 have specific practice location requirements (e.g., federal or state HPSA, rural, etc.; 81.8%).
51 Additionally, most programs require treatment of specific populations (e.g., Medicaid; 76.8%).
52 There are more applications for positions than there are positions available. The programs seem
53 to be effective in improving access to care; however, the improvement is limited by the small
54 number of positions available.

- What are dental schools doing in regards to teaching debt management and student loans?

Eighty percent of surveyed dental school deans reported that the dental school offers student debt or personal financial management information. In addition, the majority of dental school deans reported that student debt or personal financial management information is part of the dental school curriculum. This was closely correlated with survey results of recent graduates. More than 70% of surveyed recent graduates and current students believe that the dental school should provide more student debt or personal financial management information than is currently offered.

- What innovations could dental schools do in collaboration with the American Dental Association to reduce student debt?

The Taskforce came to the conclusion that the ADA can be most effective in addressing the student debt issue through a defined program of advocacy at the federal level and through development of a robust information portal to help current and prospective students be fully informed, financially literate consumers about a career in dentistry, including workforce forecasting reports, student debt, expected income, and life-long financial planning.

The Board carefully considered the report of the ADA Taskforce on Dental Education Economics and Student Debt (Appendix) and thanked the Taskforce for its fine work in developing the report. The Board believes that the ADA has a professional interest and obligation to support dental education and dental students by leading a collaborative effort in addressing the cost of dental education, the dental student debt burden, and the access to care issue. The Board supported the Taskforce recommendation calling for the ADA Success Program to be reviewed and revised to include more content on debt management and financial planning for students. Because the ADA Success Program is managed by the New Dentist Committee (a Standing Committee of the Board), the Board adopted Resolution B-102-2013 at its August meeting directing the New Dentist Committee to pursue the enhancements to the Success Program as outlined by the Taskforce.

The Board also concurred with the other recommendations presented by the Taskforce, noting that advocacy efforts on behalf of dental education and students must be strengthened, research efforts in dental education financing and student debt must be expanded, and the accreditation standards for predoctoral programs must be revised to emphasize the need for instruction in personal debt management and financial planning.

The Taskforce Report suggests and the Board agrees that a re-examination of the “dental education model” must be conducted to better prepare for the future, perhaps similar to the study conducted by the Institute of Medicine’s Committee on the Future of Dental Education in 1995. Such a study would require participation by dentistry’s broad communities of interest, with ADA and ADEA providing the most current data/analysis of dental education economics. On behalf of current and future members, ADA should have a leadership role, becoming a thought leader in the area of dental school financing, dental student debt, student loan interest rate reform, and the rate of return to a dental education. Recognizing that a study of this magnitude will be costly (estimated to be \$1.156 million), the Board recommends that the House take the first step by allocating \$80,000 to research potential funding sources for the study, write grant proposals; conduct literature reviews, and convene one in-person meeting for stakeholders and that funding from outside sources be secured by fall of 2015 in order for the study to proceed.

Accordingly, the Board presents the following resolutions to the 2013 House of Delegates.

1

Resolutions

2

(Resolution 53:Worksheet:3078)

3

(Resolution 54:Worksheet:3079)

4

(Resolution 55:Worksheet:3080)

5

(Resolution 56:Worksheet:3081)

6

(Resolution 57:Worksheet:3083)

Appendix

REPORT OF THE ADA TASKFORCE ON

DENTAL EDUCATION ECONOMICS AND STUDENT DEBT

Resolutions 66H-2011 and 91H-2011

Adopted by the 2011 ADA House of Delegates:

66H-2011. Resolved, that the Board of Trustees with the assistance of appropriate councils and expert consultants, study, document and analyze the current and future economics of dental education, student debt and the impact on dental practice and access to care, utilizing existing environmental scan and other available data, and be it further

Resolved, that the Board with the assistance of CDEL and consultants with expertise in dental education identify innovations in dental education that reduce costs without diminishing quality and recognize barriers to broader implementation, and be it further

Resolved, that the Board, with the assistance of consultants with expertise in practice economics and subsidized care, consider the role educational institutions, students, residents and new graduates have played in the dental "safety net," and innovative ideas to improve that function while reducing student debt, and be it further

Resolved, that the Board prepare a detailed report including short term and long range action recommendations to reduce dental student debt for consideration at the 2012 House of Delegates.

91H-2011. Resolved, that the appropriate councils and ADA agencies investigate the development and implementation of a student loan repayment grant program for dentists working in a non-profit community dental clinic, and report to the 2012 House of Delegates.

Resolution B-204-2011

Adopted at the December, 2011 Board of Trustees meeting in support of 66H-2011:

B-204-2011. Resolved, that per the HOD Directive 66H-2011, the ADA President appoint a Taskforce made up of three members of the Board of Trustees; two members of the Council on Dental Education and Licensure; one member of the Committee on the New Dentist; and other appropriate councils and expert consultants, which the Taskforce may engage external consultants as deemed necessary for the study outlined in Res. 66H, and monitor the study's progress, and be it further

Resolved, that the Board prepare a detailed report including short term and long range action recommendations to reduce dental student debt for consideration by the 2012 House of Delegates.

Resolution 113H-2012**Adopted by the 2012 ADA House of Delegates:**

Resolved, that the Taskforce on Dental Education Economics and Student Debt conduct the research as outlined in this report and report findings to the 2013 House of Delegates, and be it further

Resolved, that the \$230,000 be returned to the General Fund and allocated in the 2013 budget for completion of the study.

INTRODUCTION AND BACKGROUND

In response to resolutions 66H-2011, 91H-2011, and B-204-2011, Dr. William R. Calnon, ADA president, appointed members to the workgroup as follows: Dr. Ken Rich, chair (6th district), Dr. Maxine Feinberg (4th district), Dr. Gary S. Yonemoto (14th district), Dr. James M. Boyle (CDEL Representative); Dr. Teresa A. Dolan (CDEL Representative); and Dr. Brian M. Schwab (New Dentist Committee Representative). Ms. Karen Hart, director of CDEL, Marko Vujicic, Ph.D., managing vice president, Health Policy Resources Center (HPRC), and Dr. Anthony J. Ziebert, senior vice president, Education/Professional Affairs provided staff support for the workgroup. Due to the complexity of the research requested by the House of Delegates, and the need to generate data not currently collected by the ADA through the HPRC, the project was extended into 2013 for a report to the 2013 House of Delegates (resolution 113H-2012). Subsequently, ADA President Dr. Robert Faiella appointed Dr. Feinberg to replace Dr. Rich as chair, while Dr. Julian (Hal) Fair III (16th District) was appointed to serve on the Taskforce. In addition, the Taskforce invited a representative from the American Student Dental Association (ASDA), Mr. Martin Smallidge, to attend the meetings held in April 2013.

The Taskforce met via conference calls on April 18, 2012, January 16, 2013, and July 15, 2013. Meetings were held at the ADA Headquarters Building on January 5, 2013, April 14-15, 2013 and June 7, 2013. Two outside consultants were hired with expertise in the field of higher education financing: Howard Bailit, DDS, PhD, professor emeritus, University of Connecticut School of Medicine and Director, University of Connecticut Health Center Health Policy & Primary Care Research Center (1996-2005); and Sean Nicholson, PhD, professor, Cornell University, Department of Policy Analysis and Management (PAM) and a research associate at the National Bureau of Economic Research.

The Taskforce learned that student debt is perceived as a national higher education problem at all levels; however, the existing data on the issue of student debt is sparse, making analysis of trends and implications for the dental profession difficult to determine. At the April 2012 meeting, the Taskforce developed eight research foci to serve as a basis for data collection and analysis on the current financial state of dental schools; the rapidly increasing average debt load that dental students incur throughout their education; the potential impact dental student debt has on the way dentistry is commonly practiced in the United States; and the potential impact all these factors have on access to care in underserved communities. The research questions, along with the methodology for collecting relevant data and the individual or group responsible for data collection and analysis, are outlined below in Table 1.

TABLE 1

Research Foci and Question(s)	Methodology	Primary Researcher
What are the trends in dental student debt? How does this compare to higher education in general?	Analysis of ADEA senior survey data; various micro data sets with income and education debt data; Association reports; literature review.	Dr. Nicholson
What are the operating costs of a dental school? How are these operating costs financed (e.g. tuition, government) and how has the financing pattern changed over time? Does institutional setting (public vs. private) matter?	Analysis of CODA surveys of dental schools (2004-2011); literature review; key informant interviews.	Dr. Bailit
What innovations have dental schools pursued to reduce operating costs?	Analysis of CODA surveys of dental schools (2004-2011); literature review; key informant interviews.	Dr. Bailit
What is the role of educational institutions, students, residents and new graduates in the dental "safety net" and what innovations are there in recent years?	Analysis of CODA surveys of dental schools (2004-2011); Literature review; Key informant interviews.	Dr. Bailit
What impact does student debt have on graduates' employment choices?	Analysis of ADEA senior survey data (2004-2011) for intended choices; survey of 1996, 2001, 2006, 2011 graduate cohorts for actual choices.	Dr. Nicholson
How many loan forgiveness programs are available to dental students? How effective are these programs in reducing student debt and improving access to care for the underserved?	Web search to augment ADA Division of Government Affairs inventory of loan forgiveness programs; survey of heads of the loan forgiveness programs.	ADA staff from the Health Policy Resources Center and the ADA Division of Government Affairs
What are dental schools doing in regards to teaching debt management and student loans?	Survey of dental students (ASDA reps); Survey of 2011 graduates; Survey of dental school deans.	ADA staff from the Health Policy Resources Center

What innovations could dental schools do in collaboration with the American Dental Association to reduce student debt?	Suggested resolutions for action by the HOD submitted by the Taskforce outlined in this report	Taskforce
--	--	-----------

The research questions generated by the Taskforce and the subsequent analysis of the data have resulted in the most comprehensive information available, to date, on dental student debt, dental school finances, and the dental “safety net.”

Data and Methods, Key Findings, and Policy Implications

1. What are the trends in dental student debt? How does this compare to higher education in general?

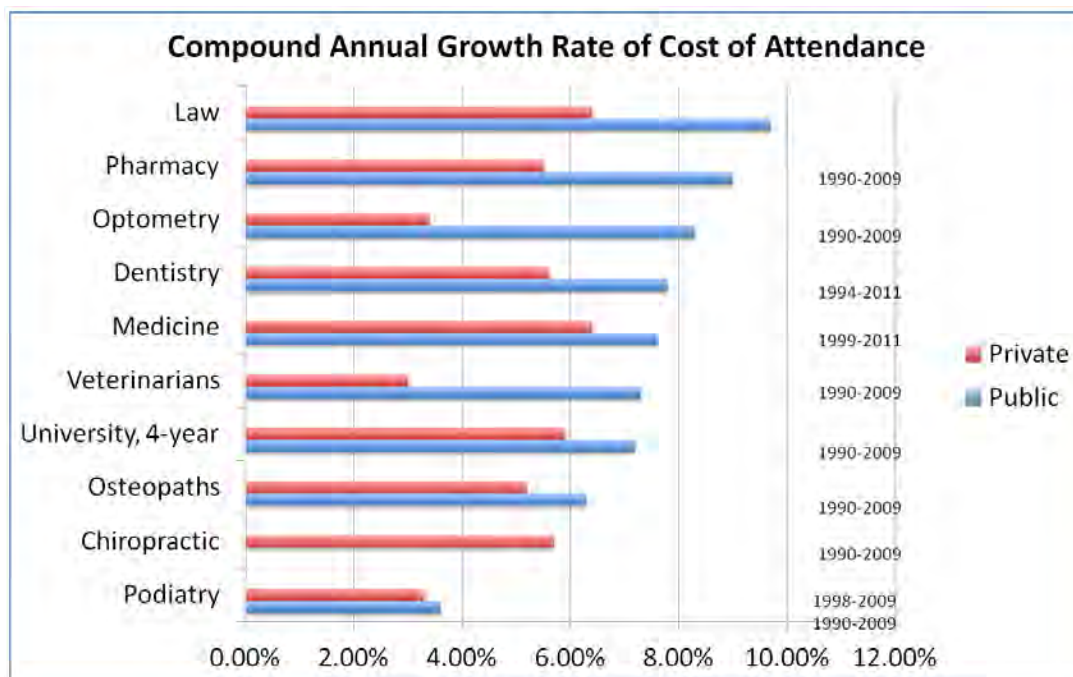
Methods and Data

Data for this study were obtained from the annual ADEA Survey of Dental School Seniors . The dataset obtained was from 2004 through 2011. The average age of the seniors surveyed was 28 years old. Observations with age less than 24 years old or greater than 50 years were excluded to remove observations with inaccurate entries. Additional information was drawn from a variety of government databases, a literature review, and various associations using proprietary data (See Appendix A-Debt Trend Literature Review).

Key Findings

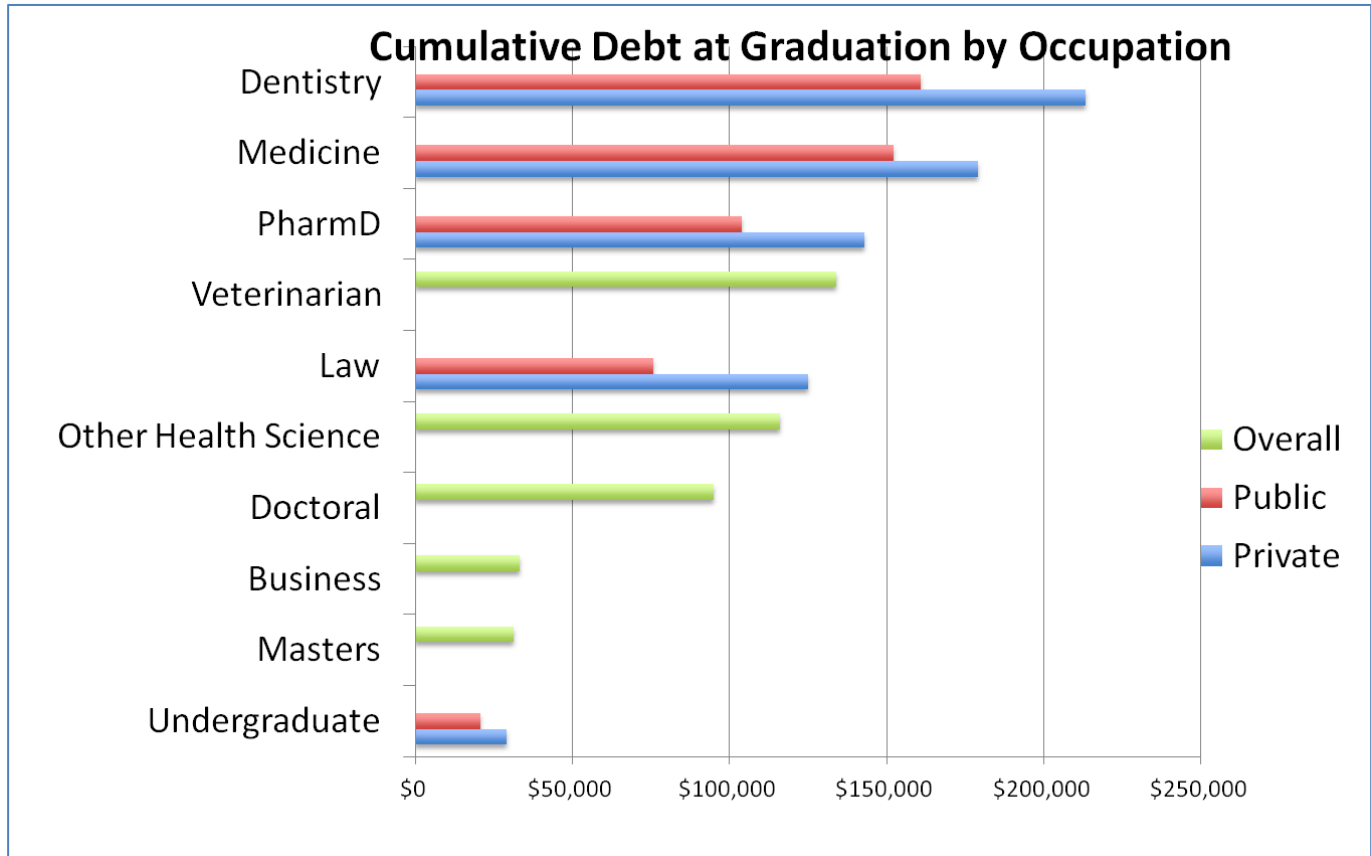
Cost of attendance (tuition and fees) for professional degrees is rising much faster than inflation. Dentistry is by no means an outlier. Between 1994 and 2011, the 4-year cost of attending a public dental school increased at an average annual rate of 7.8%. The cost of attending a private dental school increased at a slightly slower rate of 5.6%. The rates represent a compounded annual growth rate and are similar to the rates of increase at medical schools and four year undergraduate programs (Figure 1). The rates are significantly higher than the rate of inflation over this period, which was 2.5%.

Figure 1: Growth Rate of Dental Education Relative to Other Programs



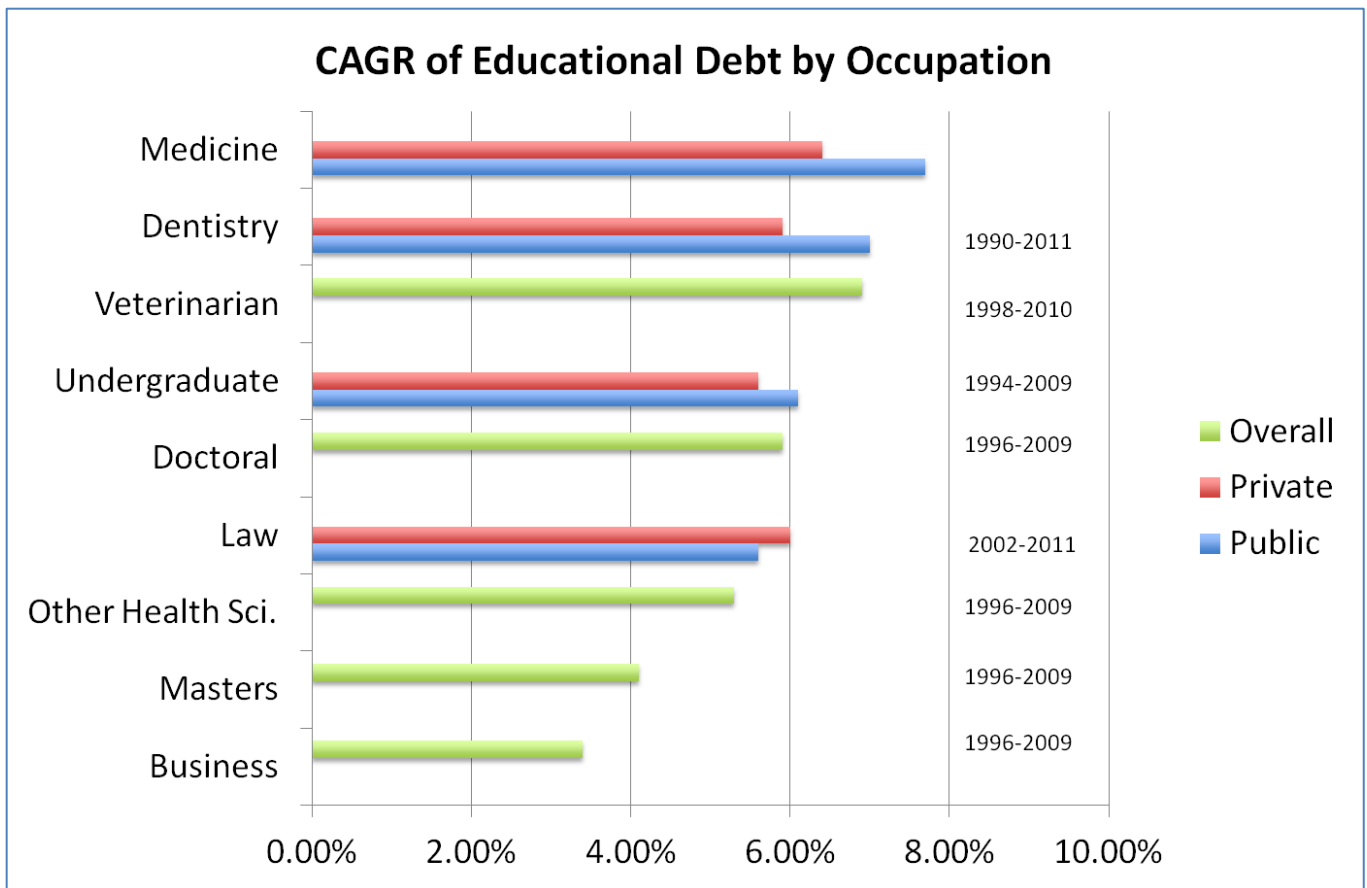
In addition, dental school graduates have higher than average debt loads. In 2011, the average total educational debt was \$213,000 for those who graduated from private schools and \$161,000 for those who graduated from public schools. According to the best available data for various occupations, dental students have more educational debt, on average, than any of the other high-income professions for which data could be found (Figure 2). As with other occupations, debt levels are higher for graduates of private dental schools.

Figure 2: Cumulative Debt of Dental Students Relative to Other Professional Students



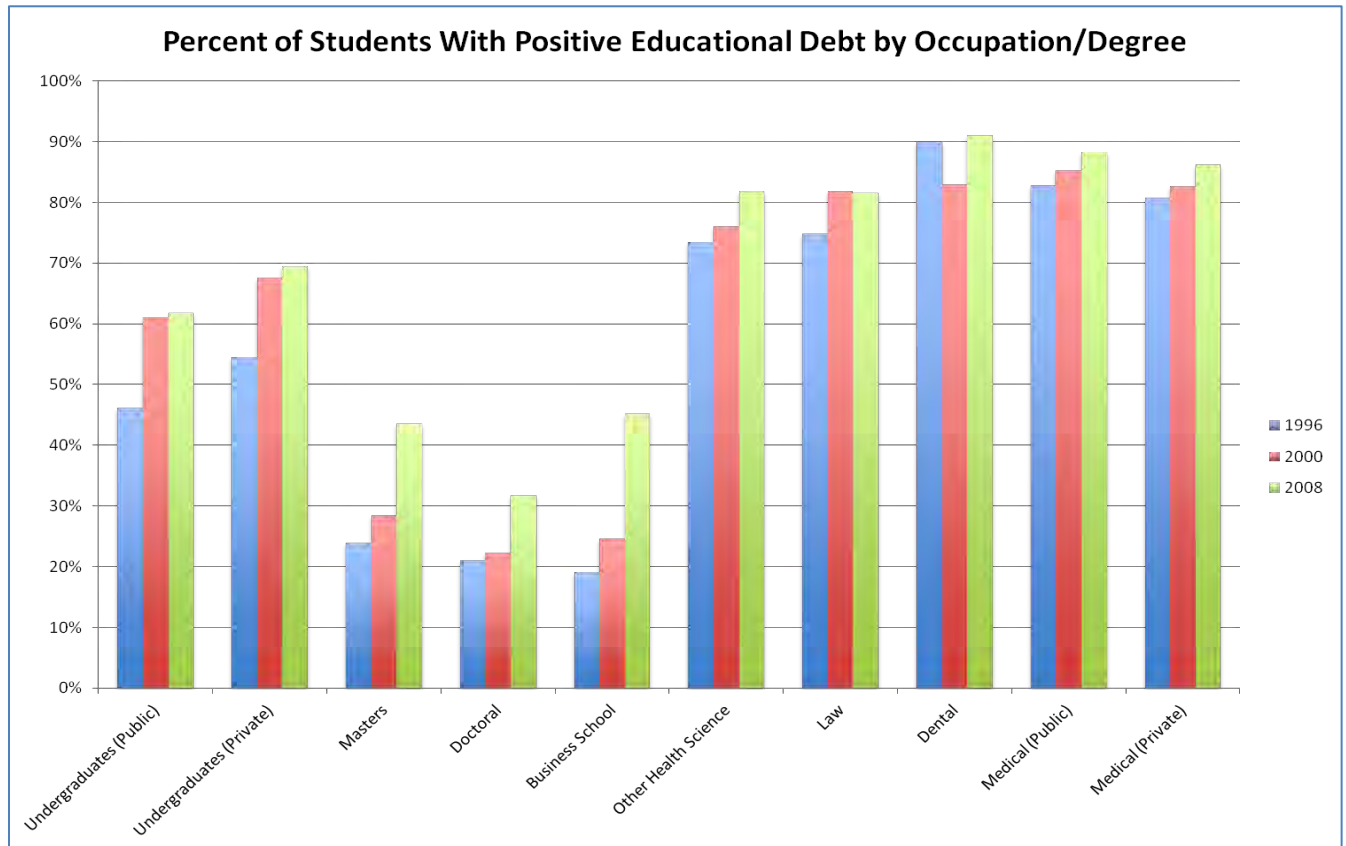
The increase in dental education debt is being driven by increases in cost of attendance. Cumulative educational debt at the time of graduation grew at an average annual rate of 7.0% and 5.9% for students attending public and private dental schools, respectively, between 1990 and 2011 (Figure 3). These rates of increase are very close to the growth rates in the cost of attendance reported in Figure 1. This indicates students are borrowing more in order to offset increasing tuition rates. Dental student debt is growing at rates similar to those of medical and veterinary students, and slightly faster than in other high-income occupations.

Figure 3: Cumulative Average Growth Rate (CAGR) of Debt for Dental Students Relative to Other Students



More than 90% of dental students who graduated in 2008 had some educational debt. This percentage has not changed much since 1996. In fact, more than 70% of law, medical, dental, and other health sciences students have educational debt since the 1990s (Figure 4). Undergraduates and students in business school, as well as masters and doctoral programs, have experienced larger increases in the percentage of students with educational debt than dental students. However, these students started from a lower base in the mid-1990s.

Figure 4: Educational Debt for Dental Students Relative to Other Students



The debt to income ratio (total average debt at graduation divided by average annual net income) – a standard and widely-accepted measure of cost versus benefit – has increased substantially for dental students but also for other occupations over the last decade. Dentistry is not an outlier. Students graduating from private dental schools in 2011 had cumulative educational debt that was 119% of the median dentist's income in that year. For graduates of public dental schools, the ratio of debt-to-income was 90% in 2011. In 1990, these figures were 76% and 46%, respectively, so the debt burden has increased over time. One major reason for the increase is that median dental income, which grew steadily between 1990 and 2003, started growing more slowly between 2003 and 2006, and then actually declines beginning in 2006. Dental graduates are not alone, however, as these trends in debt to income are the same for other occupations. The debt-to-income ratio has increased for most occupations and degrees, with business students and other masters students being the exceptions (Figure 5). The dental debt-to-income ratio in 2011 was similar to that of private law school graduates. Veterinarian graduates (Figure 6) have the highest ratio by far, approximately 275%, two to three times higher than dental graduates.

Figure 5: Debt-to-income Ratio of Dental Graduates Relative to Other Graduates

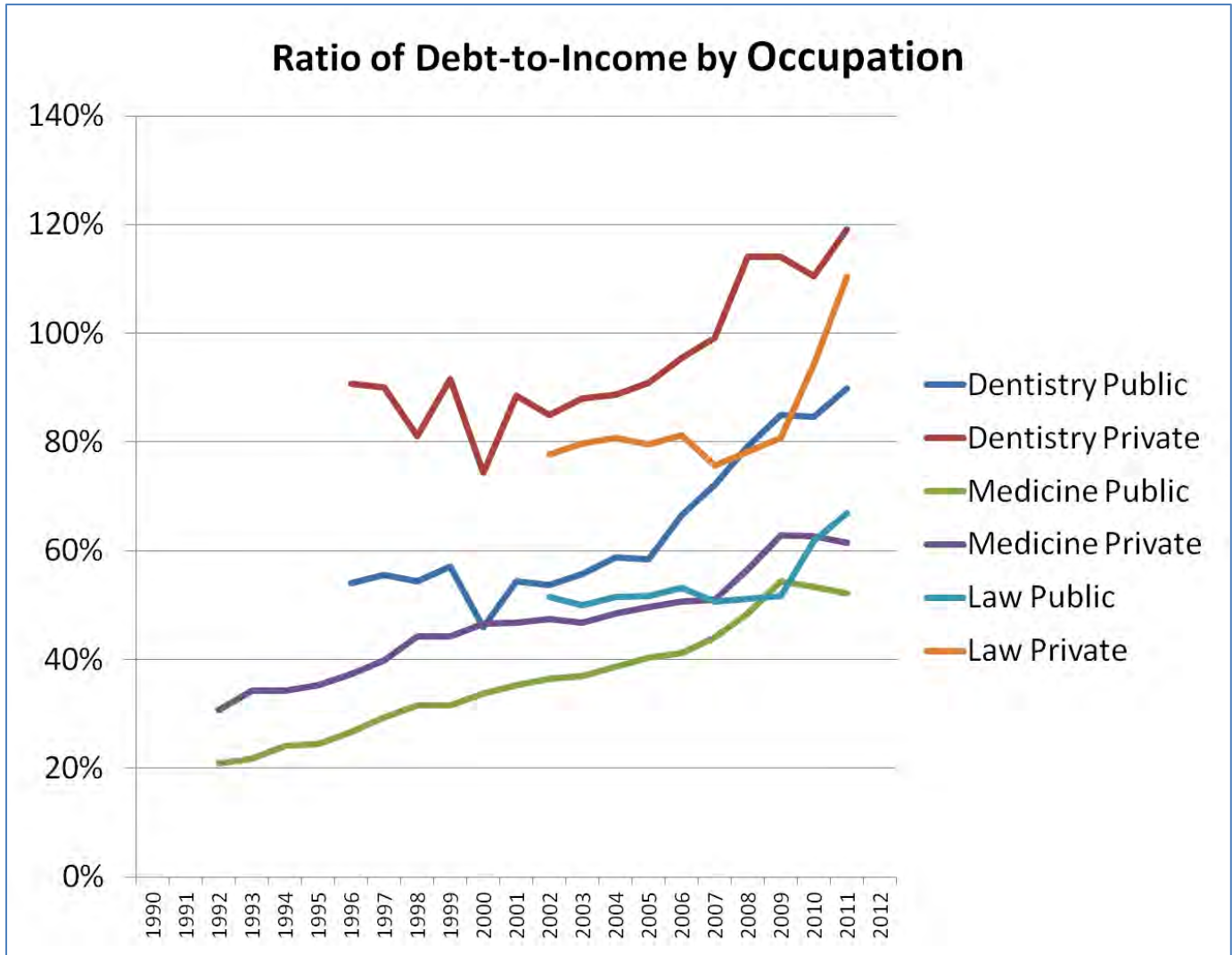
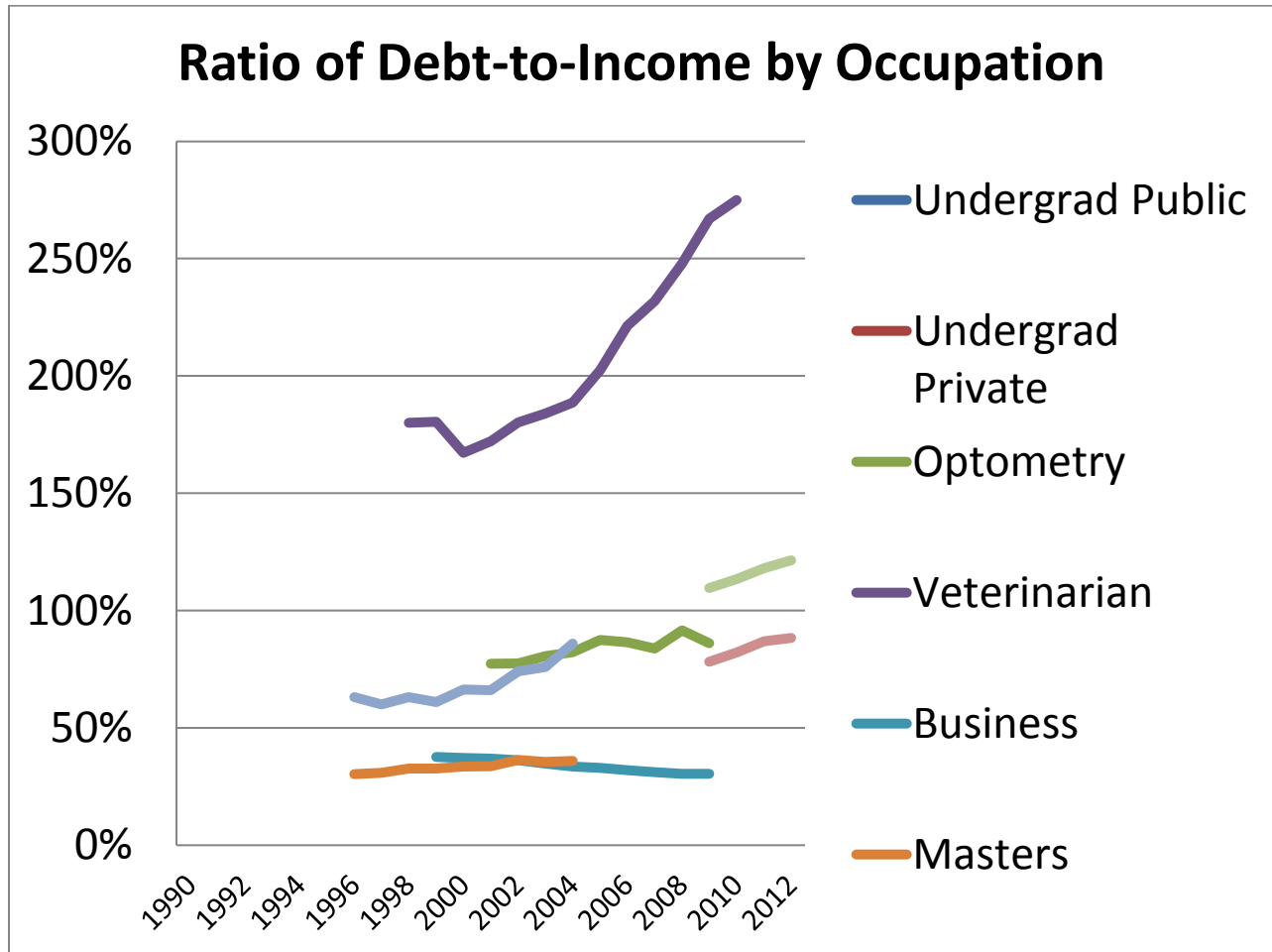


Figure 6: Debt-to-income Ratio of Undergraduates and Other Professional Graduates



Policy Implications

- The trends in student debt for dental school graduates are also occurring for other occupations, to varying degrees. Debt levels have increased steadily since the early 2000's for most higher education occupations. However, the sharp slowdown and decrease in dentist earnings since the mid-2000's has led to a sharp increase in the debt to income ratio, a key measure of the "attractiveness" of the profession.
- Tuition increases have driven increases in student debt. If tuition increases continue and dentist incomes remain flat, the rate of return for a dental education will be dramatically reduced. Schools have been able to pass increases in operating costs on to students in the form of higher tuition and fees, because of a large, well-qualified applicant pool. Now that growth in dentists' incomes is slowing, and student debt is at an all-time high, this financing strategy may come to an end. However, the fact that debt to income ratios are increasing for a wide variety of occupations will reduce the rate of return to these other occupations as well. This interplay will be one of the key factors driving the future dental school applicant pool. In a sense, the professions who experience the smallest decrease in the rate of return to education investment will likely be successful in maintaining significant numbers of qualified applicants.

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- The growth in dental income has slowed substantially over the last decade whereas tuition and educational debt have not. This may make dental school less appealing to qualified applicants compared with business school or medical school, for example. Although two-thirds of dentists who graduated in 1996 are now debt free, they started with a much lower debt burden than today's graduates. Ninety percent of younger dentists are experiencing stress over educational debt and more than 60% describe their stress as "a lot" or "extreme." As demonstrated in the ratio of debt to income by occupation figures, growing educational debt is a problem for graduates in all professional fields, but the debt-to-income ratio for dentists is among the highest.

Recommended Actions by Taskforce

- Develop a robust information program to help students become fully informed consumers about a career in dentistry, including workforce reports, debt, expected income and financial planning.
- Pursue research efforts to collect better data on dental school applicants' knowledge about the economics of the profession and their career choices. One source of these data could be the candidate application survey associated with the Dental Admissions Test.
- Advocate for more loan forgiveness programs for dentists at the state and federal levels.
- Advocate for dentists to be eligible for all health professions loan forgiveness programs.

2. What are the operating costs of a dental school? Does institutional setting matter? How are these operating costs financed and how has the financing pattern changed over time?

Methods and Data

The data comes from the annual financial survey of all dental schools carried out by the ADA Health Policy Resources Center on behalf of CODA and a literature review (see Appendix B-Dental School Finances). The information in the survey is self-reported annually by the dental schools. The study covers all dental schools from 2000-2001 to 2011-2012. Due to changes in the survey format, some analyses focus on the 2004-2005 to 2011-2012 time-frame. The data were examined for all schools, then separately for both public and private schools. For each revenue and expense category, the mean and standard deviation and percent nominal and real mean changes were calculated. The characteristics of schools with the lowest expenditures per student were examined. Multivariate analyses investigated the factors that explain variation in the cost of educating students and residents. All the percent changes in revenues and expenses presented are in real dollars (i.e., adjusted for inflation).

Key Findings

The number of dental school students and residents grew almost twice as fast as the U.S. population over the last decade. From 2000 to 2011, the average growth rate of the number of dental students was 1.6% (from 17,242 to 20,547 students). Specialty residents grew even faster, 2.1% per year (from 2,447 to 3,061 residents). The number of residents in postdoctoral general dentistry programs (AEGD and GPR) increased 3.5% per year, but this was from a very low base. At the same time, schools decreased enrollment of allied health students 1.1% per year. The U.S. population grew an average of 0.9% per year during that time. While the 1980's and 1990's saw a decrease in enrollment compared to the 1970's, in the 2000's, enrollment has been expanding significantly. According to the data, total revenues per year increased faster than total expenses per year and the average school ran a surplus for all years except 2000-2001. From 2000-2001 to 2011-2012, revenue increased faster than total expenses (4.3% vs. 3.4%) across all schools. In 2011-2012, the surplus across all schools combined was \$265 million (8% margin).

This resulted from greater revenues from tuition and fees, patient care, and university indirect subsidies. Revenues and expenditures differed by type of school. For public schools, total revenues increased only 1.0% from 2004-2005 to 2011-2012 (Table 1). Most of the increase resulted from a large expansion of revenues from tuition and fees as well as patient care. At the same time, state support for dental schools declined substantially. Private dental schools, on the other hand, increased total revenues 21.1% and, similar to public dental schools, some of this increase was from higher tuition and fees as well as patient care. The size of endowments varies considerably among all schools and remains a relatively small proportion of operating revenue. Increasing dental school endowments could be a strategy for schools to pursue for enhancement of revenue.

Table 1:

Total Change in Real Revenue, 2004-2005 to 2011-2012,
By Type of School

Revenue Source	Public	Private
Tuition/fees	68.5%	38.9%
Patient care	25.0%	15.3%
State support	-17.2%	N/A
Endowment	-2.3%	55.5%
Total Revenue	1.0%	21.1%

Public schools were more successful at controlling their expenses than private schools. Total public school expenses increased 11.8% compared with a 17.3% increase at private schools (Table 2). Private school expenses for libraries, technology, and facilities were much higher than similar expenses for public schools. The changes in expenses do not account for the age of the facility (i.e., equipment, technology, renovations and/or new construction).

Table 2:

Changes in Expenses, 2004-2005 to 2011-2012
By Type of School

Expense	Public	Private
Education	4.6%	15.7%
Patients	16.2%	17.1%
Library/computers	- 8.4%	29.5%
Facilities	-19.2%	15.6%
Total Expenses	11.8%	17.3%

The breakdown of revenues and expenses clearly shows the main difference in financial health between public and private schools is the decline in state support.

The schools with the lowest expenses per "full-time equivalent student" (FTE) were mainly private, but there was no simple explanation for their lower costs. A better measure of financial health than total revenues and expenses is the revenue and expenses per FTE, which controls for school enrollment.

While there is no simple answer as to why schools had low expenditures, they tended to have fewer curriculum hours, smaller research programs, and fewer full-time clinical faculty. There were large differences in revenues per FTE among schools. The school with the highest revenues had revenues that are more than three times greater than the school with the lowest revenues. The five schools with the highest revenues had average revenues that were more than twice the average of the lowest five (Table 3). Further, the nominal increase in revenues over the seven years was much greater in the highest revenue schools.

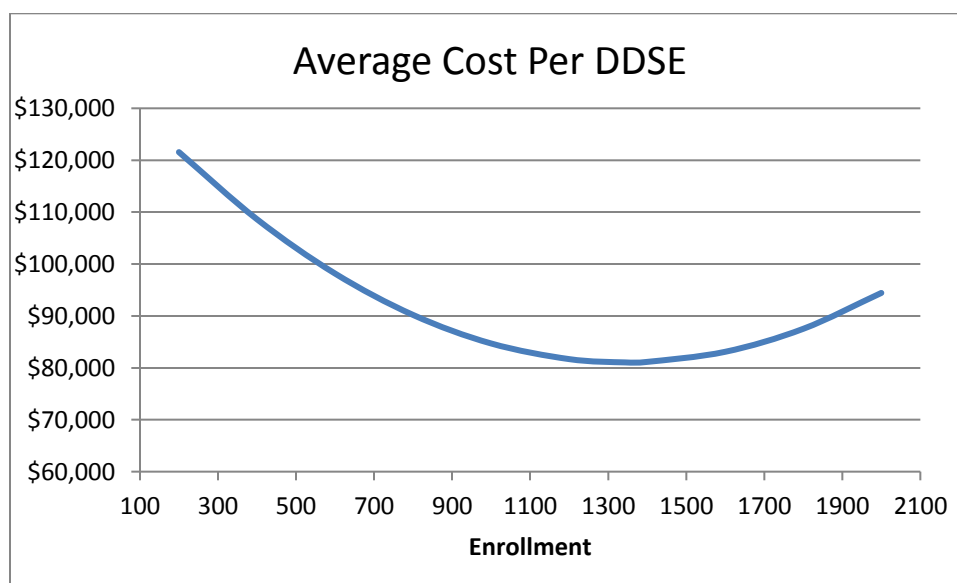
Table 3:

Revenues per FTE for Five Schools Ranked by the
Highest and Lowest Values in 2011/12

Type	Rank H Vs. L	Revenues per FTE		Nominal Difference
		2004/05	2011/12	
Public	H	\$178,872	\$212,224	\$33,352
Private	H	125,359	186,495	61,136
Public	H	142,732	180,857	38,125
Public	H	115,283	168,694	53,411
Public	H	123,260	165,525	42,265
Public	L	\$81,233	\$65,278	-\$15,955
Private	L	56,834	84,360	27,526
Public	L	67,431	84,644	17,213
Private	L	65,575	90,244	24,669
Public	L	103,496	99,361	-4,135

The average cost per “dental student equivalent” (DDSE=1.0 X undergraduate DDS enrollment + 1.7 X advanced specialty enrollment + 0.5 X allied enrollment + 1.0 X post-doctoral general dentistry enrollment) varies based on school size. The average cost per DDSE decreases as DDSE (i.e., the size of dental school) increases from 200 to 1,343, and then increases as the size exceeds 1,343 (Figure 1). With existing educational technology, 1,343 DDSE represents the most efficient size based on econometric analysis. Increasing the size of a small dental school can lower average costs markedly. Average costs decrease or increase slowly between 1,000 and 1,600 DDSE, but more rapidly outside this range. In 2010, the average DDSE was 460.2 per school. The largest DDSE is 1,577.5, while the smallest is 169.6.

Figure 1: Estimated Average Cost Curve, 2011-2012,
holding all variables other than DDSE constant



More than 90 percent of the variation in total expenditures across dental schools over multiple time periods can be attributed to the size of the school's enrollment; personnel; faculty practice and research activities; and whether a school was public or private. The technology of dental education has changed with the internet, electronic records, computerized management systems, and new simulation methods. These technical innovations may have affected the cost structure of dental schools. To test for this possibility, similar cost functions were estimated for the years 1990-1991, 1995-1996, and 2010-2011. The results indicate that, while marginal changes occurred in the cost structure of dental education, the factors that are important now were also important in earlier years.

There is a critical need to reassess the method of collecting financial data from dental schools for both accreditation and research purposes, and to assess its overall reliability and value. There were many concerns with various data elements, and this raises some caution in interpreting the results of the analysis.

Policy Implications

- The financial trends seen in the last 11 years (2000-2011) were already evident in the previous 11 years (1990-2001) based on previously published analyses. For public schools, state support started to decline 20 years ago and schools responded by increasing tuition and fees for students and advanced specialty residents. They also kept investments in the basic medical sciences, libraries, and physical plants below the inflation rate. Private schools also raised tuition and fees faster than the rate of inflation, even though they did not have the problem of declining public support. Overall, private schools appear to be in better financial shape than public schools and some private schools appear to have run surpluses.
- Both public and private schools were able to raise tuition and fees above the rate of inflation because the number and quality of dental students increased significantly. In large part, the increase in applicants was related to the expected return on an investment in a dental education. The assumption was graduates would be able to pay off their debt in a reasonable length of time and go on to have productive and well-paid careers in dentistry. Until recently, this was a sound

1 assumption. This may no longer be the case, as the rate of increase in dentists' incomes has
2 slowed and even declined.

- 3
- 4 • Thus far, the number and quality of dental school applicants has not declined, and new dental
5 schools are under development; however, there are significant concerns about the future. This
6 suggests that the market signals are not obvious to large numbers of applicants and new schools.
7 Schools may not be able to support traditional clinical dental education programs if they are
8 unable to increase tuition and fees at the same rate as in the past.
9
 - 10 • The following are potential revenue-enhancements/expense offsets for consideration:
11
 - 12 ○ **Graduate Medical Education Funds** - One approach is to obtain federal (Center for
13 Medicare and Medicaid Services) approval for dental school eligibility for Graduate
14 Medical Education (GME) funds. At this time, only hospitals and community clinics can
15 obtain GME funds. Most hospitals are not interested in funding dental residency
16 programs, except for Oral and Maxillofacial Surgery and Pediatric Dentistry. Even when
17 hospitals form joint residency programs with dental schools, they usually keep all or most
18 of the indirect GME support. These indirect funds cover the cost of administering the
19 program and paying the additional clinical expenses associated with residency training.
20 The reality is that dental schools, rather than hospitals, cover most clinical training
21 expenses. Hospitals are able to keep these indirect GME funds, because of their superior
22 negotiating leverage compared to dental schools. The GME direct payments provide
23 residents a stipend and fringe benefits. Depending on the number of residents, dental
24 schools may receive partial funding for a faculty member to supervise residents. If dental
25 schools could obtain federal GME approval for dental residency programs, it would be a
26 major source of new revenue. It is difficult to judge the political feasibility of obtaining
27 federal GME approval for dental schools. There is a growing national concern about
28 hospital costs and the large sums of money spent on GME. The federal government may
29 reduce hospital-based GME support, making it difficult to obtain GME funds for dental
30 school-based residents.
31
 - 32 ○ **Safety Net Clinics** - Patients treated by dental students are often underserved;
33 however, due to the dental school clinics' educational mission,(for example, the nature of
34 the teaching environment; the pace of dental care delivered; the patient populations that
35 are treated; and the patients limited ability to afford comprehensive treatment), relatively
36 few patients receive care compared to the estimated total number of underserved
37 patients in the general population. There is a national concern about the large disparities
38 in dental care, and approximately \$10 billion dollars have been allocated to expand
39 Federally Qualified Health Centers (FQHCs) in the Affordable Care Act legislation. A
40 strong case can be made to use some of these funds to provide dental schools additional
41 resources to care for Medicaid and other underserved patients. In other words, the idea is
42 to make dental schools part of the national dental safety net system and provide them
43 similar levels of funding as FQHCs. The latter organizations are paid per visit for treating
44 Medicaid eligible patients, and they receive a grant from the federal government to cover
45 non-Medicaid eligible indigent patients.
46
 - 47 ○ **Larger but Fewer Schools** - The analysis shows that most dental schools are too small
48 to operate at maximum efficiency. Schools with approximately 1,300 DDSEs (students
49 and residents) would operate more efficiently than schools with 500 DDSEs – the size of
50 many dental schools. The potential savings from having fewer but larger schools are
51 significant. If all schools had 1,300 DDSEs, the cost of dental education could be reduced
52 20% or more and fewer schools would be needed to educate the current numbers of
53 dental and auxiliary students and residents. While this strategy is compelling, it has little
54 practical feasibility. Each public and private school operates independently. It is unlikely

that specific states or universities would close their dental schools based on a national voluntary plan for dental education.

- ***New Clinical Education Models*** - About 80 percent of dental school expenditures are for patient care programs, so substantial reductions in school operating expenses must come from clinical programs. Dental schools are the only health professional schools that own and operate their own patient care clinics. These clinics are run as teaching laboratories, with the primary goal of dental student education. Medical, nursing, and pharmacy education use a fundamentally different clinical education model. Students and residents are trained in clinical settings that are not owned or operated by the schools. In this sense, the schools pass the cost of clinical education on to these delivery sites (e.g., hospitals, outpatient clinics, pharmacies). Medicine also requires several years of clinical training after graduation to become eligible for licensure and specialty certification. This allows medical schools to focus on the basic and clinical sciences rather than technical skills which are learned after graduation. This is in direct contrast to dental schools which focus on technical skills, since graduates are expected to be ready to enter practice after four years.
- ***“Medical” model of clinical education***- This is no longer a new idea, and the transformation is already underway. Many schools are increasing the time that senior dental students spend in “community rotations,” receiving clinical training in community clinics, hospitals, and other patient care settings that are not owned or operated by dental schools. Known as community-based dental education (CBDE), at some schools senior students now spend over half the year providing care in community facilities (see Appendix C-Community-Based Dental Education). The available evidence suggests that students are much more productive in community settings, because they have the support of a professional clinical and administrative staff. In this model, community-based faculty continue to practice as they supervise one or two students, so large numbers of underserved patients receive care.

Recommended Actions by Taskforce

- Encourage the ADA/CODA/ADEA Liaison Committee for Surveys and Reports to continue the process of refining the dental school finance survey. Outside consultants should establish 5-6 efficiency measures for benchmarking.
- Advocacy for dental schools to be approved FQHCs or partner with FQHCs.
- Encourage increased use of community clinics for the clinical education of dental students and residents.

3. What innovations have dental schools pursued to reduce operational costs?

Methods and Data

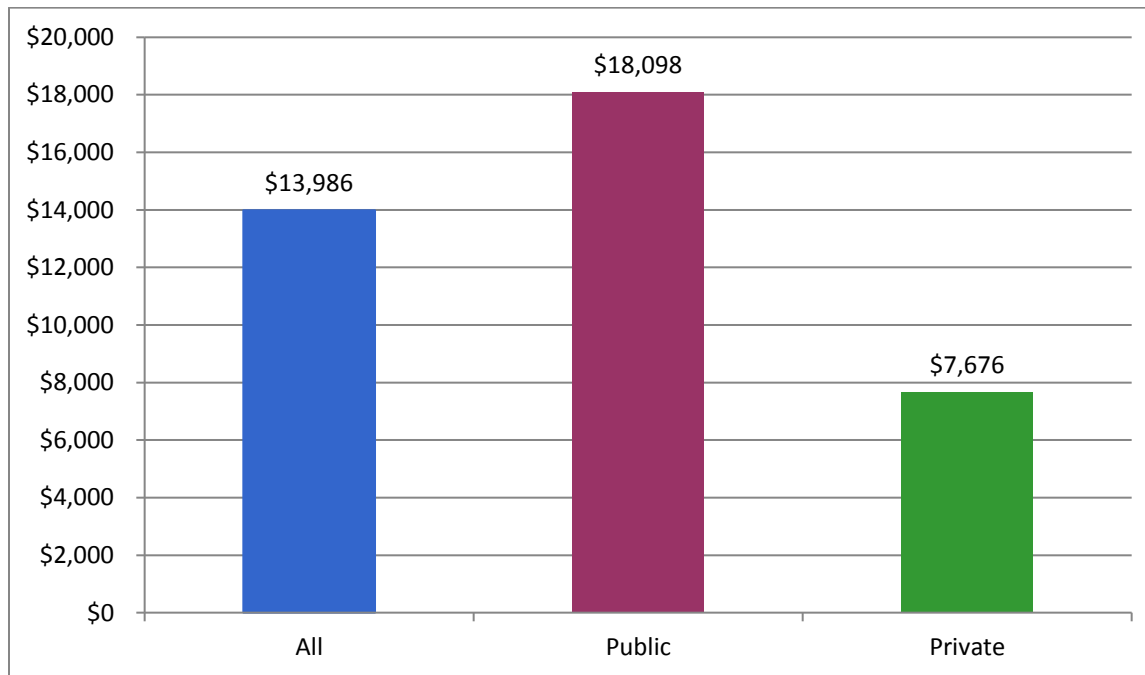
The data comes from the annual financial survey of all dental schools carried out by the ADA Health Policy Resources Center on behalf of CODA. The study covers all dental schools from 2000-2001 to 2011-2012. Because of changes in the survey format, some analyses focus on the 2004-2005 to 2011-2012 period. The data were examined for all schools, then separately for both public and private schools. For each revenue and expense category, the mean and standard deviation and percent nominal and real mean changes were calculated. The characteristics of schools with the lowest expenditures per student were examined. Multivariate analyses investigated the factors that explain variation in the cost of educating students and residents. All the percent changes in revenues and expenses presented are in real dollars (i.e., adjusted for inflation).

Key Findings

It is questionable as to whether there have been any large scale major innovations to reduce dental school costs, most likely because schools have not been “forced” to innovate. Schools have been able to raise tuition and fees as well as patient care revenues in order to compensate for increasing expenses and reduced public funding. Nevertheless, there are large differences between high cost and low cost schools in terms of costs per full time equivalent student (FTE). High cost schools tend to have larger research programs, more curriculum hours and more full-time faculty. Reductions in expenses per FTE student come mainly from economies of scale – increased enrolments rather than innovations. While state funding has declined for most public schools, a few still receive a substantial direct subsidy from state government. Some universities protected their dental schools from severe state budget reductions by making “hard” decisions on which academic units to support or close. Other schools came from states that had the resources to provide public universities adequate funding.

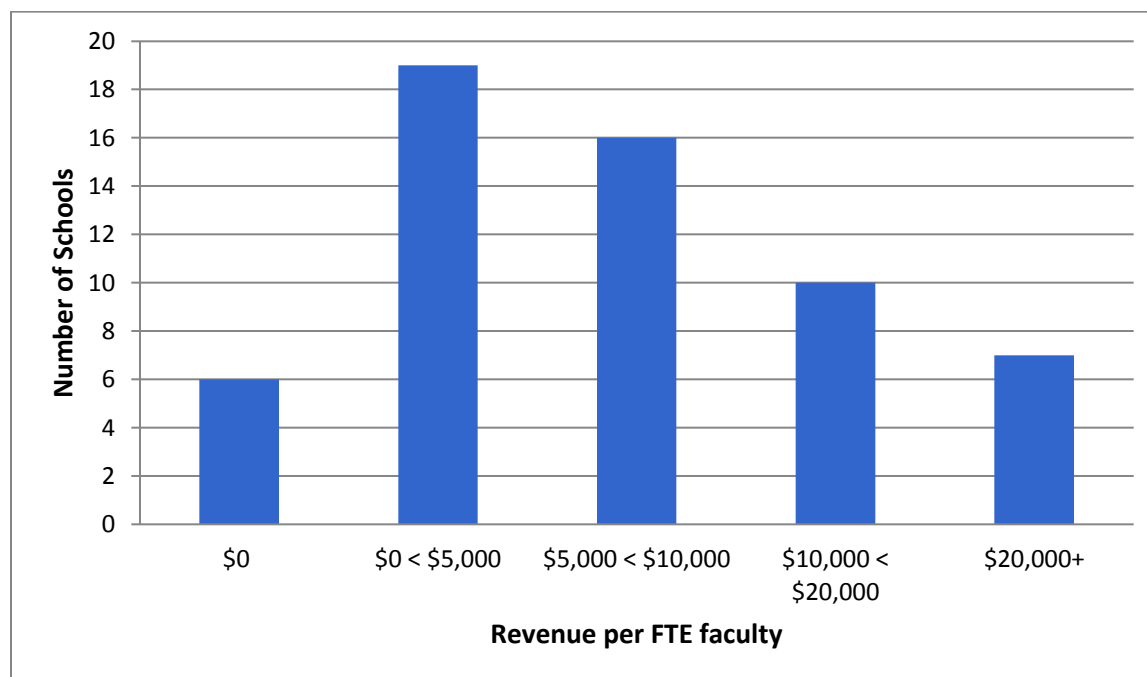
Many universities assisted their dental schools by increasing cross-subsidies and/or reducing overhead charges. Thus, the direct state allocation to dental schools is only part of the story. Universities have the flexibility to allocate public funds, endowment dollars, and other support differently among their academic units. All dental schools are part of universities and academic health centers, and there are many opportunities of universities to cross-subsidize the operations of dental schools. The average public school received \$8.9 million in university support in 2011-2012 and the average private university \$2.8 million in university support in 2011-2012. In real dollars, this support decreased in public dental schools, but increased substantially in private schools since 2004-2005. At the same time, universities also charge dental schools for certain services. Public schools paid universities an average of \$3.5 million, much less than the \$8.9 million in subsidies they received from the university. Further, the university charges declined about 10% in real dollars from 2004-2005 to 2011-2012. It appears that universities recognized the financial problems of public dental schools and made an effort to assist with fewer overhead charges. The situation with private schools is much different. University overhead charges averaged \$6.3 million in 2011-2012, much more than the average \$2.8 million received. Yet, from 2004-2005 these charges declined 20.7 percent in real dollars. Since private school universities increased the value of their services to dental schools and decreased overhead charges, it is evident that universities tried to assist private dental schools financially.

Looking at university indirect support on a revenue/FTE student basis reveals the differences between public and private dental schools (Figure 1). Across all schools, the average indirect support was almost \$14,000/FTE student. Public schools averaged over \$18,000/FTE student in indirect support from their universities, while private schools averaged just over \$7,600/FTE student. In addition, 12 of 19 private schools provided no indirect support, while just one of 38 public schools did not provide indirect support.

Figure 1: University Indirect Support for Dental Schools, Average Revenues/FTE

Many dental schools increased the market value of their endowments. The average dental school endowment is about \$22 million, which generates about one million dollars annually in available operating funds. If schools continue to increase endowments at the same rate as the past ten years, this will generate additional operating funds and disposable income.

Schools varied substantially on the amount of revenue generated by full time equivalent faculty (see Figure 2). As schools are hard-pressed to pay clinical faculty competitive salaries, an effective faculty practice has considerable potential to provide schools additional resources. Most schools provide full-time faculty the opportunity to generate additional income by providing care to private patients in school-owned faculty practices, with schools keeping a certain percentage of gross faculty practice revenues to cover overhead expenses. In addition, some schools "tax" the faculty practice, with the dean retaining a percentage of net revenues to cover school operating costs. The amount of the tax varied widely among schools, but the modal tax was about five percent. Most schools generated less than four million dollars in faculty practice gross revenues.

Figure 2: Variation in Faculty Practice Revenue, 2011-2012

There are numerous issues with the quality of the financial data on dental schools. There is a critical need to reassess the method of collecting financial data from dental schools for both accreditation and research purposes, and to assess its overall reliability and value. There were many concerns with various data elements, and this raises some caution in interpreting the results of the analysis.

Policy Implications

Strategies that are successful in one school may not be easily transferred to other schools with different local environments. Dental education is “a local business,” and schools use different strategies to adapt to their local environments. The primary analysis looked at changes in total and average revenues and expenditures over time, but it masked large differences among dental schools. To address this issue, an analysis of the variation in selected critical variables was done. These analyses point to the great variation among schools as they try to adapt to local environmental conditions. Opportunities for schools to generate substantial new net revenues from patient care appear limited. As a result, schools need to look for other revenue-generating innovations or innovations that reduce expenses. Some possibilities include:

- Cooperation among schools - Most dental schools are too small to operate efficiently. One way to deal with this problem is to have schools located in the same city, state, or region share resources such as faculty, staff, and facilities. There are huge potential savings if schools would cooperate, and this is especially true for graduate specialty programs. It makes little economic sense for small schools to run these programs with just a few residents. This is also true in regards to specialized faculty in areas, such as oral and maxillofacial pathology and oral and maxillofacial radiology, along with interest areas in general dentistry, such as dental materials and oral medicine. Currently, there are almost no organized cooperative programs among geographically-related schools. Most likely, it will have to take a great deal more financial hardship before schools seriously consider giving up some of their autonomy to improve their financial situations.

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- Closer Integration with Medical Education - It has been more than 150 years since the professions of medicine and dentistry separated in the United States. In large part, this separation explains why most dental schools are small, and why there are so many dentists (e.g., 185,000 dentists versus 115,000 internists). In the future, a stronger background in the basic and clinical sciences for dentists may be necessary, due to an anticipated increase in geriatric patients that have complex medical issues; new prevention and treatment technologies; and a shortage of primary care physicians. A case can be made for fewer but better trained dentists; however, this is a large, complex issue and cannot be fully explored in this paper.

Recommended Actions by Taskforce

- Encourage the ADA/CODA/ADEA Liaison Committee for Surveys and Reports to continue the process of refining the dental school finance survey.

4. What is the role of educational institutions, students, residents and new graduates in the dental “safety net” and what innovations have there been in recent years?

Methods and Data

The data comes from the annual survey of all dental schools carried out by the ADA Health Policy Resources Center on behalf of CODA; the Medical Expenditure Panel Survey (MEPS) (data on access disparities); and the annual ADEA Survey of Dental Seniors. An extensive literature review was conducted (see Appendix D-Dental Safety Net).

Key Findings

Dental schools account for relatively little of the total care provided to the underserved population. To attract patients, dental student clinic fees are usually set 40-60% below usual and customary market fees. As a result, students mainly treat patients from lower-income families. Students and residents are not as efficient in providing treatment compared with an experienced private practitioner. In addition, dental student clinics are not organized to maximize efficiency. Although dental student patients are often low income and underserved, relatively few patients receive care within dental school settings. Combining student and resident patients, an upper bound estimate is that dental schools treat about 1.3 million low income patients annually, only a small fraction of the estimated 30 million underserved people in the United States with a dental visit. Currently, the majority of low income patients receive dental care in private treatment settings. Two studies came to similar conclusions, estimating that between 65% and 75% of low income patients received care in private practice settings. In large part, this is because the overall capacity of the safety net system is only about 10 million patients. Dental school graduates from underrepresented minority (URM) backgrounds (i.e., African American, Hispanic, and Native American) are more likely to care for minority and underserved patients than graduates from other racial/ethnic groups.¹ Likewise, dental school graduates from rural areas are six times more likely to practice in rural areas than urban areas.² Based on the ADEA survey completed by graduating seniors, twice as many seniors from URM (45%) vs. White (23%) backgrounds agreed that dentists have an ethical and professional obligation to provide care to underserved patients. Likewise, a much higher percentage of URM (25%) vs. White (10%) seniors expect to have at least 30% of their patients from disadvantaged backgrounds. It also appears that relatively more URM graduates work in dental safety net clinics and that minority private practice dentists have relatively more minority patients.

There is a national concern about the large disparities in access to dental care. To partially address this issue, approximately \$10 billion have been allocated to expand Federally Qualified Health Centers (FQHCs) in the Affordable Care Act (ACA). FQHCs are paid per visit for treating Medicaid eligible patients and they receive a grant from the federal government to cover non-Medicaid eligible indigent patients.

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Policy Implications

While dental schools cannot solve the access problem, they can have a major impact if the payment and delivery strategies discussed are implemented. Importantly, these strategies will also improve the quality of dental education and provide schools with additional revenues that they can invest in slowing the growth of tuition and improving academic and research programs. There are several strategies that dental schools and the profession can use to decrease access disparities and expand the role of students and residents in the dental safety net, including:

- Increase the number of community-based dental education programs and increase the amount of time dental students and residents spend in these programs for clinical education-Instead of treating two patients a day (as is common in dental school clinics), students tend to treat more than two patients a day in the community-based clinics, due to increased numbers of allied dental staff in these clinics. If all schools had seniors spend 70 days in community sites, such as FQHCs, an additional 1.2 million patients could receive dental care. In addition to helping reduce disparities, community-based dental education can have a significant and positive effect on dental school finances.
- Encourage increases in enrollment and number of residency programs- Approximately 50% of dental school graduates enroll in advanced education programs in the dental specialties and general dentistry. Since most postdoctoral general dentistry education programs provide care to large numbers of underserved patients, an increased number of residency programs would still have a small impact on access disparities due to the significant underserved population. Assuming all these programs took place in efficiently run clinics and practices, another two million patients could receive dental treatment.
- Increased fees for treating low income patients - Medicaid reimbursement rates for dental care are generally very low in most states. In at least two states (North Carolina and New York) dental schools have negotiated an enhanced reimbursement rate for treating Medicaid patients. Dental schools could advocate for cost-based reimbursement on par with what FQHCs receive. With adequate Medicaid fees, dental students, residents, and faculty would have an incentive to care for Medicaid patients. Although this will have some effect on both access disparities and dental school finances, the reality is that while dental students mainly treat low-income patients, only about 13% are covered by Medicaid. This is because many states do not cover adult dental care.
- Recruit more students from underserved areas – research has shown that students from underserved areas are more likely to return to those areas and practice than other students; however, their overall impact on reducing access disparities is limited.

Recommended Actions by Taskforce

- Advocate for increased Medicaid fees and cost-based reimbursement for dental schools.
- Advocate for dental schools to be approved FQHCs or partner with FQHCs as an example of community-based education for dental students and residents.
- Encourage increased use of community clinics for clinical education of dental students and residents.

5. What impact does student debt have on graduates' employment choices?

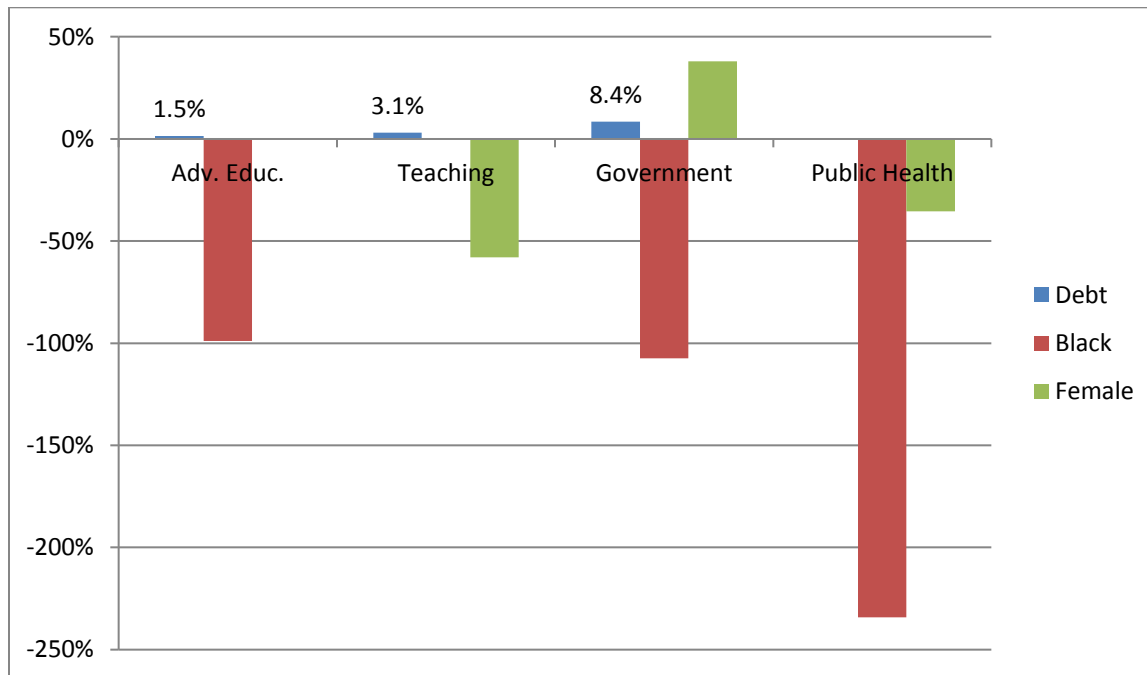
Methods and Data

Data for this study came from three sources. First, historical data were obtained from the ADEA Annual Survey of Dental School Seniors, which is self-reported data collected at the time of graduation on expected post-graduate employment and/or education plans. The dataset obtained was from 2004 through 2011. The average age of the seniors surveyed was 28 years old. Observations with age less than 24 years old or greater than 50 years were excluded to remove observations with inaccurate entries. Second, new data were collected by the ADA. The methods consisted of surveying dental students who graduated in 1996, 2001, 2006, and 2011. More than 1,800 dental graduates completed the survey, which was conducted in January and February of 2013. The survey collected information regarding how much educational debt a dentist had upon completion of dental school, the current debt balance, the current practice situation, including annual income, average weekly hours worked, patient characteristics, attitudes toward debt, and other information. Regression analysis was performed to determine whether there is an association between the amount of a debt a student had when completing dental school and their actual career choices, such as whether they are in private practice, whether they own their practice, and whether they practice in an underserved area. The survey also asked how many dentists have paid off their educational loans, and the balance of those who are still paying off their loans. Unlike prior studies that focus on simple bivariate correlations between debt and career choices and outcomes, this new research use multivariate regression analysis to control for a variety of co-founding factors influencing career choice. The key career choices examined were: willingness to pursue specialty training, willingness to work in faculty settings, willingness to work in underserved areas, willingness to treat Medicaid patients, willingness to work in public health settings, hours worked per week, and practice ownership. Finally, a literature review was done (see Appendix E-Employment Choices).

Key Findings

Students graduating with relatively large amounts of debt are more likely to plan on entering private practice, less likely to pursue advanced education, and less likely to plan on a government position, but, the magnitude of these effects is small. For each \$10,000 increase in debt, the model predicts a student's likelihood of choosing advanced education relative to private sector employment was lowered by 1.5%, choosing teaching was lowered by 3.1% and choosing a government career was lowered by 8.4% (Figure 1). While all these results were statistically significant, race and gender played a much larger role in career decisions than educational debt. Blacks were approximately twice as likely as whites to enter advanced education or government careers relative to private practice, and over three times more likely to choose public health. Females are 58% more likely to choose teaching, 38% less likely to enter government, and 35% more likely to enter public health than their male counterparts.

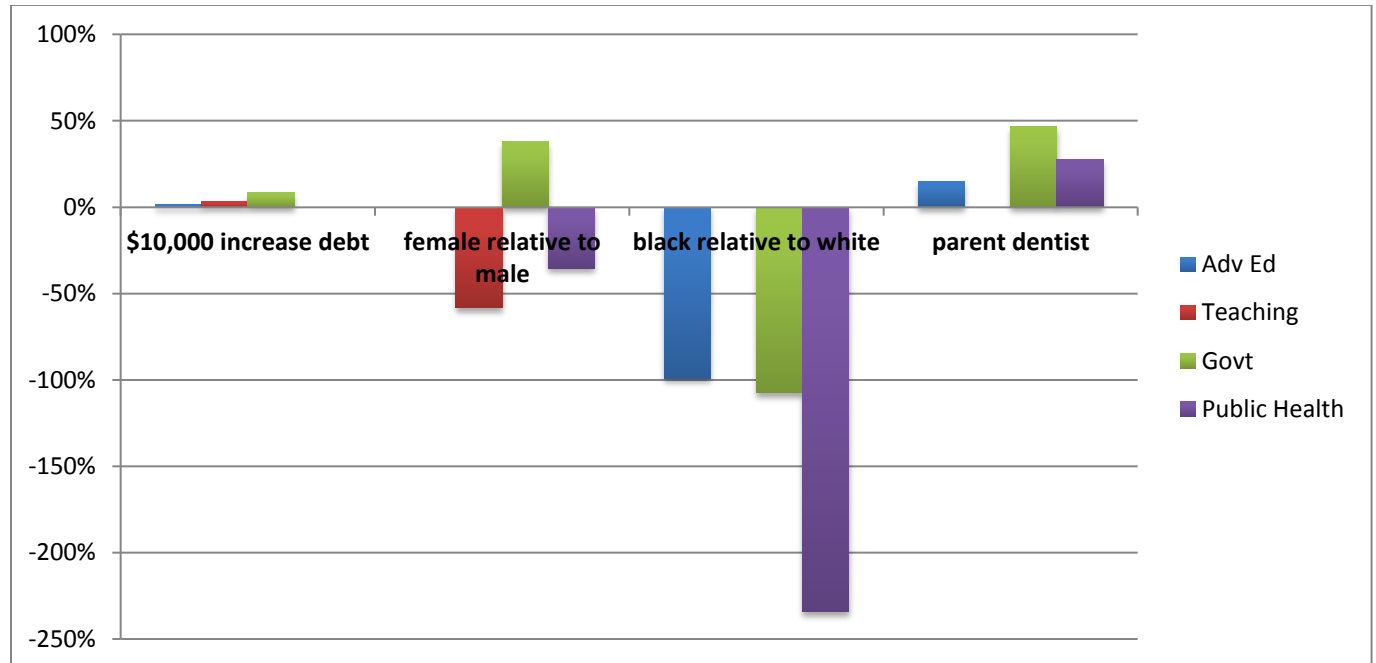
Figure 1: Effect of Debt, Race, and Gender on Intended Career Choice Relative to Private Practice, Among Dental School Seniors (regression-adjusted)



Note: Values > 0% mean private practice is more likely relative to other options,
Values < 0% mean private practice is less likely relative to other options

The study modeled the change in career choice when debt increased \$35,000 (Figure 2). The \$35,000 amount was chosen because this is the amount average debt loads actually increased from 2004 to 2011. Extrapolating the effect of a \$35,000 increase in debt over the total number of graduates between 2004 through 2011, the analysis indicates there would be 1,140 (8.4%) more individuals in private practice, 551 (5.3%) fewer in advanced education, 17 fewer teaching (10.9%), and 572 (2.9%) fewer in government over the eight year period. Factors other than debt have a dramatic impact on career intentions. The magnitude of the influence of different control variables on anticipated employment is seen in Figure 2. For a \$10,000 increase in debt, there is a small increase in probability that a student will choose private employment over advanced education, teaching or government. Female students are more likely to choose teaching and public health over private employment, but less likely to choose government. Black students are much more likely to choose advanced education, government and public health over private employment. Finally, if a parent is a dentist, the student is more likely to choose private employment over advanced education, government and public health.

Figure 2. Comparison of the Effect of Various Factors on the Probability of Dental School Seniors Wanting to Enter Private Practice Versus Other Career Choices (greater than 0% means private practice more likely; less than 0% means private practice less likely)



Educational debt is not a deterrent to treating underserved patients. Contrary to conventional wisdom, educational debt had a small, but positive correlation with the likelihood of working with low-income patients in the regression analysis. This means that students with debt were actually more likely to treat underserved patients than those with less debt. A student is considered to have plans to work with the underserved if the student answered “definitely” or “probably” when asked if at least 25 percent of patients are expected to be underrepresented minorities, rural, or special needs. The control variables include whether a parent is a dentist, race, age, gender, father’s and mother’s education, and public or private school. Analysis of actual career choices provides very similar conclusions on the relatively small impact of debt levels on some career choices. For example, 86% of the 1991, 1996, 2001, and 2011 graduating classes were in private practice. Controlling for various factors, debt did have an impact on the likelihood of entering private practice, holding a government position (e.g. working in an FQHC or the military) and pursuing advanced education; however, the magnitude of the effect is small compared to other factors, such as gender and race. The table below shows that, for example, there is a 0.4 percentage point increase in the likelihood of being in private practice for every \$10,000 in educational debt, compared to a 20 percentage point effect due to race. The results are summarized in Table 1.

TABLE 1

Factor	Entering Private <u>Practice</u>	Accepting a Government <u>Position</u>	Advanced Education/ <u>Specialization</u>
\$10,000 increase in educational debt	+0.4	-0.3	-0.5
Female (vs. male)	-3.6	N/S	-11.1
Black (vs. white)	-19.8	+15.0	N/S
Father went to grad school (vs. not)	N/S	N/S	+4.7
Baseline % making this decision	86.3%	8.8%	18.4%

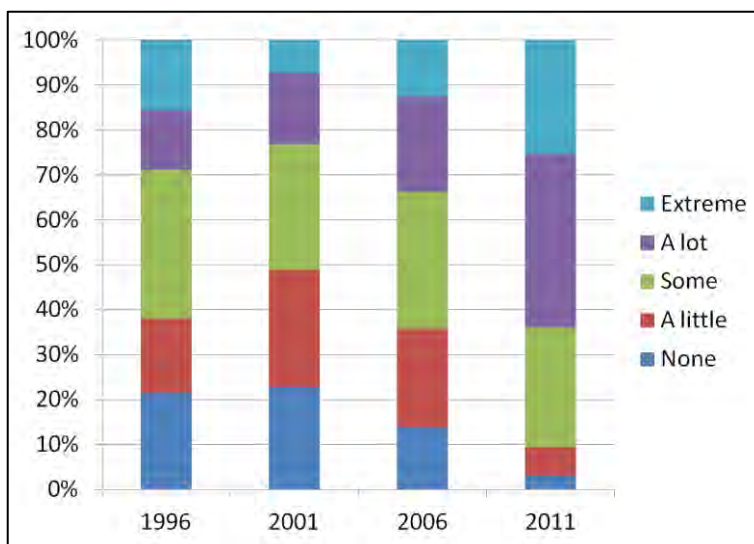
Educational debt levels do not have an impact on practice ownership, hours worked, treating the underserved, or working in public health settings, once confounding factors are controlled. Even for career choices where debt does have an impact, the magnitude is small. This is summarized in Table 2. The multivariate modeling demonstrates that a \$35,000 increase in debt increases the probability of choosing private practice relative to other career choices from a baseline of 86.3% to 87.6%.

TABLE 2

<u>Career Decision</u>	Baseline <u>Percent/Avg.</u>	With \$35,000 <u>more debt</u>	Percent <u>Change</u>
• Private practice	86.3%	87.6%	+1.5%
• Own practice	59.2%	N/S	
• Faculty position	2.2%	2.0%	-7.9%
• Government position	8.8%	7.9%	-10.2%
• Public health	2.3%	N/S	
• Advanced education	18.4%	16.6%	-10.0%
• Underserved area	13.8%	N/S	
• Poor patients %	16.4%	N/S	
• Hours worked/year	1,641	N/S	

Younger dentists are experiencing more stress about educational debt than older dentists. More than 60% of dentists who graduated in 2011 reported “extreme” or “a lot” of stress when it came to their educational debt compared with less than 30% of 1996 graduates (Figure 3).

**Figure 3: Stress Over Educational Debt by Graduating Cohort,
Among Dentists with a Positive Debt Balance in 2013**



Policy Implications

- Debt is correlated with career choices, but the magnitude of the effect of debt on private employment is not as large as prior studies have implied. Previous studies did not control for other factors that influence career choice such as gender and race. The results of this study run counter to the conventional wisdom that debt has a major influence on pushing students toward private employment and away from specialization and public health. Rather, the most important factor influencing the decision to pursue advanced education or government was race, not debt. The most important factors influencing those pursuing public health were gender and race, regardless of debt level.
- The significance of educational debt as a factor in career choice could grow if debt continues to increase while salaries stagnate. The increase in dental salaries has flattened over the last decade, but educational debt continues to increase significantly. At some point, graduates may give more weight to their educational debt when making career decisions, although the point at which this begins to happen is extremely difficult to predict. Over the past five years, applications to law schools have decreased significantly, as it has become common knowledge that the job market for lawyers has been significantly affected by the recent recession.^{3,4} In contrast, more than 94% of 2012 graduates of dental education programs report that they obtained a position within the field of dentistry at the time of graduation.⁵ If this number begins a downward trend, it may be an indication that a critical threshold has been reached and that further increases in dental school enrollment may not be advisable.

Recommended Actions by Taskforce

- Develop a robust information program by the ADA to help students be fully informed consumers about a career in dentistry, including workforce reports, debt, expected income, and financial planning.
- Continue with research efforts to better understand the factors affecting career choices, and collect better data (via the DAT, for example) on dental school applicants' knowledge about the

economics of the profession and their intended career choices, and track actual career choices using the DENTPIN as the identifier.

6. How many loan forgiveness programs are available to dental students? How effective are these programs in reducing student debt and improving access to care for the underserved?

Methods and Data

In an ADA interdivisional effort, the Health Policy Resources Center, the Office of Student Affairs, and the Division of Government and Public Affairs staff identified 59 loan repayment programs by combining resources from previous research initiatives with primary data collection (see Appendix E-List of Loan Repayment Programs). Telephone interviews were conducted with program representatives. Loan repayment programs were included if it was known that dentists were eligible. Thus, programs that only target other health professionals were not included in this research. Calls were placed in March and April 2013. Complete information for 52 of the 59 programs and partial information for all programs was gathered. Descriptive statistics were calculated for all program characteristics. These programs offer funds to offset student loan costs after graduation from dental school and are distinct from scholarship programs, which offer funding during education.

The loan repayment programs were classified into seven funding categories:

	Description
Military	Dentists working for the military, active-duty or Reserves.
Federal	Funded with federal dollars.
State	Funded with state dollars.
NHSC/State	Funded with a combination of National Health Service Corps and state dollars.
State with federal funding	Funded with a combination of state and federal dollars.
State with local matching	Funded with a combination of state and local/site dollars.
Private	Funded through private organizations.

At the time of analysis, complete data were not available from military programs. These are not included in the results below.

Key Findings

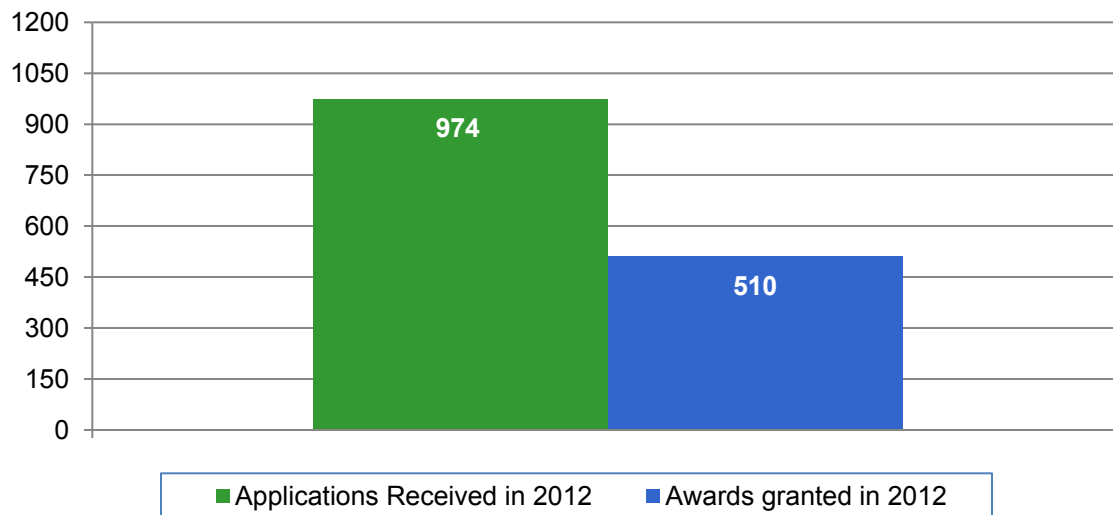
Overall, 59 programs offer loan repayment for dentists, with 1,615 dentist participants. Fifteen programs are for dentists only, and 44 are open to other health professions as well. The largest funding source category was NHSC/state (n=24). On average, these programs provide participants with \$97,278 in loan repayment funds over the course of their service. The breakdown of programs by funding source is seen in Table 1.

TABLE 1-Key Program Characteristics

	Number of programs	Number of dentists participating	Average maximum loan repayment
Military	5	NA	\$80,000
Federal	5	1,180	\$110,000
State	13	74	\$113,851
NHSC/State	24	141	\$87,158
State with federal funding	4	33	\$92,500
State with local matching	3	31	\$120,000
Private	5	156	\$101,667
TOTAL	59	1,615	\$97,278

The programs have more applications than accepted dentists. However, it is not clear if this indicated that programs are oversubscribed. There is no system in place to track multiple applications by the same dentists. For programs where data were available, the programs received a total of 974 applications from dentists in 2012 (46 programs) and accepted 510 dentists (48 programs) (See Table 2). There are two outliers with an unusually large number of applications: the Indian Health Services Loan Repayment Program (107 applications, all accepted) and the National Health Service Corps Loan Repayment Program (556 applications, 252 dentists accepted). Without including these outliers, seven applications per year are received per program and three dentists per year are accepted per program, on average. However, many program representatives commented that they were not overburdened with dentist applications and they would be happy to have more dentists apply. Indeed, many programs admitted all the dentists who applied in 2012. Representatives did not express opinions regarding reasons for low dentist application rates. In addition, further research is needed to determine whether dentists apply to multiple programs at the same time.

TABLE 2-Dentist Applications across Program Types



The majority of programs cannot predictably quantify the number of openings per application cycle. Typically, number of openings varies based on applications received and/or funding. However, for the 19 programs that do quantify openings, there were 263 spots available in 2012. There are three outliers with an unusually large number of openings: Alaska's Support-for-Service to Healthcare Practitioners – II (90 positions), the Michigan State Loan Repayment Program (33 positions), and the New York Primary Care Service Corps (30 positions). Without including these outliers, there are seven openings per program on average. Again, these are total openings, since openings are not earmarked for dentists. Obligations and repayment terms vary widely. The average service commitment is a minimum of 2 years and a maximum of 4 years. The average annual payment ranges from \$20,701 to \$35,809. The average maximum total compensation across the entire service obligation is \$97,278. Most programs do not allow participation after total debt is repaid and will not pay any amount greater than total debt. The majority of programs (92.3%) do not have debt level requirements for participation, but 41.2% of programs consider debt level when determining the amount of support provided. Method of payment was split evenly between direct payment against loan (48%) and payment to beneficiary with a requirement to document loan repayment (52%). Most programs require participants to take steps towards improving access to care for certain populations. The majority of programs have specific practice location requirements (e.g., federal or state HPSA, rural, etc.; 81.8%). Additionally, most programs require treatment of specific populations (e.g., Medicaid; 76.8%). Military programs are not included in these statistics, but military dentists are required to treat service members and their families, and they must be willing to re-locate.

Policy Implications

- There are approximately 1,700 dentists participating in loan forgiveness programs, most of which involve underserved areas or populations. This is less than 1% of practicing dentists, and is far below the estimate of almost 10,000 dentists needed in health professional shortage areas designated by HRSA. There is considerable opportunity to scale up loan repayment programs for dentists. The average annual amount of loan repayment ranges from a minimum of \$20,701 to a maximum of \$35,809.
- The existing slots could be oversubscribed – i.e. more dentists apply than are accepted – but the data do not allow for a full analysis. Nationally, there were 974 applications for 510 accepted dentists into various programs. This suggests that dentists are interested in taking up these

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programs; however, further research is needed to determine whether the same dentist applies to multiple programs.

- If more positions were allocated to dentists, this could increase the number of dentists working in underserved areas. Many program administrators expressed eagerness to enroll dentists into loan forgiveness programs. There is opportunity to expand the reach, potentially earmark more resources for dental slots within programs, and advocate for dentists to be eligible for programs for which they currently are not eligible.

Recommended Actions by Taskforce

- Advocate for more loan forgiveness programs for dentists at the state and federal levels
- Advocate for dentists to be eligible for all health professions loan forgiveness programs
- Advise existing loan repayment programs to increase dentist outreach and recruitment efforts
- Include information about loan repayment programs in educational efforts to help students be fully informed consumers about a career in dentistry.

7. What are dental schools doing in regards to teaching debt management and student loans?

Methods and Data:

To learn more about the student debt and personal financial management information that students receive while in schools, the ADA's Health Policy Resources Center conducted a web-based survey among three groups: all 2012 dental school graduates, all dental school deans, and all ASDA chapter leaders (see Appendix G-Web-based survey). E-mail invitations were sent to individuals in the sample (as described in Table 1 below) on April 8, 2013. Reminders were sent to non-respondents on April 11 and April 17. Data collection was cut off on May 2, 2013.

TABLE 1-Response Rate

	Sample size	Number of respondents	Adjusted response rate
2012 dental school graduates	4,957	681	15.0%
Dental school deans	64	30	46.9%
ASDA chapter leaders	63	23	36.5%

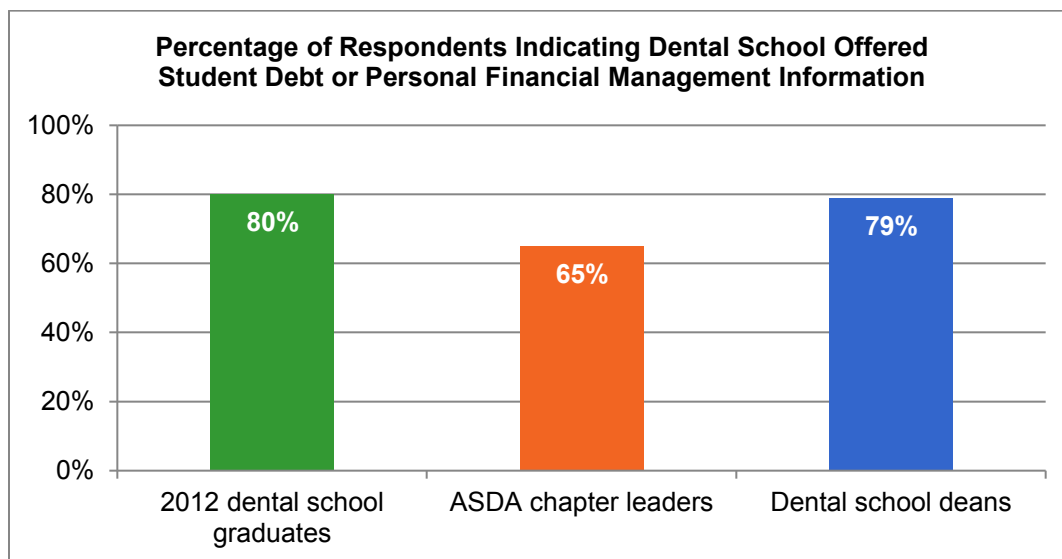
Please note that, while the response rate for dental school deans and ASDA chapter leaders was high, the low number of actual respondents invites caution when interpreting the results, as any additional response could have had a substantial impact on the final calculation. Nevertheless, the response rates are in the acceptable range for web-based surveys.

Key Findings:

Most dental schools offer student debt or personal financial management information; however, views varied widely among the three responding groups. Four in five 2012 dental school graduates (80%) indicated that their dental school offered student debt or personal financial management information.

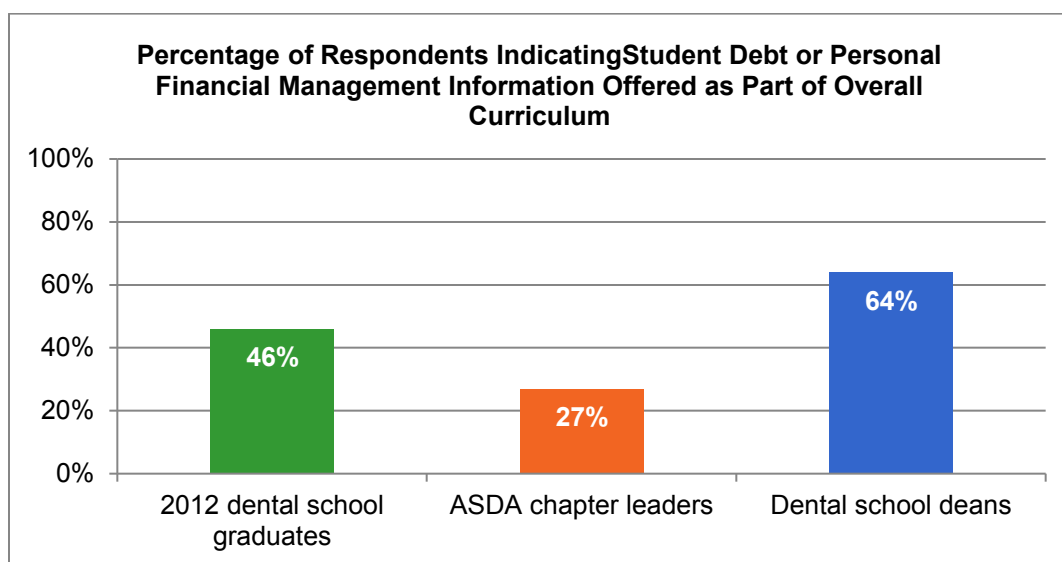
About the same percentage of responding dental school deans (79%) indicated so, while the percentage of responding ASDA chapter leaders was lower, 65% (See Table 2).

TABLE 2



Student debt or personal financial management information is not usually part of the curriculum, although views varied by group. While about two-thirds of responding dental school deans (64%) indicated so, a smaller proportion of 2012 dental school graduates (46%) and ASDA chapter leaders (27%) believed that the information was offered as part of the overall curriculum. This could be a true disconnect, or a result of the sampling, or a combination (See Table 3).

TABLE 3



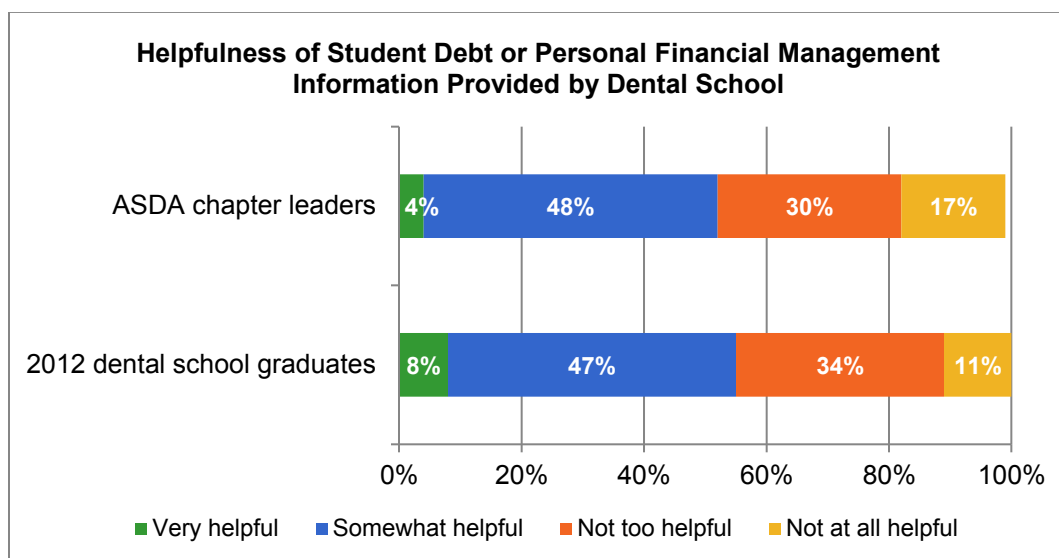
Among respondents who indicated that the information offered was part of the curriculum, between half and four-fifths, depending on the group of respondents, stated it was specifically part of a practice

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management curriculum (66% of 2012 dental school graduates, 50% of ASDA chapter leaders, and 79% of dental school deans.) Dental school students want student debt or personal financial management to be part of the curriculum. Respondents who indicated that the student debt or personal financial management information provided was not part of the school's overall curriculum were then asked, "Do you think your school should offer student debt or personal financial management information as part of the curriculum?" A majority of respondents in the group, 74% of 2012 graduates and 82% of ASDA chapter leaders, indicated that they thought student debt or personal financial management information should be part of the curriculum.

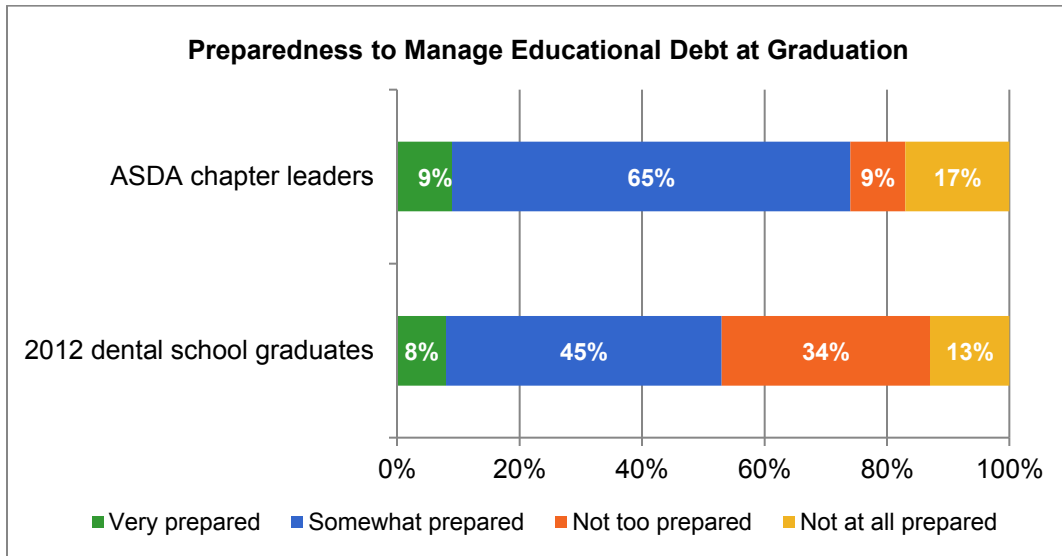
The majority of dental schools offer student debt or personal financial management support outside their curricula. Two-thirds of 2012 dental school graduates (67%) indicated so, compared to 4 in 5 ASDA chapter leaders (80%) and 73% of responding dental school deans. The most often cited examples of support offered outside the curriculum were lunch and learns, one-on-one discussions with a financial adviser, counseling provided by the financial aid department, and guest speakers. About half of 2012 dental school graduates and ASDA chapter leaders found the information provided by their dental school to be helpful (see Table 4). While just over half of 2012 dental school graduates (55%) and responding ASDA chapter leaders (52%) indicated the information was either "very" or "somewhat helpful," the remaining respondents (45% of 2012 graduates and 47% of ASDA chapter leaders) thought the information was either "not too helpful" or "not at all helpful."

TABLE 4



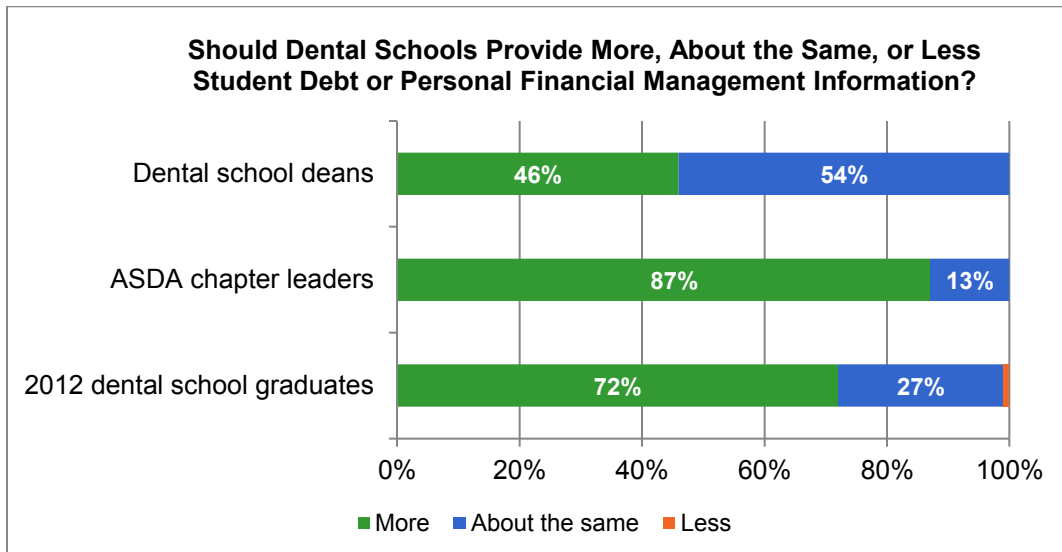
Almost half of 2012 dental school graduates (47%) did not feel prepared to manage their educational debt at graduation. Responding ASDA chapter leaders felt more positively, with only a quarter indicating they felt "not too prepared" or "not at all prepared" (please note that ASDA chapter leaders had not yet graduated at the time of the survey.) This could suggest a disconnect between how dental students feel in terms of their preparedness to manage their student debt, and how new graduates feel once they leave dental school and enter the profession (See Table 5).

TABLE 5



Dental school students want much more information on managing student debt and personal financial management. Deans' opinions on whether the school should provide more, about the same or less student debt or personal financial management information was different than that of 2012 dental school graduates and ASDA chapter leaders. While 46% of responding deans stated that the amount of information provided should increase, that percentage was much higher among 2012 dental school graduates (72%) and ASDA chapter leaders (87%) (See Table 6).

TABLE 6



Based on the survey findings, it appears that dental students and new graduates feel they need more information on the cost, expected debt load, and expected income of a dental career. Approximately 25% of 2012 dental school graduates provided further comments about the student debt or personal financial management information that they received from their dental school. This is a very high response rate for written comments, indicating that this is a major issue of interest among students and recent graduates. Most of the comments were on the high cost of dental education and the lack of information for making good decisions on managing their debt. There were also numerous comments on the attractiveness and rate of return to a dental education, and the disconnect between faculty and students. Below are a few examples:

"A time is coming when the cost versus benefits of entering this profession won't be in balance in the future. While in dental school, I didn't need the school to tell me to be financially responsible. I lived frugally but it was a drop in the bucket compared to the total cost of tuition and all the additional fees that I had no say over. The cost of educating a new dentist is way too high and new grads have to shoulder the burden of a bloated and overpriced educational program."

"After paying off loans for a year now, I realize how little I truly knew about the payback process. The school provided little information on payoff strategies. [The loan providers] have been horrible to work with. My husband (a dental classmate of mine) and I have been misled numerous times by them with 'policy changes,' payment plan selection, and more. The amount of student debt owed has postponed our practice purchase options."

"All we received was a 15-minute interview telling us how much we owed and IBR vs. traditional. Really? I just sunk \$300K into your institution and my education, and you give me 15 minutes?! A class on financial management should be offered by dental schools. We graduate drowning in debt, in a poor economy, and are then placed into high tax brackets for the rest of my life. Fifteen minutes hardly seems to be enough to prepare me for financial success. I am grateful for my education and love dentistry, but more financial education should be offered either from schools or from the ADA."

"Dental education is becoming horrendously expensive. Starting out, I had no CLUE how much debt I would have, or how it should be handled. More personalized financial outlook planning should be required at the outset of dental school. For example, any student who wants to borrow money should have to sit down with a human being and review real prospective numbers regarding how much he will borrow. The required 'financial counseling' offered by the government isn't informative enough."

"Reducing the cost of education is the solution. Mediocre advice from dental educators whom themselves have not suffered the burden of hundreds of thousands of dollars of debt is teetering on disrespectful."

"The cost of education for dental schools is out of control and still keeps climbing yearly. If this continues, students should be informed, by using the curriculum, about ways to manage their debt, so that they are prepared when they leave school. Students should be aware of their options so that no matter what job or continuing education avenue they pursue, they should be prepared and ready with numerous ways to handle their debt."

"This information should be made available to the students before they begin dental school. That way, they will know what they are getting themselves into financially. \$200,000.00+ in student loan debt is very difficult to manage and had I known the implications this debt was going to have on my life once I graduated I would have explored alternative means of paying for school. Now I find myself having to do a stint of public health for several years in order to make my student loan debt from dental school more manageable."

1 *"While my school provides classes on how to deal with the educational debt, it doesn't change the*
2 *fact that the amount of debt new dentists have is outrageous! Too many speakers and financial*
3 *professionals over inflate the earning potential of new graduates. The amount of debt is*
4 *unsustainable. The schools do not promote how severe it is to have that much debt when you get*
5 *out of school."*

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7 **Policy Implications:**

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- There is a need to make information on the rate of return of a dental career accessible to current and prospective students. Many dental students and new graduates do not have accurate information on the total cost, expected debt, and expected earnings associated with a career in dentistry. As a result, they are graduating and entering practice to find their expectations are not in line with reality.
 - There is a difference in perception between dental school deans and students regarding the need for more personal financial management resources. Dental school deans were much less likely to feel an urgent need for additional resources provided to students on how to manage student debt, and personal financial management in general. Dental students and new graduates felt that the resources provided to them were inadequate.

21 **Recommended Actions by the Taskforce:**

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- The ADA Health Policy Resources Center (HPRC), the Liaison Committee for Surveys and Reports, and the Center for Professional Success (CPS) develop a robust information portal via ADA.org to help students and prospective students be fully informed, financially literate consumers about a career in dentistry, including workforce forecasting reports, student debt, expected income, and life-long financial planning.
 - Encourage the ADA New Dentist Committee to continue to develop, expand, and market the ADA "SUCCESS" program to all dental schools. In addition, the Taskforce suggests that modules related to financial management be enhanced to address student concerns for more information in this subject area.
 - Urge the Commission on Dental Accreditation to revise the accreditation standards for dental education programs in the area of practice management to require debt and financial management information be included in all dental school curricula.

SUMMARY

Dentistry is experiencing the same trends in student loan debt as most other high-income professions. Dental school debt has increased over time due to increases in the cost of attending dental school. The rates of increase are in line with those experienced by other professional students (e.g., physicians, veterinarians). There is great variation in operating costs among schools, which can be attributed mostly to expenses associated with the number of full-time faculty and staff. As long as the “return on investment” allows students to pay off educational debt in a “reasonable” amount of time, the profession will continue to attract a large number of qualified applicants to fill the total number of available positions. Institutional setting (public versus private) does not seem to matter as a driver of overall revenue and overall expenses, particularly in recent years when financial support from states to their public universities has diminished. There have not been significant innovations in dental school models that notably reduce operating costs. The increased number and quality of applicants over the past fifteen years has allowed dental schools to increase tuition without adversely affecting enrollment. In addition, to some extent, dental schools have been able to increase enrollment without substantially increasing expenses. Overall, dental schools are currently financially sound.

Debt appears to have a small effect on some of dentists’ career decisions. The magnitude of the effect is very small compared to other factors such as gender and race. In regression models, students graduating with relatively large amounts of debt are more likely to plan on entering private practice, less likely to plan on completing advanced education, and less likely to plan on pursuing a government position. Debt levels do not have an impact on the likelihood of owning a practice. There is a difference in perception between dental school deans and students regarding the need for more personal financial management resources. Dental students and new graduates felt that the resources provided to them were inadequate.

Due to the limited number of students and residents available to provide treatment compared to the estimated total number of underserved patients, dental schools alone cannot “solve” the access-to-care problem, but they can be part of the solution. Most dental schools currently include off-campus clinical rotation sites such as Federally Qualified Health Centers (FQHC) for a portion of students’ clinical education. There are approximately 1,700 dentists participating in loan forgiveness programs, most of which involve underserved areas or populations. This is far below the estimate of almost 10,000 dentists needed in health professional shortage areas designated by HRSA. There are more applications for positions than there are positions available. The programs seem to be an effective strategy to improve access to care; however, the impact is limited by the small number of positions available.

The Taskforce concluded that the ADA can be most effective in addressing the student debt issue through a defined program of advocacy at the federal level and through development of a robust information portal to help current and prospective students be fully informed, financially literate consumers about a career in dentistry, including workforce forecasting reports, student debt, expected income, and life-long financial planning. Further, the results of this study suggest that a re-examination of the “dental education model” must be conducted to better prepare for the future, perhaps similar to the study conducted by the Institute of Medicine’s Committee on the Future of Dental Education in 1995. The Taskforce believes that such a study would require participation by dentistry’s broad communities of interest, with ADA and ADEA providing the most current data/analysis of dental education economics. On behalf of current and future members, ADA should have a leadership role, becoming a thought leader in the area of dental school financing, dental student debt, student loan interest rate reform, and the rate of return to a dental education.

RECOMMENDATIONS

8. What innovations could dental schools do, in collaboration with the American Dental Association, to reduce student debt?

The results of this report suggest that there are limited opportunities for dental school innovation that can directly decrease the cost of dental education, decrease the dental student debt burden, and solve the access to care issue. Innovations explored to reduce student debt loads included admitting students to dental education programs after the third year of undergraduate education; requiring the vast majority of basic sciences courses as prerequisites; and condensing the dental curriculum to less than four years. The limitations of each of these strategies (for instance, student maturity and readiness issues; difficulties in assessing the quality and rigor of prerequisite courses) outweigh the minor impact that might be realized through national implementation at all dental schools. None the less, the Taskforce believes that the ADA has a professional interest and obligation to support dental education and dental students by leading a collaborative effort in the following initiatives:

- The ADA advocacy agenda on behalf of dental education, dental students, and recent dental school graduates include:
 1. Dental school approval as Federally Qualified Health Centers (FQHC) or ability to partner with FQHC's.
 2. Graduate Medical Education (GME) funding for non-hospital-based programs (i.e., dental schools).
 3. Increased Medicaid fees and cost-based reimbursement for dental schools.
 4. Increased number of loan forgiveness programs at the state and national level, including additional debt relief programs targeting rural/underserved areas.
 5. Financial incentives to practice permanently in underserved areas through supplemental payments or tax credits.
 6. Increased eligibility for dental graduates for all health profession loan forgiveness programs
 7. Student loan interest rate reform.
- The ADA Health Policy Resources Center (HPRC), the ADA/ADEA/CODA Liaison Committee for Surveys and Reports, and the Center for Professional Success (CPS), in collaboration with the communities of interest, develop a robust information portal via ADA.org to help current and prospective students be fully informed, financially literate consumers about a career in dentistry, including workforce forecasting reports, student debt, expected income, life-long financial planning, and a central registry of all loan/tuition relief programs.
- The ADA Health Policy Resources Center (HPRC), in preparation for the future of the profession and reexamination of the dental education model, expand its research efforts in the area of dental education financing, the impact of student debt and other factors on career choices in order to better position the ADA as a thought leader and knowledge broker in this area and to strengthen advocacy efforts.
- The ADA, in collaboration with the broad communities of interest, conduct a comprehensive study of the current dental education model, to include:
 1. Evaluation of the sustainability of dental school finances.
 2. Evaluation of all the current dental school curricula.
 3. Analysis of the competency and outcomes-based educational model.
 4. Analysis of dental school outcomes data.
 5. Analysis on the impact of student debt on career and practice choices.

6. A determination of whether students are being adequately prepared for the practice of dentistry.
 7. A determination of whether dental schools that are opening in non-traditional academic health centers are meeting the appropriate level of scholarship to ensure that dentistry continues to be a learned profession.
- The New Dentist Committee enhance the ADA Success Program to include more content related to personal debt management and financial planning.
 - The Commission on Dental Accreditation be urged to revise the Accreditation Standards for Dental Education Programs related to practice management to include instruction on personal debt management and financial planning.

APPENDICES

Appendix A-Debt Trend Literature Review

Appendix B-Dental School Finances

Appendix C-Community-Based Dental Education

Appendix D-Dental Safety Net

Appendix E-Employment Choices

Appendix F- List of Loan Repayment Programs

Appendix G-Web-based Survey

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Appendix C

Program Length and Experience in Extramural Facilities/Community-Based Dental Education (CBDE)(in weeks), 2011-12

	1st Yr Total	1st Yr CBDE	2nd Yr Total	2nd Yr CBDE	3rd Yr Total	3rd Yr CBDE	4th Yr Total	4th Yr CBDE	Total Length	Total CBDE
National Average	39.6	0.4	42.1	0.4	43.8	1.7	39.0	5.9	163.5	8.2
<i>Percentage</i>		<i>0.9%</i>		<i>1.0%</i>		<i>3.8%</i>		<i>15.1%</i>		<i>5.0%</i>
Maximum	50	8	48	8	52	8	48	33	192	33
Minimum	30	0	30	0	36	0	28	0	132	0
Median	40	0	43	0	44	1	40.5	4	164	6

Source: American Dental Association, Survey Center, *Surveys of Dental Education 2011-2012* (Group I)

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Repayment of program	Name of Program	Funding source	Are only dentists eligible (yes/no)	How many openings per application cycle?	How many dentists applied to the program in 2012	How many dentists were accepted into the program in 2012	How many health care professionals are currently in the program	Minimum length of service for dentists: # yrs	Maximum length of service for dentists: # yrs	Minimum amount of financial support per year for dentists: \$	Maximum amount of financial support per year for dentists: \$	Maximum total support across service obligation	Average amount of financial support per year for dentists: \$	Is there a maximum educational debt level required to be eligible for the program (yes/no)	Does the amount of financial support depend on educational debt level (yes/no)	Is there a requirement to provide care in a specific geographic area of need (e.g. HPSA) (yes/no)	Is there a requirement to provide care to specific population groups? If so, list (yes/no)	Are payments made directly against an account or is cash paid directly to the beneficiary? (loan accounts)	Contact person	Email	Phone	NOTES	Center			
Military	Active Duty Health Professions Loan Repayment Program (ADHPLRP)																									
	ARMY	Military	No	varies					2	8		\$40,000	\$120,000		No	No	No	No	Against loan					Must be active-duty	AO	
	AIR FORCE	Military	No	varies												No	No	No	Against loan	Patricia Faustman	Patricia.Faustman.af@af.mil			AO		
	NAVY	Military	No	varies					2	4		\$40,000		NA	No	No	No	No	Against loan	David Hartleb, Sandra Yehes	David.h.hartleb@med.navy.mil, sandra.yehes@med.navy.mil			AO		
	Reserve HPLRP	Military	No	varies	6	6	18	117	2	4	Balance	\$40,000	\$160,000	NA	No	No	No	No	Against loan	Ken Klusa	keneth.klusa.1@us.af.mil		Reserve member version of ADHPLRP	AO		
	Army National Guard SLRP	Military	No	varies by state					6				\$50,000			No	No	No	Against loan			1-800-454-8273		National Guard version of ADHPLRP	AO	
National	Indian Health Service Loan Repayment Program (IHSLRP)	Federal	No	varies	107	107	1227	143	2	Unltd repayment	Balance	\$24,000	Total debt	NA	No	Yes	Yes	Yes	Beneficiary	Timothy Lorton	Timothy.Lorton@hhs.gov	(201) 443-2486		Get dentist info from ADA statement re: HHS	AO	
	National Health Service Corps Loan Repayment Program (NHSCSLRP)	Federal	No	varies	556	262	8634	1037	2	4	\$10,000	\$60,000	\$100,000	NA	No	No	Yes	Yes	NA	Renae Jackson	rsjohnson@nhsa.gov	301-443-6769		Must be a general or pediatric dentist. Payment amount is tied to the HPSA "score" (two-tiered system, sites with lower scores pay less). May not receive more funds than debt	AO	
	Veterans Affairs Education Debt Reduction Program (EDRP)	Federal	No																	Sylvia Delta		501-257-4556		Must be working at a VHA facility. Details available through VHA facility HR departments.	AO	
	VA Student Loan Repayment Program (VSLRP)	Federal	No										\$10,000	\$60,000						Sylvia Delta		501-257-4556		"	AO	
			Federal	No	varies	NA	NA	NA	NA	2	Unltd repayment	Balance	\$35,000	Total debt	NA	Yes	Yes	No	No	Against loan	Shelly Tringali		866-846-4547		Specifically for RESEARCH (at least 20 hours per week) in any of the following areas: clinical, pediatric, health disparities, or clinical research for individuals from disadvantaged backgrounds. you must have total qualified educational debt equal to or in excess of 20 percent of your institutional base salary at the time of award.	AO
State-based	AK Support-for-Service-to-Healthcare-Practitioners (SHARP) SHARP-I	NHSC/State	No	3	3	2	74	8	2	NA	NA	\$35,000	\$70,000		NA	No	No	Yes	Yes	Against Loan	Robert Sewell	robert.sewell@alaska.gov	907-465-4565			SZ
	Support-for-Service-to-Healthcare-Practitioners (SHARP) SHARP-II	State	No	90	12				3	6	NA	\$47,000	\$141,000	NA	NA	NA	Yes	No	Either	Robert Sewell	robert.sewell@alaska.gov	907-465-4566		SHARP II is a new program with solicitations now in progress therefore most of this information is not available	SZ	
AZ	Arizona Loan Repayment Program	NHSC/State	No	varies	2	2	13	2	2	4	\$32,000	\$60,000	\$87,000	NA	No	No	Yes	Yes	Against loan	Anna Ricciardi	anna.riicardi@azdhs.gov	602-542-1066			SZ	
CA	California Health Professions Loan Repayment Program	State	No	varies	1	0	29	0	2	2	\$10,000	\$10,000	\$20,000	NA	No	No	Yes	Yes	Beneficiary	Meaghan Harrington	meaghan.harrington@calhnp.ca.gov	(916) 326-3654			SZ	
	California State Loan Repayment Program	NHSC/State	No	varies	2	2	204	13	2	NA	NA	\$60,000	\$140,000	NA	NA	No	Yes	No	Beneficiary	Monique Voss	monique.voss@calhnp.ca.gov	916-326-3745			SZ	
CO	Colorado Health Service Corps	NHSC/State	No	varies	39	9	146	15	3	4	NA	\$33,333	\$100,000	NA	No	No	Yes	Yes	Beneficiary	Rich Marquez, Workforce Planner	richard.marquez@state.co.us	303-691-4916		Must work at least 40 hours per week	SZ	
	Expanded Dental Loan Repayment Program	State	Yes	varies	NA	3	3	3	2	2	NA				NA	No	Yes	Yes	Beneficiary	Rich Marquez, Workforce Planner	richard.marquez@state.co.us	303-691-4916		No limited work hours	SZ	
DE	Delaware State Loan Repayment Program	NHSC/State	No	unlimited	4	0	24	5	1	3	\$21,000	\$35,000	\$105,000	NA	No	No	Yes	Yes	Against loan	Ruben Lawrence	Ruben.Lawrence@state.de.us	302-759-2750			SZ	
DC	DC Health Professional Loan Repayment Program	NHSC/State	No	varies	2	2	39	5	2	4	NA	\$61,229		NA	No	Yes	Yes	Yes	Beneficiary	Lauren Ratner	lauren.ratner@dc.gov	202-442-6950			SZ	
IL	Illinois State Loan Repayment Program	NHSC/State	No	varies	NA		40	10	2	4	\$25,000	\$25,000	\$50,000	NA	No	No	Yes	Yes	Beneficiary	John Casper	john.casper@illinois.gov	217-762-1624			SZ	
IA	Iowa Loan Repayment Program	State	No	varies	3	0	16	1	2	Unltd repayment	NA	\$50,000	\$100,000	NA	No	No	Yes	Yes	Against loan	Sara Schriener	sara.schriener@iowadhs.gov	515-281-7630			SZ	
KS	Kansas State Loan Repayment Program	NHSC/State	No	varies	1	1	17	4	2	Unltd repayment	NA	\$30,000	Total debt	\$30,000	No	No	Yes	Yes	Beneficiary	Barbara Huske	bhuske@ksdhs.gov	785-296-2742		Employment must be with a public or non-profit private agency or facility.	SZ	
KY	Kentucky State Loan Repayment Program	NHSC/State	No	varies	0	0	10	2	2	Unltd repayment	NA	\$35,000	Varies	NA	No	No	Yes	Yes	Beneficiary	Larry Allen	lallen@ky.edu	606-493-5577/6933		50/50 match loan requirement for qualified educational loans	SZ	
LA	Louisiana State Loan Repayment Program	NHSC/State	No	varies	2	1	6	6	5	2	7	NA	\$30,000		NA	No	No	Yes	Yes	Beneficiary	Dore Thurlady	dore.thurlady@la.gov	225-342-1593		Must have a sliding fee scale for low income patients	SZ
ME	Maine Dental Education Loan Repayment Program	State	Yes	varies	4	4	13	13	2	4	\$20,000	\$80,000		NA	Yes	No	Yes	Yes	Beneficiary	Claude Roy	croy@mainedental.com	NA			SZ	
MD	Maryland Dent-Care Loan Assistance Repayment Program (MDC-LARP) for Dentists	State	Yes	5	22	5	14	14	3	NA	\$23,470	\$71,220	\$213,660	NA	No	Yes	Yes	NA	NA	Harry Goodman	harry.goodman@maryland.gov, healthmdd@dmh.state.md.us	410-767-5942		Must treat a minimum 30% MMAP-recipients as a portion of the total patient population	SZ	
MA	Massachusetts State Loan Repayment Program (MSLRP) for Dental Professionals	NHSC/State	Yes	varies	5	5	56	8	2	4	NA	\$50,000	\$100,000	\$50,000	Yes	Yes	Yes	Yes	Beneficiary	Julia Dyck/Nicole Watson	julia.dyck@state.ma.us,nicole.watson@state.ma.us	617-624-5224		May not receive more funding than debt	SZ	
MI	Michigan State Loan Repayment Program (MSLRP)	NHSC/State	No	30	3	1	60		2	4	\$25,000	\$35,000	\$140,000	\$25,000	No	Yes	Yes	Yes	Beneficiary	Ken Miller	kenmiller@mihs.gov	(317) 241-9446			SZ	
MN	Minnesota State Loan Repayment Program (SLRP)	NHSC/State	No	5	1	2	11	2	2	4	\$20,000	\$30,000	\$60,000	\$30,000	No	Yes	Yes	Yes	Beneficiary	Debra Jahnes	debra.jahnes@state.mn.us	651-261-2645		Award cannot exceed debt	AO	
	Minnesota Dental Loan Forgiveness Program	State	Yes	1	7	1	6	6	3	4	NA	\$25,000	\$100,000	NA	NA	No	Yes	Yes	Beneficiary	Monique Samaha	monique.samaha@state.mn.us	651-201-3870		Licensed dentists who are seeing 25 percent public program patients are eligible to apply. students and residents in their final year of training receive highest preference	AO	
MS	Dental Loan Repayment Program	State w/federal	No	10	12	9	9	9	3	6	NA	\$40,000	\$120,000	\$40,000	Yes	No	Yes	Yes	Beneficiary	Myrle Small	smallm@nhsa.com	601-881-1817		Correct person	AO	
MO	Missouri Health Professional Loan Repayment Program	NHSC/State	No	10	3	1	19	2	2	Unltd repayment	NA	\$25,000	\$50,000	NA	No	No	Yes	Yes	Beneficiary	Terry Widenstam	ben.harvey@health.mo.gov	800-891-7415		May not receive more funding than debt	AO	
MT	Montana State Loan Repayment Program	NHSC/State	No	15	0	0	15	0	2	2	Balance	\$15,000	\$30,000	NA	No	No	Yes	Yes	Against loan	Lisa Benzel	lisa@mta.org	(406) 683-2790		No funding available at this time but they do have a stack of applications that they will go through pending re-funding. They are hopeful that they will get re-funded.	AO	
NE	Nebraska Loan Repayment Programs	State w/ local matching	No	NA	NA	9	87	9	3	3	NA	\$40,000	\$120,000	NA	No	No	Yes	Yes	Against loan	Marlene Janssen	marlene.janssen@nebraska.gov	402-471-0148		Award varies based on debt load and available funds. Blank spaces were refused by Ms. Janssen	AO	
NV	Nevada Health Service Corps	NHSC/State	No	varies	1	1		0	2	2	NA	\$40,000		NA	No	No	Yes	Yes	Beneficiary	Keith Clark	keithc@nvhealthservice.nv.gov	775-738-3828			AO	
NH	New Hampshire State Loan Repayment Program	State	No	unlimited	3	3		3	2	5	\$13,750	\$25,000	\$115,000	NA	No	No	Yes	Yes	Beneficiary	David Roberts	davidr@nhstate.nh.us	603-271-2276		\$75,000 for three years full-time plus possible 2-year extension at \$40,000; \$27,500 for two years part-time plus possible 1-yr extension at \$10,000	AO	
NJ	Primary Care Loan Redemption Program	NHSC/State	No	rolling	16	10	24	2	4		\$26,000	\$33,690	\$120,000	NA	No	Yes	Yes	Yes	Against loan	Sharon Bryant	bryant@njmhi.edu	973-972-4605		Support varies by year, see email	AO	
NM	Health Professional Loan Repayment Program	State	No	varies	15	4		7	2	Unltd repayment		\$35,000	Total debt		No	Yes	Yes	Yes	Against loan	Heather Romero	heather.romero@state.nm.us	505-476-8410			AO	
NY	Primary Care Service Corps	NHSC/State	No	33	new	new	new	new	2	5	50% of total debt	\$32,500	\$150,000	NA	No	Yes	Yes	Yes	Beneficiary	Cathy Wistar	cwist1@health.state.ny.us	516-473-7919		New program this year.	AO	
	The Dental Loan Repayment Program	NHSC/State	Yes	3	9	3	12	12	4	4		\$20,000	\$60,000	NA	No	Yes	Yes	Yes	Beneficiary	Gary Cleveland	gcleveland@state.ny.us	716-328-4839		Amount paid will not exceed debt level	AO	
OK	Oklahoma Dental Loan Repayment Program	State	Yes	varies	12	5	5	5	2	4	\$25,000	\$35,000	\$120,000	NA	No	Yes	Yes	Yes	Against loan	Sandy Brado	sandy.brado@okdhs.gov	330-643-1301			AO	
OR	Oregon Partnership Loan Repayment Program	State w/ local matching	No	varies	5	7	15	2	5	15	\$25,000	\$125,000	\$50,000	NA	No	No	Yes	Yes	Against loan	Sandy Brado	sandy.brado@okdhs.gov	330-643-1301		May not receive more funding than debt	AO	
	Oregon Partnership Loan Repayment Program	State w/ local matching	No	varies	1	1	8	1	2	5	25% of total debt	\$35,000		\$30,000	No	Yes	No	Beneficiary	Julie Heller	heller@oregon.gov	503-344-4400			AO		
PA	Pennsylvania Primary Health Care Practitioner Loan Repayment Program	NHSC/State	No	10	0	0	39	4	3	4	Balance	varies	\$64,000	NA	No	Yes	Yes	Yes	Against loan	Jacquelyn Holbert	jholbert@pa.gov	717-772-6268		May not receive more funding than debt; different discount rates paid per year (see handout)	AO	
RI	Rhode Island Dental Education Loan Repayment Program	NHSC/State	No	6	12	4	5	4	2	2		\$25,000		NA	No	Yes	Yes	Yes	Against loan	Carl Walker	walker@rihsa.com	401-488-1737		May not receive more funding than debt	AO	
SD	Recruitment Assistance Program	State	Yes	5	1	1	3	3	3	25% of total contract	75% of total contract	Varies	NA	NA	No	NA	No	Yes	Beneficiary	Joak Peterson	joak.peterson@state.sd.us	605-773-3517		Technically this is a RECRUITMENT program, not a loan repayment program.	AO	
TN	Tennessee State Loan Repayment Program	NHSC/State	No	varies	30	4	21	21	3	2	5	\$30,000	\$40,000	\$100,000	NA	No	Yes	Yes	Against loan	Angie Allen	angie.allen@tn.gov	615-743-6226		Maximum loan repayment amounts are \$60,000 for an initial two-year award and \$40,000 for extensions	AO	
VT	Vermont Educational Loan Repayment Program for Dentists	State w/ local matching	Yes	varies	30	4	21	21	1	6	NA	\$20,000	\$100,000	NA	No	No	Yes	Yes	Against loan	Elizabeth Cole	elizabeth.cole@vermont.edu	(802) 656-0030			AO	
VA	Virginia Dental Loan Repayment Program	State w/federal	Yes	4	13	13																				

Appendix G

2013 Student Debt Management Survey

Did/does your dental school offer students debt or personal financial management information (that goes above and beyond federal requirements for student loans)?

Was/is the student debt or personal financial management information provided part of the school's overall curriculum?

More specifically, was/is the student debt or personal financial management information provided part of your practice management curriculum?

Do you think your school should/does your school offer student debt or personal financial management information as part of the curriculum?

Did/does your school offer student debt or practice financial management support outside the curriculum?

Please describe what type of additional student debt or personal financial management support was/is offered (outside the curriculum):

How helpful was/is the information provided by your dental school on student debt or personal financial management? (grads and ASDA only)

How prepared did/do you feel to manage your educational debt when you graduate(d)? (grads and ASDA only)

Do you believe your dental school should provide more, about the same, or less student debt or personal financial management information than it currently offers/offered to you and your classmates?

Any comments about the student debt or personal financial management information your dental school provided to its students/you and your classmates?

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² McFarland, K, Reinhardt, J, Yaseen, M. Rural dentists: Does growing up in a small community matter? *JADA* 2012; 143(9):1013-1019.

³ Harper Steven J. Pop Goes the Law. *The Chronicle Review*; March 15, 2013.

⁴ Mangan, Katherine. Law Schools Confront "New Normal" in Job Market. *The Chronicle of Higher Education*; January 6, 2013.

⁵ 2011-2012 Survey of Dental Education-Academic Programs, Enrollment, and Graduates-Volume 1; unpublished data.

Resolution No. 53 NewReport: Board Report 13 Date Submitted: August 2013Submitted By: Board of TrusteesReference Committee: Dental Education, Science and Related MattersTotal Net Financial Implication: None Net Dues Impact: Amount One-time Amount On-going FTE 0ADA Strategic Plan Goal: Collaboration (Required)1 **ADA ADVOCACY AGENDA**2 **Background:** (Board Report 13, Worksheet: 3036)3 **Resolution**4 **53. Resolved,** that the ADA advocacy agenda on behalf of dental education, dental students,
5 and recent dental school graduates include:

- 6 1. Dental school approval as Federally Qualified Health Centers (FQHC) or ability to
7 partner with FQHC's.
- 8 2. Graduate Medical Education (GME) funding for non-hospital-based programs (i.e.,
9 dental schools).
- 10 3. Increased Medicaid fees and cost-based reimbursement for dental schools.
- 11 4. Increased number of loan forgiveness programs at the state and national level,
12 including additional debt relief programs targeting rural/underserved areas.
- 13 5. Financial incentives to practice permanently in underserved areas through
14 supplemental payments or tax credits.
- 15 6. Increased eligibility for dental graduates for all health profession loan forgiveness
16 programs
- 17 7. Student loan interest rate reform.

18

19 **BOARD RECOMMENDATION: Vote Yes.**20 **BOARD VOTE: UNANIMOUS**

Resolution No. 53S-1 NewReport: NA Date Submitted: October 2013Submitted By: Ninth DistrictReference Committee: Dental Education, Science and Related MattersTotal Net Financial Implication: None Net Dues Impact: Amount One-time Amount On-going FTE 0ADA Strategic Plan Goal: Members (Required)

SUBSTITUTE FOR RESOLUTION 53: ADA ADVOCACY AGENDA

The following substitute for Resolution 53 (Worksheet: 3078) was submitted by the Ninth Trustee District and transmitted on October 17, 2013, by Ms. Michelle Nichols-Cruz, Board and House Administrator, Michigan Dental Association.

Background: Substitute Resolution 53S-1 is being proposed to best position ADA advocacy efforts in areas most likely to achieve success.

Bullet 1

By current guidelines, dental school approval as a Federally Qualified Health Center cannot be accomplished. FQHC guidelines require an institution to provide the full scope of services - scope including medical, dental, and mental health services. Dental schools, by definition, do not provide the full scope of FQHC services.

Bullet 2

HRSA makes grants to organizations to improve and expand health care access and services for the underserved, focusing on the following program areas: Health Professions | HIV/AIDS | Maternal & Child Health | Office of the Administrator | Primary Health Care/Health Centers | Rural Health | Healthcare Systems | Organ Donation.

The addition of HRSA as a funding agency, in addition to the Centers for Medicaid and Medicare Services (CMS) which provides the GME funding, is most appropriate due to the fact that subsequent to health care reform, increasingly greater numbers of community based clinical funding opportunities will be offered through HRSA.

Bullet 3

Intergovernmental transfers (IGTs) are tools used to increase state Medicaid reimbursement rates by enhancing federal financial participation. Many states (Arizona, California, Colorado, Florida, Iowa, Kansas, Michigan, Minnesota, Missouri, New Hampshire, New Jersey, New York, North Carolina, Pennsylvania, Washington, Wisconsin) have turned to IGTs as the best strategy to raise their state Medicaid shares.

IGTs are exchanges of public funds between different levels of government and are a common feature in state finance. In the early 1990s, many states began to use IGTs as a way to leverage federal Medicaid dollars to continue or expand coverage of services or to pay higher reimbursement rates to providers. The transfer of funds may take place from one level of government to another (i.e., counties to states) or

within the same level of government (i.e., from a state university hospital to the state Medicaid agency). Thus, states can use county or state expenditures to generate a federal match for enhanced support.

In some cases, states have required local government providers (e.g., county-run nursing homes or municipal hospitals) to transfer back to the state some or all of the enhanced federal Medicaid funds originally paid to those providers. States have used these transferred funds for Medicaid or for other purposes such as to fill state budget shortfalls for other programs or to draw down additional federal Medicaid dollars.

Resolution

(Additions underscored; deletions stricken through)

53S-1. Resolved, that the ADA advocacy agenda on behalf of dental education, dental students, and recent dental school graduates include:

- ~~Dental school approval as Federally Qualified Health Centers (FQHC) or~~ The ability of dental schools to partner with FQHC's.
- Graduate Medical Education (GME) and Health Resources and Services Administration (HRSA) funding for non-hospital-based programs (i.e., dental schools).
- Increased Medicaid fees and cost-based reimbursement for dental schools, and the use of intergovernmental transfers for enhanced Medicaid reimbursement.
- Increased number of, and funding levels for, loan forgiveness programs at the state and national level, including additional debt relief programs targeting rural/underserved areas.
- Financial incentives to practice ~~permanently~~ long term in underserved areas through supplemental payments or tax credits.
- Increased eligibility for dental graduates for all health profession loan forgiveness programs
- Student loan interest rate reform.

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

Resolution No. 54 NewReport: Board Report 13 Date Submitted: August 2013Submitted By: Board of TrusteesReference Committee: Dental Education, Science and Related MattersTotal Net Financial Implication: \$25,000 + \$64,000 Net Dues Impact: _____Amount One-time \$25,000 Amount On-going \$64,000 FTE Total .5ADA Strategic Plan Goal: Collaboration (Required)1 **DEVELOPMENT OF A ROBUST INFORMATION PORTAL**2 **Background:** (Board Report 13, Worksheet: 3036)3 **Resolution**

4 **54. Resolved,** that the ADA Health Policy Resources Center (HPRC), the ADA/ADEA/CODA Liaison
 5 Committee for Surveys and Reports, and the Center for Professional Success (CPS) in collaboration
 6 with the communities of interest develop and promote a robust information portal via ADA.org to help
 7 current and prospective students be fully informed, financially literate consumers about a career in
 8 dentistry, including workforce forecasting reports, student debt, expected income, life-long financial
 9 planning, and a central registry of all loan/tuition relief programs.

10

11 **BOARD RECOMMENDATION: Vote Yes.**12 **Vote: Resolution 54**

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. 54S-1 SubstituteReport: Board Report 13 Date Submitted: October 2013Submitted By: First Trustee DistrictReference Committee: Dental Education, Science and Related MattersTotal Net Financial Implication: None Net Dues Impact: _____Amount One-time _____ Amount On-going _____ FTE 0ADA Strategic Plan Goal: Collaboration (Required)

**SUBSTITUTE FOR RESOLUTION 54:
DEVELOPMENT OF A ROBUST INFORMATION PORTAL**

The following substitute to Resolution 54 (Worksheet: 3079) was submitted by the First Trustee District and transmitted on October 23, 2013, by Dr. Judith M. Fisch, First District Caucus Chair.

Resolution

(Additions underscored; deletions stricken through)

54S-1. Resolved, that the ~~ADA Health Policy Resources Center (HPRC), the ADA/ADEA/CODA Liaison Committee for Surveys and Reports, and the Center for Professional Success (CPS)~~ appropriate agencies of the ADA in collaboration with the communities of interest develop and promote a robust information portal via ADA.org to help current and prospective students be fully informed, financially literate consumers about a career in dentistry, ~~including workforce forecasting reports, student debt, expected income, life-long financial planning, and a central registry of all loan/tuition relief programs.~~

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

Resolution No. 55 NewReport: Board Report 13 Date Submitted: August 2013Submitted By: Board of TrusteesReference Committee: Dental Education, Science and Related MattersTotal Net Financial Implication: \$112,000 Net Dues Impact: \$1.02Amount One-time 0 Amount On-going \$112,000 FTE 1ADA Strategic Plan Goal: Collaboration (Required)**EXPANDING RESEARCH EFFORTS IN THE AREA OF DENTAL EDUCATION FINANCING****Background:** (Board Report 13, Worksheet: 3036)**Resolution**

55. Resolved, that the ADA Health Policy Resources Center (HPRC), in preparation for the future of the profession and reexamination of the dental education model, expand its research efforts in the area of dental education financing, the impact of student debt and other factors on career choices in order to better position the ADA as a thought leader and knowledge broker in this area and to strengthen advocacy efforts.

BOARD RECOMMENDATION: Vote Yes.**Vote: Resolution 55**

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

Resolution No. 56 NewReport: Board Report 13 Date Submitted: August 2013Submitted By: Board of TrusteesReference Committee: Dental Education, Science and Related MattersTotal Net Financial Implication: \$80,000 Net Dues Impact: .80Amount One-time Amount On-going 0 FTE 0ADA Strategic Plan Goal: Collaboration (Required)**A COMPREHENSIVE STUDY OF THE CURRENT DENTAL EDUCATION MODEL****Background:** (Board Report 13, Worksheet: 3036)**Resolution****56. Resolved**, that the ADA seek collaboration with the broad communities of interest to conduct a comprehensive study of the current dental education model, to include:

1. Evaluation of the sustainability of dental school finances.
2. Evaluation of all the current dental school curricula.
3. Analysis of the competency and outcomes-based educational model.
4. Analysis of dental school outcomes data.
5. Analysis on the impact of student debt on career and practice choices.
6. A determination of whether students are being adequately prepared for the practice of dentistry.
7. A determination of whether dental schools that are opening in non-traditional academic health centers are meeting the appropriate level of scholarship to ensure that dentistry continues to be a learned profession;

and be it further

Resolved, that the ADA's financial implication for this resolution shall not exceed \$80,000, to be used to identify funding sources for the study; write grant proposals; coordinate conference calls; hire a consultant to do a literature review; and provide funds for one in-person stakeholder meeting, and be it further**Resolved**, that funding (estimated to be \$1,156,000) be raised from outside sources within a two year period in order for the study to proceed.

1 BOARD RECOMMENDATION: Vote Yes.**2 Vote: Resolution 56**

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

Oct. 2013-H

Resolution No. 56S-1 SubstituteReport: Board Report 13 Date Submitted: October 2013Submitted By: Sixteenth Trustee DistrictReference Committee: Dental Education, Science and Related MattersTotal Net Financial Implication: \$80,000 Net Dues Impact: .80Amount One-time Amount On-going 0 FTE 0ADA Strategic Plan Goal: Collaboration (Required)

**SUBSTITUTE FOR RESOLUTION 56:
A COMPREHENSIVE STUDY OF THE CURRENT DENTAL EDUCATION MODEL**

The following substitute for Resolution 56 (Worksheet: 3081) was submitted by the Sixteenth Trustee District and transmitted on October 16, 2013, by Mr. Phil Latham, executive director, South Carolina Dental Association.

Resolution

(Additions underscored; deletions stricken through)

56S-1. Resolved, that the ADA seek collaboration with ~~the~~ broad communities of interest, including dental educators, students, practicing dentists, health economists, and others with appropriate expertise to conduct a define the scope and specific aims of a ~~comprehensive study of the current dental education models, to include:~~

1. Evaluation of the long-term sustainability of dental schools finances.
2. Evaluation of ~~all~~ the efficiency of the current dental school curricula and delivery methods.
3. Analysis of the impact of student debt on dentistry as a career choice and subsequent practice choices competency and outcomes based educational model.
4. ~~Analysis of dental school outcomes data.~~
5. ~~Analysis on the impact of student debt on career and practice choices.~~
6. ~~A determination of whether students are being adequately prepared for the practice of dentistry.~~
7. 4. A determination of whether dental schools that are opening in non-traditional academic health centers are meeting the appropriate level of scholarship to ensure that dentistry continues to be a learned profession;

and be it further

Resolved, that the ADA's financial implication for this resolution shall not exceed \$80,000, to be used to define the scope and specific aims of the study, to determine the estimated cost of the study, to identify potential funding sources for the study, and to report to the 2014 ADA House of Delegates. ~~identify funding sources for the study; write grant proposals; coordinate conference calls; hire a consultant to do a literature review; and provide funds for one in-person stakeholder meeting, and be it further~~

Resolved, that funding ~~(estimated to be \$1,156,000)~~ be raised from outside sources within a two year period in order for the study to proceed.

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

Resolution No. 57 NewReport: Board Report 13 Date Submitted: August 2013Submitted By: Board of TrusteesReference Committee: Dental Education, Science and Related MattersTotal Net Financial Implication: None Net Dues Impact: Amount One-time Amount On-going FTE 0ADA Strategic Plan Goal: Collaboration (Required)**1 REVISION OF ACCREDITATION STANDARDS****2 Background:** (Board Report 13, Worksheet: 3036)**3 Resolution**

4 57. Resolved, that the Commission on Dental Accreditation be urged to revise the Accreditation
5 Standards for Dental Education Programs related to practice management to include instruction on
6 personal debt management and financial planning.

7**8 BOARD RECOMMENDATION: Vote Yes.****9 BOARD VOTE: UNANIMOUS**

Resolution 56H-2013 Comprehensive Study of the Current Dental Education Model

56H-2013. Resolved, that the ADA seek collaboration with broad communities of interest, including dental educators, students, practicing dentists, health economists, and others with appropriate expertise to define the scope and specific aims of a comprehensive study of current dental education models, to include:

1. Evaluation of the long-term sustainability of dental schools.
2. Evaluation of the efficiency of the current dental school curricula and delivery methods.
3. Analysis of the impact of student debt on dentistry as a career choice and subsequent practice choices.
4. A determination of whether dental schools are meeting the appropriate level of scholarship to ensure that dentistry continues to be a learned profession;

and be it further

Resolved, that the ADA's financial implication for this resolution shall not exceed \$80,000, to be used to define the scope and specific aims of the study, to determine the estimated cost of the study, to identify potential funding sources for the study, and to report to the 2014 ADA House of Delegates.

A Report of The ADEA Presidential Task Force on the Cost of Higher Education and Student Borrowing



March
2013

ADEA

AMERICAN
DENTAL
EDUCATION
ASSOCIATION

**A Report of
The ADEA Presidential
Task Force on the Cost of Higher
Education and Student Borrowing**

March 2013

Acknowledgments

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This report was produced by the ADEA Policy Center.

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Foreword

The cost of higher education has been in the national headlines like never before. The economic downturn, decreases in state and federal higher education funding, and plummeting university and college endowments have all contributed to financial burdens and budget cuts that have forced college and university administrators to make difficult decisions. Over the decade from 1999 to 2009, state appropriations as a share of institutional revenues per student dropped from 49% to 34% in public research institutions. Academic dental institutions have not been immune to these issues, leading to what some view as exponential increases in tuition and student fees. The average cost of attending dental school is up nearly 50% since 2000, and similar increases have been noted in allied and advanced dental education programs. During this time, statistics also show substantial increases in student debt. Today, the average debt load for all dental students is more than \$200,000, an increase of 66% in the past 10 years. Leaders in dental education and organized dentistry are concerned that these higher debt loads are beginning to impact post-graduation decisions—such as the ability of dental school graduates to choose solo private practices, for others to seek gainful employment, and for all graduates to enter academic careers or to devote time providing care to underserved populations—and that ultimately these decisions will have a negative impact on the professions.

In April 2012, I appointed a special Task Force to study the cost of dental education and student borrowing to better understand dental, advanced dental, and allied dental education in the context of the changing economics of higher education. Over the past year, the Task Force and ADEA staff have worked diligently and methodically to understand the borrowing patterns of predoctoral, advanced dental, and allied dental students, and the unintended consequences of student debt in the broader context of student loan debt and the U.S. economy. The Task Force evaluated the relationship between missions of academic dental institutions, education models and costs, student debt loads, and career choices. The ultimate goal was to determine what role ADEA and its members can play in improving the financial position of academic dental institutions in the United States, and to ensure that the future of the professions is not negatively impacted by the economic factors facing students and academic dental institutions. In this report, the Task Force seeks to develop recommendations that will lead to national and local actions to address the increasing costs and debt management.

Gerald N. Glickman, D.D.S., M.S., M.B.A., J.D.
ADEA President

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Executive Summary

In the past decade, the cost of higher education has risen, resulting in record levels of student debt. For many policy makers, the dramatic increase in student debt raises two concerns. The first concern is that in the near term, new graduates who hold substantial debt may choose not to see low-income patients because of low reimbursement rates from such public assistance programs as Medicaid.¹ A second concern is that the rising costs of education and of student indebtedness may make a dental career appear so unaffordable for future dental school and allied dental program applicants—especially those who are economically disadvantaged—that the entire profession becomes unattractive. To ensure that negative economic factors—facing schools, programs, students, residents, and fellows—do not impact the profession's future, the following challenge has gone out to dental education stakeholders: to take steps to improve the financial position of dental education programs and contain student debt.

With this backdrop, this report outlines the complex financial issues facing dental education programs and the resulting impact on students, residents and fellows, especially in terms of possible implications for decisions upon graduation. Through analysis of recent trends and emerging models, the report explores policies to improve the financial position of academic dental institutions, as well as tools and methods for providing students with information that will allow them to properly prepare for the possible financial challenges of their education and practice.

Dental school leaders surveyed report that tuition and fees keep rising in response to revenue reductions (such as decreases in state appropriations for public institutions), the need to invest in new information technologies, increases in salary and benefits, and increases in parent institution support expenditures. These financial

pressures moderate the ability of these dental education leaders to control costs and stabilize an ever expanding system. This report attempts to better explain the costs of a dental education and resulting student debt in the broader context of higher education and provides recommendations for the American Dental Education Association (ADEA) leadership, its members, and other dental education stakeholders on how to improve the financial position of allied dental education, dental schools and advanced dental education programs. To that end, the report presents:

1. A review and evaluation of the recommendations from the 1999 *Report of the AADS President's Commission on the Cost of Education*,
2. A review of relevant literature and investigative reports,
3. A review of dental education costs and dental school deans' perceptions,
4. The creation of a conceptual model that describes cost and borrowing pressures,
5. A review of borrowing characteristics of students, and
6. A review of the legislative and regulatory environment affecting dental student debt.

The report culminates in recommendations to the dental education community and organized dentistry highlighting the dual need to contain dental educational cost increases and reduce growth in student borrowing. The future attraction of the dental professions and the continued improvement in oral health² may greatly depend upon affirming and carrying out the following six recommendations:

1. Promote financial literacy and ensure that the highest quality financial aid service and counseling is available to prospective and current students, residents, and fellows;
2. Continue to pursue funding for scholarships from stakeholder communities;

3. Continue to promote mission alignment with resource management in academic dental institutions;
4. Explore alternative dental education models;
5. Enhance advocacy partnerships with other dental organizations; and
6. Continue to take a leadership role in representing the interests of ADEA's membership on issues related to the cost of dental education and student borrowing by focusing on the following critical issues:
 - Link federal and state advocacy work to loan repayment/forgiveness programs for new dentists who practice in underserved areas or serve underserved populations;
 - Revise Graduate Medical Education (GME) and Teaching Health Center Graduate Medical Education (THCGME) funding criteria payments biases that favor hospital-based services;
 - Amend the federal rules governing Federally Qualified Health Centers (FQHCs) to acknowledge dental schools as part of the health care safety net.

Introduction

The two headlines about rising higher education costs and about record student borrowing levels have pierced the consciousness of many policy makers and stakeholders, especially in the past decade. The 2007-09 recession drastically reduced state and federal higher education funding. The recession also had a significant impact on university and college endowments at private and public colleges.³ These factors forced college and university administrators to make difficult decisions. At four-year public colleges and universities, for example, revenue from tuition and fees per full-time equivalent student increased nearly 15% in inflation-adjusted value from 2004-05 to 2009-10.⁴ Concomitantly, dental education programs have not escaped these pressures, leading to what some view as exponential increases in tuition and student fees to cope with lost or reduced revenue streams.^{5,6,7}

This is not the first time dental education has formally faced the questions of educational cost and student borrowing. In 1998, amid a similar concern related to what some viewed as the spiraling cost of dental education, the President of the American Association of Dental Schools (AADS)—now the American Dental Education Association (ADEA)—appointed a group to study educational costs and student debt related to dental education.⁸ The group also developed strategies to address the cost of dental education and debt management and laid them out in the *Report of the AADS President's Commission on the Cost of Education (AADS President's Commission Report)*.⁹ This 1999 report raised important questions:

- Does dental education provide an adequate return on investment (ROI)?
- Does educational debt affect career choices?
- Does education debt affect access to care?

The report also recommended the following strategies for academic dentistry to cope with rising costs and student borrowing:

- Develop a public relations strategy to show the values of dental education.
- Encourage new efforts in debt management education.
- Determine the effect of debt on career choice and access to care.
- Ascertain capital expenditure trends for dental school physical plants and implications for the future.
- Investigate ways for dental schools to control costs and increase revenues.

In response to the contemporary cost and borrowing environment, ADEA President Dr. Gerald N. Glickman appointed the ADEA Presidential Task Force on the Cost of Higher Education and Student Borrowing in July 2012 to better understand dental education in the context of the changing economics of higher education. The Task Force worked to examine the borrowing patterns of students, residents, and fellows and the potential unintended consequences of student debt on advanced dental education plans and career choices. As part of its work, the Task Force investigated the relationship between institutional mission and the determinants of educational costs. The Task Force activities aimed to answer four critical questions:

1. Why does dental education cost so much?
2. Can dental educators reduce the costs without sacrificing quality?
3. Does the high level of student debt influence career decisions?
4. Do high dental education costs influence who applies for and attends dental education programs?

Finally, the Task Force aspired to determine what roles ADEA, its members, and other dental education stakeholders can play in improving the financial position of academic dental institutions in the United States, and to ensure that the future of the professions is not negatively impacted by the economic

challenges facing both the schools and students and academic dental institutions.

Task Force Activities

The Task Force reviewed materials, deliberated on various cost and borrowing topics, and consulted experts. Seven activities sum up the Task Force's work:

- Review and evaluate the recommendations from the 1999 AADS report.
- Review the relevant literature and investigative reports.
- Review the dental education costs and dental school deans' perceptions.
- Create a conceptual model that describes cost and student borrowing pressures.
- Review borrowing characteristics of dental students.
- Review the legislative and regulatory environment affecting dental student debt.
- Make recommendations to the dental education community and organized dentistry

The following summarizes each of these activity areas.

Review and Evaluate the Recommendations from the 1999 AADS Report

In retrospect, many of the 1999 recommendations have found life while some after a time were set aside in favor of other more compelling developments and initiatives. **Table 1** (pp. 5 and 6) summarizes the progress made in implementing the recommendations.

Review of the Relevant Literature and Investigative Reports

Published work in the last two decades highlights the challenging environment in which higher education, and specifically dental education, operates. State support has declined significantly since 1980, when states provided on average 46% of operating support for public colleges and

universities. Twenty-five years later, state support declined to 27%. The decline in state support also affects private colleges and universities because many states provide financial assistance to their residents to attend both public and private institutions. This and other key factors have led to significant increases in tuition. According to the American Council on Education, "tuitions are a direct function of a combination of realities including: decreased state support for public institutions; increased federal, state, and regulatory requirements; increased health care and other employee benefits costs; increased energy costs; the demand and need for up-to-date information technology; and, student and family demands for increased services and amenities."¹⁰ Over the span of three decades, from 1982-83 to 2012-13, undergraduate tuition and fees for one year (excluding other expenses) have increased from \$10,901 to \$29,056 at private nonprofit four-year institutions, from \$2,423 to \$8,655 at public four-year institutions, and from \$1,111 to \$3,131 at public two-year institutions (all numbers are in 2012 dollars).¹¹

The growth in the number of Americans pursuing postsecondary education and the rising cost of attending college have led to record debt levels. Various sources estimate that the total for all student loan debt (for current and past students) is nearly \$1 trillion, more than the \$679 billion in credit card debt among Americans.¹² According to the Project on Student Debt at The Institute for College Access & Success, "students who borrowed for college and earned bachelor's degrees in 2011 graduated with an average \$26,600 in student loan debt." The rise in student debt has not led to widespread efforts to increase government support of higher education; rather, the increase has caused greater scrutiny of college affordability and accountability. Instead of giving more support, the federal government is challenging higher education to do more with less and show greater accountability in

Table 1: 1999 Report of the AADS President's Commission on the Cost of Education

Recommendation	1999 Action Plans	Status in 2013
1. Does educational debt affect career choices?	a. Conduct a study modeled after the 1994 <i>New England Journal of Medicine's</i> study to ascertain the economic ROI in a dental education.	Brown and Nash (forthcoming).
	b. Determine the intangible benefits of the dental profession that students and practitioners value most.	ADEA's ExploreHealthCareers ¹³ and GoDental [®] websites, plus the <i>ADEA Official Guide to Dental Schools</i> (updated and published annually), provide information about the intangible benefits of the dental profession from the point of view of students and practitioners.
	c. Publish the findings of the studies (a. and b.) in the <i>Journal of Dental Education</i> , the <i>Bulletin of Dental Education</i> , and other relevant publications read by the higher education community.	Various publications.
	d. Develop a promotional brochure that explains the value of dental education. Target these audiences: health professions advisors, university administrators, students (high school and college), the practicing community, and under-represented minorities.	In 2011, ADEA launched the GoDental website, which, in part, explains the value of a dental education.
	e. Educate policy makers and government leaders about the unique contributions of the dental student to his or her education (for example, the requirement to generate clinical revenue and the payment of instrument rental fees).	Regular ADEA advocacy efforts continue and communication materials are updated or developed.
2. Encourage new efforts in debt management education.	a. Develop debt management education on the AADS website. Consider developing a model similar to that used by the AAMC ¹⁴ . Engage the AADS Financial Aid Section in this project.	Update debt management resources annually and make them available on the ADEA, GoDental, and ExploreHealthCareers websites. Also, materials continue to be distributed to financial aid administrators.
	b. Ascertain the level and types of debt management education currently conducted at dental schools.	The Task Force designed a survey to obtain this information.
	c. Create collaborative projects at the AADS Annual Session and through involving the AADS Council of Students, the American Student Dental Association, and the AADS Section of Financial Aid Administration.	At the ADEA Annual Session & Exhibition, host a recruitment fair aimed at providing admissions and financial information to prospective dental students.
	d. Develop a section on debt management for publication in the <i>AADS Admission Requirements of U.S. and Canadian Dental Schools and Opportunities for Minority Students in U.S. Dental Schools</i> .	The <i>ADEA Official Guide to Dental Schools</i> includes the chapter "Financing a Dental Education." ADEA collaborates with AAMC on the annual Professional Development Conference for Health Professions Financial Aid Administrators. ADEA annually produces and distributes materials for students, graduates, and financial aid officers to use in entrance and exit interviews.

**Table 1: 1999 Report of the AADS President's Commission on the Cost of Education
(Continued)**

Recommendation	1999 Action Plans	Status in 2013
3. Determine the effect of debt on career choice and access to care.	a. Revise the <i>AADS Survey of Dental School Seniors</i> ¹⁵ so that debt level can be correlated to decisions to practice in specific geographic locations.	<i>ADEA Survey of Dental School Seniors</i> collected information on debt level, and correlations to general practice locations have been made, though not to specific geographic locations.
	b. Utilize the <i>AADS Survey of Dental School Seniors</i> to determine if debt influenced students not to choose particular career paths (for example, the influence of debt in choosing specialty education).	<i>ADEA Survey of Dental School Seniors</i> data have been analyzed. Correlation of debt to students' choosing specific career paths has yet to be established.
	c. Explore with HRSA* and others the expansion of existing loan repayment options and the creation of new repayment options associated with service to underserved populations.	In 2005, HRSA released <i>Financing Dental Education: Public Policy Interests, Issues and Strategic Considerations</i> . This report recommends loan-forgiveness programs for graduates who practice in underserved areas or treat underserved populations. There was no ADEA involvement in this report.
4. Ascertain capital expenditure trends for dental schools' physical plants and implications for the future.	a. Utilizing the <i>ADA Survey of Predoctoral Dental Education Institutions</i> , determine and publish trends in dental school expenditures for physical plant maintenance.	<i>U.S. State-Supported Dental Schools: The article "Financial Projections and Implications,"</i> ¹⁶ published in 2006 in the <i>JDE</i> [†] , uses ADA surveys of predoctoral dental education to examine expenditures for dental schools' physical plant operations for the period 1990 to 2002.
	b. Engaging the Association of Higher Education Facilities Officers, develop a model to help individual dental schools determine appropriate levels of spending for facility maintenance and improvement.	Not started. No plans at this time to pursue this recommendation.
5. Investigate ways for dental schools to control costs and increase revenues.	a. Explore alternative ways of teaching, including delivery of educational programming through regional centers of excellence and distance education.	Examples of pursuing alternative ways of teaching include creating partnerships with AAMC for MedEdPortal and developing curriculum materials as part of the ADEA Curriculum Resource Center and the ADEA Online Library.
	b. Develop specific strategies for dental schools to pass on cost savings to students.	ADEA, through media such as the <i>Bulletin of Dental Education</i> , has highlighted specific strategies dental schools have taken that have resulted in substantial cost savings but to date has not encouraged schools to pass on these savings to students. Work on this recommendation is not planned at this time.
	c. Provide best-practice models for efficient use of dental school facilities.	Still under development.

* Health Resources and Services Administration

† *Journal of Dental Education*

metrics, such as student learning, job placement, and earnings.¹⁷

These same issues directly affect dental education and have some unique impacts on the various parts of dental education. The profession of dental education exists at all higher education levels, including certificate programs and associate's, bachelor's, master's, and doctoral degree programs. Dental education programs can be found at institutions ranging from the nation's smallest community colleges to the largest research universities. The challenge of undergraduate student debt described above affects both allied dental students at the certificate, associate, and baccalaureate levels and students in the pipeline to enter predoctoral dental education programs.

Most of the remainder of this report will focus both on the rise in cost at the predoctoral dental education level and on the resulting impact on current and prospective students. Further research is needed to understand the impact undergraduate debt has on current and prospective students in allied dental education fields, such as dental assisting, dental hygiene, and dental laboratory technology.

Nearly 20 years ago, in 1995, the Institute of Medicine (IOM) conducted a major study, *Dental Education at the Crossroads: Challenges and Change*, which documented the turbulent environment in which dental schools found themselves during the early 1990s.¹⁸ According to the report, in the 1960s and 1970s, federal and state funding supported new dental schools and the expansion of existing schools. By the 1990s, however, in response to a slow and uneven recovery from a prolonged recession, federal and state funding for many health care programs either stopped keeping pace with inflation or was in decline.¹⁹ Additionally, a majority of dental schools cut enrollments, and seven schools closed from 1986 to 2001. According to the IOM study and other sources, in a time of financial strain, several universities re-

examined their missions, as well as the match between their missions and activities. As a result of this re-examination, these universities restructured, consolidated, and eliminated dental education programs. The IOM report did not explain why dental schools cut enrollments, but some have speculated that the positive oral health effects of fluoride and other factors decreased the demand for dental services and, in turn, the need for dental practitioners.²⁰

Dental Education at the Crossroads also takes a comprehensive look at key facets of dental education. The report examines the nation's oral health, the dental school and its multiple missions within the university, and the oral health care workforce. The study notes, among other challenges, the difficulty in determining the true education costs per student. The total expenditure per student reported in 1992, according to the report, was nearly \$53,000; however, the total expenditures per student varied dramatically from institution to institution—from \$39,100 at private schools to \$60,400 at public schools. The report explains most of the difference between public and private schools as stemming from state appropriations.

As part of its work, the IOM conducted a survey of dental school deans that finds among them two major sources of concern—general funding problems and problems related to an overreliance on tuition—as the dental school revenue streams rely more on tuition and fees and less on faculty practice income.

Dental Education at the Crossroads issues a set of 22 recommendations to position dental education for the future. One recommendation calls for dental schools to develop accurate cost and revenue data for their educational, research, and patient care programs, and another recommendation calls for the schools to implement a mix of actions to reduce costs and increase revenues.

Following the IOM report, the Surgeon General, in 2005, issued the first and only Surgeon General's report on oral health. Entitled *Oral Health in America: A Report of the Surgeon General*,²¹ this document describes not only the great strides made in improving the nation's oral health during the twentieth century, but also the important connection oral health has to overall health. The Surgeon General's report also calls attention to stark disparities in oral health and access to oral health care. The report highlights the fact that limited access to oral health care providers forms one of the major barriers to adequate oral health.²² This issue—limited access to oral health care providers—underlines the importance of understanding the connections between student indebtedness, the national oral health delivery system, and the individual practitioner. According to the Surgeon General's report, any strategy to improve oral health care access must consider that underserved areas are the very communities that dental education graduates with high debt levels are likely to find less financially attractive.

In 2005, the National Conference of State Legislatures prepared a report, *Financing Dental Education: Public Policy Interests, Issues and Strategic Considerations*, for the U.S. Department of Health and Human Services (HHS) Health Resources and Services Administration (HRSA). Recognizing that there is a public interest in an adequate supply and distribution of dental care providers, the report seeks to inform state and federal policy makers about dental education.²³ Affirming that oral health is integral to overall health and that there are significant portions of the U.S. population with limited access to oral health care, the report draws attention to the issues surrounding the supply and education of dentists. The report points out numerous factors that contribute to the high cost of dental education and indicates dental schools' reliance on three main financing sources: student tuition and fees,

income from school-based clinics, and state appropriations (for public schools).

The HRSA report also notes that the high costs of dental education are mainly attributed to the model (adopted after the 1926 publication of the Gies Report, *Dental Education in the United States and Canada*²⁴) that calls for didactic and clinical education to occur entirely within the dental school itself. Unlike medical schools—whose hospitals and clinics share the financial responsibility for clinical education—the dental school contains most of the clinical education component of the dental education curriculum, a factor that creates a primary cost driver. Moreover, the HRSA report notes that the national fiscal environment limits expectations of growth in state appropriations, leading HRSA to focus concern on increasing program costs, which, in turn, drive escalating student cost and resulting indebtedness. HRSA urges dental education and government at the state and federal levels to work together to position dental education as a national resource.

The challenge laid out in 1995 by *Dental Education at the Crossroads*, to identify and implement strategies to reduce costs and increase revenues, is even more critical today. As the U.S. economy continues its slow recovery from the 2007-09 recession,²⁵ the resulting economic challenges faced by states and the federal government make it unlikely that in the near future there will be a major increase in the investment in dental education by public sources. Although HRSA's *Financing Dental Education* makes a strong case that it is in the public's interest to have access to dental services and that dental education should be considered an essential national resource, there has been little to no increase in public funding for dental education since the 2005 report's release.²⁶

Review of Dental Education Costs and Dental School Deans' Perceptions

Characteristics of Dental Education Costs

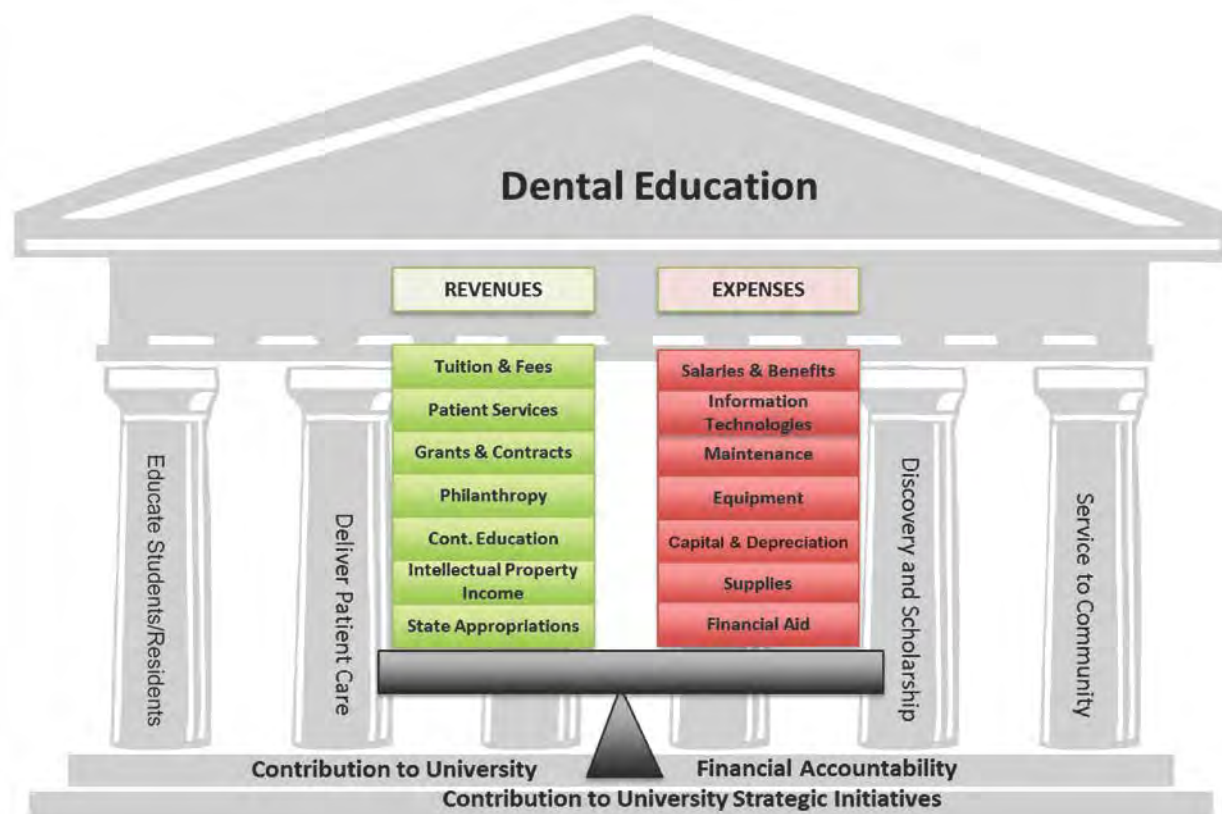
Understanding dental education costs requires the analysis of multiple expenditures and revenues in a complex context of a higher education institution and a health care provider. Furthermore, the entire enterprise has become more complex over the past 40 years, with changes to accounting systems and more pressures on diversifying revenue streams. Figure 1 illustrates the complexity.

As illustrated in Figure 1, there are typically seven different revenue streams into a dental school. These seven are tuition and fees, patient services, grants and contracts, philanthropy, continuing education, intellectual property income, and state appropriations.

intellectual property, and state appropriations. The proportion that each contributes to the total enterprise varies by school mission and within a school over time. For example, as state appropriations or philanthropy diminishes, tuition and fees may rise to make up the difference. The ever increasing expenditure side of dental education usually has just as many categories as the revenue stream side and includes salaries and benefits, information technologies, maintenance, equipment, capital, depreciation, supplies, and student financial aid. In addition to the expenses for dental school operations noted in Figure 1, it is not unusual for dental schools to contribute to the parent university's budget.²⁷

The interconnectedness of dental education to the parent university is also important to understand. Although some dental schools operate independently with no support from their parent universities, some must

Figure 1: Complexity of Dental Education Finances



contribute to their parent universities' budgets.²⁸ In the context of a large university, dental education is one of many graduate professional programs. At many universities, the overall budget is structured so that more financially lucrative programs and schools help subsidize less financially viable programs. One of the great challenges dental school deans face is balancing budgets for dental schools with increasingly limited resources that are at the same time part of large universities faced with the same challenges of balancing overall budgets with limited state and federal support. In this context, dental schools and programs may appear more financially viable than other areas with less student demand.²⁹

Challenges for U.S. Dental Schools

As described above, dental schools are operating in an environment fraught with challenges, especially the substantial decline of public funding. To better understand the pressures facing dental school deans, ADEA fielded a survey to capture deans' professional perceptions regarding the driving forces on dental education costs and student borrowing. The survey was administered online in January 2013 to the deans of the 63 Commission on Dental Accreditation (CODA) approved ADEA member dental schools in the United States. Email solicitations were sent to deans to request participation, and 42 deans responded, for a response rate of 67%.³⁰

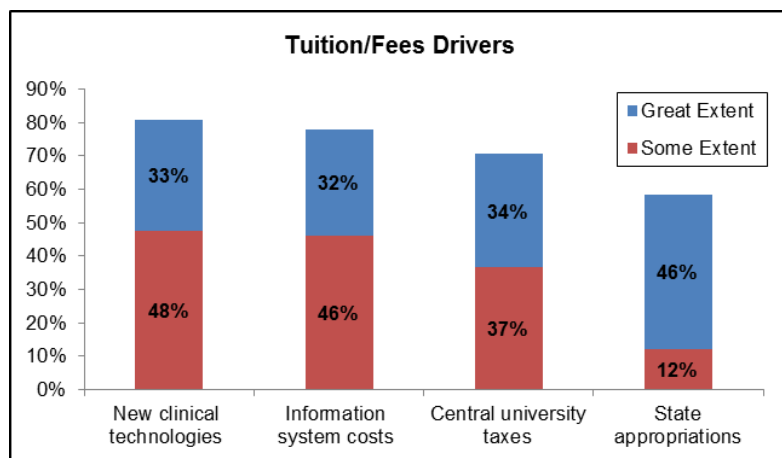
For the survey, the Task Force drafted several fixed-choice and open-ended questions to explore the perceptions of deans regarding cost and borrowing in dental education. Because the limited purpose of this survey was to capture the deans' professional opinions on the cost and borrowing topic, the Task Force used only descriptive statistics to analyze and describe the data. Figure 2 (next page) provides a snapshot of survey results, focusing on deans' perceptions of factors that are driving up and keeping down tuition

and/or fees, steps that schools have taken to control student borrowing, and level of concern for student indebtedness.

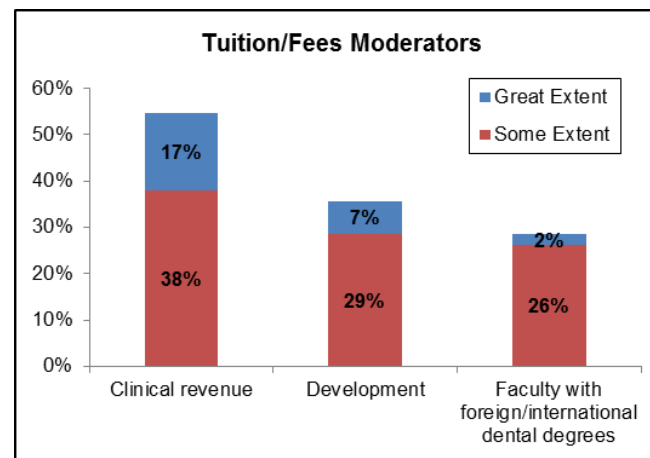
Deans were asked to what extent several possible factors were driving up tuition and/or fees at their dental school. Overall, respondents most often report that decreases in state appropriations drive up tuition and/or fees at their dental schools to a great extent (46%). Deans most often indicate that the need to invest in new clinical technologies, increases in information system costs, and increases in central university taxes (contributions to the parent institution's budget for overall operating expenses) drive up tuition and/or fees at their schools. Fifty-five percent of deans report that expanded clinical revenue keep tuition and/or fees down at their institutions. Deans also say development (38%) and hiring of faculty with foreign/international dental degrees (38%) keep tuition and/or fees down at their institutions, but not as much as expanded clinical revenue.

All responding deans report being concerned about student indebtedness, with 61% of deans reporting being very concerned and 39% being somewhat concerned. When comparing all students and disadvantaged students³¹ specifically, deans report that they think their dental schools' tuition and/or fees are most impacting all students' ability to buy a practice (83%) and disadvantaged students' choosing dentistry as a career (88%). Deans also say that tuition and/or fees impact the decision of all students—especially those who are from disadvantaged backgrounds—to practice in an underserved community.

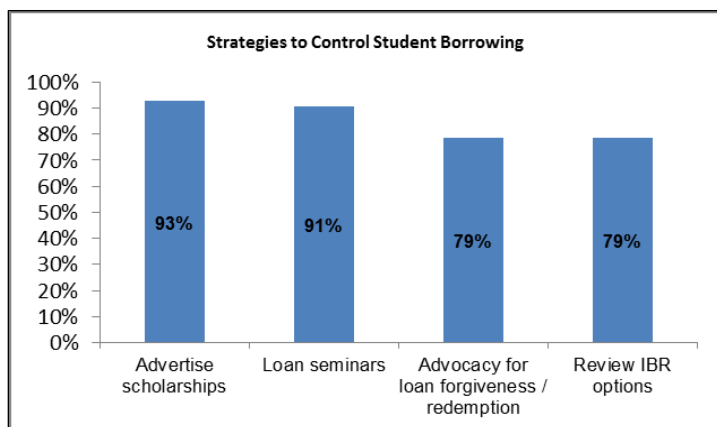
Figure 2: Deans' Survey on Cost and Borrowing Perceptions



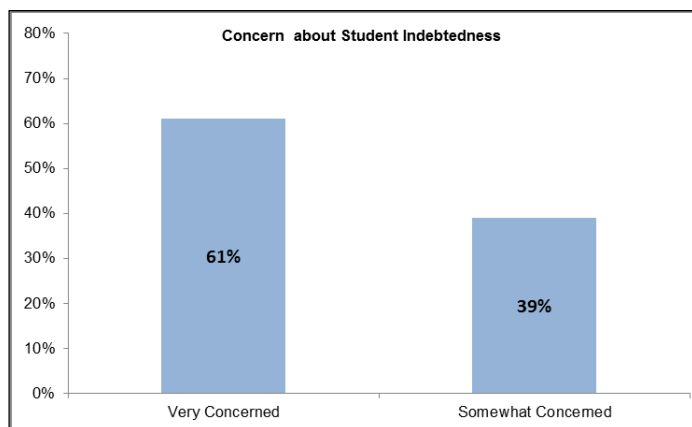
Question: To what extent is each of the following driving up tuition and/or fees for your dental school? Responses (in graph): Increases in new clinical technologies; increases in information systems (e.g., digital radiography, implants, CAD/CAM, lasers); increases in central university taxes; decreases in state appropriations.



Question: To what extent is each of the following keeping down tuition and/or fees for your dental school? Responses (in graph): Expanded clinical revenues; development (e.g., fundraising); hiring of faculty with foreign/international dental degrees.



Question: Have you, and/or your central financial aid office, taken any of the following steps to control student borrowing? Responses (in graph): Advertise student scholarship opportunities; hold seminars on loan forgiveness/loan redemption opportunities; advocate for loan forgiveness/loan redemption in your state if the student practices in an underserved community upon graduation; review with students income-based repayment options.



Question: How concerned are you about student indebtedness? Response options: Very concerned; Somewhat concerned; Not concerned.

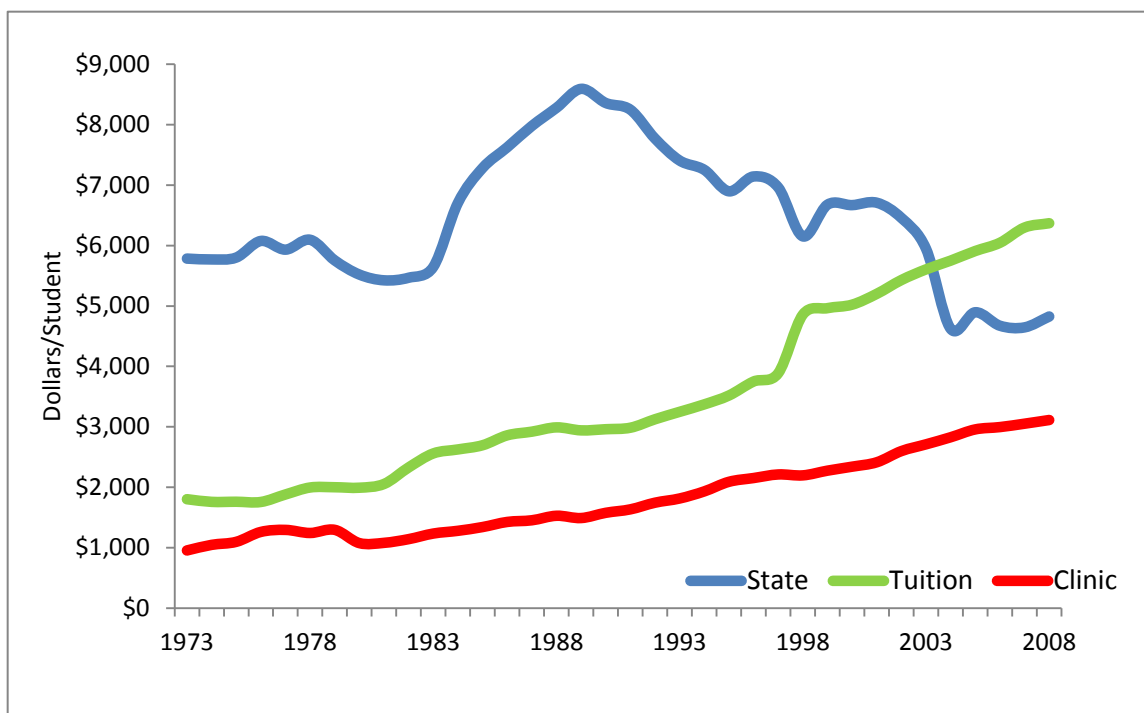
According to the respondents, most schools (68%) provide scholarships to offset the cost of tuition and/or fees specifically for disadvantaged students but not for students identifying a desire to practice in underserved communities. Dental schools and/or their central financial aid offices are using the following strategies, among others, to control student borrowing: advertising scholarships (93%), holding loan forgiveness/redemption seminars (91%), and encouraging loan forgiveness/redemption programs for practicing in an underserved community (79%). In addition to these efforts, about half of deans (45%) have implemented or are planning to implement a six- or seven-year articulation program (undergraduate and dental school combined) that would reduce the number of years of dental school and/or require additional prerequisites (51%) to minimize the time to completion of the dental degree. However, no deans are planning to follow the lead of the University of Pacific Arthur A. Dugoni School of Dentistry and implement a three-year curriculum.

State Funding

As nearly half (46%) of deans responding to the survey note that decreases in state appropriations drive up tuition and/or fees at their dental schools to a great extent, the Task Force has further investigated this topic. As seen in Figure 3, and as previously noted in this report, over the past two decades, state funding for dental education has steadily declined.³² Current funding levels are in stark contrast to the 1960s, when public funding increased in response to a federally mandated expansion of dental education.^{33, 34} Figure 3 shows that after the 1960s, there was a flattening in public funding during the early 1970s, followed by some increases and decreases during the latter part of the decade. The modest funding changes during the 1970s were followed by large increases in the 1980s and substantial decreases since 1990.

Unfortunately, there has been little recognition that the lack of public funding for dental education has a negative impact not only on dental students but also on local communities. Dental schools provide

Figure 3: Dental School Revenue Sources (in 1973 constant dollars)³⁵



the necessary resources for their own daily activities and for extramural programs providing safety nets by treating—with little or no reimbursement—patients in the general population. Given dental schools' safety net role, any reduction in funding can have devastating effects on providing services at reduced fees and on training students to work in underserved communities.

Dental schools in the United States have always provided dental care at reduced cost and with extended payment plans for populations without the financial means or insurance to be treated by private practitioners. As public funding has decreased, some dental programs have attempted to gain revenue by various means, such as increasing clinical fees. Raising clinical fees, however, can negatively impact the many dental school patients who cannot afford increased fees. The ability to increase clinical fees jeopardizes the capability of some dental schools to continue functioning as safety nets for underserved populations. It also may jeopardize the ability of the dental school to ensure a well-balanced comprehensive clinical experience for students.

Decreased public support also has important consequences for dental schools' research functions. It is essential that U.S. dental schools operate as laboratories of new knowledge, producing innovative and cutting-edge research. Dental schools should especially conduct basic, translational, and clinical science research. Research is so essential to the education of dental students that CODA's research standard³⁶ emphasizes the importance of faculty's generating dental research and students' being exposed thereto. Regrettably, costs are associated with research programs, and research funding structure is sensitive to funding from the federal government, private industry, and private foundations.³⁷ Some believe that removing research from the dental school would help to decrease the cost of dental education. Such a step is probably not a practical direction, since programs seeking accreditation will have to respond to the

CODA standard on research, and many must also meet the expectations of their parent universities' research goals and missions. Dental school mission alignment and resource management are critical in the context of the parent university mission and goals. Concomitantly, reducing the research mission of dental school would be devastating to the dental profession and ultimately to the health and well-being of the citizenry.

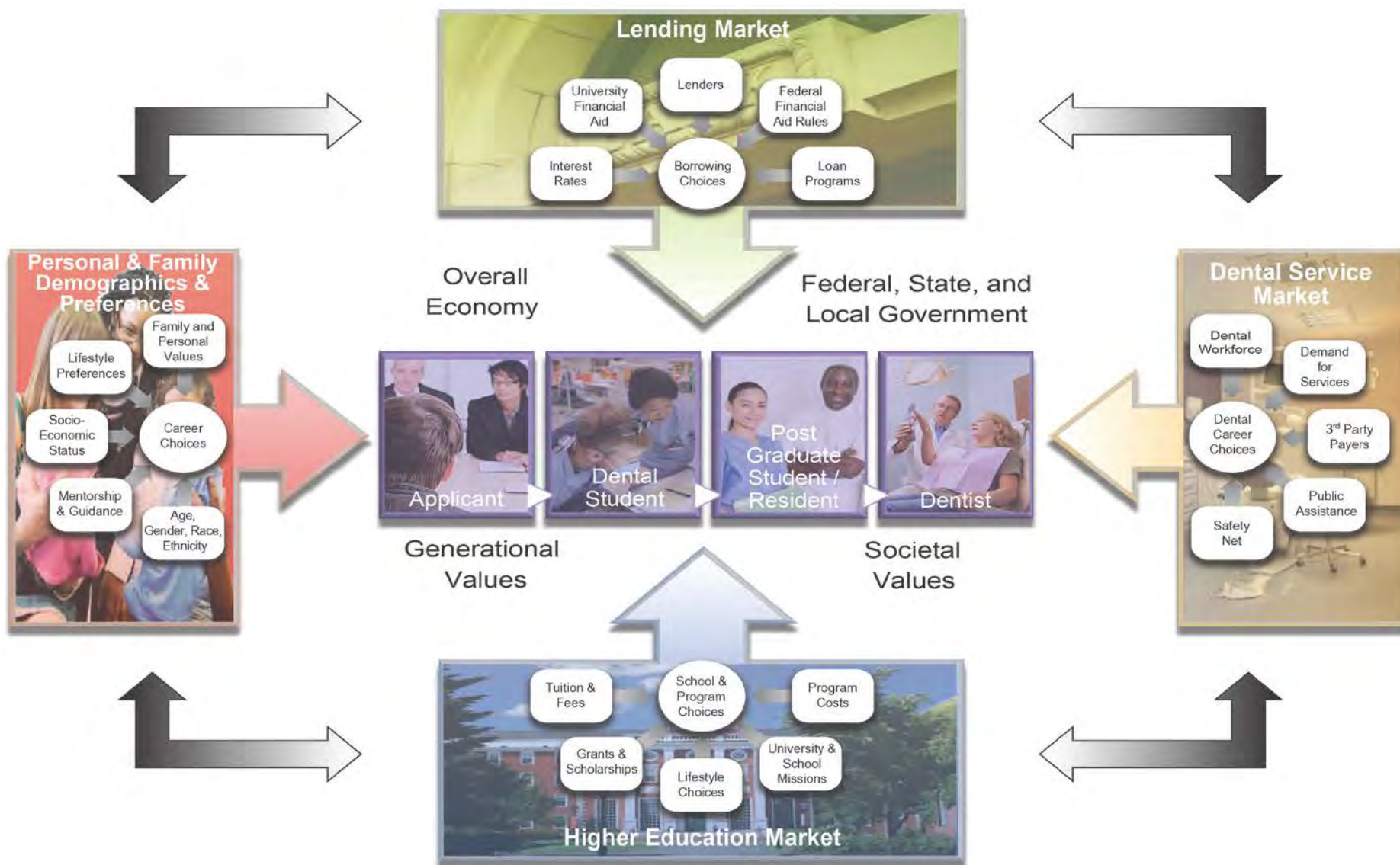
The decline in public funding continues to pose a serious challenge. In the ADEA survey for this report, respondents noted a state appropriations decrease more often (46%) than any other possible factor driving up tuition and/or fees at dental schools. Concern exists among the wider dental education environment that decreases in state and other public funding threatens dental education's innovation, capital improvement, and technological upgrades and innovations, not to mention its ability to provide quality oral health services in the United States and to recruit and retain faculty.

A Conceptual Model of Dental Education Costs and Student Borrowing Pressures

Throughout the Task Force's work, a substantial amount of time involved understanding the complex forces that drive the costs of dental education and levels of student borrowing. While the literature describes some of the factors affecting dental education revenues and dental education costs, there is no literature that places these revenues and costs into the context of an entire dental education system.

The dental education system is multifaceted, with many factors influencing the financial positions of academic dental institutions and, ultimately, the price charged to students for their attendance. To capture the committee's combined thinking, explain trends, and provide context for developing recommendations, the Task Force developed the graphic shown in Figure 4 (next page) illustrating the various cost and systematic pressures on the system.

Figure 4: Conceptual Model of Cost and Borrowing Pressures



Pathway from Applicant to Dentist: The center of Figure 4 shows the pathway to becoming a dentist. Applicants from diverse backgrounds enter the system via the application process. With about two-thirds of bachelor's degree recipients borrowing money for college,³⁸ many applicants enter with debt incurred for their undergraduate education.

Approximately 90% of dental students use student loans to finance their dental educations. Individual dental student debt levels are driven by many factors, including socioeconomic status, family resources, dental school attended, general financial aid, and institutional grant or scholarship opportunities.

In most states, dental school graduates may enter practice immediately upon completing the D.D.S. or D.M.D. degree (and successfully passing licensure examinations). Approximately 49% of dental graduates opt to pursue advanced education programs, for degrees either in general dentistry or in the dental specialties. These degrees can occur in programs that provide stipend-paying settings and do not charge tuition, such as hospital-based programs supported by GME funding, or they can occur in tuition-charging programs, frequently found in many dental schools. Residents in tuition-charging programs are usually considered students (for financial aid purposes), and they frequently acquire additional student loan debt.

Dental Services Market: Some speculate that student loan debt levels have an impact on career choices; however, very few studies have examined the impact of debt on practice choice (e.g., private practice, underserved communities, etc.), practice location, or consideration of alternative careers (e.g., academic dentistry, the military, public health, and community service). The intention of dental students—before they have accumulated significant amounts of debt—must be considered. According to surveys of graduating students, the top reasons (listed as “very

important”) for pursuing a career in dentistry are: to control time (61%), to serve others (58%), and to be self-employed (51%). Only 23% listed “providing care to underserved” as a top reason for pursuing dentistry. Regardless of the variables that affect dental graduates' career choices, career choices do affect a dentist's income potential.

The ROI for a dental education is of critical importance. For dentistry to have a vibrant future, there must be a positive economic return on students' time and money investment. Generally, students should be willing to pay a higher price for their education and engage in a higher borrowing level in exchange for entering a higher paying profession. ROI affects the demand—as reflected in the annual dental applicant numbers—for dental education.

Higher Education Market: Most dental schools exist in larger university systems. The cost structure, therefore, is partly driven by (1) the university's mission (i.e., at a research-intensive parent institution, the dental school must help support a vibrant research infrastructure), (2) the university's expectations (i.e., the dental school must contribute toward overall infrastructure expenses), (3) the university's strategic initiatives (i.e., the dental school must make required contributions), and (4) the university's financial health. If the dental school is located in an academic health center, the latter's financial well-being may also drive the former's cost structure.

Lending Market Factors: Students' ability to cover dental school attendance costs depends on the availability of financial capital. This capital can come from several sources, including family savings, federal loans, family and private loans, institutional scholarships, and other forms of institutional financial aid. Nearly 90% of students attending dental school today must finance at least part, if not all, of their education. Loans are obtained through a number of loan programs, with the various lenders including the federal government, state

government, and private lenders. Additional details about current and proposed loan and loan repayment programs are provided later in this report.

Personal and Family Demographics and Preferences: The majority of dental school graduates come from families with higher socio-economic backgrounds. High levels of student debt pose a threat to many—especially to individuals from lower socio-economic backgrounds—so that they do not even consider a career in dentistry. Dental education costs drive decisions about choosing dental school.

The General Economy: Just as supply and demand behaviors drive the U.S. economy, so they are key in driving the dental service economy. In a growing economy, as discretionary income rises, the demand for dental services increases—thereby increasing dentist salaries—and the demand for dental education increases. In a recession economy, the reverse is generally true: Discretionary income decreases, the demand for services decreases, dentists' salaries decrease, and, ultimately, the demand for dental education decreases. Market forces, therefore, have a significant impact on the number of applicants to dental schools, along with the revenue raised by dental schools' clinical enterprises.

There is no evidence that the demand for dental education drives the price thereof; rather, the demand is driven by the perceived benefits of becoming a dentist. The price of dental education is driven by program cost, university expectations, external support (including federal, state, and philanthropic support), and dental reimbursement levels for delivered oral health care services.

General economic conditions also affect the cost of dental education. During good economic times, state support for dental education can increase, while during bad economic times, state support can dramatically decrease resulting in costs

being shifted to dental students via tuition and fee increases.

Federal, State, and Local Government Influences: Other environmental factors have a confounding effect on these market forces. For example, health care reform has the potential to dramatically influence the funding mechanisms for health care services, thereby affecting the demand for services. The introduction of new allied dental professionals can positively impact the efficiency of dental practice, while new technologies can affect the range of services provided, as well as the cost of those services.

Generational Values: Generational values impact lifestyle and career choices. Living above one's means and making decisions with little consideration of future implications result in higher levels of borrowing. Similarly, career choices, including work hours and professional drive, impact a dentist's income level and ability to pay off a graduate's debt.

Society Values: Societal expectations and values impact the nation's health care programs and ultimately the career choices and income levels of health care providers. Over the years, salaries of primary care physicians and medical specialists have dramatically changed due in part to changes in our health care system and health care financing.^{39,40} Dentistry may be at a crossroads, as the financing of dental care, particularly for our safety net service providers, depends more on our public health care system than ever before. Because reimbursement for these services has dramatically decreased, safety net providers' income levels are in danger. Equally important is the perceived appropriate income level of health care providers. Since many believe that dentist incomes are already high, state or federal support for dental students may be of little or no concern to the public.

Borrowing Characteristics of Students in Dental Education Programs

The rise in postsecondary tuition has affected dental education students in all programs. The average dental hygiene program's tuition and fee costs in 2010-11 ranged from \$20,571 (in-state student) to nearly \$30,000 (out-of-state student).⁴¹

These costs come in addition to the cost of the postsecondary prerequisites required for admission to 69% of accredited dental hygiene programs. Nearly 19% require less than one year of college coursework; 30% require one year of college; 12% require two years of college; and 8% require "other," a term that is defined most commonly as specific courses.⁴² The financial challenge facing allied dental students can be substantial because of (1) the total number of years required, even for an associate's degree, and (2) the difficulties encountered by some at community colleges receiving financial aid. According to a report by the Project on Student Debt, "about nine percent of community college students nationally—more than one million students in 31 states—are enrolled in colleges that summarily block their students' access to federal student loans"⁴³ because these schools have opted out of the federal loan program.

Further research is needed to determine the education debt among allied dental students in the context of their employment opportunities. The *U.S. News & World Report* ranks dental hygiene tenth in its list, "100 Best Jobs of 2013," and notes a low unemployment rate of 2.8%.⁴⁴ However, according to data collected by CODA, dental hygienists in some regions are struggling to find adequate work, and the national unemployment rate is 8.6% among 2010 graduates.⁴⁵ That said, while some dental hygienists are finding it difficult to find adequate employment, recent dental hygiene graduates are faring better than others. Last year, about 1.5 million (53.6%) of bachelor's degree holders under the age

of 25 were jobless or underemployed, the highest share in at least 11 years.⁴⁶

Among dental students, first-year resident tuition and fees at public dental schools rose by an annual average of 10.3% over the past decade, increasing from \$10,642 to \$25,618, while at private dental schools the amount increased by an annual rate of 6.2%, rising from \$30,955 to \$52,697.⁴⁷ Furthermore, these increases show the acceleration in the total cost of attendance as illustrated in Figure 5 (next page) from the American Dental Association (ADA) report. Among all U.S. dental schools, total cost of attendance over the past 10 years for four years of dental school rose dramatically—by 93% for in-state residents (from about \$89,000 to \$171,000) and by 82% for out-of-state residents (from \$128,000 to \$234,000).

This rising cost of education requires most dental students to carry large debt burdens after graduation. The *ADEA Survey of Dental School Seniors* reports that the graduating class of 2012 had an average combined undergraduate and dental school debt of \$221,713, up from \$105,969 in 2000, an increase of 109% in more than 10 years.⁴⁸ Not surprisingly, student debt rises at nearly the same rate as the cost of attendance.

Although the total average indebtedness for graduating dental students in 2012 was a little more than \$200,000, the distribution of this debt across the graduating class varies significantly and is dramatically different by type of school attended. In 2012, nearly one in five graduates (18%) had little (under \$50,000) to no debt.⁴⁹ However, another one in five graduates (22%) had debt above \$300,000.⁵⁰ Among graduates from private dental schools, nearly 38% had debt above \$250,000, compared to 11% of graduates from public dental schools.⁵¹ The question driving much of the dental community's concern about the rising debt is the belief by some that high student indebtedness—because it may negatively impact graduates' ability to choose from among

Figure 5: Average Total Resident and Nonresident Costs for All Four Years, 2001-02 to 2010-11

starting a private practice,⁵² entering the public sector, joining academic dentistry, or serving low-income patients—could either discourage talented individuals from considering a career in dentistry or limit the career options of graduates.

In spite of the cost increases of attending dental school and the resulting student debt, individuals still pursue careers in dentistry, although class composition may be less economically diverse than previously.⁵³ The number of students applying to dental school has stayed at about 12,000 annually from 2008 to 2012. Rising tuition and fees could potentially change dental class profiles by attracting more students from higher socioeconomic backgrounds, who can afford the tuition increases and who may be less concerned about paying back student loans, and fewer students from lower socioeconomic backgrounds, who may be intimidated by the high cost of tuition. This hypothesis is supported by Walker et al., who reported that from 1998

to 2006, the number of dental students who come from families with incomes of \$100,000 or more increased, while the number of students whose families have incomes lower than \$50,000 declined. Additionally, the *ADEA Survey of Dental School Seniors* shows that less than 20% of graduating seniors in 2012 reported parental income of less than \$50,000, while 50% reported parental income of more than \$100,000. In today's dental classes, a higher percentage of dental students come from more affluent families with incomes to support increased tuition and fees.⁵⁴

There is a concern that the cost of attending dental school negatively impacts low-income students' educational access and choice. Anderson et al. used data from the *ADEA Survey of Dental School Seniors, 2007 Graduating Class*, and found that students with a lower parental income (less than or equal to \$50,000) are more likely to plan to practice in public service (community clinics or government service) than students

with higher parental income (more than \$50,000).⁵⁵ This finding suggests that recruiting more low-income students may lead to improved access to dental care for underserved individuals, who receive dental care in community clinics or via government services.

The dental profession is committed to improving access to health care for underserved populations.⁵⁶ Consequently, most dental programs, seeking to inculcate the value of service into their curricula, have incorporated into their programs externships, partnerships with community health clinics, community oral cancer screenings, health fairs, and service to Medicaid patients. These are all experiences that serve to train students to care for and treat patients from traditionally underserved populations. Graduates who have had experiences serving these populations are likely aware that reimbursement for services provided to these populations is generally low or nonexistent. As noted earlier, graduates may be inclined to pursue work opportunities that will allow them to pay down their educational debt quickly. The question driving much of the concern within the dental community about the rising debt is the belief that such large debts limit the career options of graduates, negatively impacting their ability to purchase a private practice, work in underserved urban and rural communities, enter the public sector, or become an educator. Rising debt may unfortunately mean that many graduating dentists who have been educated to treat underserved patients will not choose to serve in rural and other underserved areas, where reimbursement levels are low. Therefore, finding mechanisms that help limit the increases in debt are important so that future graduates will carry forward what they learn in dental school and seek opportunities to serve an ethnically and economically diverse patient population.

While there is anecdotal evidence that educational debt influences dental students' plans after graduation, the evidence in the

dental education literature is inconclusive.⁵⁷ Some studies suggest that educational debt influences plans after graduation. Anderson and colleagues (2010),⁵⁸ for example, find that "issues concerning graduation debt are importantly related to plans for public service. Students with a large debt (\$168,000–\$350,000) are three times less likely to plan public service than those with a low debt (less than \$70,000)." A 2011 study at the University of Pennsylvania School of Dental Medicine supports the conclusions of Anderson et al. that debt influences post-graduation decisions. This study of dental students' perceptions of dental specialties and career choices reports that students with the greatest amount of expected accrued debt plan to pursue private practice in general dentistry or postdoctoral general dentistry (i.e., enter General Practice Residency/Advanced Education in General Dentistry programs) and not a dental specialty. The authors conclude that students with the highest debt are choosing options after graduation that will allow them to pay off their debt as quickly as possible.⁵⁹

Other studies, however, conclude that debt has little to no influence on students' perceived plans after graduation. A recent study (2011) by Lucas-Perry⁶⁰ assesses the intentions of graduating dental students to work in underserved areas. The study analyzes dental education debt and determinants related to student demographics, socioeconomic factors, social beliefs and behaviors, work preferences, community-based clinical rotation experience, and dental school environment. The study uses the *ADEA Survey of Dental School Seniors, 2011 Graduating Class*. Results show that 31% intend to work in underserved areas, 38% are unsure, and 27% have no intention of practicing in underserved areas.

Contrary to previous research findings, the study does not find a relationship between debt and intention to work in underserved areas. Students planning to work in underserved areas do not consistently have

lower debt. For example, although 40% of low-income students have plans to work in underserved areas, they report a significantly higher average debt (\$198,567). This level of debt compares to 26% of their high-income counterparts, who report an average debt of \$172,536. Ultimately, the author notes that the relationship between debt and intention to work with underserved populations is inconclusive in the current literature, thus warranting further research.⁶¹

Another concern is the effect high debt loads will have on interest in advanced dental education programs. According to the *ADEA Survey of Dental School Seniors, 2011 Graduating Class*, half of all seniors applied or planned to apply for dental postdoctoral or advanced education programs. Despite higher average debt than 25 years ago, this is slightly higher than the 47.5% in 1986. The financial cost and benefits of attending an advanced dental education program vary considerably. Some of these programs, such as hospital-based programs supported by GME funding, provide a stipend and do not charge tuition. Others can occur in tuition-charging programs, frequently found in many dental schools. Residents in tuition-charging programs are usually considered students for financial aid purposes and frequently acquire additional student loan debt. While exact figures are not available, students graduating from advanced dental education programs may have about the same or higher debt than predoctoral graduates. However, there is a significant increase in earnings that clearly compensates for any increase in debt and additional years of deferred income. In 2009, the average net income of independent (i.e., owner) general practitioners was about \$193,000 compared to about \$306,000 average net income among independent specialists.⁶² If that gap were to persist for a decade, the difference in earnings would be more than \$1 million.

Review Legislative and Regulatory Environment Affecting Dental Student Debt

Students in all types of dental education programs depend greatly on the availability of financial aid, mostly in the form of student loans. It is important to examine the current financial aid landscape at the federal level to better understand financing and repayment options currently available or being proposed. Summarized below are the most relevant proposed legislation and federal regulations (at the time of this report) with the potential to affect dental student borrowers.

Legislative Environment

Concerns about college affordability abound on Capitol Hill, so it is no surprise that several pieces of legislation have been recently introduced to address concerns about overall college cost and cost specifically for students in all types of dental education programs. Proposed House bills would have (1) increased the tax deduction of interest paid on qualified educational loans⁶³ and (2) required higher education institutions both to determine whether the student had applied for and exhausted federal Title IV student aid and to inform him or her accordingly.⁶⁴ The same proposed House bills would have required institutions of higher education participating in Title IV programs to take part in and provide all the data required for an individual-level integrated postsecondary education data system.⁶⁵ None of these bills, however, was successful.

In the 112th Congress (2011-2013), two bills were introduced to expand access to oral health care in underserved communities, particularly through Medicare and Medicaid. Legislation entitled the *Comprehensive Dental Reform Act of 2012* was introduced in both chambers. Senator Sanders filed S. 3272 and Representative Cummings filed H.R. 5909, respectively.

Recently, the *Fairness for Struggling Students Act* was introduced by Sen.

Richard (Dick) Durbin (D-Ill.). If successful, the *Act* would allow private student loans to be discharged in instances of bankruptcy. As currently stipulated by bankruptcy law, borrowers who demonstrate an “undue hardship” may have their loans discharged in bankruptcy. In March 2012 testimony provided to the Senate Subcommittee on Administrative Oversight and the Courts, Justin Draeger, President of the National Association of Financial Aid Administrators, stated that the association “does not find the ‘undue hardship’ clause to be sufficient protection for private education loan borrowers.”⁶⁶ Despite the concern among some legislators about rising student debt, the current fiscal environment has created difficult choices for elected officials. In an effort to save a portion of the Federal Pell Grant Program (geared toward low-income students), *The Budget Control Act of 2011* eliminated the in-school interest subsidy on Stafford Loans for graduate students, effective July 1, 2012.

During the course of its work, the Task Force examined data on private student loans. Out of the \$113.4 billion in total student loan dollars awarded in 2011-12, an estimated \$6.4 billion were from private lenders.⁶⁷ The portion of that \$6.4 billion going toward allied dental, predoctoral, and advanced dental education students is unknown. There is concern about growth in private loans among students in dental education programs because of the considerably higher interest rates and unfavorable repayment terms of most private loans. The Task Force discussed anecdotal evidence of a large increase in users of private student loans. Task Force members also discussed being aware of students at their own schools who rely on these loans and of a fall 2012 meeting of the ADEA Council of Students, Residents, and Fellows, during which student representatives discussed their use of these types of loans. The Task Force’s conversations questioned why dental students are taking out private loans, given their less-than-favorable rates and terms in

comparison with federal financial aid loans, assuming the latter (e.g., federal Graduate PLUS [Grad PLUS] loans) allow students to borrow the full out-of-pocket cost of attendance. One theory discussed is that the cost of attendance for the Grad PLUS loan is calculated by the institution. Students, however, may be calculating their own cost of attendance and concluding that it is much higher and that they need more funding than that provided by the Grad PLUS loan.

Dental educators’ knowledge of how much students are borrowing is also limited. Some institutions may have agreements with lenders to process private student loans through the institutions,⁶⁸ but there also exist direct-to-consumer private loans that are not certified by the school.⁶⁹ A school, therefore, may never know about this additional educational debt that students are incurring. The *ADEA Survey of Dental School Seniors, 2012 Graduating Class* reports the percentage of students who use the following types of loans: personal bank loans (9%), family/relative loans (6%) and “other” loans (9%). It is not known, however, why students are taking out these loans or how much they are borrowing. The ADA also collects data on student loans, but it does not ask students to differentiate between types of loans. Additional data is needed to determine if dental education has an accurate understanding of students’ borrowing patterns.

Regulatory Environment

In December 2012, the U.S. Department of Education (ED) announced new rules to amend federal loan programs to implement a new Income Contingent Repayment (ICR) plan and amend the Income-Based Repayment Plan (IBR) pursuant to President Obama’s “Pay as You Earn” repayment initiative.⁷⁰ The ICR and IBR plans are repayment methods for federal student loans (except Parent PLUS Loans). These methods are designed to enable borrowers to limit their monthly student loan repayment amounts based on the

relationship between their federal student loan payments and what might be considered their “discretionary” income or the portion of their adjusted gross income exceeding 150% of the poverty line applicable to their family size.

HRSA administers loan repayment programs to meet the anticipated demand for health care providers, including dentists and registered dental hygienists, in underserved areas across the United States. Increased demand is anticipated as the federal government implements the *Patient Protection and Affordable Care Act* (ACA) and more Americans receive health care, both in health insurance marketplaces and in states deciding to expand their Medicaid program under the ACA.

Specifically, HRSA administers the federal National Health Service Corps (NHSC) Loan Repayment Program (LRP) and provides grant funding for state agencies to administer the State Loan Repayment Program (SLRP).

The federal NHSC LRP offers dentists and registered dental hygienists the opportunity to have their student loans repaid in exchange for providing health care in urban, rural, or frontier communities with limited access to care. These health care providers may earn up to \$60,000 for a two-year full-time or four-year part-time commitment to serve at a NHSC-approved site located within a Health Professional Shortage Area (HPSA).

The SLRP is administered by state agencies receiving grant funding from HRSA. As state legislatures grapple with state budget concerns, some states are unable to offer the SLRP. Under the SLRP, states must obtain funding to support a dollar-for-dollar match requirement. The SLRP offers states flexibility in the loan repayment amounts offered, the eligibility requirements (although most states include dentists and registered dental hygienists as eligible health care providers), and the minimum service commitment.

In FY 2012, NHSC made nearly 4,600 loan repayment and scholarship awards, totaling \$229.4 million in funding from ACA. During FY 2012, the NHSC loan repayment program made 4,267 awards (2,342 new and 1,925 continuation contracts), totaling \$169 million. Additionally, during FY 2012, 32 grants were made to states operating SLRPs, totaling \$9.8 million.

Summary

As outlined in the introduction, this report builds on the 1999 *President’s Commission Report* and examines the continuing issue of access to allied dental, dental, and advanced dental education programs. The report also explores the challenge of access to dental care for select populations, with a great deal of the inequity attributable to monetary concerns. To meet the access to oral health care challenge, more allied dental professionals and dentists must be willing to work in underserved areas (either in private practices or public clinics) or to accept an increasing number of patients using government aid, such as Medicaid. While many believe that career choices are influenced by a graduate’s debt, dental education study findings are contradictory and inconclusive. A larger barrier is formed by the practice and lifestyle expectations of the many dental students who come from upper-middle class or wealthy families. Therefore, the amount a dental student must borrow may be a significant barrier for low-income students to gain entrance to dental education. The same students most likely intend to practice in underserved communities or serve traditionally underserved populations. In a similar manner, despite the strong earnings potential, the cost of earning a degree in dental hygiene may discourage underrepresented minority and low-income students.

Clearly, increasing public funding for all types of dental education programs would be a way to decrease the cost of a degree. Increased public funding may also alleviate student indebtedness and the

maldistribution of allied dental and dental practitioners. Unfortunately, public funding at the local, state, and federal levels for dental education programs has steadily declined for several decades. Instead of an increase, dental education has been “deprived of financial support analogous to that given to medical education,”⁷¹ a concern put forward as far back as the 1926 Gies report, *Dental Education in the United States and Canada*. Reductions in federal and state funding for dental education—combined with weak economic conditions—have contributed to the closure of seven dental schools in the last two decades.

Given limited expectations of growth in the public funding of dental education, many schools raise tuition to maintain educational, research, and patient care programs. Yet, there is a growing concern about the effect of an increased reliance on tuition and fees on the affordability of dental education for potential applicants. Dental schools have also attempted to increase their revenues by raising clinical fees, given that the primary driver of dental schools’ costs today is the clinical education component of the dental education curriculum. However, clinical fees can have a negative impact on the large portion of dental school patients who do not have the financial means to afford a continual increase in fees.

Thus, the goals of lowering the cost of dental education and student borrowing continue to challenge leaders of allied, predoctoral, and advanced dental education programs. At a time when a federal health care law—ACA—includes provisions related to access to care and health disparities reduction,⁷² considerable gaps exist between the United States’ estimated underserved population in terms of dental care and the number of additional dentists needed to increase the population-to-dentist ratio in underserved areas.⁷³ Given the rising costs of dental education programs and student debt, these gaps will continue to increase unless the public and policy makers take an interest in and support

dental education and the access to dental services it provides.

As the dental professions look toward the implementation of the ACA, a critical issue is whether dental education programs can increase public and governmental support for reducing the cost to students.

Notwithstanding that dental education programs and students should contribute considerably to the cost of education, the public policy aspects of dental education programs, including general availability of basic dental services, warrants broad, sustained support from policy makers.⁷⁴

With both of these premises in mind, the following section highlights existing initiatives and recommends new strategies for achieving these goals: (1) containing the cost of dental education programs and student debt, and (2) making basic dental services available to all. These recommendations take into account the financing challenges and public interest of meeting the oral health care needs identified in this report.

Current ADEA Initiatives and New Recommendations for Lowering Dental Education Costs and Reducing Student Borrowing

Current ADEA Initiatives

ADEA provides a number of advocacy services for its members. These services include the following: Field Advocacy Workshops, Advocacy Days on Capitol Hill, Leadership Institute Legislative Workshops, and *ADEA Washington Update* newsletters. Together, these initiatives strengthen the advocacy skills of ADEA members by informing them how laws are made, how to identify key committees in Congress, and how to interact with state and federal legislators and their staff. ADEA has been encouraged to increase the number of members involved in state and federal legislative advocacy by ensuring that they are made aware of all association resources and tools available for these efforts.

In addition to strengthening skills of ADEA members, the association's Advocacy and Government Relations (AGR) staff actively engages members of Congress and ED. ADEA's advocacy focus areas during 2012 included working on regulations related to IBR, Title IV Funding/Repeated Coursework Restrictions, and Gainful Employment. In addition to continuing this important work, AGR will continue linking these issues to access to care. Policy makers should know, for example, that areas with poor oral health are the same areas that attract students from less affluent backgrounds; however, these students need significant financial aid. It is also recommended that the AGR team engage with state policy makers and higher education coordinating boards to provide a workforce that supports their states' oral health needs.

New Recommendations

There are six recommendations for addressing the challenges of the cost of dental education and student borrowing. These recommendations focus on the two core groups—academic dental leaders and students—who shoulder the major responsibility for controlling costs and slowing borrowing. The recommendations also consider actions the broader community, including organized dentistry and policy makers, can take to support dental education and future generation oral health practitioners.

1. Promote financial literacy and ensure that the highest quality financial aid services and counseling are available to prospective and current students, residents, and fellows.

Dental education program administrators must ensure that financial aid advising, counseling, and resources are available to all current and future students. Allied dental program directors, dental school academic and clinic administrators, and advanced dental education program directors must strengthen partnerships with financial aid administrators. Deans, associate deans, and program directors must become

acquainted with the scope of financial aid services—including the application and awarding processes—currently provided at their institutions. They must also take opportunities to interact with current and future students' financial literacy issues, the financial aid process, counseling, and related services. Dental education programs must develop and implement strategies to maximize the following: (1) financial literacy initiatives, including content, timing, and delivery; (2) mandatory entrance and exit counseling, whether in-person or online; and (3) financial aid counseling services, along with related initiatives and resources.

ADEA will continue to serve as a forum for dental education program financial aid administrators to share best practices, and also to promote active participation in health professions financial aid meetings. ADEA will provide—both for current and future students—timely, up-to-date resources, including the *ADEA Official Guide to Dental Schools*, GoDental.org, and ExploreHealthCareers.org. In response to feedback from financial aid administrators, ADEA will continue to offer resources such as financial aid entrance and exit interview PowerPoint presentations and the annual “Primers” series for the graduating class. ADEA will also continue not only to collaborate with other health professions associations to advocate for legislation and regulations at the state and national levels, but also to encourage dental educators and financial aid administrators to participate in such efforts.

Plans are now underway for ADEA to partner with the Association of American Medical Colleges (AAMC) to offer students, residents and fellows access to a student loan organizer and calculator. This tool helps borrowers to organize and better understand the terms of their student loans and to project various repayment scenarios based on different career and loan repayment options.

2. Continue to pursue funding for scholarships from stakeholder communities.

Allied dental program directors, dental school deans, and advanced dental education program directors must work with stakeholder communities to keep them informed about the levels of graduating student debt and the positive value of scholarships in dental education.

3. Continue to promote mission alignment with resource management in academic dental institutions.

Dental education programs need to continue to align their missions, core competencies, and revenue engines. Steps for aligning revenues and expenditures with missions and core competencies include estimating the effect of any proposed changes on revenues, discussing how changes in resources will impact human resources, and assessing the impact of proposed changes on academic quality.⁷⁵ Among other benefits, aligning fiscal resources with mission and core competencies can increase a dental education program's ability to balance program expansion, mission and core competencies, and financial problems. If dental education leaders review their budgets through the lens of their missions and core competencies, they may be able to reduce duplicative, redundant, or ineffective activities and redistribute funds to limit education costs and thus contain student borrowing.

4. Explore alternative dental education models.

A new dental education model would likely be required to create the system needed to improve the financial position of dental schools and ensure that the debt facing dental school graduates is manageable. However, not every dental school can pursue alternative models. Some must use a model that fits within an existing university structure and meets the needs of the larger university community. Dental education

programs at all levels should examine the many initiatives that have the potential to change the dental education model. Additional strategies for finding ways to “do more with less” may also be found in cost containment models both inside and outside health care and the education models that have emerged with the opening of new dental schools. Dental education programs should adopt models that not only set out to mitigate increasing levels of educational debt and the rising costs of dental education, but also fit their mission and core competencies.

Key among these alternative models may be the adoption and support of Interprofessional Education (IPE) activities. An ADEA study on IPE surveyed academic deans of dental schools and concludes that “the importance of IPE in dental education is widely recognized by ... schools” and that there appears “to be sufficient interest for dental schools to take on these challenges and plan and develop IPE.”⁷⁶ At the same time, however, another finding is that a major challenge to incorporating IPE into dental school curricula is the need for funding sources. Despite this financing challenge, a number of dental schools are preparing and carrying out IPE experiences for students, either because they have adopted IPE as a fundamental principle, or in response to the new CODA standards⁷⁷ on team-based education that will be in effect for the 2013 accrediting cycle.⁷⁸ Given funding challenges and the new CODA standards, dental school leaders will need to seek sustained funding for IPE activities so as not to add to the cost of dental education and dental student borrowing.

5. Enhance advocacy partnerships with other dental organizations.

Because associations often struggle to be heard by legislators, partnerships are critical. Organized dentistry should continue working together to strengthen a shared message, even when their core goals differ. Rather than let these differences come

between them and their legislative objectives, dental associations need to become allies and advocate for legislation that will positively affect their organizations and members. Advocacy partnerships would also provide opportunities for dental organization leaders to come together to share best practices and resources and to brainstorm solutions for the common concern over rising educational costs and student borrowing.

6. Continue to take a leadership role in representing the interests of ADEA's membership on issues related to the cost of dental education and student borrowing.

ADEA has a long track record of advocating for its members. As the advocacy work proceeds, specific effort should be made on three critical issues: (1) linking federal and state advocacy work to loan repayment/forgiveness programs for new dentists; (2) remedying GME payment bias for hospital services, and Teaching Health Center GME funding criteria; and (3) amending the federal rules governing FQHCs to acknowledge dental schools as part of the health care safety net.

Loan Repayment/Forgiveness Programs

Local, state, and federal governments should adopt loan repayment/forgiveness programs such as those identified in a 2005 HRSA report, *Financing Dental Education*. This report advocates for federal loan forgiveness programs for new dentists who practice in underserved areas or treat underserved populations. Another source demonstrates that there are only 978 NHSC dental providers⁷⁹ at a time when 6,617 dental physicians are needed to address 4,600 designated HPSAs.⁸⁰

ADEA and dental education institutions must (1) continue to advocate for expanded federal and state loan repayment programs that provide the financial incentives necessary for new graduates to participate and (2) link new graduates to these

programs. ADEA should serve as a forum for sharing models, such as the North Carolina model, which uses state loan repayment programs to incentivize new graduates to practice in underserved areas.

GME and THCGME

Another focus area should be the revision of GME and THCGME payments. Most federal GME funding goes to training physicians.⁸¹ The reason for this is that GME payments for services have traditionally favored hospital-based residency programs.⁸² In August 2012, HRSA announced the THCGME program, which provides payments to community-based ambulatory patient care centers that operate a primary care medical or dental (general or pediatric) residency program.⁸³ Under GME and THCGME funding processes, residency programs based in dental schools are not eligible for payments.

The emphasis on hospital- and community-based residency programs puts dental schools at a considerable financial disadvantage. This disadvantage should be of concern to policy makers because school-based residents largely provide dental care at a reduced cost to populations without the financial means or insurance to be treated by private practitioners. Additional federal funding would be helpful to dental schools in expanding residency programs. This expansion, in turn, could increase access to dental care for underserved populations.

FQHCs

Dental schools are a critical part of the U.S. health care safety net, yet they are ineligible to receive some funds available to FQHCs. Like FQHCs, many dental schools serve populations with limited access to health care; are located in or serve high-need communities; provide comprehensive primary health care services (as well as supportive/enabling services that promote access to health care); have fee structures that are generally less than private practice fees; and meet performance and

accountability requirements regarding administrative, clinical, and financial operations.⁸⁴ Dental schools that provide safety net functions but do not receive funding available to FQHCs represent a significant challenge for expanding, and perhaps even continuing, safety net activities. Therefore, dental schools, like FQHCs, should be granted “benefits in recognition of the challenges they face and populations they serve.”⁸⁵ If this funding is made directly available it is likely the stress of tuition and fees could be reduced.

Suggestions for Future Research

After reviewing all of their activities, the Task Force also suggests areas of future research to promote more clarity and better understanding of this complicated topic. These suggestions are listed below.

1. Conduct more extensive trend analyses of available cost and borrowing data.

ADEA and ADA surveys have for years collected data about dental schools, students, and factors that contribute to the cost of dental education and student borrowing. While these surveys have provided reliable, objective data on an annual basis, an examination of this data over time is needed to show trends. Trend data would provide a dynamic view of dental education’s⁸⁶ financial standing and of the revenues and expenditures that can have an impact thereon. For trend data to be most useful, these analyses must be tied to the concepts of lowering the cost of dental education and student borrowing. As a suggestion, a study of trends could reveal the overall pattern of change in cost and borrowing indicators (by comparing different time periods, geographic areas, student populations), and delve deeper into the relationship between educational debt and career choice.

2. Establish data sharing agreements among various stakeholders.

During the development of this report, it became clear that a variety of groups are collecting data on the cost of dental education and student borrowing but data sharing is limited. Because data sharing is not widely practiced, however, and given that ADEA data is limited, the Task Force could not draw firm conclusions on some questions raised in this report. Data sharing would prove the quickest and least expensive way to remedy the problem of limited data.

Data sharing between dental organizations, which can be an important part of an overall plan to lower cost and student borrowing, discourages duplication of collection efforts. Sharing also generates knowledge, as other users may generate questions (and find answers) that the initial data collectors may not have considered.⁸⁷ Sharing data, which encourages accountability and transparency and enables organizations to validate one another’s findings,⁸⁸ provides a promising practice mechanism for building and participating in effective research partnerships.⁸⁹

3. Refine ADEA and CODA surveys so they provide information that supports planning, policy, and decision making associated with the cost of dental education and dental student borrowing.

First, evaluating existing surveys can be a particularly useful way to ask questions that collect accurate and informative cost and borrowing data. A recommended approach is to identify all of the cost and borrowing questions in ADEA surveys and evaluate whether they generate desired and valuable data.

Closely related to the design of survey questions is the frequency with which ADEA surveys are being implemented. Currently, instruments such as the *Survey of Dental School Seniors* ask graduating dental students questions about their loans and

noneducation debt only once, and then again at the conclusion of their predoctoral educational training. Understandably, a cross-sectional study design is desirable because it is less costly and quicker than other designs, but it does not provide information about what happens after the survey. For example, a student may report that he or she will participate in a loan repayment program, but there is no direct evidence that the student actually participated. Therefore, dental education and organized dentistry could coordinate efforts that contribute to longitudinal cost and borrowing research that surveys dental practitioners 5 and 10 years after graduation to more deliberately understand the impact of high debt on career choices.

4. Encourage both local and national qualitative research that examines the status of students' educational loans.

Quantitative studies have already provided information regarding the educational loan repayment behaviors of new dentists. Nonetheless, qualitative methods, such as interviews, have the power to provide “a complex, detailed understanding”⁹⁰ of issues affecting the status of graduates' educational loans. A qualitative research design enables graduates to reveal the reasons for their survey responses and the ways their answers are shaped by their particular circumstances. Qualitative approaches can also prove valuable in highlighting the presence or absence of the information and assistance necessary for graduates to manage education debt. Dental education programs should consider conducting in-depth interviews with their students. ADEA should include open-ended questions in its surveys and analyze survey text responses along with other survey data.

5. Conduct a national study to identify the costs of implementing alternative educational models, especially IPE.

The new CODA standards⁹¹ on team-based education will be in effect for the 2013 accrediting cycle. While this report urges

dental school leaders to identify funding sources to help fund IPE, more research is needed to identify the costs of carrying out IPE activities. Having accurate information about the true costs of the financial resources required for IPE is essential to ascertaining the most effective ways to implement these CODA standards. Additionally, by identifying costs, appropriate recommendations can be made about the best ways to grow and sustain IPE activities.

A national study that examines the cost trends among dental education programs that have implemented IPE activities would also expand knowledge of which IPE activities have had the best results for schools. The study would use both quantitative and qualitative methods. One approach to designing this study might be to collect survey data from a large sample and select a small sample of survey respondents for in-depth interviews.

6. Examine implications of rising debt among allied dental students.

While much is known about dental education costs and student and graduate borrowing, the same is not true for allied dental education costs and student borrowing. These programs are typically shorter in length but often require extensive educational support, especially in the clinical component. To obtain a full picture of the true costs of dental education and student borrowing, deliberate research needs to be undertaken in the allied dental education area. Among the key topics are programmatic costs, levels of student borrowing, and career choices (including practice location and opportunities).

Conclusion

Over the past few months, the Task Force on the Cost of Higher Education and Student Borrowing reviewed reports and available literature, developed a conceptual model of cost and borrowing pressures on students, and reviewed the current regulatory and legislative environment. The

Task Force efforts culminate with recommendations and suggestions for future research. As stated in the introduction of this report, the members seek to answer four critical questions. In answering those questions, the Task Force comes to the conclusions below.

Why does dental school cost so much?

The Task Force agrees that dental education costs are driven by complex forces that involve the competing missions of teaching, research, community service, and patient care, all in a setting demanding new technology and educational methods. Moreover, changes in federal and state funding for higher education, patient care reimbursement, and accountability requirements (such as accreditation standards), put pressure on the dental education environment, driving up expenditures that current revenue streams may be ill prepared to support.

Can dental educators reduce the costs without sacrificing quality?

The Task Force agrees that reform is vital to prepare a workforce that meets the population's future needs. Preparing to meet these needs involves new technologies, innovative educational practices, and support for basic science and patient research. At the same time, ADEA, through channels such as the 1999 *AADS President's Commission Report*, has demonstrated its commitment to making a dental education accessible and affordable to all students. This ADEA Presidential Task Force report builds on the AADS report by reviewing and evaluating the latter's recommendations within the context of today's dental school environment. The Task Force report also makes updated recommendations to the dental education community and organized dentistry in light of new challenges faced by U.S. dental schools since the release of the 1999 report.

From the perspective of academic deans, decreases in state appropriations are driving up tuition and fees at dental schools to a great extent. Deans also most often indicated that the need to invest in new clinical technologies, increases in information system costs, and increases in central university taxes (parent institution support expenditures) drive up tuition and fees at their schools. The Task Force believes that the dental education community and organized dentistry can mitigate these challenges, but not without considerable commitment and resources. Implementing initiatives to increase the economic prosperity of dental schools is an investment worth making.

Moreover, dental education programs strive to provide high-quality patient care in their role as community safety-net oral-health institutions. Thus, mission alignment activities and strategic planning are key to moderating the sharp increases in cost while maintaining quality education and clinical environments. Two decades of eroding public funding have destabilized and weakened the professional education environment. Dental education programs can strive to contain cost, but maintaining quality and institutional alignment despite significant cost reductions does not appear feasible.

Does the high level of student debt influence career decisions?

The Task Force concludes that the available evidence was not certain or conclusive regarding the relationship of student debt to career choice. Certainly, some students voice concern about the potential impact of their indebtedness, but total lifetime earnings remain positive for dental professionals, as currently reflected in the ROI research.⁹² Much more research needs to be done to determine what early- and mid-career practice decisions dentists make and how these relate to specific debt levels.

Do high dental education costs influence who applies and attends dental school?

This final question is perhaps the most critical for the future of the dental profession. The most recent research provides some evidence that attracting and sustaining those students who come from lower socioeconomic background yields oral health benefits to underserved communities by providing practitioners who desire to serve traditionally underserved patients or work in these communities. Hence, more research along this line is recommended to clarify the relationship between applicants' characteristics and actual practice decisions.

In conclusion, dental education leaders, students, organized dentistry, and policymakers must partner to find ways to slow the growth in dental education costs and contain student borrowing. Most importantly, organized dentistry must play a role in improving the financial position of U.S. dental education programs to ensure they are not negatively impacted by the economic factors facing students, and, ultimately, to guarantee the profession's future, as well as its ability to function as a safety net for underserved populations.

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COVER STORY

Educational debt and intended employment choice among dental school seniors

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Dental school students' debt levels are rising. The average educational debt of graduating dental school seniors, including both dental school debt and prior educational debt, rose from \$122,000 in 2004 to \$179,000 in 2011 according to calculations we performed by using data from the ADEA (American Dental Education Association) Survey of Dental School Seniors. Dentists' income has not risen as rapidly over the same period. As a result, average educational debt rose from 70 percent of dentists' median income in 1996 to 103 percent of dentists' median income in 2011.¹ This rise suggests an increase in the burden placed on dental school graduates.

The rising debt relative to income may be exacerbated by an influx in new dental school graduates. The application to enrollment ratio reached a historical high of 2.9 applicants for each first-year dental school student spot in 2007 before easing slightly to 2.5 in 2008, but it remained well above the 1950-2008 average of 1.7.²⁻⁴ The high demand for dental education is spurring an increase in the number of dental schools. Thirteen new dental schools have been planned or proposed in the past few years.²⁻⁴ If the increased supply of dentists is not met with a comparable increase in demand for dental services, then the higher supply of dentists is expected to further limit wage gains and exacerbate the declining return to dental education.

Rising educational debt without a comparable increase in expected income has the potential to affect

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ABSTRACT

Background. The authors examined the association between educational debt and dental school seniors' intended activity after graduation.

Methods. The authors used multinomial logit regression analysis to estimate the relationship between dental educational debt and intended activity after graduation, controlling for potentially confounding variables. They used data from the 2004 through 2011 ADEA (American Dental Education Association) Survey of Dental School Seniors.

Results. Fourth-year dental school students with high levels of educational debt were more likely to express an interest in choosing to go into private practice, although the magnitude of this effect was relatively small. For each \$10,000 increase in debt, the likelihood of choosing advanced education relative to private practice was 1.5 percent lower (relative risk ratio [RRR], 0.985 [95 percent confidence interval {CI}, 0.978-0.991]). For the same \$10,000 increase in debt, the probability of choosing teaching, research and administration was 3.1 percent lower than that for choosing private practice (RRR, 0.969 [95 percent CI, 0.954-0.986]) and was 8.4 percent lower than that for choosing a government service position (RRR, 0.916 [95 percent CI, 0.908-0.924]).

Conclusions. Although educational debt was statistically significant for predicting intended activity after graduation, the magnitude of influence of other variables such as sex, race and whether a parent is a dentist was substantially larger.

Practical Implications. Concerns regarding rising educational debt and its effect on the dental labor market may be misplaced. The characteristics of the dental school student body may be a more accurate predictor of employment choices than dental school seniors are making than are total educational debt levels.

Key Words. Education; career choice; students; dental economics.

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graduates' career choices—including specialty training, willingness to work in underserved areas and willingness to treat Medicaid patients—as well as practice ownership options.^{5,6} In theory, rising educational debt is expected to encourage students who are choosing between different employment options to seek the position with a higher income. The higher income is needed for the graduate to maintain a standard of living comparable with those of previous dental school graduates. The result is that educational debt may increase the likelihood of choosing private practice instead of government service; teaching, research and administration; or public health positions. The effect of educational debt on advanced education is more ambiguous. Higher debt could influence a graduate to seek employment sooner to start repaying loans, or it could encourage the pursuit of advanced education to achieve a higher salary later.

Empirical evidence for the effect of total educational debt is mixed. Typically, educational debt plays a central role in the decision-making process. One exception is students who already were obtaining advanced education. In one study, surgical residents reported that total educational debt did not play a role in their choosing to go into an academic program instead of private practice, except at the highest debt levels.⁷ Residents with debt greater than \$301,000 were more likely to choose private practice. On the other hand, more than one-half of practicing dentists in several graduate cohorts from one dental school reported that educational debt levels influenced their career choices.⁸

Investigators in studies have used the results of the ADEA's annual Survey of Dental School Seniors to examine the role of educational debt in employment choice.^{9,10} The results of a multivariate analysis showed that debt reduced the likelihood of planning to enter public service, and entry into a loan repayment program increased the likelihood of public service relative to other plans.⁹ The results of a study of 2009 dental school graduates showed a correlation between total educational debt and plans to enter private practice.¹⁰ The authors of the study did not, however, control for other student characteristics. In the same study, no clear majority response emerged when questions on the survey asked students to what extent educational debt influenced their choice of activity after graduation.¹⁰ Twenty-eight percent of seniors with debt indicated that their debt did not influence their choice, 39 percent indicated that it influenced their choice somewhat or moderately, and 33 percent indicated that it influenced their choice much or very much.

Empirical evidence regarding whether educational debt influences the decision to pursue advanced education is mixed. The authors of two studies who conducted their own surveys of dental school students found opposing results.^{11,12} The results of a multivariate analysis of data from surveys distributed to both fourth-year

students and advanced-standing students at one dental school showed that respondents' debt levels reduced their intentions to pursue specialty training, even after controlling for sex, age and class year.¹¹ The result is consistent with those of an annual ADEA survey, which showed that senior dental school students with higher debt loads were less likely to have intentions of pursuing specialty training.¹⁰ Alternatively, investigators in a survey that tracked 138 students from six publicly funded dental schools found that students' plans to pursue advanced education were not influenced by higher debt levels, higher than expected debt, sex, race or whether they had children.¹² Rather, the decision to pursue advanced education was influenced by whether the student had a dental school mentor, a high grade point average (GPA) or encouragement from significant others.¹² However, for the latter result, investigators controlled only for whether debt was less than or greater than \$100,000, which may not have provided sufficient variation to identify an effect on graduation plans.

We conducted a study in which we used the ADEA's dental school senior surveys to extend the previous research in several ways. We examined several years of data to increase the sample size and look at the correlation between the total educational debt and employment choice over time. We used multinomial logit regression analysis to control for various (observable) confounding factors, and we examined the impact of educational debt on several distinct career choices.

METHODS

Data sources. We obtained the data for our study from the annual ADEA survey of senior dental school students. The surveys are provided to dental schools in March and administered to students during the spring or summer shortly after graduation. The Institutional Review Board for Health Sciences Research at the University of Virginia (Charlottesville) reviewed our study and determined it to be exempt from institutional review board oversight. Response rates ranged from 62 percent in 2009 to 86 percent in 2005, with an average of 75 percent. We used *t* tests to compare the survey respondent characteristics with the American Dental Association's survey of dental school graduates from 2004 through 2010.¹³ We found no statistical difference in sex or race, with the exception of 2010 when a higher proportion of white students took the ADEA survey than did non-white students.

We pooled data from 2004 through 2011 to increase the sample size. We excluded students who reported they were younger than 24 years or older than 50 years (329 respondents) and students who reported that they had more than \$600,000 of debt (74 respondents) to remove

ABBREVIATION KEY. ADEA: American Dental Education Association. GPA: Grade point average.

TABLE 1

Summary statistics of dental seniors, 2004-2011.		
VARIABLE	OBSERVATIONS, NO.	MEAN (STANDARD DEVIATION)
Age	27,122	28.28 (3.48) years
Total Educational Debt*	27,716	\$15.67 (\$96.52) [†]
Total Educational Debt	27,716	\$16.83 (\$10.18) [†]
Female	27,572	44 (0.50) percent
Parent a Dentist	23,759	14 (0.35) percent

* Total educational debt includes dental school debt and prior educational debt.
[†] Dollar amounts were inflation adjusted and divided by \$10,000.

TABLE 2

Summary statistics of dental school seniors, according to race or ethnicity, 2004-2011.		
RACE OR ETHNICITY	FREQUENCY, NO. OF OBSERVATIONS	PERCENTAGE
Native American	166	0.62
Asian	6,190	23.15
African American	1,287	4.81
Hispanic	1,614	6.03
White	17,487	65.39

observations that were more likely to be inaccurate. The average age of senior dental school students who completed the survey was 28 years (Table 1 and Table 2). Average total educational debt was \$168,300 (adjusted to 2011 dollars by using the consumer price index, which is a common method for adjusting for inflation).

In terms of validity, the annual survey has been conducted by ADEA for many years, and the results have been used in studies for many years. Therefore, we assumed that experts had sufficient time to examine the content of the questions and that they were valid measures. In regard to reliability, we did not conduct repeat trials to determine the accuracy of the answers each participant gave. Because students were estimating current debt, rather than debt from several years in the past, we assumed that the estimates were relatively accurate. Investigators who conducted a study in which they used the same ADEA survey as we did noted that validity and reliability were indicated by the high response rates, high number of responses for each item, consistency in responses across items and lack of concerns in the literature over the decades in which the ADEA survey has been used.⁹

Research design. We hypothesized that as educational debt increased relative to income, students on the margin of choosing between different employment options would be more likely to choose the higher-paying option. Higher income is necessary to maintain the same standard of living that the graduates had expected and that previous dental school graduates enjoyed. Therefore, other things being equal, we expected a larger number of graduates to seek more lucrative employment in private practice or potentially though advanced education as

educational debt increased relative to income. The effect of educational debt on advanced education is ambiguous because it delays loan repayment but leads to greater income in the future. At the same time, many other factors influence intended employment, such as sex, race or ethnicity, age and socioeconomic status. Some of these variables were available in the data, and we controlled for them in our analysis. Other variables that may matter—such as a person's natural ability to do well enough to pursue advanced education, marital status, importance placed on job satisfaction, availability of loan repayment plans or opportunities to participate in internships—were not available in the data, and we did not include them in our analysis. The hypothesis predicted that total educational debt influenced employment. We used the hypothesis to test the relative importance of educational debt

compared with other explanatory variables for different employment choices.

We tested the hypothesis by using a multinomial logistic regression analysis. The dependent variable was a student's intended primary activity after graduation. The data for this variable came from responses to survey question that asked students "[i]mmediately upon graduation from dental school do you intend your primary activity to be: ..." followed by a multiple-choice list of possibility activities. From 2004 through 2008, there were seven possible activities, and from 2009 through 2011, there were 11 possible activities. We consolidated activities into five intended activities: private practice; advanced education; government service; public health; and teaching, research and administration.

The independent variables for the main hypothesis were whether a student's parent was a dentist, the student's race, age, sex, father's and mother's educational level, graduation year and whether the student attended a public or private dental school. We clustered standard errors according to dental school to allow for a correlation in unobserved school characteristics that may have affected employment intentions among students who attended the same school.

In addition to the main hypothesis, we investigated a number of other hypotheses by using different combinations of control variables. One possibility was that schools had an important influence on the intended employment choices of students, independent of the schools' influence on educational debt. For some hypotheses, we included an indicator variable for each dental school rather than only including an indicator variable for attending a public school. Another possible hypoth-

esis was that the control variables were correlated with debt and therefore may have captured some of the influence of debt. We considered a hypothesis that included educational debt as the only explanatory variable. For one hypothesis, we omitted the indicator variables for each graduation year to see if those variables were capturing some of the influence of the rise in debt over time. Finally, we added a variable for educational debt squared to explore whether debt had a nonlinear effect on intended primary activity.

RESULTS

The main hypothesis predicted that as total educational debt levels rise, more students would choose to enter private practice. One way to analyze the hypothesis is to look at change in debt and intended employment choice over time.

Our observation of the data over time did not show a clear correlation between educational debt and choosing private practice. Adjusted for inflation, debt among students at public dental schools rose from an average of \$118,915 in 2004 to \$160,803 in 2011, and among students at private dental schools, debt increased from \$179,533 in 2004 to \$213,237 in 2011 (Table 3). Over the same period, we did not see a trend in students intending to enter private practice. The percentage of students intending to work in private practice ranged from 47.45 percent in 2008 to 53.56 in 2009 (Table 4).

Alternatively, when we looked cumulatively at all students and a range of debt levels, we observed a correlation between people with high educational debt and intent to enter private practice (Figure 1). This result is similar to those of other studies.^{10,14,15} However, that total educational debt changed substantially, moving from left to right on the x-axis in Figure 1, whereas the percentage of students choosing a career path did not change nearly as much on the y-axis. Thus, the association between debt and intended employment choice was not as large as it might appear visually.

TABLE 3

Total educational debt* over time for public and private schools (unadjusted and adjusted for inflation), according to year of graduation.				
YEAR	DEBT UNADJUSTED FOR INFLATION, \$		DEBT ADJUSTED FOR INFLATION, \$	
	Public Schools	Private Schools	Public Schools	Private Schools
2004	99,929	150,868	118,915	179,533
2005	104,738	162,979	120,448	187,426
2006	123,293	176,466	138,088	197,642
2007	136,378	187,539	147,288	202,542
2008	142,582	205,407	148,285	213,623
2009	148,584	199,651	156,013	209,633
2010	156,441	204,380	161,134	210,511
2011	160,803	213,237	160,803	213,237

* Total educational debt includes dental school debt and prior educational debt.

TABLE 4

Intended primary activity after graduation, according to year of graduation.					
YEAR	PRIMARY ACTIVITY, %				
	Private Practice	Advanced Education	Teaching, Research and Administration	Government Service	Public Health
2004	49.65	39.75	0.48	7.78	2.35
2005	50.00	39.94	0.77	6.35	2.93
2006	50.85	39.11	0.57	6.31	3.16
2007	49.56	39.44	0.41	6.49	4.10
2008	47.45	40.90	0.84	6.11	4.71
2009	53.56	34.00	0.39	9.85	2.21
2010	51.11	38.37	0.60	7.66	2.26
2011	51.74	38.10	0.43	7.53	2.20

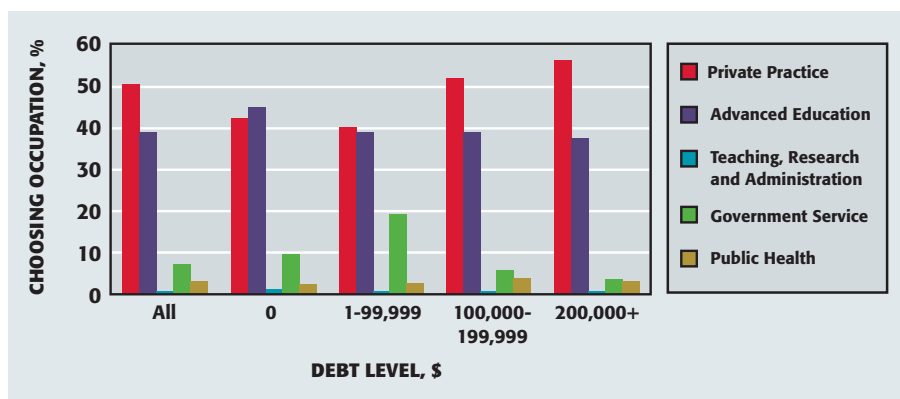


Figure 1. Employment plans, according to debt level (not adjusted for inflation).

To reconcile these two observations, we used a multinomial logit regression model to control for other factors that influence intended employment choice (Table 5). We used private practice as the baseline category for intended employment choice. The baseline for whether a parent was a dentist was no, for race it was white and for sex it was male. Relative risk ratios (RRRs) greater than

TABLE 5

Factors influencing intended primary employment choice in private practice compared with alternative activities.*

EXPLANATORY VARIABLES†	ADVANCED EDUCATION, RELATIVE RISK RATIO (ROBUST SE‡§)	TEACHING, RESEARCH AND ADMINISTRATION, RELATIVE RISK RATIO (ROBUST SE)	GOVERNMENT SERVICE, RELATIVE RISK RATIO (ROBUST SE)	PUBLIC HEALTH, RELATIVE RISK RATIO (ROBUST SE)
Total Educational Debt¶	0.985 [#] (0.003)	0.969 [#] (0.008)	0.916 [#] (0.004)	0.998 (0.005)
Parent Is a Dentist (No = 0; Yes = 1)	0.850 [#] (−0.037)	1.095 (−0.233)	0.531 [#] (−0.054)	0.724** (−0.113)
Race or Ethnicity (Baseline = White)				
Native American	0.77 (−0.155)	0.000 [#] (0.000)	2.546** (−0.93)	2.343** (−0.849)
Asian, South Pacific Islander	0.952 (−0.069)	1.034 (−0.289)	0.440 [#] (−0.05)	0.807 (−0.109)
African American	1.989 [#] (−0.396)	1.74 (−0.592)	2.074 [#] (−0.414)	3.342 [#] (−0.589)
Hispanic	1.144 (−0.179)	0.893 (−0.348)	0.90 (−0.097)	1.533** (−0.276)
Age	0.910 [#] (−0.008)	1.02 (−0.028)	0.980** (−0.009)	0.979†† (−0.012)
Sex (Male = 0; Female = 1)	0.963 (−0.035)	1.580** (−0.333)	0.620 [#] (−0.036)	1.353 [#] (−0.12)

* The total number of observations was 25,176.

† A category for the employment choice of other/unknown (n = 532) was included in the regression analysis but is not presented in the table.

‡ SE: Standard error.

§ Relative risk ratios were estimated by using robust SEs.

¶ Graduation year indicator variables were included in the regression analysis but were omitted from the table. Standard errors were clustered according to school. Total educational debt was adjusted for inflation and divided by \$10,000.

[#] Significant at the 1 percent level.

** Significant at the 5 percent level.

†† Significant at the 10 percent level.

1.0 indicated a greater likelihood that the student would choose the respective intended employment rather than private practice as the explanatory variable increased. An explanatory variable that had an RRR of less than 1.0 indicated that there was a negative relationship between the explanatory variable and the particular intended employment option.

The results show that total educational debt was associated negatively with an intention of seeking advanced education; obtaining a teaching, research or administration position; or entering government service compared with entering private practice. This finding was consistent with our hypothesis that higher debt levels could encourage more students to choose to enter private practice. However, the magnitude of the effect was relatively small compared with that of other explanatory variables.

One concern with using large data sets is that the results may be statistically significant but of such a small magnitude that they are not practically meaningful. To give context to the magnitude of our results, we translated the findings into what an increase in debt would mean for the labor market. Holding all other variables constant, each \$10,000 increase in a student's debt decreased his or her likelihood of choosing advanced education by 1.5 percent (RRR, 0.985; 95 percent confidence interval [CI], 0.978-0.991); choosing teaching, research and administration by 3.1 percent (RRR, 0.969; 95 percent CI, 0.954-0.986); or choosing a government service position by 8.4 percent (RRR, 0.916; 95 percent CI, 0.908-0.924) relative to choosing private practice. The intention to enter public health was not significantly

correlated with educational debt.

African American dental school students were approximately twice as likely as were white dental school students to intend to enter advanced education or government service compared with private practice and more than three times more likely to choose public health. The students' sex did not have a significant effect on seeking advanced education compared with entering private practice. However, female students were 58 percent more likely to choose teaching, research and administration, 38 percent less likely to choose a government service position and 35 percent more likely to choose a public health position than were male students. A student was 15 percent less likely to seek advanced education, 47 percent less likely to seek a government service position and 28 percent less likely to seek a public health position if his or her parent was a dentist.

The association between total educational debt and intended primary activity was similar across the various alternative specifications (results available on request). Total educational debt squared was not significantly associated with choosing advanced education or teaching, research and administration, and it was only significant at the 10 percent level for choosing government service and public health positions. The results also were not statistically different when compared with inclusion of all reported debt levels and all ages rather than exclusion of students who reported being younger than 24 years or older than 50 years and having total educational debt levels greater than \$600,000. The fact that the results did not change across different specifications

supports the initial finding that total educational debt was associated with a positive but relatively small increase in the likelihood of choosing private practice.

We used the values shown in Table 5 to predict how students' choices of employment would change if the mean educational debt per dental school student increased, holding other things constant. The hypothesis predicted that a \$10,000 increase in mean debt would result in 1.5 percent (RRR, 0.985) of students changing their intended activity from advanced education to private practice. Because there were 10,503 students intending to enter advanced education, the increased debt would have resulted in 158 fewer people intending to pursue advanced education cumulatively from 2004 through 2011. The increased debt also would have resulted in five (3.1 percent) fewer students pursuing teaching, research and administration and 164 (8.4 percent) fewer students seeking a government service position. Instead of those employment options, the students would have transferred their intended activity to private practice, resulting in 326 (2.5 percent) more people intending to enter private practice over the eight-year period.

Figure 2 shows the relative importance of different variables. A bar above zero percent indicated that there was a higher probability of choosing private practice. A bar below zero percent meant there was a higher probability of choosing an alternative intended employment option. For a \$10,000 increase in debt, there was a small increase in probability that a student would pursue private practice versus seeking advanced education; teaching, research and administration; or a government service position. Female students were more likely than were male students to pursue teaching, research and administration and public health positions over private practice, but they were less likely to choose government service positions. Black students were more likely to choose advanced education, government service and public health positions over private practice than were non-black students. Finally, if a student's parent was a dentist, he or she was more likely to pursue a private practice position than an advanced education, government service position or a public health position.

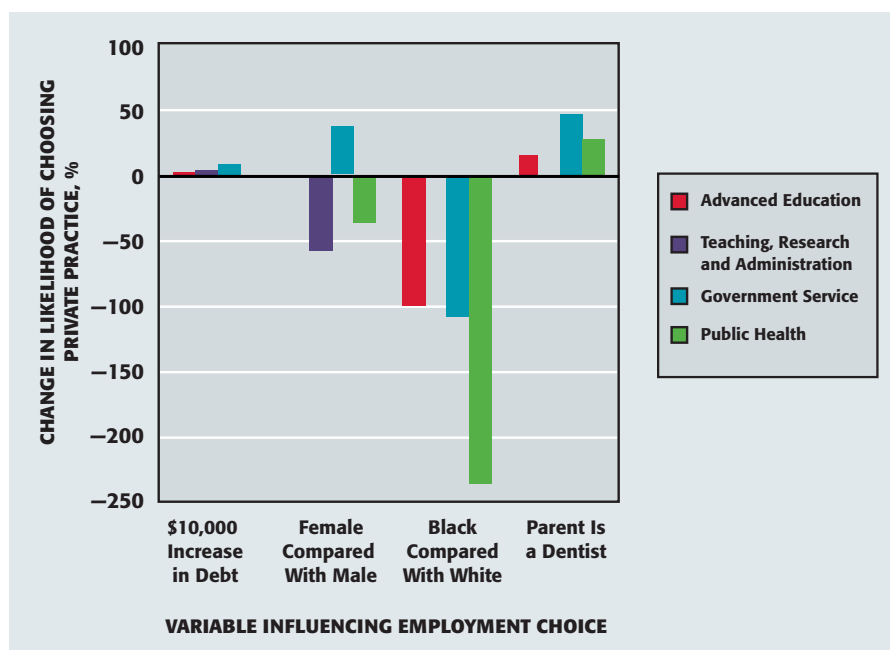


Figure 2. Comparison of magnitude of preference for private practice. A value greater than zero percent means private practice is more likely, and a value less than zero percent means private practice is less likely.

DISCUSSION

Although the findings of our analysis were consistent with the main hypothesis' prediction and with the findings of prior studies, they address the relative importance of educational debt to a senior dental school student's intent to enter private practice. Once we controlled for other characteristics, the magnitude of the effect of educational debt on intended employment choice was relatively small. These results run counter to the conventional wisdom that rising educational debt is a primary driver pushing students toward private practice. This result is consistent with our observation that students are not choosing private practice more frequently over time.

One weakness of our study was the lack of data on students' actual employment after graduation, ultimate career path and future earnings. To our knowledge, no studies have been conducted regarding the relationship between intended and actual primary activity after graduation. Because the ADEA's survey was administered close to graduation, we could only assume that intended and actual activities were correlated. The accuracy of this assumption depends on vacancy rates, the difficulty in entering different employment sectors and the availability of information given to senior dental school students regarding the job market. At a minimum, the intended primary activity indicated the demand for different activities after graduation, which can be a useful gauge of the incentives graduating seniors faced. We also do not have information on the extent to which people switch employment sectors midcareer, which would alter

expected lifetime earnings and could change willingness to work in employment sectors, such as public health, in the short term.

There were a number of other variables we omitted that could have influenced employment choice, such as GPA, student loan repayment programs, internships and other opportunities. Some variables, such as GPA, would be difficult to include directly because causality could go in either direction. A student with a high GPA may have better access to advanced education. On the other hand, a student planning on entering a graduate program may choose to study more to obtain sufficiently high grades. However, a proxy for academic ability would be a valuable addition to the hypothesis. Other variables, such as the availability of student loan repayment programs, graduate training, internships and opportunities in the military and public health, would add to the analysis. Including participation in one of these programs in the hypothesis would not clarify what the student would have done otherwise. However, inclusion of the availability or access to these programs in a given year would provide a useful contribution to the analysis. If an omitted variable is correlated with an included variable, then the effect may be attributed incorrectly to the included variable. If the omitted variable is not correlated with the included variables, then the regression analysis results will be accurate but the overall hypothesis will not explain a student's intended employment choice fully.

The results of our study show that student characteristics have a larger influence on intended employment choice than does total educational debt. Key factors in the decision to pursue advanced education or a government service position were race or ethnicity. Furthermore, female and black students were much more likely to pursue public health positions. One factor that encouraged students to pursue private practice was having a parent who was a dentist. The expectation of taking over a parent's dental practice may have explained the influence of having a parent as a dentist on the intent to enter private practice after graduation.

CONCLUSION

In this study, we focused on the relative importance of educational debt on dental school seniors' intended employment after graduation. We controlled for a variety of characteristics and found that although educational debt was significant, the magnitude of its effect was relatively small compared with other characteristics. Despite educational debt receiving a lot of attention, demographic enrollment trends appeared to be more important in determining the future dental labor market. Our findings suggest that focusing on the characteristics of the student body may be a better avenue for understanding employment after graduation.

Key areas for future research include extending the

analysis back to when major shifts in student body composition occurred. There were few changes in sex or race during our period of our study, but major changes had occurred in prior decades.¹⁵ Another area for future research is to examine the relationship between intended and actual employment, long-term career earnings and flexibility in moving between employment sectors in the dental labor market. The findings from our study, nonetheless, can help dentistry gain a better understanding of the factors that influence students' employment decisions. ■

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This article represents the opinions of the authors and not necessarily those of the American Dental Association.

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ADA Stakeholder Meeting

*Defining the Scope and Aims of a Proposed
Comprehensive Study of Current Dental
Education Models*

**ADA Headquarters
June 19-20, 2014**

Welcome & Introductions

Overview: Comprehensive Study of the Current Dental Education Model

Resolution 56H-2013. Resolved, that the ADA seek collaboration with broad communities of interest, including dental educators, students, practicing dentists, health economists, and others with appropriate expertise to define the scope and specific aims of a comprehensive study of current dental education models, to include:

Evaluation of the long-term sustainability of dental schools.

Evaluation of the efficiency of the current dental school curricula and delivery methods.

Analysis of the impact of student debt on dentistry as a career choice and subsequent practice choices.

A determination of whether dental schools are meeting the appropriate level of scholarship to ensure that dentistry continues to be a learned profession;
and be it further

Resolved, that the ADA's financial implication for this resolution shall not exceed \$80,000, to be used to define the scope and specific aims of the study, to determine the estimated cost of the study, to identify potential funding sources for the study, and to report to the 2014 ADA House of Delegates.

Goals for the Meeting

1. More clearly define questions a comprehensive study of the current dental education model should address.
2. Explore how such a study could be conducted.

Issues to Consider

- Issue 1: Long-Term Financial Sustainability of Dental Schools
- Issue 2: Efficiency of Current Dental School Curricula & Deliver Methods
- Issue 3: Impact of Student Debt on Career & Practice Choices
- Issue 4: Appropriate Level of Scholarship within Dental Schools to ensure Dentistry Continues to be a Learned Profession

Summary and Next Steps

- CDEL's Dental Education Committee will prepare a report summarizing the Stakeholder Meeting
- CDEL will consider Dental Education Committee's findings and recommendations
- Council on Dental Education and Licensure will transmit its response to Resolution 56H to the 2014 House of Delegates

Thank you

ADA Stakeholders Meeting June 19-20, 2014



SCHOOL OF DENTAL MEDICINE
CASE WESTERN RESERVE
UNIVERSITY

“Be Needed”

Danny Verne 1984

“Everything that can be counted does not necessarily count; everything that counts cannot necessarily be counted.”

- Albert Einstein 1879-1955

“We use statistics like a drunk man uses lamp-posts ... for support rather than illumination.”

- Anonymous

DAN ARIELY

New York Times Bestselling Author of *Predictably Irrational*

A stylized profile of a human head facing left, composed of three overlapping outlines in blue, yellow, and green. The head is set against a solid orange background.

THE UPSIDE OF IRRATIONALITY

*The Unexpected Benefits
of Defying Logic
at Work and at Home*

“In matter of opinion I’m seldom wrong.”

- Talmud 200-500 A.D.

Mission

Case Western Reserve University *improves and enriches*
people's lives through research that capitalized on the
power
of collaboration, and education that dramatically
engages our
students.

Vision

We aim to be recognized internationally as an institution that ***imagines and influences the future.***

Toward that end, we will:

- Support the advancement of ***thriving disciplines as well as new areas of interdisciplinary excellence.***
- ***Provide students with the knowledge, skills and experiences*** necessary to become leaders in a world characterized by rapid change and increasing interdependence.
- Nurture a community of exceptional scholars who are ***cooperative and collegial***, functioning in an atmosphere ***distinguished by support, mentoring, and inclusion.***
- Pursue distinctive opportunities to build on our special features, ***including our relationships with world-class health care, cultural, educational, and scientific institutions.***

Discover the Future of Dental Medicine



University Leadership

(President, Provost and B.O.T.)

Quality of Education

Creating new impactful knowledge

Reputation/Visibility

Societal Value

- Interprofessional and interdisciplinary
- Community impact

Financial Sustainability

University – Dental School – Profession – Society

Goals are easily aligned

Priorities?

Trends?

Learned Profession

- Perception
- AAU and AAU like
- Vision

Mission

- Role of service

Financial Model

Tuition

Return On Investment (R.O.I.)

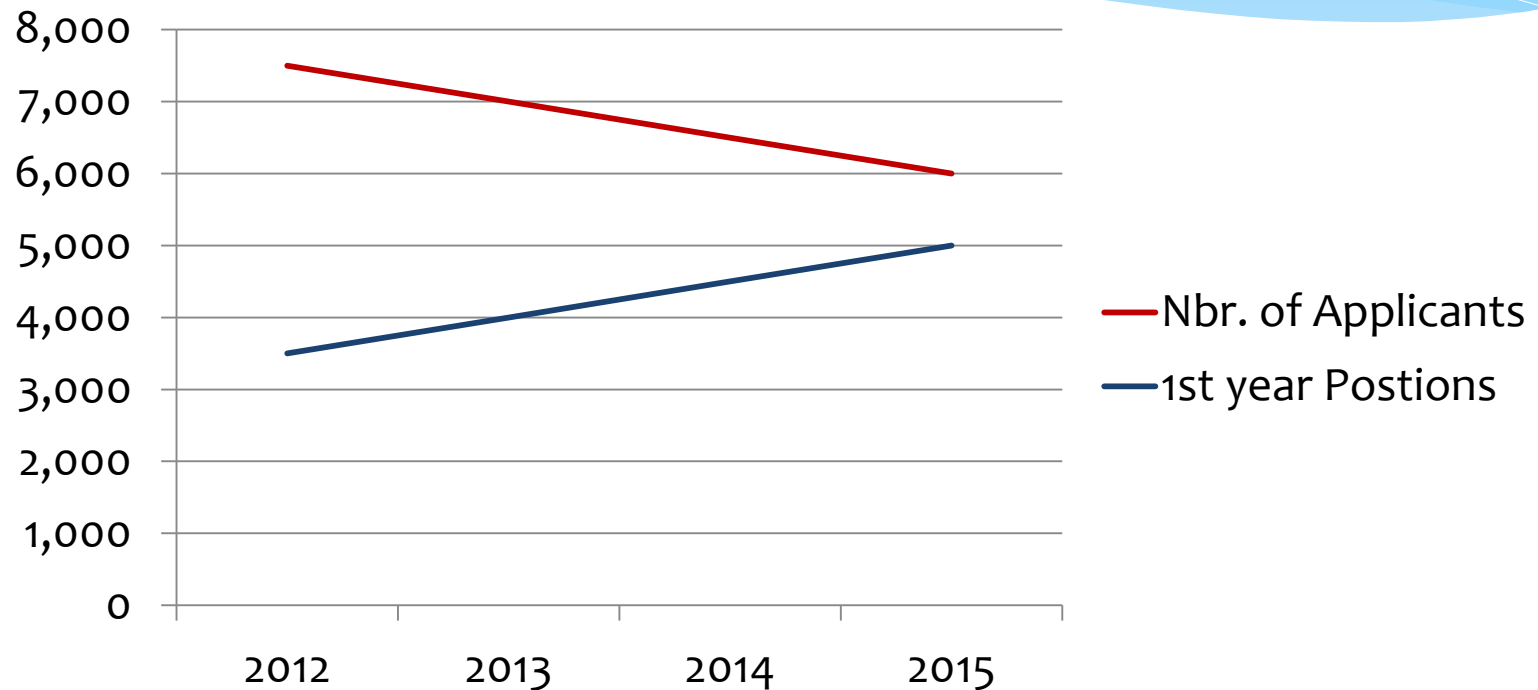
Costs

- Research
- Clinics
- Active Learning
- Distributed Model
- Shared Teaching
- Distant Teaching

Priorities

Infrastructure

Financial model (cont.)



* Research intensive at greatest risk

Synergies and Alignment

- Research
- 1^o Health Care
- I.P.E.
- Partnerships

Reputation

- Internal Marketing
- Alignment
- Objective outcome
- Rankings

“Be the change you wish to see in the world”

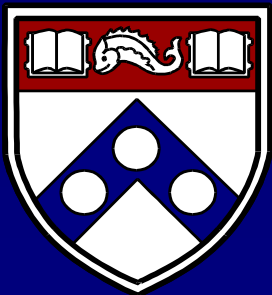
- Mahatma Gandhi 1869-1948

“Influence the future or be consumed by the present”

- Jerold Goldberg 2014

The Business Model for Dental Schools and Dental Education

American Dental Association Stakeholder Meeting
June 19, 2014



David A. Asch, MD, MBA

The Perelman School and The Wharton School
University of Pennsylvania
Department of Veterans Affairs

Quick, think of a brand name product



The business case: What business are we in?

- Kodak was late to recognize it was not in the camera and film business—it was in the imaging business.

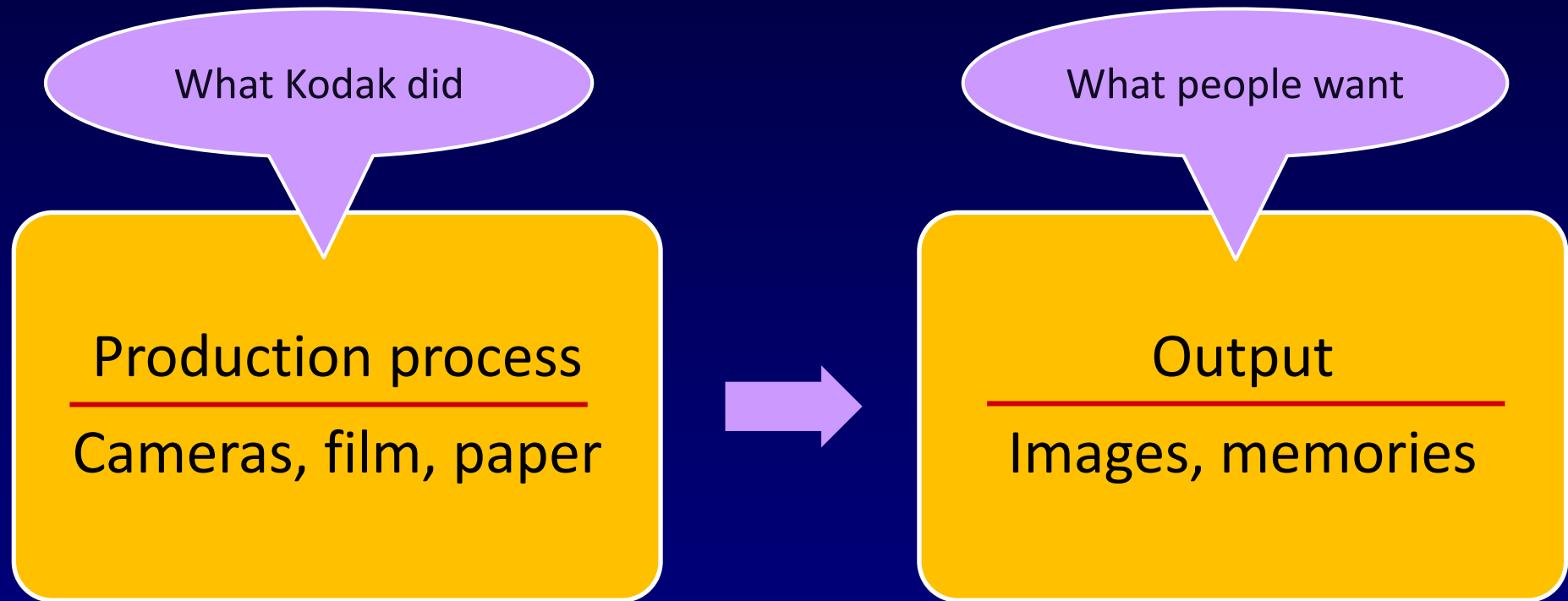


- It is better to define a business by what consumers want than by what a company can produce.
- By that standard, hospitals should eventually leave the health care business and soon enter the health business.

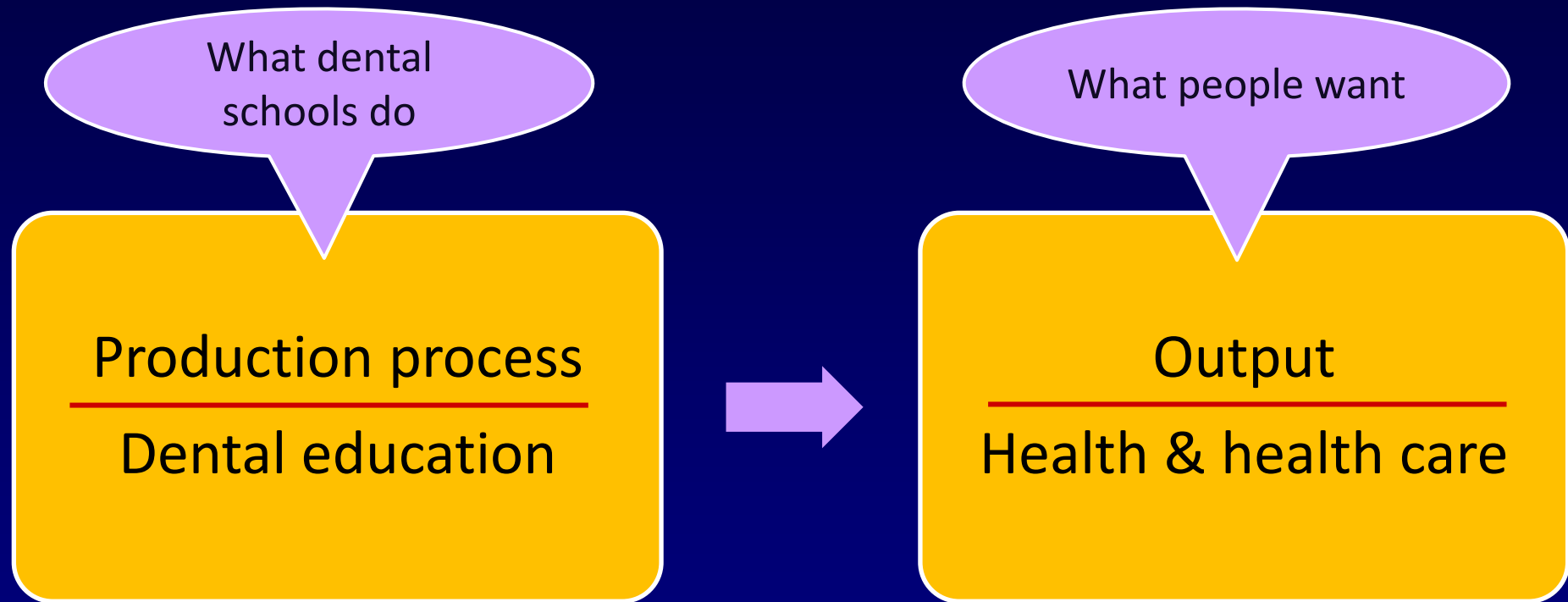
Health is the goal

The single purpose that justifies our enormous investment in medical and dental education is improving the health of individuals and populations.

A business model of photography

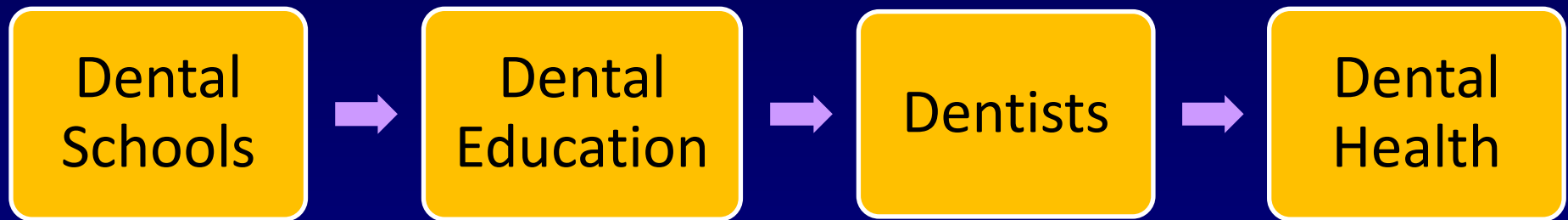


A business model of dental education



A customer-focused system of dental education

The long term survival of any industry depends entirely on adding value to what it is people want, rather than perpetuating what the industry does.



What are the best ways to support school revenue and reduce school costs?

If the customers
are dental
schools

- Raise tuition?
 - Expand research?
 - Reduce research?
 - Commercialize technology?
 - Expand markets?
-

What are the best ways to train dentists?

If the customers
are dentists

- Shorten training?
 - Lengthen training?
 - MOOCs?
 - Make it a specialty of Medicine?
-

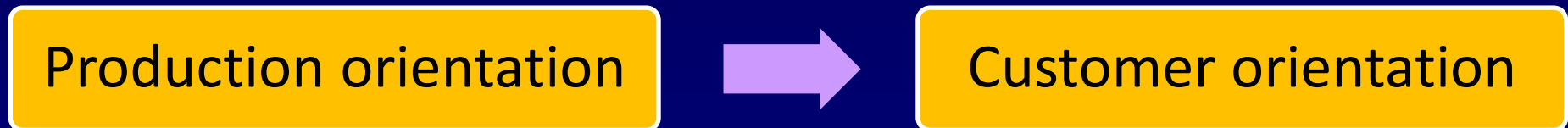
What are the best ways to advance the dental health of patients and populations?

If the customers
are patients and
populations

- Fluoridate water
 - Expand research
 - Support non-dentist providers
-

A customer-focused system of dental education

Move from a focus on what is produced to a focus on what people want.

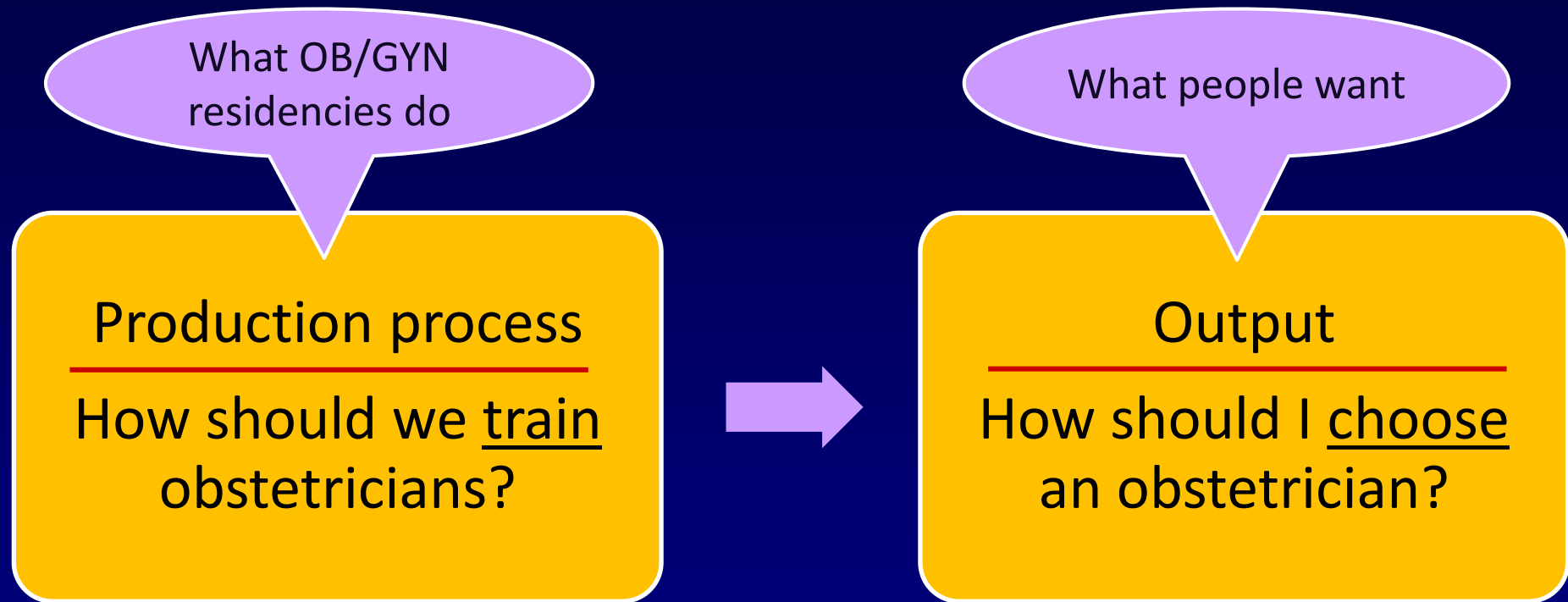


What should we mean if we say a dental school is good, or better than another school?

If the goal of dental school is improving the health of individuals and populations, then...

- ...good schools are those that produce graduates who take care of patients well, and
- ...better schools are those that produce graduates who take care of patients better.

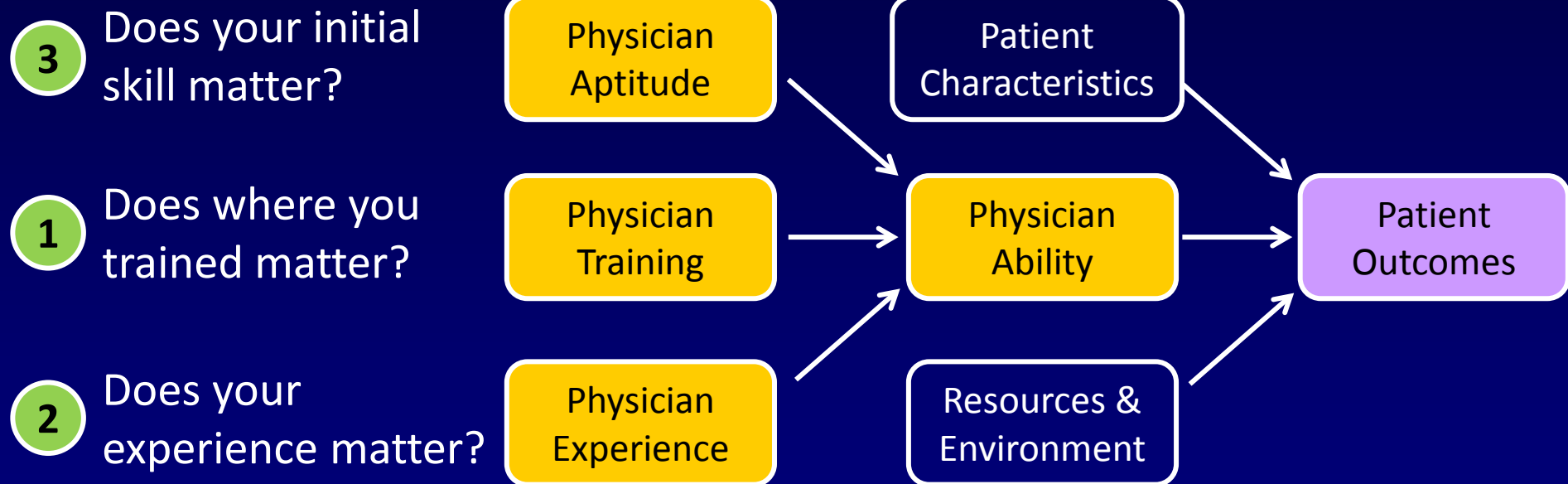
A business model of obstetrics



Why obstetrics?

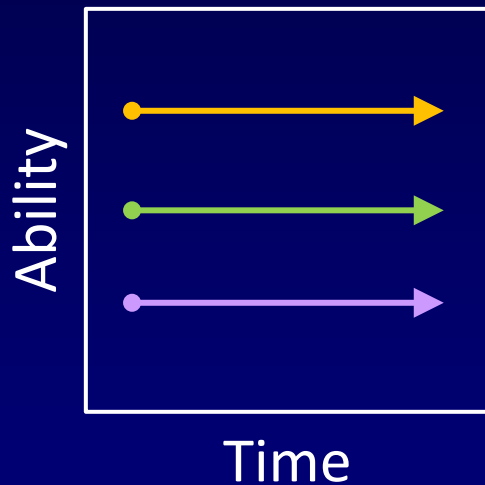
- Obstetrics is a useful setting for understanding the determinants of quality.
 - » Relatively narrow field
 - » High volume
 - » No great need for severity adjustment
 - » Outcomes are largely attributable to a single clinician
- Many of these conditions apply to dental medicine in its various forms.

What drives the production of good outcomes?

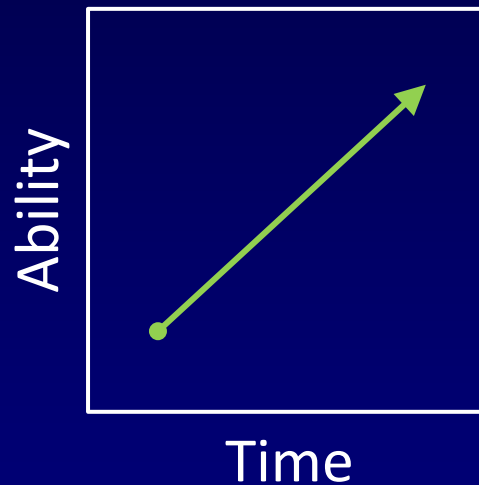


Three questions about quality of care and training

1 If all that matters is where you trained



2 If all that matters is experience



3 If all that matters is how you started



- The first two of these are easily observable by customers.
- The answers to these questions might also provide direction to new training approaches.

Does where you trained matter?

- Intuitively, most people seem to think so.
 - » Medical students aim to get accepted into certain residencies.
 - » Physicians may brag about their residencies.
 - » Health systems may give hiring advantages to graduates of some residencies.
- However, these may all be empty signals.

If all that matters is where you trained



Hospital deliveries in Florida and New York 1992-2007

- 7,130,457 deliveries, reduced to:
- 4,906,169 deliveries reflecting:
 - » licensed physicians who completed OB residencies and performed at least 100 deliveries.
 - » From residency programs contributing at least 10 physicians
- 4,124 physicians
- 107 residency programs (of 249) from 22 states and DC

Maternal complication rates

- Substantial and stable differences in complication rates across programs
- Consistent across vaginal, cesarean, and total deliveries ($p = 0.51$; $P < 0.001$)
- Consistent across individual complications
- Adjusted for comorbidities and hospital characteristics

	Rate	95% CI
1	10.3%	10.1-10.5
2	11.3%	11.3-11.4
3	11.9%	11.9-12.0
4	12.4%	12.3-12.5
5	13.6%	13.1-14.0

Production-oriented questions

- What is it about some programs that allows them to produce physicians who are consistently better at achieving important patient outcomes?
- Can we identify that and can we export it?

Customer-oriented questions

- Should I choose my obstetrician by where he or she trained?

This is not hard to do.

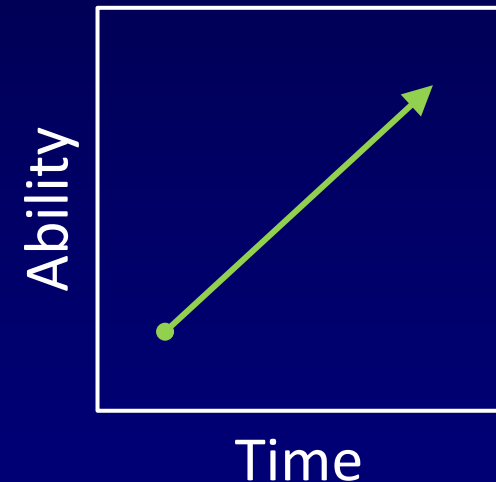
Three questions

1. Does where you trained matter?
2. Does experience matter?
3. Does initial skill matter?

Does experience matter?

- Intuitively, most people seem to think so.
- There is a literature that associates higher volumes with better outcomes.
 - » Does practice make perfect?
 - » Or do outcomes drive volume, particularly for obstetrics, where women have time to search for obstetricians.
- Years of experience is easier to measure and not subject to concerns about reverse causation. (Good quality can lead to delivering more babies, but it should not lead to being older.)

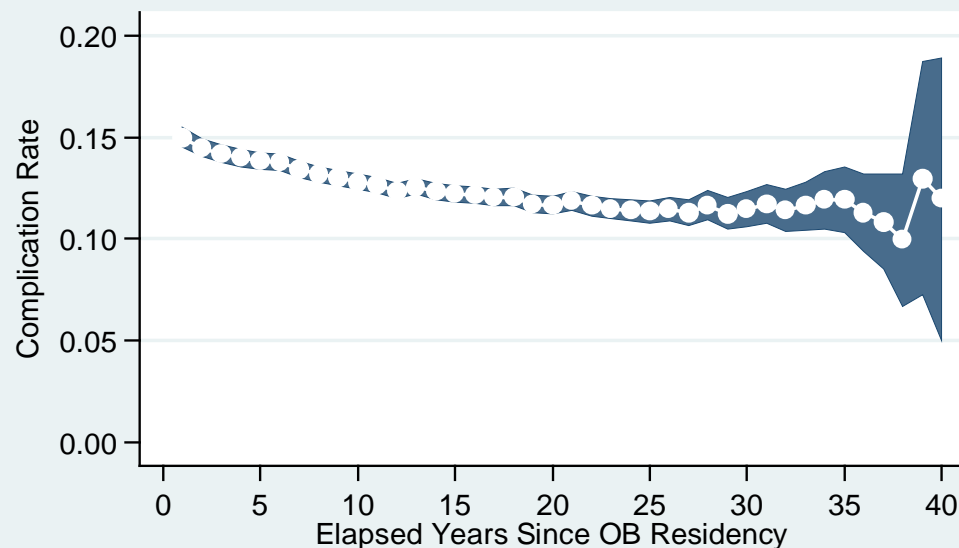
If all that matters is experience



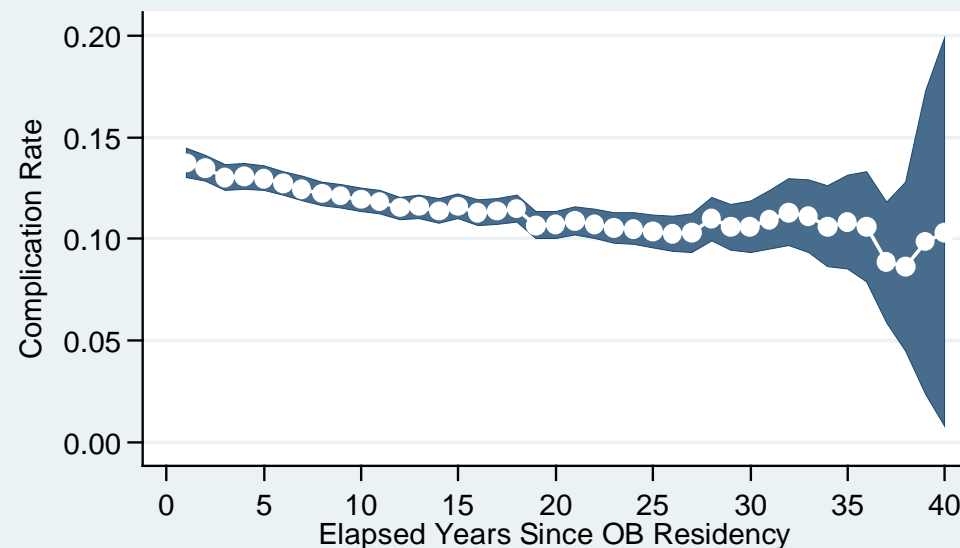
Hospital deliveries in Florida and New York 1992-2010

- 8,500,303 deliveries, reduced to:
- 6,704,311 (79%) performed by 5,175 physicians reflecting
 - » licensed physicians who completed OB residencies after 1969 and have deliveries in more than one year.
 - » performed in the 18 academic years between July 1, 1992 and June 30, 2010.
- 54,736 physician-year observations
- Repeat analysis of 37,354 physician-year observations from 3,044 physicians (59%) who performed deliveries through AY 2009 as a robustness check of survivor bias.

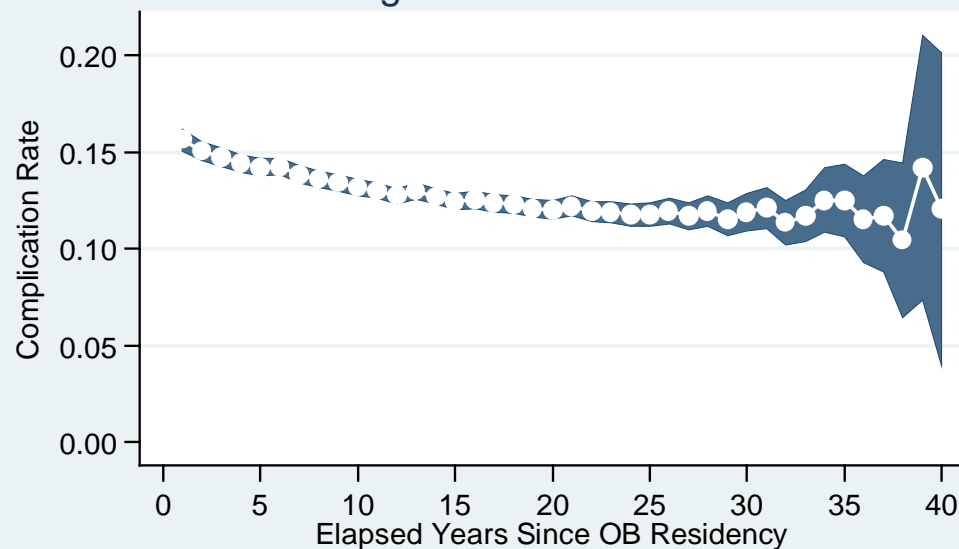
All Deliveries



Cesarean Deliveries



Vaginal Deliveries



Maternal complication rates decline with experience:

- Persistent declines in maternal complication rates through 30 years of experience
- No change when adjusting for survivor bias

Yes, experience matters

- Predicted first year complication rate is 15%
- After a decade of experience, this falls by 2%
- After another decade, this falls by an additional 1%
- After another decade, this falls by an additional 0.5%
- These results are robust whether one examines all deliveries or vaginal or cesarean deliveries separately.
- *What is it that obstetricians are learning in their second decade that they didn't learn in their first?*

Production-oriented questions

- Should we train obstetricians much longer?
- Can we emulate the returns from experience with new training models (e.g., coaching)?
- Should we delay the typical mid-career change to gynecology?

Customer-oriented questions

- Should I choose my obstetrician by how long ago he or she trained?

This is not hard to do.

Three questions

1. Does where you trained matter?
2. Does experience matter?
3. Does initial skill matter?

Does initial skill matter?

- If so much of your later quality is determined by your residency program, maybe it is initial skill that offers the most predictive signal?
- We can separately examine:
 - » Performance in first year after residency (initial skill)
 - » Cumulative volume (learning)
 - » Contemporaneous volume (scale)
 - » Years of experience

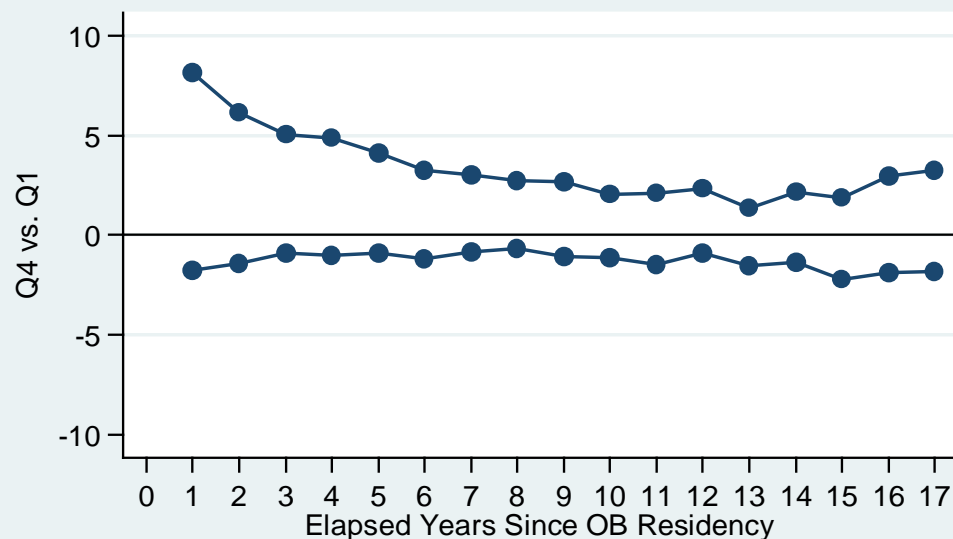
If all that matters is how you started



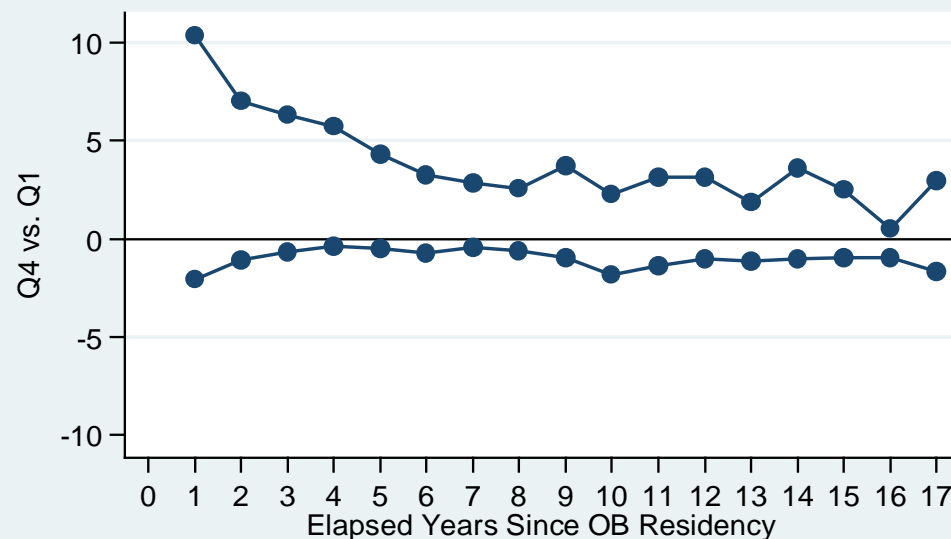
Hospital deliveries in Florida and New York 1992-2010

- 1,864 new obstetricians
- 15,675 physician-years
- 2,005,043 deliveries

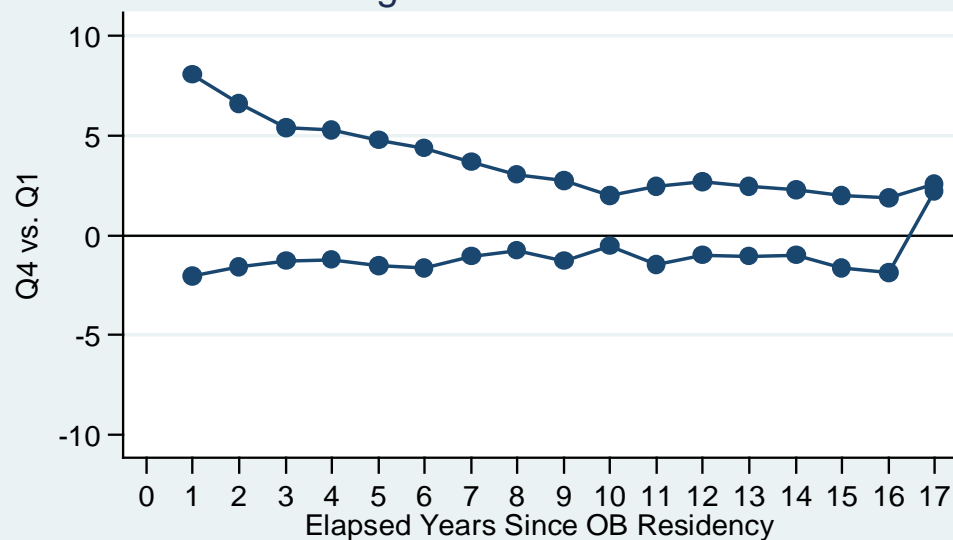
All Deliveries



Cesarean Deliveries

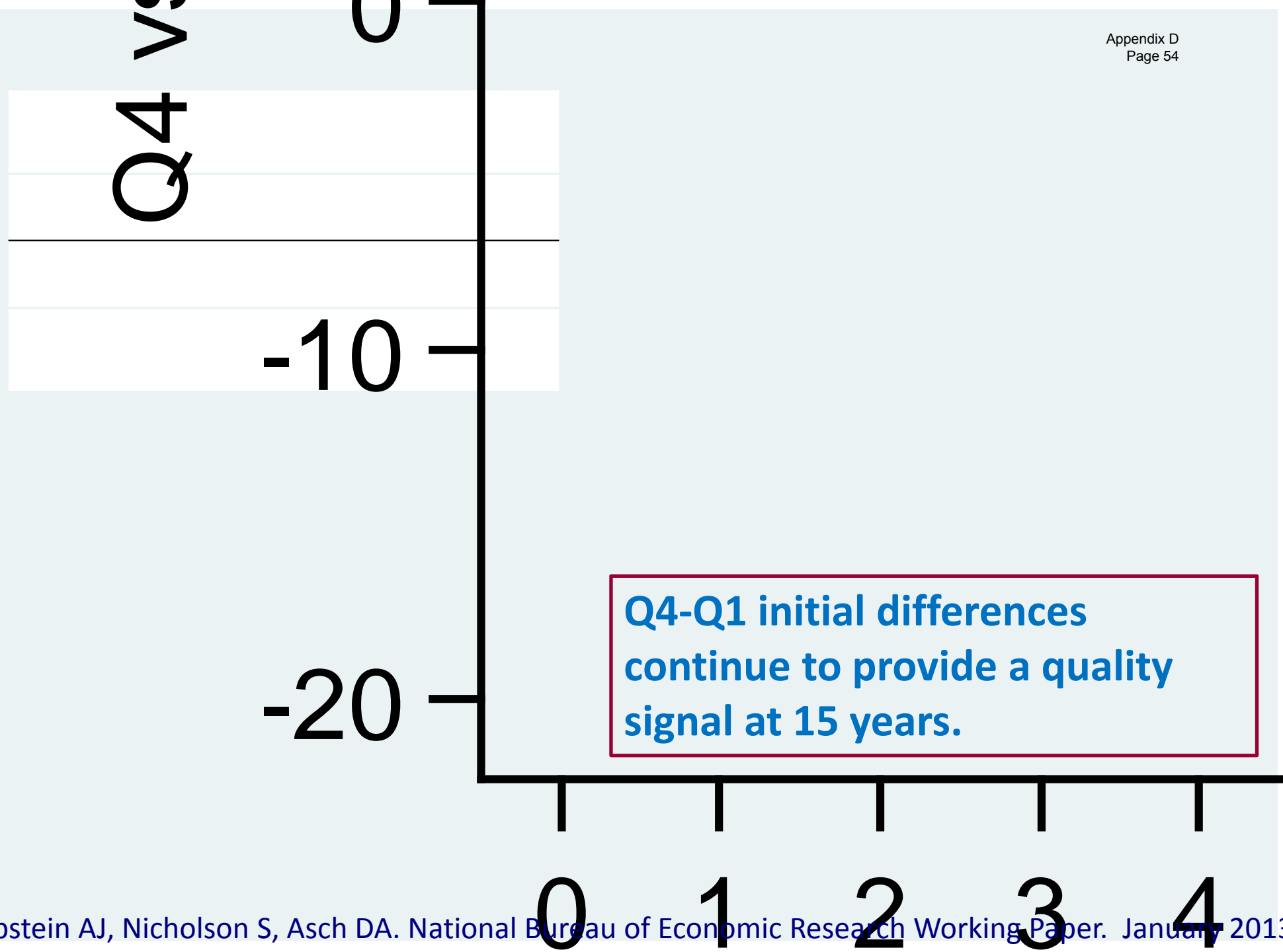


Vaginal Deliveries



Initial complication rates predict later complication rates:

- Over time, the best and worst quartiles approach the mean.
- They do so gradually.
- They never get there, meaning that differences persist



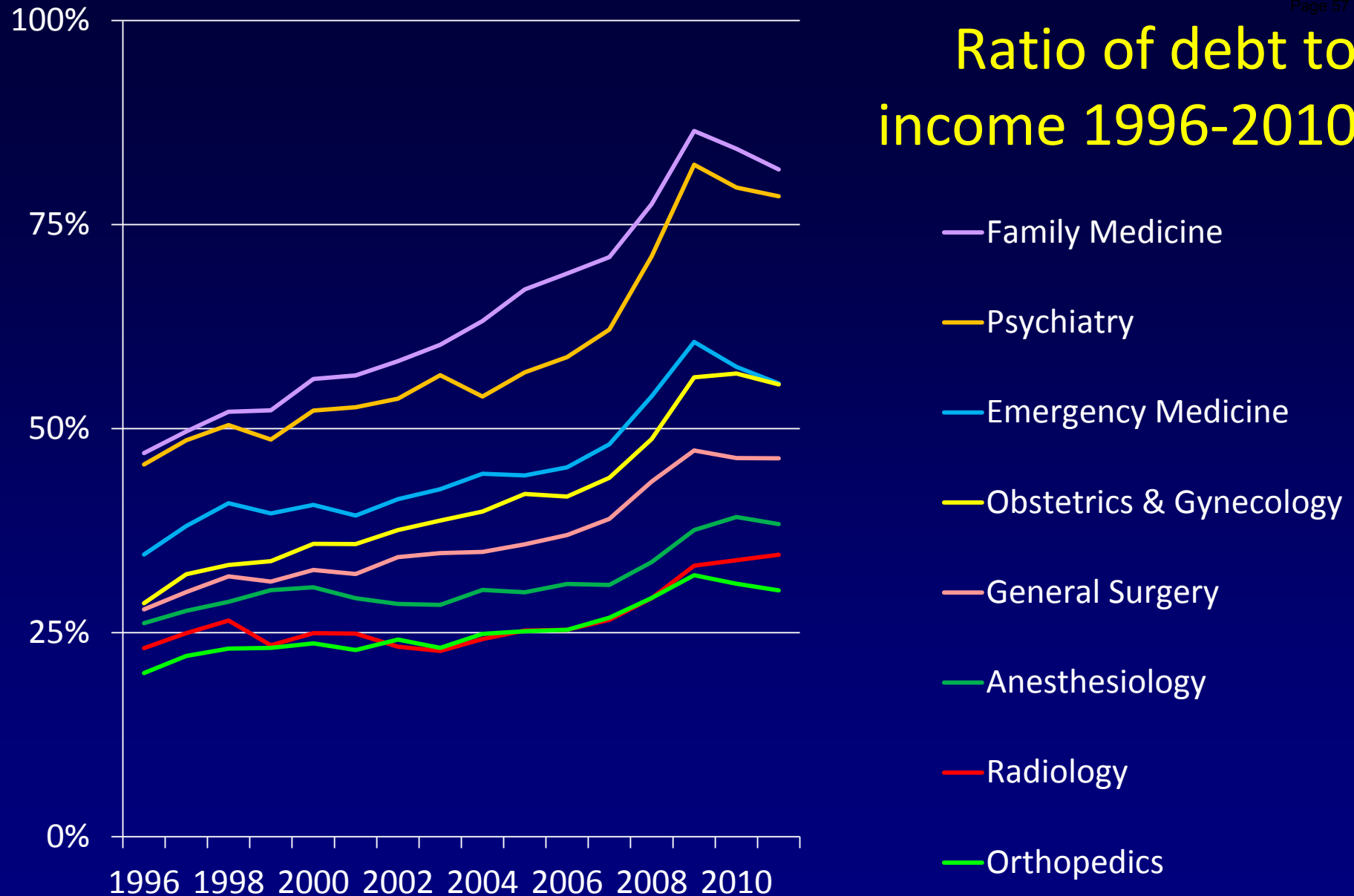
Summary findings

1. Training Site Matters. Where an obstetrician trained is strongly associated with later maternal complication rates.
2. Experience Matters. New obstetricians improve steadily with additional years of experience, an effect that continues through 30 years.
3. Initial Skill Matters. But, obstetrician initial skill explains more of between-physician variation than does scale, learning-by-doing, and years of experience.

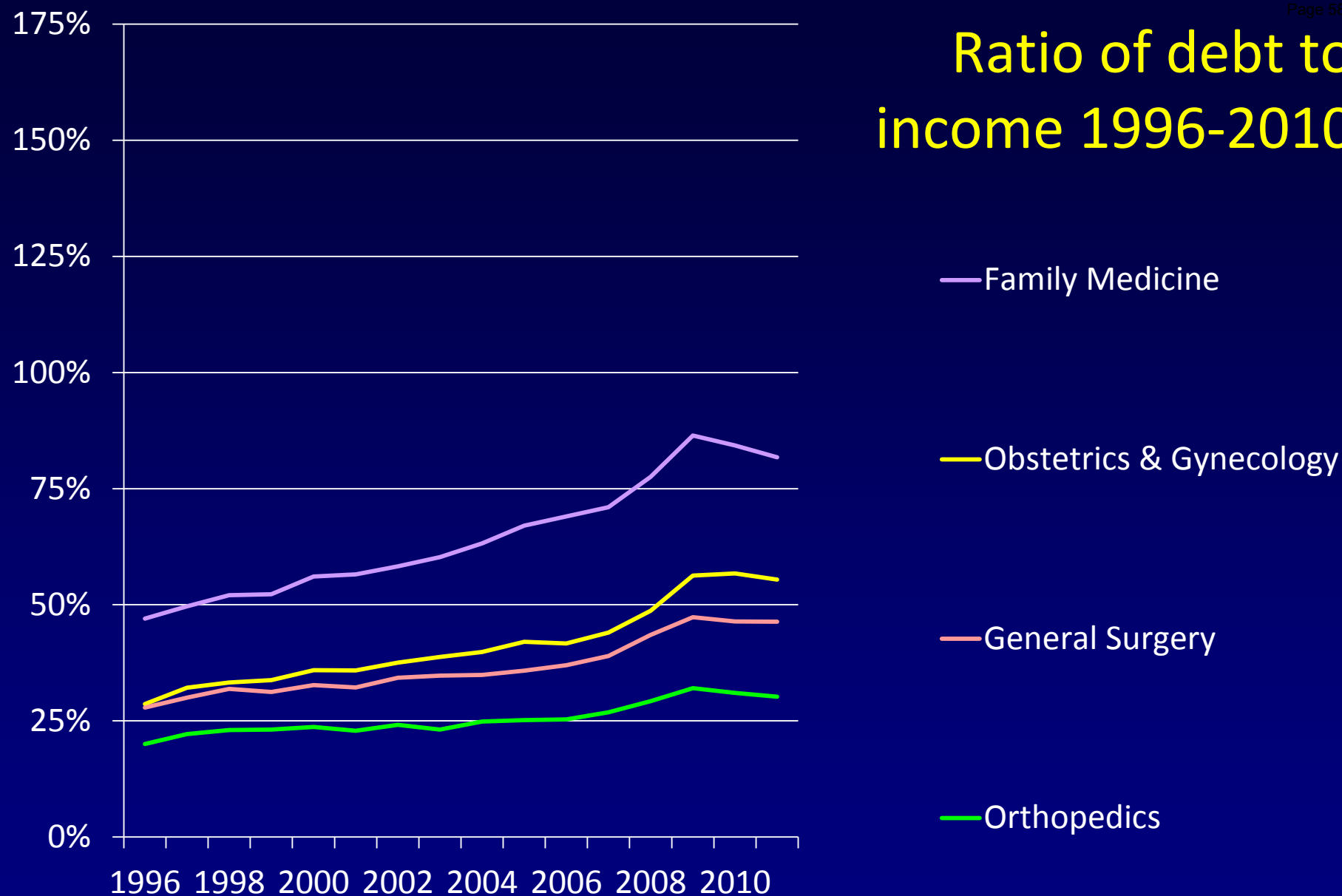
Economics matters: Debt-to-income ratios

- If you have \$250,000 in debt when you graduate and your first year income is \$125,000, then your debt-to-income ratio is 200%
- Net present value (NPV) is more financially precise, but less intuitive
- Debt-to-income ratios may better reflect how students actually feel about buying education—and how much they have to go into the hole to pay for it
- They reflect differential access to capital

Ratio of debt to income 1996-2010

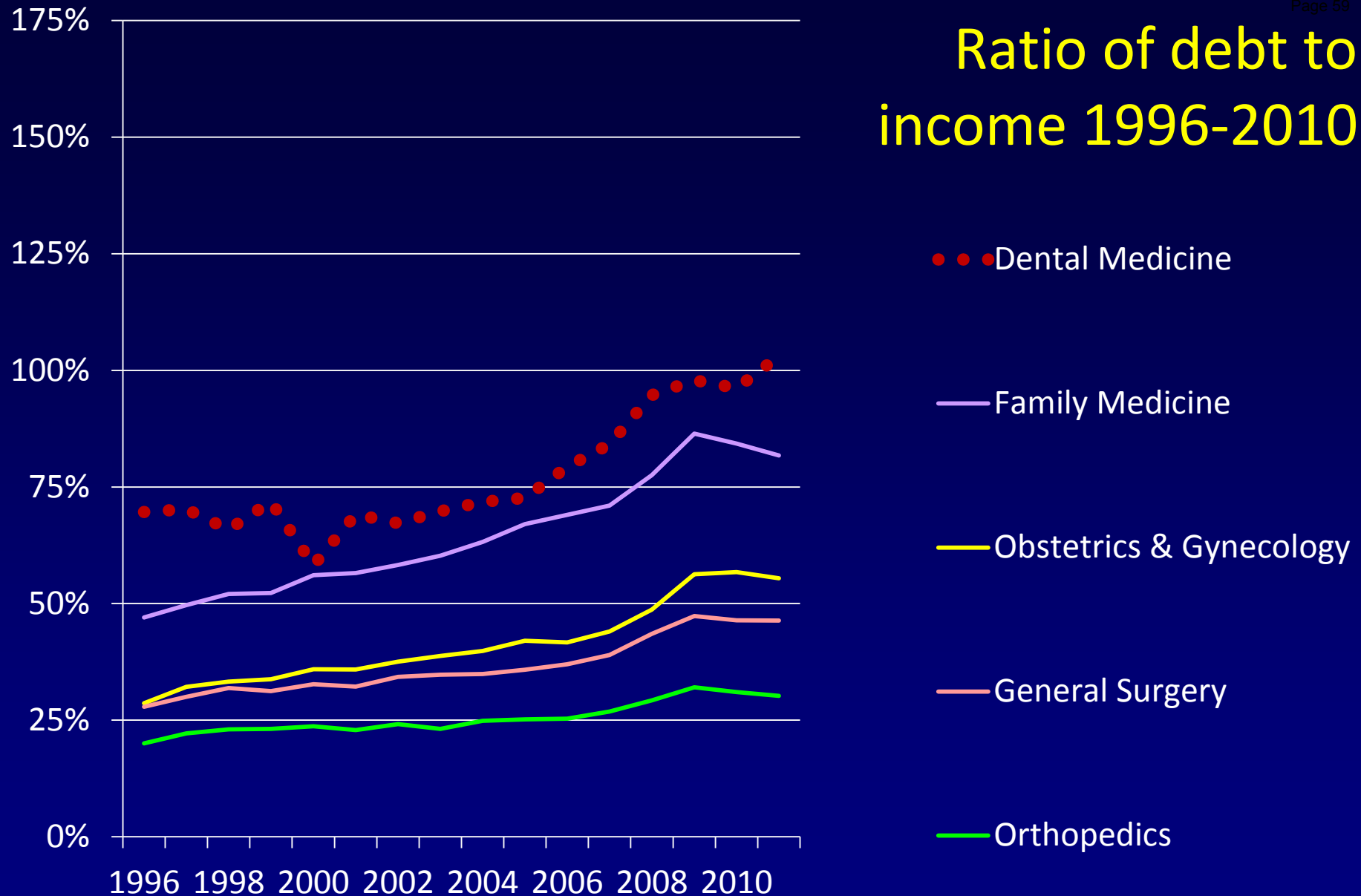


Ratio of debt to income 1996-2010

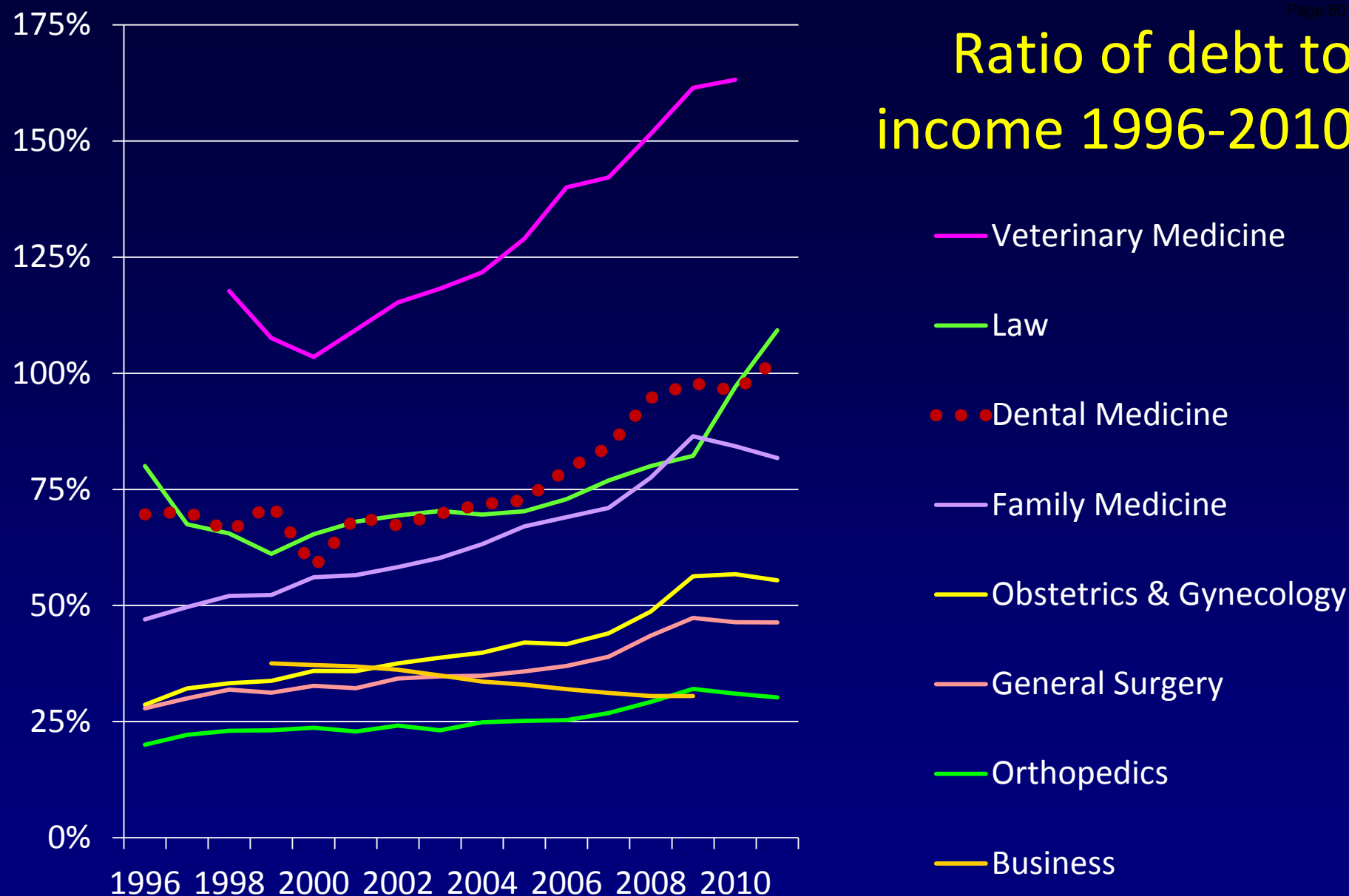


Asch, Nicholson, Vujicic. Are we in a medical education bubble market? NEJM. 2013; 369:1973-1975.

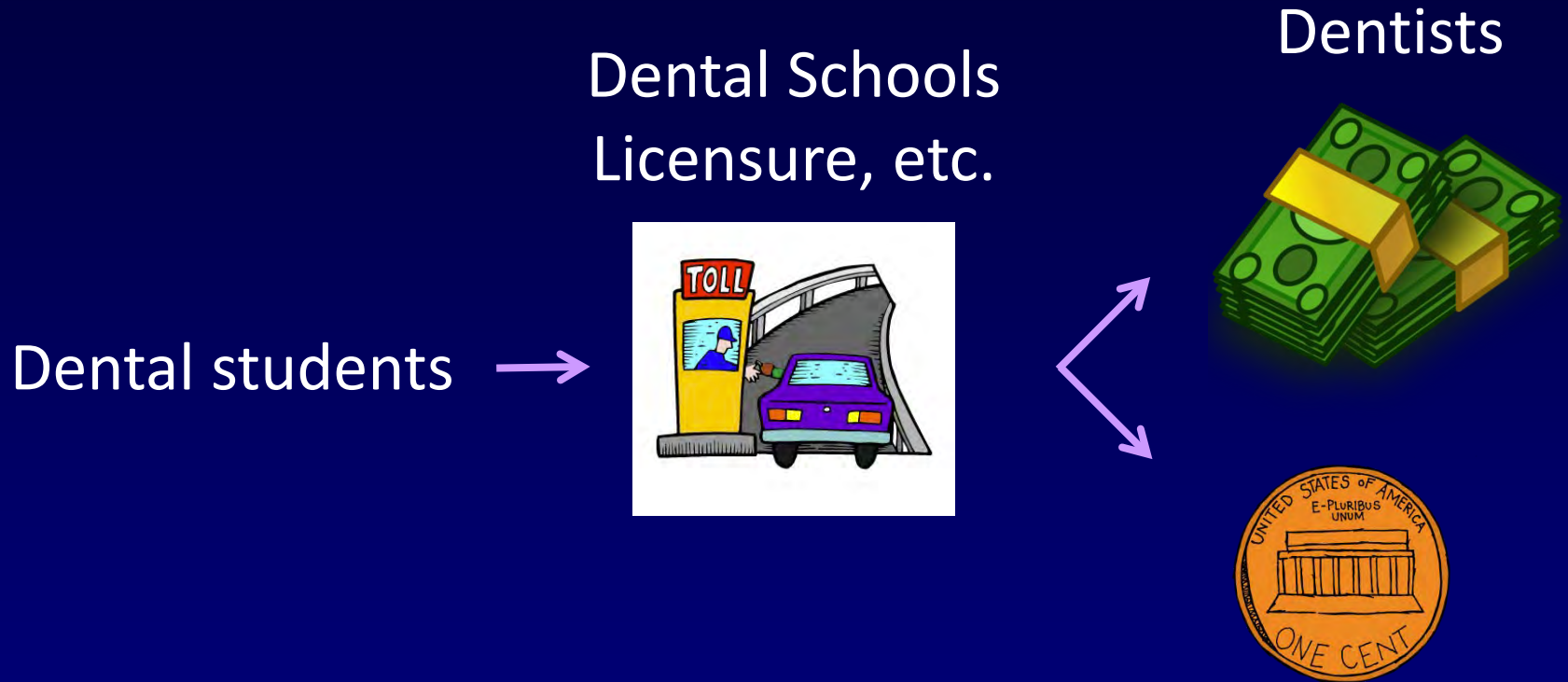
Ratio of debt to income 1996-2010



Ratio of debt to income 1996-2010

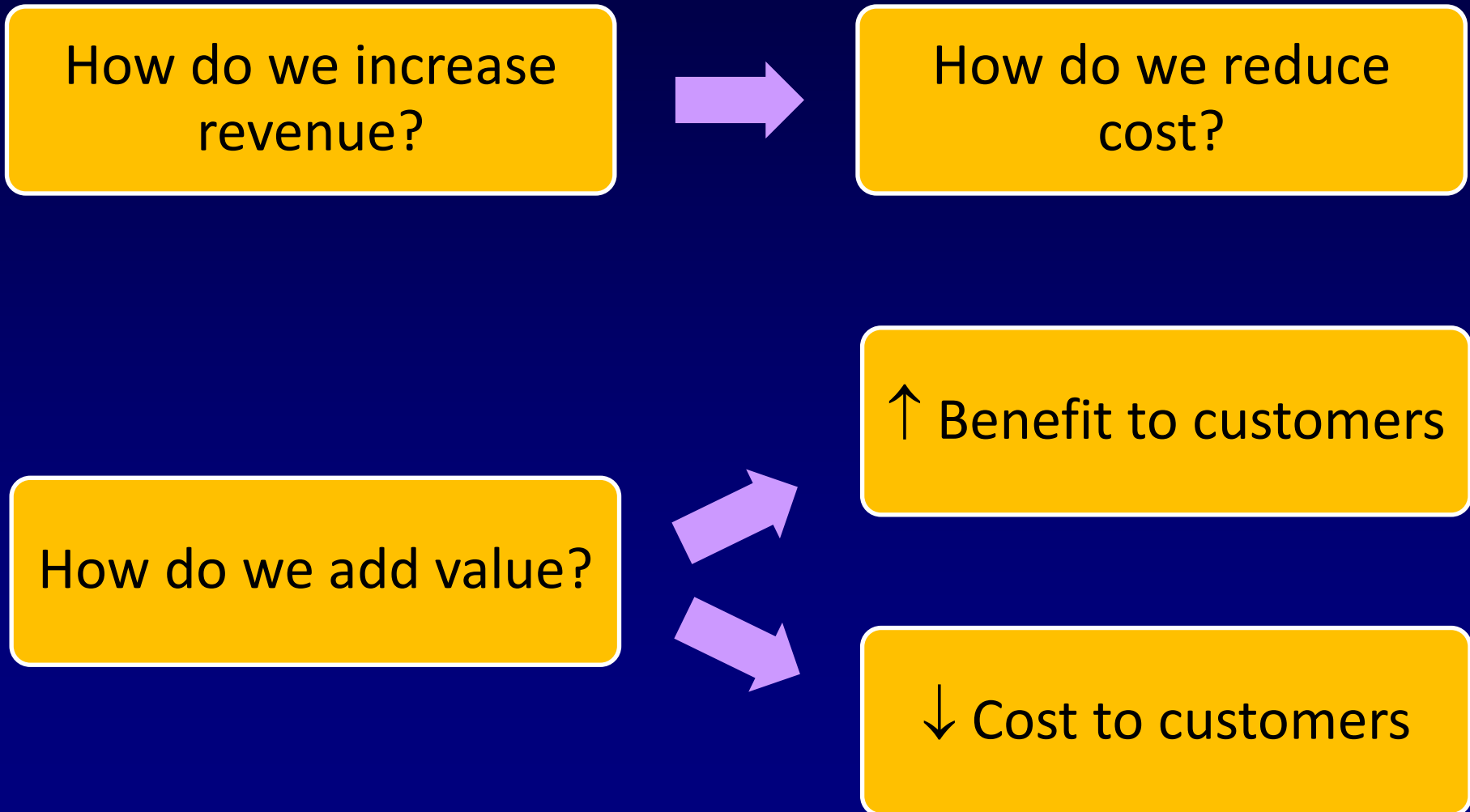


Tuition and income are tightly linked



- As incomes rise, the cost of becoming a dentist can rise.
- As incomes fall, the cost of becoming a dentist must fall

The economics of adding value to customers



Some possible accountability outcomes

Individual orientation

- Dentists who are trained well
- Dentists who function well
- Patients who are cared for well
- Patients who have good outcomes
- Dentists who are trained less expensively
- Patients who are cared for less expensively

Population orientation

- A workforce that is well distributed geographically
- Lower cost
- Better access
- Population health

Long-term Sustainability of Dental Schools

Bill Dodge

UTHSCSA School of Dentistry

June 19, 2014

My Assignment

Provide background – where are we?

Describe the current model

Cost

Cost and revenue drivers

Other models

Issues

Current Model

Four years

Horizontal scheme

Dense – median clock hours = 4942

Clinical clock hours = 3755

Lecture and active learning

On-campus clinical instruction

Competency-based

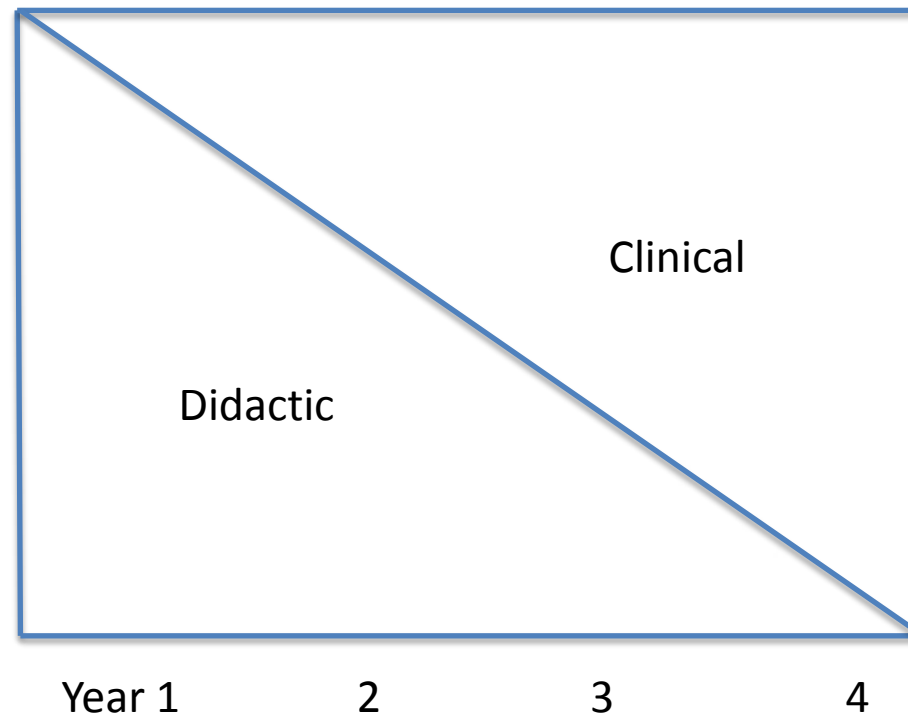
Graduate/residency programs

Research/scholarship

State and tuition supported

Increasing reliance on clinical revenue

Horizontal Scheme



Current Model

Four years

Horizontal scheme

Dense – median clock hours = 4942

Clinical clock hours = 3755

Lecture and active learning

On-campus clinical instruction

Competency-based

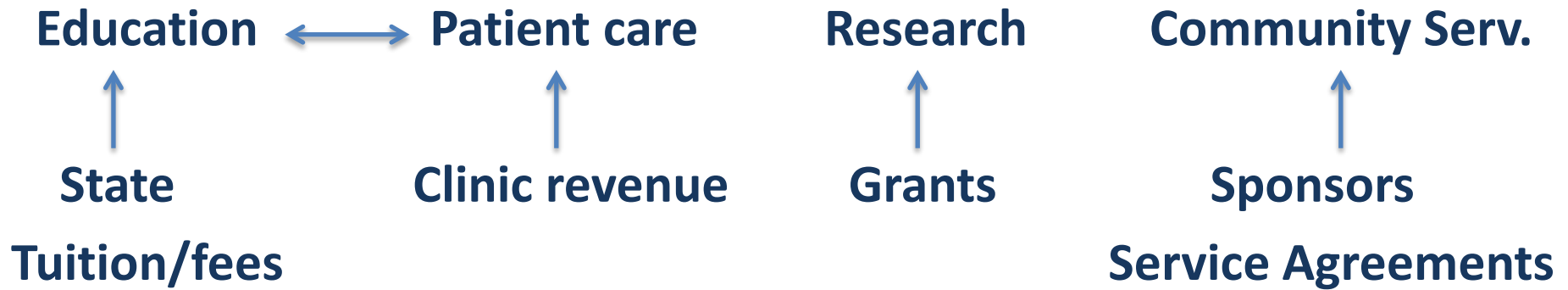
Graduate/residency programs

Research/scholarship

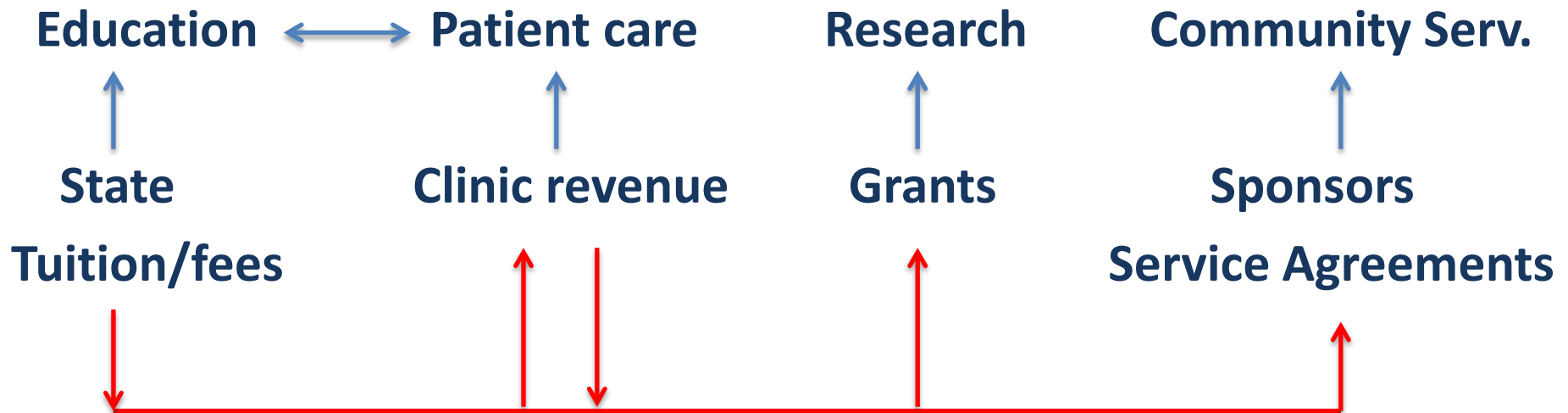
State and/or tuition supported

Increasing reliance on clinical revenue

Missions



Missions



What Does it Cost?

Public School with class size of 80 – 110

With research mission and specialist programs

\$45M - \$60M/year

Aggregate from Alumni Magazines

Why so expensive?

Highly skilled workforce

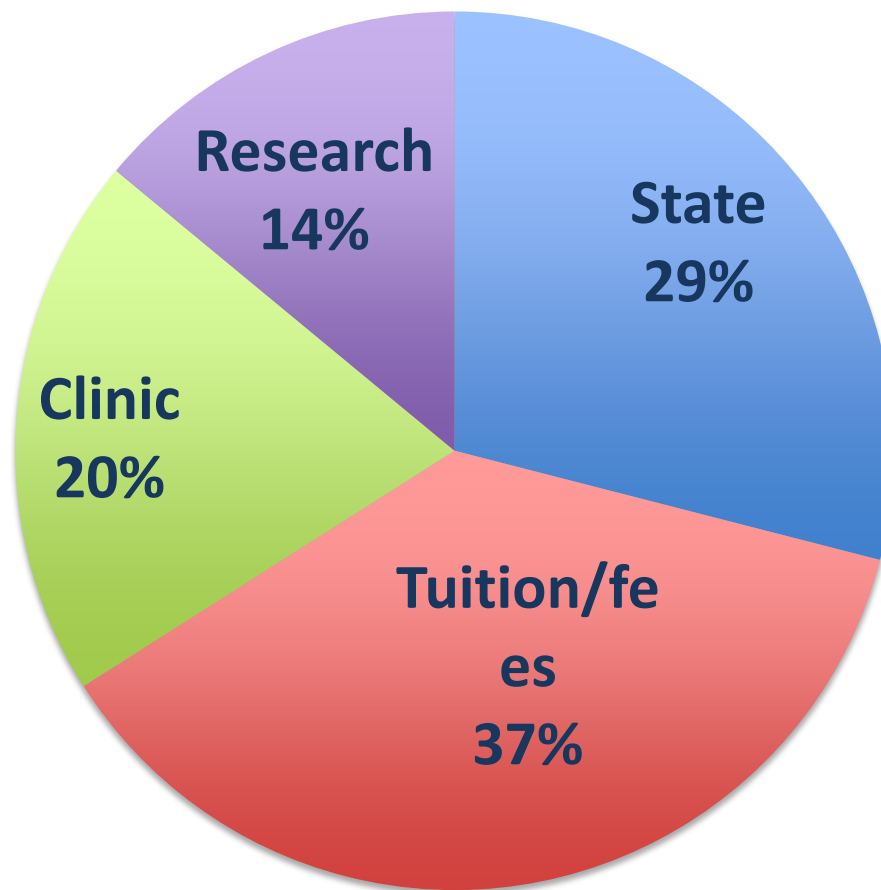
Clinic operation

Technology

Research

Depreciation

Where does the \$ come from?*

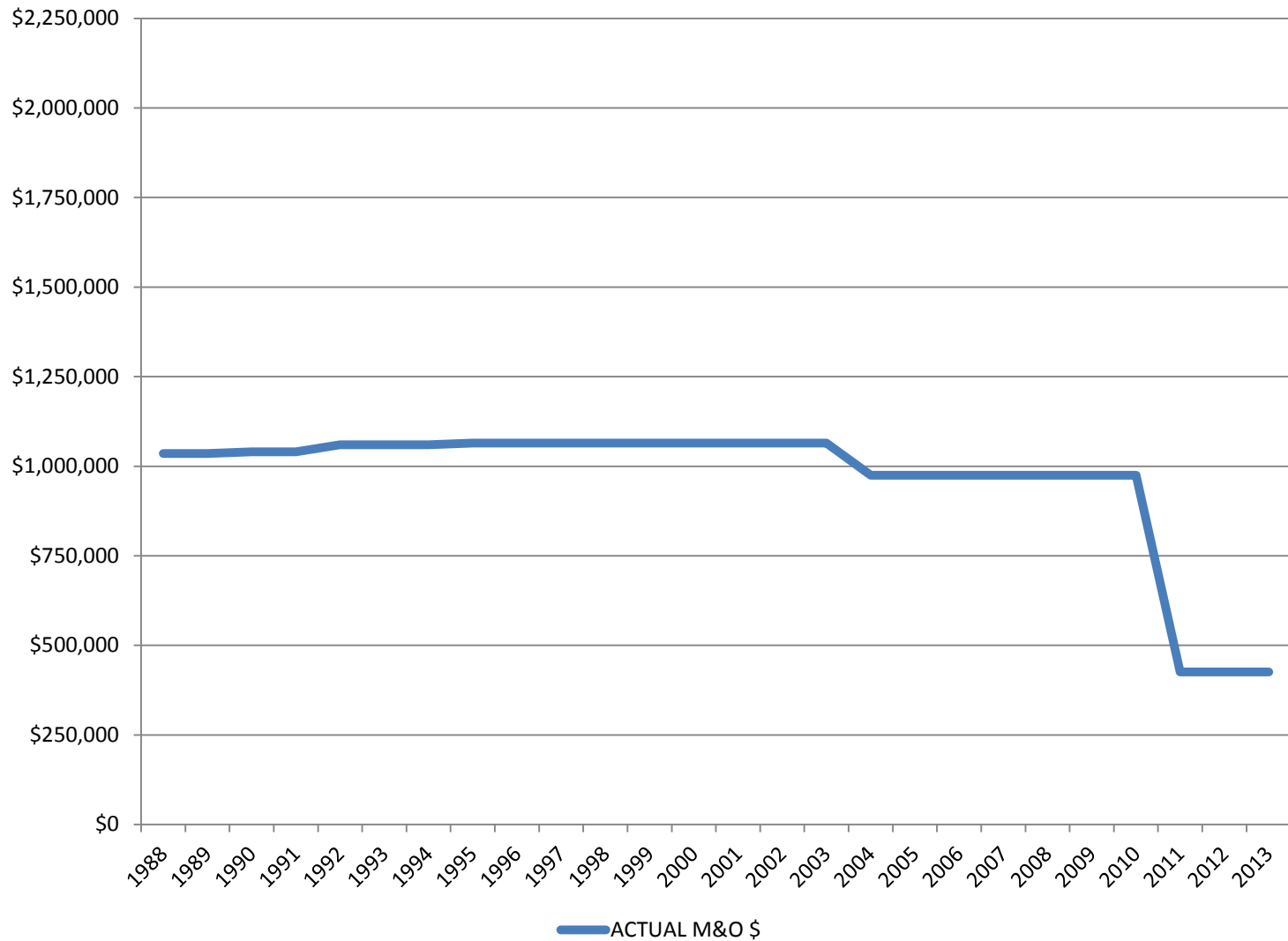


**Aggregate from Alumni Magazines*

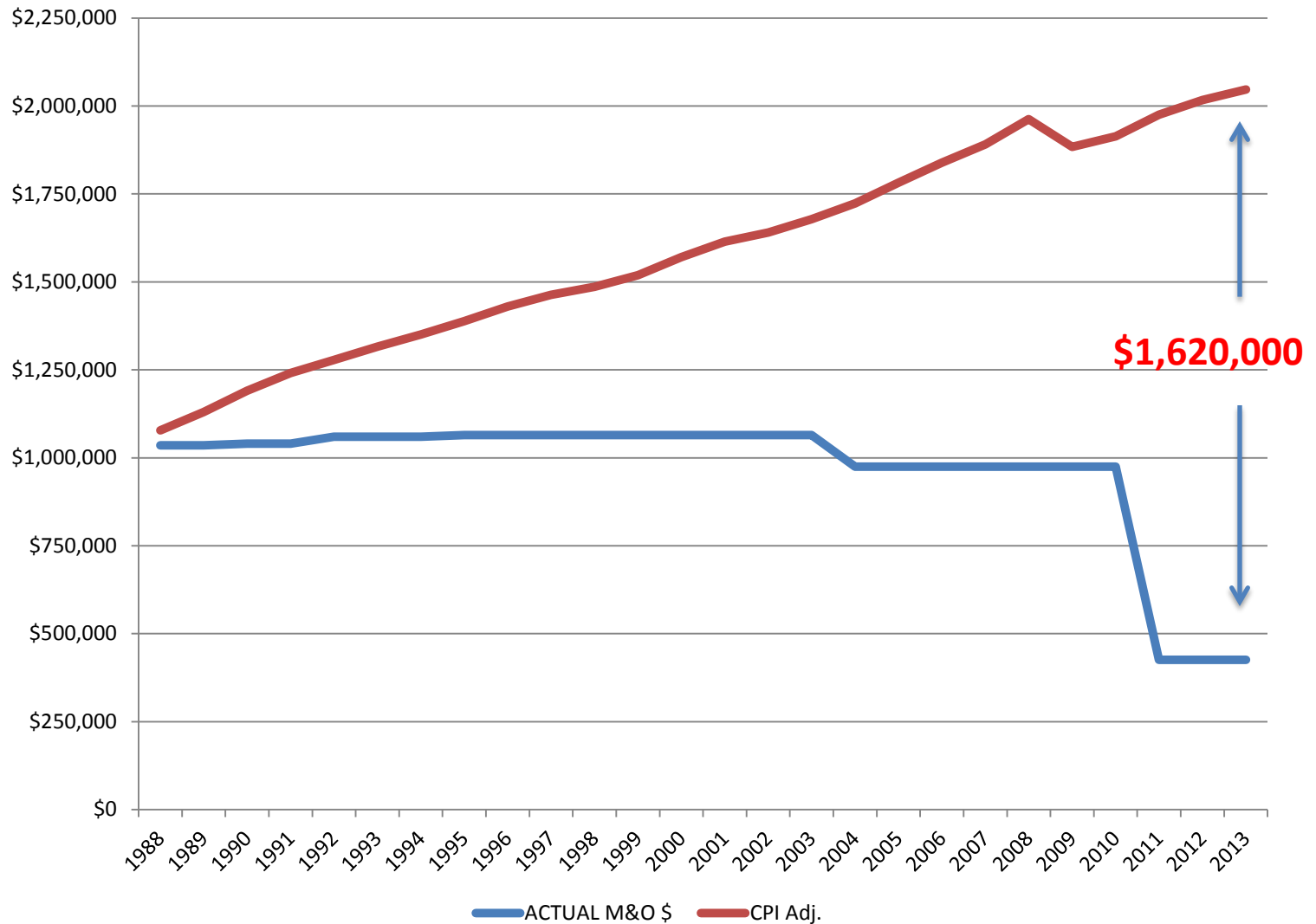
Where are revenue and expenses headed?



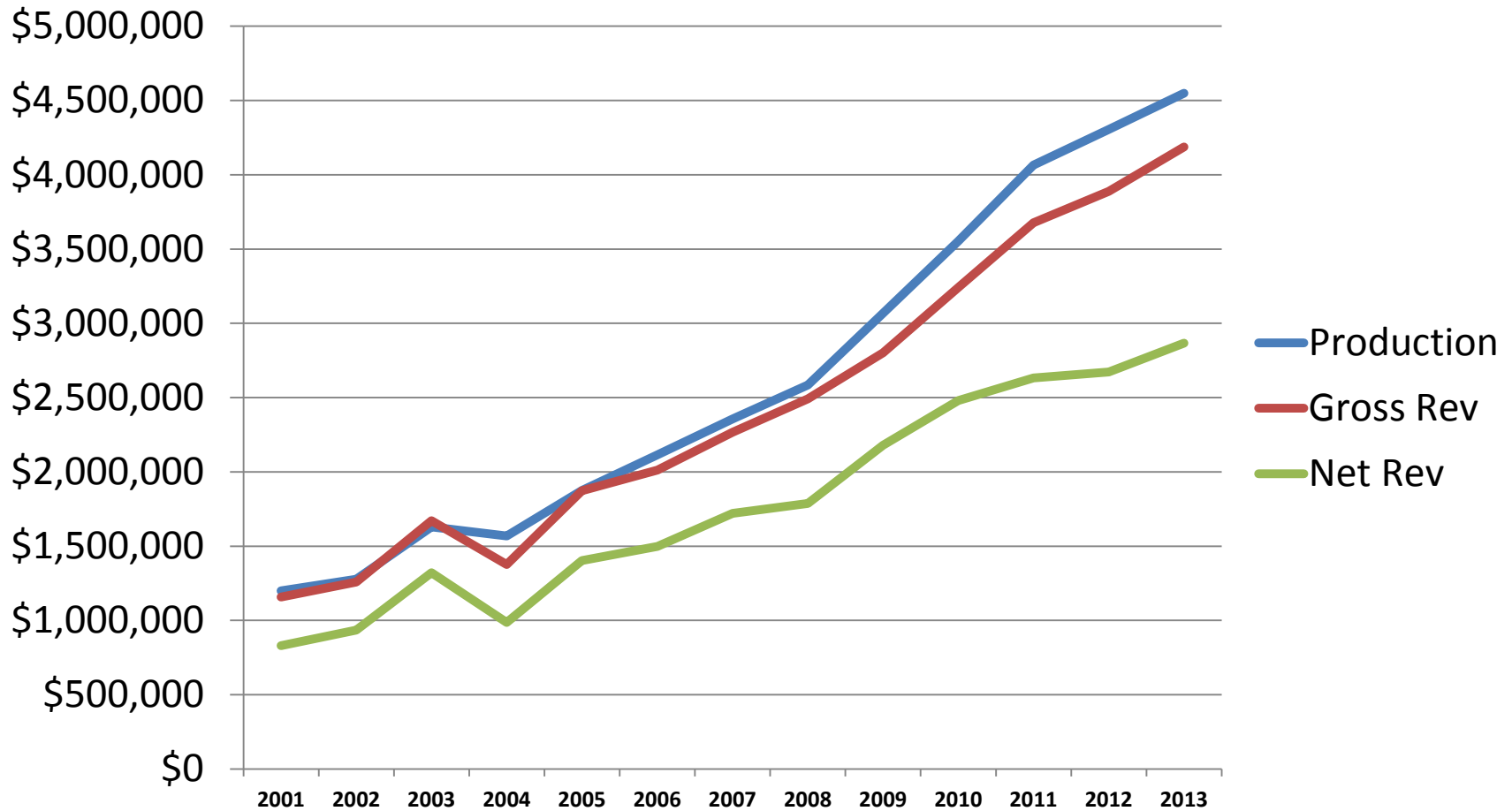
Dental Student Clinic Operating Budget



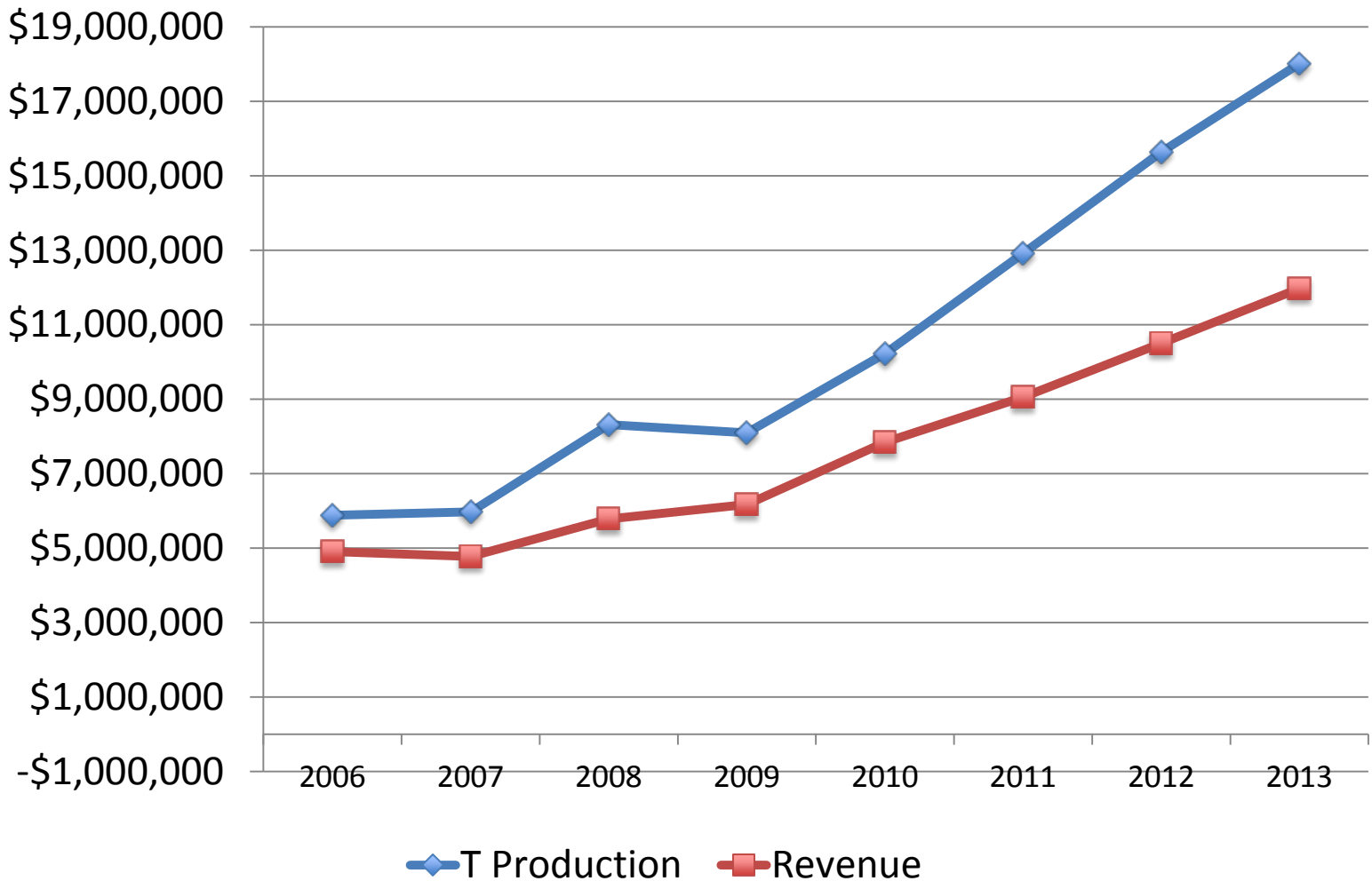
Dental Student Clinic Operating Budget



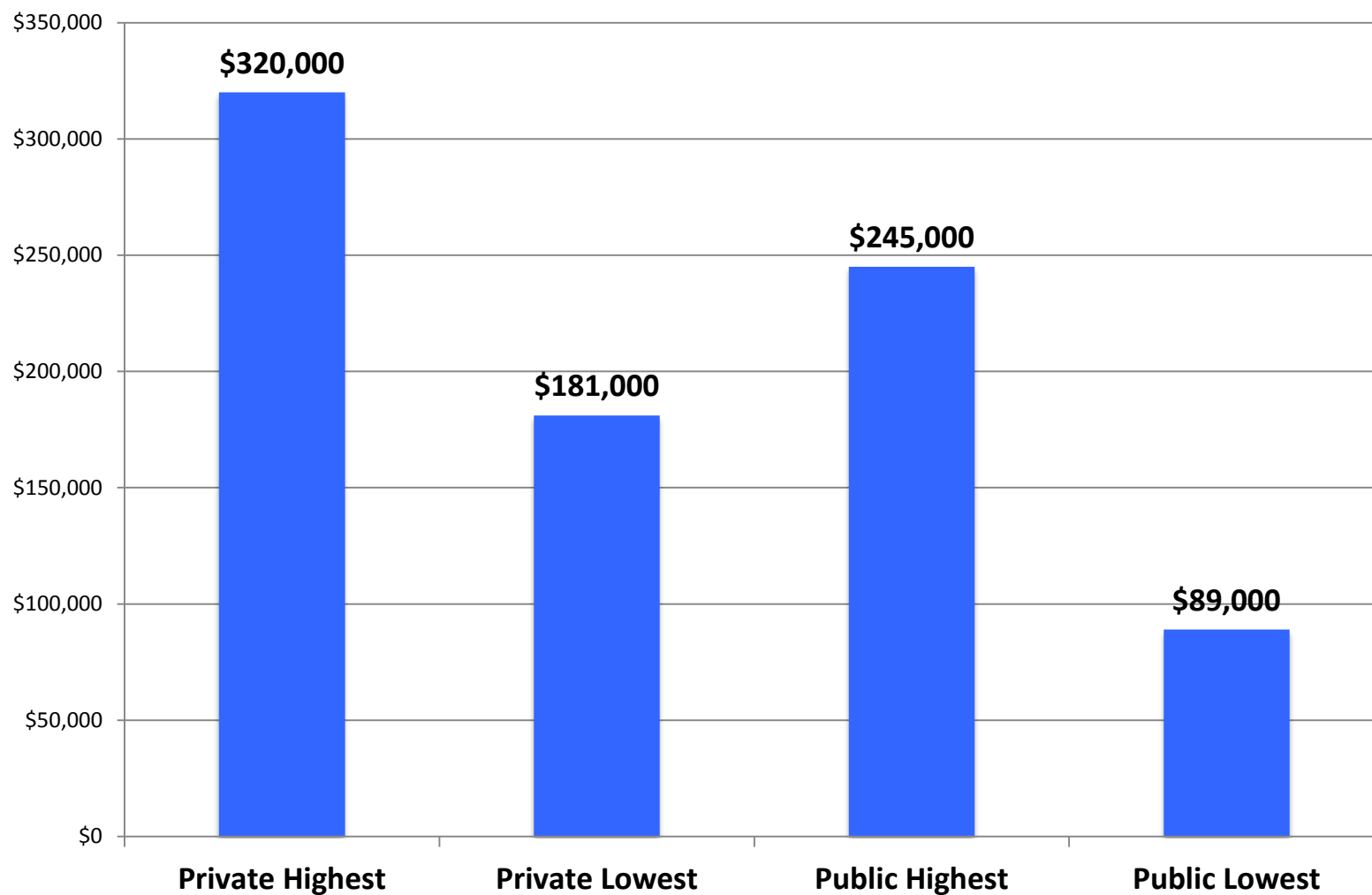
Predoc Income History



FY 2006-13 Residency Program Revenue



4-year Cost of Education



2012-13 ADA Survey of Dental Education

Other Models

Community-based clinical training

3 – Year curriculum

Paired students

European/Central So. America

Simulation

Shared resources

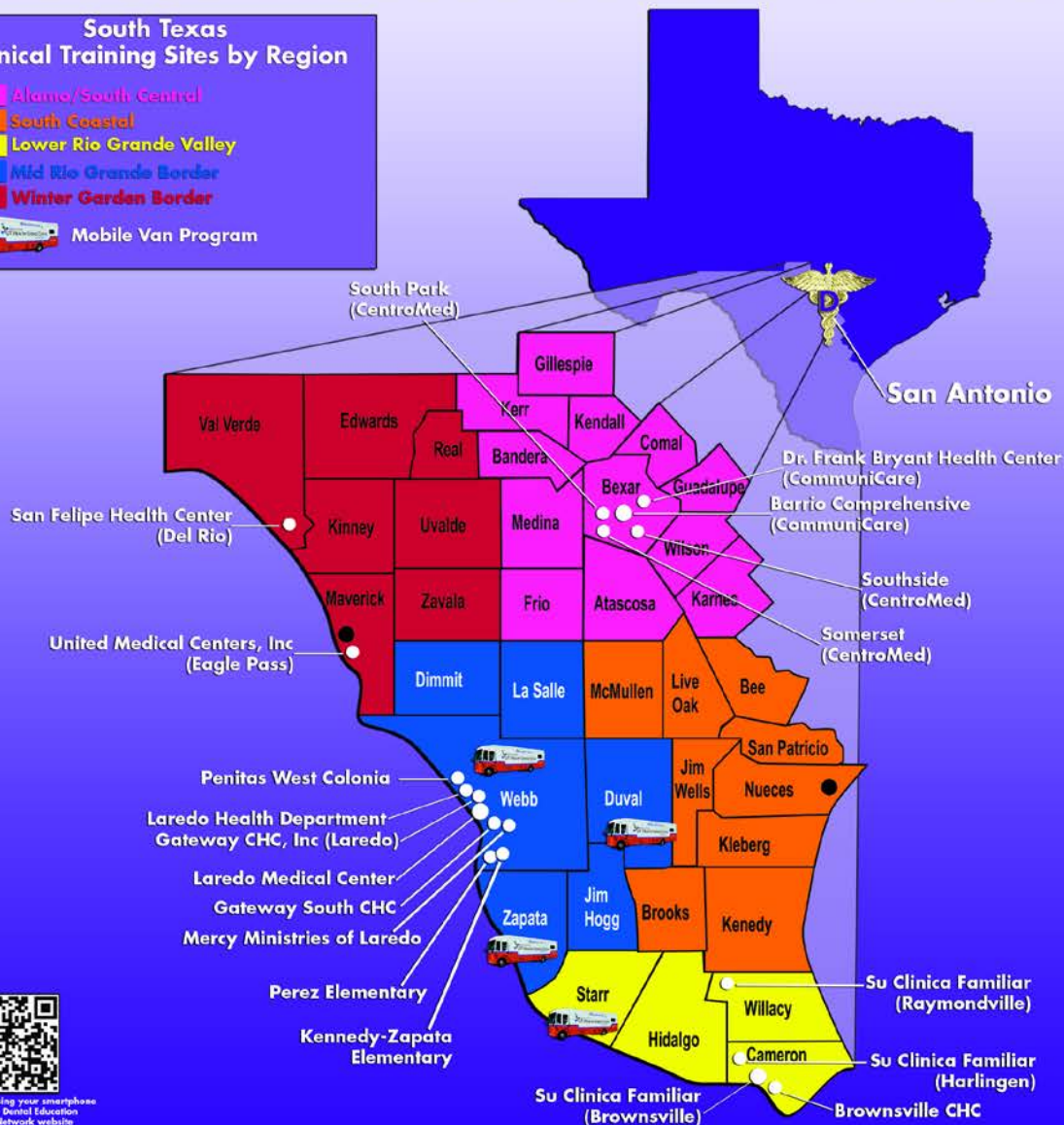
Texas



**South Texas
Clinical Training Sites by Region**

- Alamo/South Central
- South Coastal
- Lower Rio Grande Valley
- Mid Rio Grande Border
- Winter Garden Border

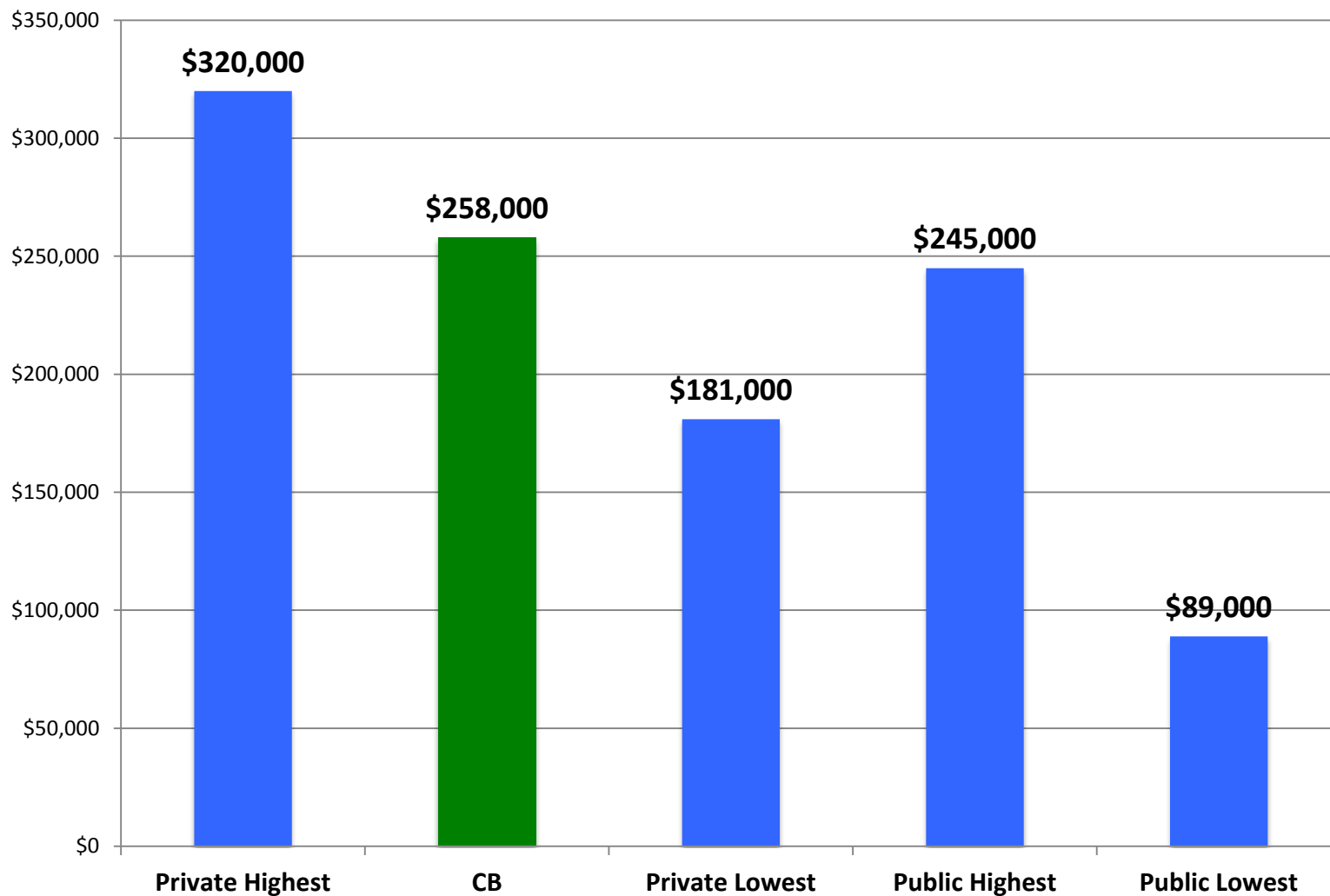
Mobile Van Program



Scan this code using your smartphone
to access the Dental Education
Outreach Network website



4-year Cost of Education



Other models

Community-based clinical training

3 – year curriculum

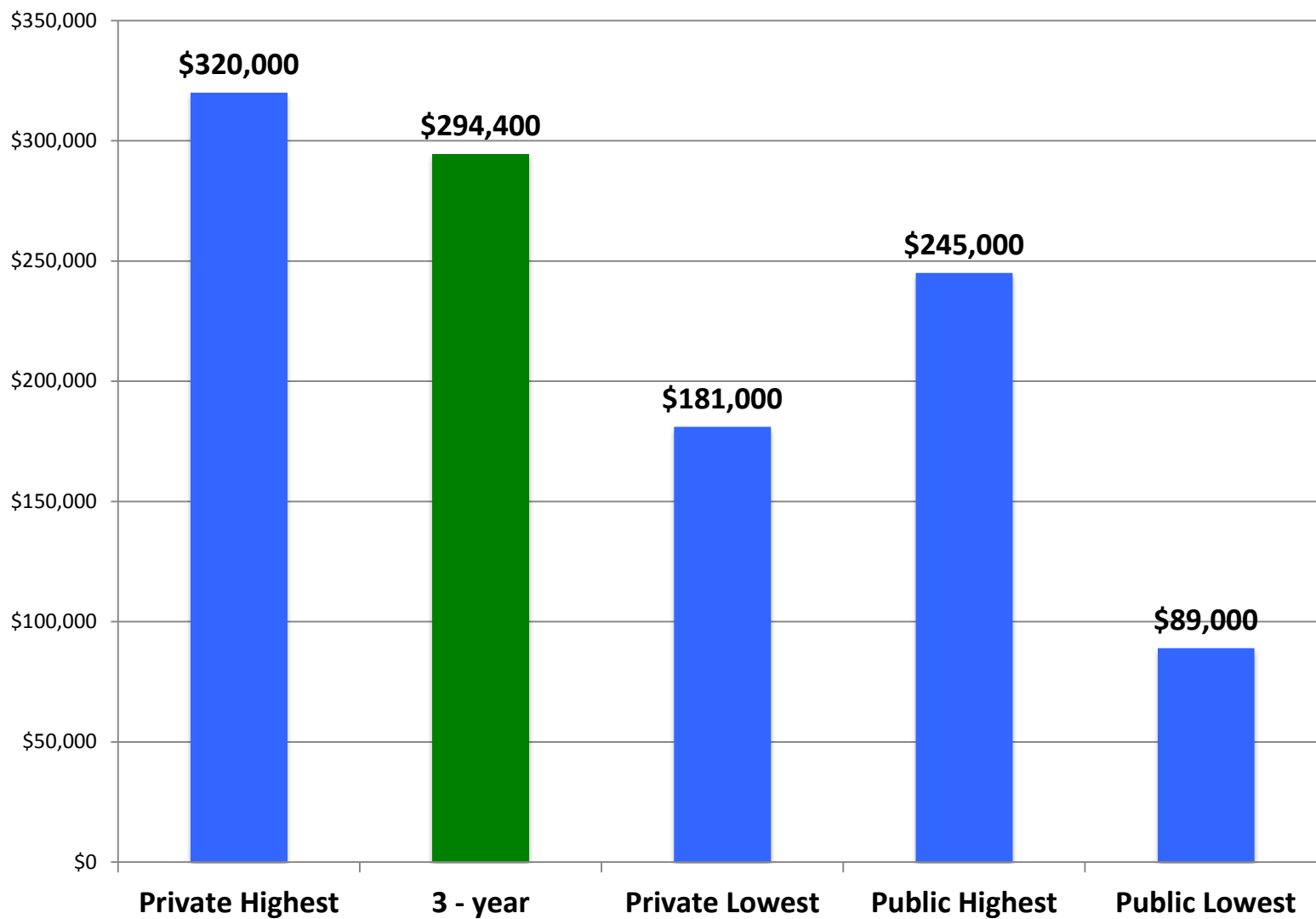
Paired students

European/Central So. America

Simulation

Shared resources

Cost of Education



2012-13 ADA Survey of Dental Education

Other models

Community-based clinical training

3 – year curriculum

Paired students

European/Central So. America

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Shared resources

Issues

Clinical/preclinical staffing ratios

Tenure

Job satisfaction

Faculty compensation

Full time v. Part time faculty

Research

Clinical fees and productivity

Town – gown

Class size

Accreditation standards

Clinical requirements

Competency and licensure exams

Academic calendar

4 year curriculum

Issues

Clinical/preclinical staffing ratios

Tenure

Job satisfaction

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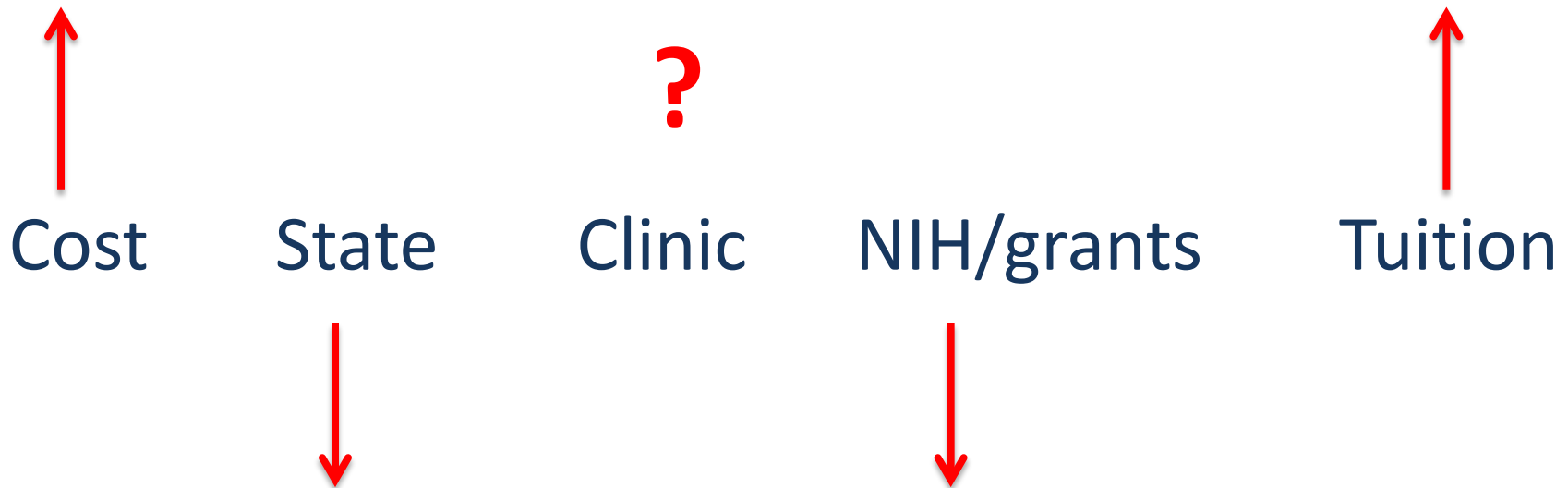
Academic calendar-schedule

4 year curriculum

**Is the current dental education
model sustainable?**



Issue #1: What do we know about revenue and expense drivers?



What We Do and Don't Know about the Efficiency of Different Dental Curricular Models

ADA STAKEHOLDERS MEETING
JUNE 19, 2014

Presenter:

Denise Kassebaum, DDS, MS

Dean, University of Colorado School of Dental Medicine



Dental Curriculum Models Discussion

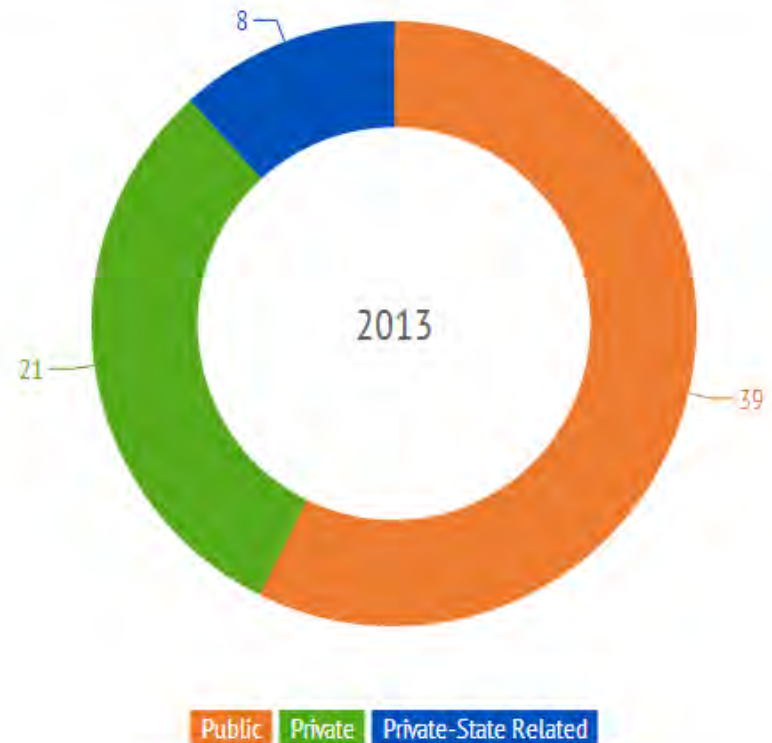
- Current US dental schools
- Factors influencing dental curriculum models
- Change drivers
- Methods of instruction
- Current curricular models – perceived pros and cons of each
- Efficiency



Current US Dental Schools

65 Dental Schools | 2013

- **7 US dental schools closed** between 1986 and 2001 – all private or private/state-related
- **1 private opened** in 1997
- **1 public opened** in 2002
- **11 new schools** have opened from 2003 – 2015, 2 public and 9 private



Dean's Briefing Book 2013 – ADEA American Dental Education Association | www.adea.org/deansbriefing



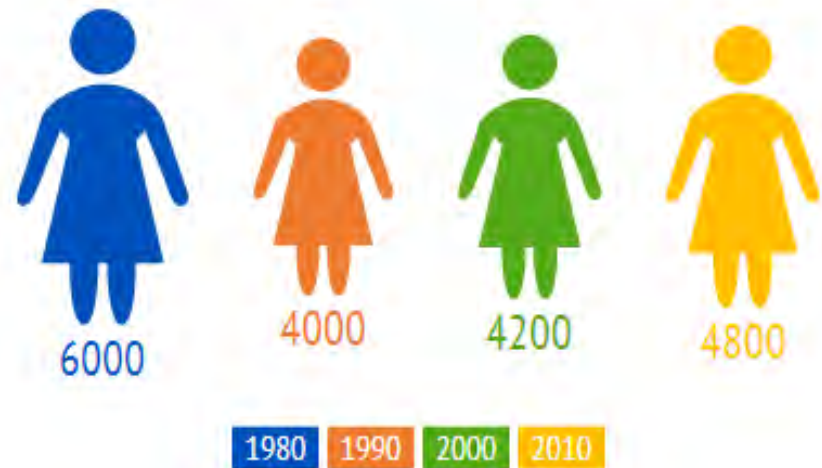
Current US Dental Schools

In **1980**, 6000 dental grads;
US pop was 227,000,000;
1 dental grad / 38,000 Americans

In **1990**, 4000 dental grads;
US 250,000,000;
1 dental grad / 62,500 Americans

In **2000**, 4200 dental grads;
US pop 281,000,000;
1 dental grad / 67,000 Americans

In **2010**, 4800 dental grads;
US pop 308,000,000;
1 dental grad/ 64,000 Americans



Factors Influencing Dental Curriculum Models

- Parent institution and mission
- State and local factors
- National foundation initiatives
- ADEA CCI
- CODA Accreditation Standards
- National Boards
- Regional Boards and State Licensing Requirements



DePaola DP. The revitalization of US Dental Education. J Dent Educ 2008; 72(2):28-42; page 40, Figure 4.



Drivers of Curricular Change

2000-2014

ADEA CCI

Macy Study

**Pipeline, Profession
and Practice**

- **ADEA CCI** has published a series of white papers to assist schools as they develop innovative curricula; a set of competencies describing the new general dentist; initiated a liaisons program with 185 representatives from fifty-six dental schools that serve as a learning community to share new pedagogies, assessment methodologies, and strategies for change; and increased general awareness of curricular challenges facing dental education.
- **Macy Study** recommendations published in 2008. Bailit suggested two models for dental education: 1) Move significant portion of senior year to community clinics; 2) operate pt.-centered dental school clinics where faculty provide care while supervising students.
- **RWJF** in collaboration with **The California Endowment** and **WK Kellogg Foundation** provided funds to 23 US dental schools. Significant conclusions drawn to share with other dental schools.



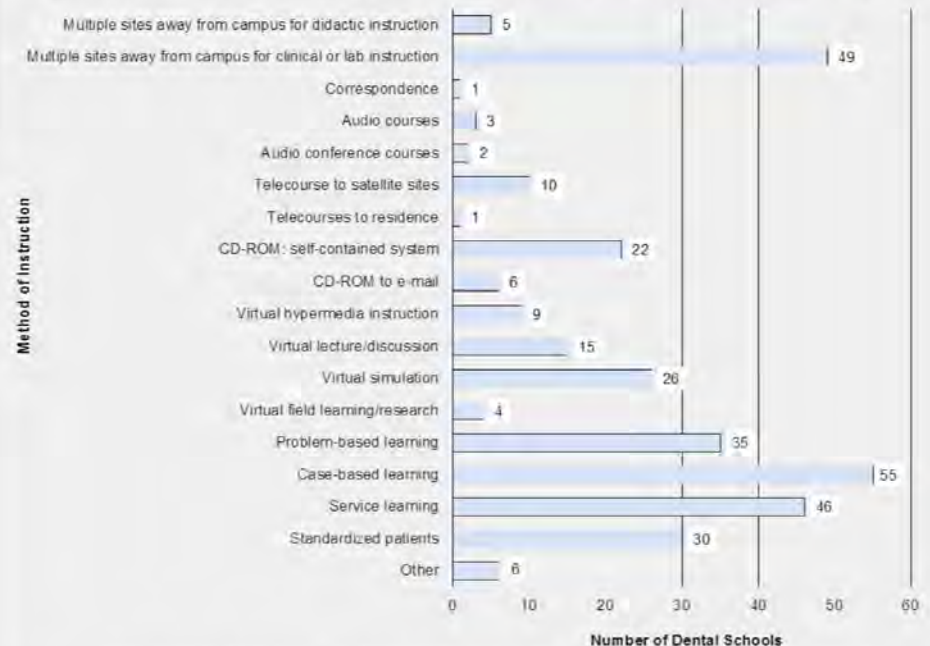
Methods of Instruction

Influences on Instruction Provided

- Faculty availability and roles
- Facilities
 - On-site clinics
 - Community clinics – different care delivery methods
 - School ownership or
 - FQHC's or safety-net clinics
- Technology
 - Simulation and other
 - Distributed and elearning
- IPE – Interprofessional Education
- Patient availability

Figure 19 reports the number of United States dental schools that offer selected instruction methods. *Case-based learning* was offered by the largest number of dental schools (55 schools), followed by *multiple sites away from campus for clinical or laboratory instruction* (49 schools) and *service learning* (46 schools). Table 28, beginning on page 65, provides detailed information on instruction methods used at each United States dental school.

Figure 19: Number of United States Dental Schools Offering Selected Instruction Methods, 2010-11



Source: American Dental Association, Survey Center, 2010-11 Survey of Dental Education (Group II, Question 19)

Student Educational Preparation for Dental Curriculum

Predental Education of US Dental Students in 2012 - 2013

2 yrs	3yrs	4 yrs	Bachelors	Masters	PhD	Other
0.1	2.4	3.2	84.0	9.1	0.2	2.0

American Dental Association, Health Policy Resources Center,
2012-13 *Survey of Dental Education* (US Group II, Question 12.
Canada Group II, Question 5.) © 2013 American Dental
Association



Dental Curriculum Models

Traditional 2 + 2

Basic sciences and preclinical courses

- 2 years of distinct basic science courses and preclinical courses
- Curriculum divided into pre-clinical and clinical activities
- Faculty-driven student learning

Clinical activities

- Possible structures - discipline-based years 3 and 4, or discipline-based in year 3 + general practice year 4, or Comp care teams year 3 and 4
- School owned & operated clinics

Pros

- Faculty calibration easier
- Patient care continuity

Cons

- Student-centered care delivery
- Clinical operation expenses
- Low fees and long appointments

Systems-Based or Integrated

Basic sciences and preclinical

- Integrated basic sciences around strands, body systems or themes
- Small-group, case-based learning
- Ground rounds case conferences
- Integrated clinical sciences

Clinical activities

- Early clinical activities in year 2
- Clinical practice in care teams
- School owned & operated clinics

Pros

- Improved sequencing of content
- Fosters critical thinking
- Evidenced-based approach to clinical decision-making

Cons

- Student-centered care delivery
- Clinical operation expenses
- Low fees and long appointments

PBL – Problem-based Learning

Basic sciences and preclinical

- Student determines learning objectives
- Small group, active learning
- Faculty serve as tutors/guides

Clinical activities

- May conduct usual year 3 & 4 traditional team care, or
- Can employ “clinical PBL” – i.e., Pre-session and Research-Phase clinical treatment activities
- School owned & operated clinics

Pros

- Foster enhanced critical thinking
- Teaches lifelong learning skills
- Evidence-based dentistry

Cons

- Clinical operation expenses
- Appointment length
- Low fees and long appointments



Dental Curriculum Models

CBDE – I

Early adopters model

3 + 1 model

- Accelerated basic sciences
- NB Part I taken after year 1

Clinical activities

- Early clinical activities in year 2
- Year 3 – in on-campus dental clinic
- Comp care teams year 3 and 4
- School owns and operates school-based clinics
- Year 4 – student in community-based sites for 90 -100 days
- 3 weeks of classes during year 4

Pros

- Higher student productivity in diverse patient care venues
- Service to the underserved
- Such clinics **not** school owned
- Preceptors perform care while attending to students

Cons

- Faculty and preceptor calibration
- CB clinic fees are not shared

Block

- Leaner administrative structure
- Integrated basic science, clinical, public health coursework
- Fewer full-time faculty
- Part-time adjunct faculty teach basic science modules and preclinical courses
- No departments - Disciplines led by directors or co-directors.

Clinical activities

- Year 3 – in on-campus dental clinic
- Year 4 – 50% of Clinical dentistry performed in on-campus dental clinic; 50% performed in external clinical rotation sites

Pros

- Faculty salary savings
- Increased student productivity
- Service to the underserved

Cons

- Maintaining contract faculty

CBDE – II

- 3 + 1 model
- Systems-based basic sciences
- Case-based teaching
- Vertically integrated team assignments in year 2
- Distributed learning technology connects 4th year students at the Community Service Learning Centers
- Cultural competency training for students prior to rotations

Clinical activities

- Year 3 in school-based clinic
- Year 4 in Community Service Learning Center (7 planned now)
- School owned & operated clinics
- Multiple student roles at CSLC

Pros

- Faculty providing care with residents and students



Dental Curriculum Models

Hybrid Models

- 2 years of distinct basic science courses and preclinical courses
- Case-based in some courses
- Faculty-driven student learning in others
- Student interest tracks in research, leadership, academics, global health and others

Clinical activities

- Evidence-based clinical care
- Comp care teams
- Participation in school owned & operated clinics, or
- Participation in community-based non-school owned clinics
- Different care delivery methods

Pros

- Provides students with opportunity to customize certain parts of their curriculum

IPE - Influenced

- Integrated basic sciences around strands, body systems or themes
- Interprofessional small-groups consisting of dental, med, PA, nursing, pharmacy working together on chronic disease management, ethics, team-training, communication, quality and safety
- Ground rounds case conferences
- Integrated clinical sciences

Clinical activities

- Community-based rotations in interprofessional care facilities that practice Team-based care

Pros

- Prepares graduates to work in health care teams of the future



Informing what we know

- ADEA Resources –
 - Reports – Deans' Briefing Book 2013
 - ADEA CCI - Commission on Change and Innovation whitepapers
 - Several articles in JDE
 - Also, 2008 JDE Supplement on the Macy Study Report
- ADA Curriculum Center –
 - 2011 Curriculum Survey
 - 2010-11 Survey of Dental Education (Group II)



References for Dental Curriculum Change Models

Traditional 2 + 2

Pyle, M. New models of dental education and curricular change: their potential impact on dental education. J Dent Educ 2012;76(1):89-97.

Systems-based or Integrated

Nadershahi NA, Bender DJ, Beck L, Alexander S. A case study on development of an integrated, multidisciplinary dental curriculum. J Dent Educ 2013; 77(6):679-87.

Problem-based Learning PBL

Fincham AG, Shuler CF. The changing face of dental education: The impact of PBL. J Dent Educ 2001;65(5):406-21.



References for Dental Curriculum Change Models

CBDE I – “early adopter” model

Formicola AJ; Bailit HL. Community-Based Dental Education: History, Current Status, and Future. J Dent Educ 2012; 76(1):98-106.

Block – the Arizona Model

Smith KP, Woldt JL, Cottam WW, Cederberg RA. The Arizona Model: A New Paradigm for Dental Schools. J Dent Educ 2011; 75(1):3-12.

CBDE II – Community Service Learning Centers and FQHC's

<http://www.ecu.edu/dentistry/> and www.atsu.edu/mosdoh/

IPE – Influenced <http://www.westernu.edu/dentistry/>



Drivers and Measures of Curricular Efficiency

Student Outcomes

- Graduation or attrition rates
- Plans after graduation – 88.9% of 2012 Graduates are in Dental-related activity

Faculty Roles

- Faculty providing care while supervising

Clinical locations

- Number of patients treated
- Clinical ownership

Technology

- Sustainability of financial viability of dental institutions
- Connecting to distant locations



Questions

Thank you



Student Debt

Marko Vujicic, PhD
Chief Economist & Vice President
Health Policy Institute

Student Debt



The NEW ENGLAND JOURNAL *of* MEDICINE

Are We in a Medical Education Bubble Market?

David A. Asch, M.D., M.B.A., Sean Nicholson, Ph.D., and Marko Vujicic, Ph.D.

Student Debt

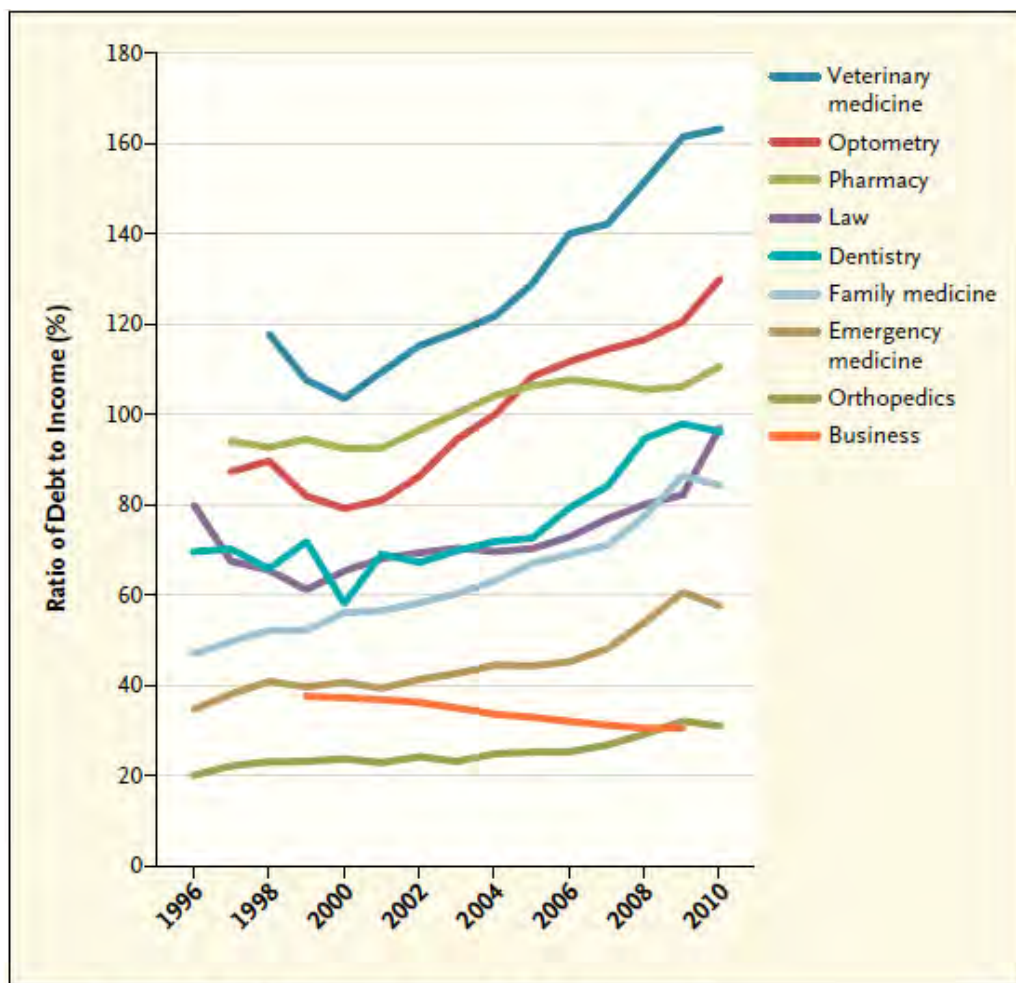
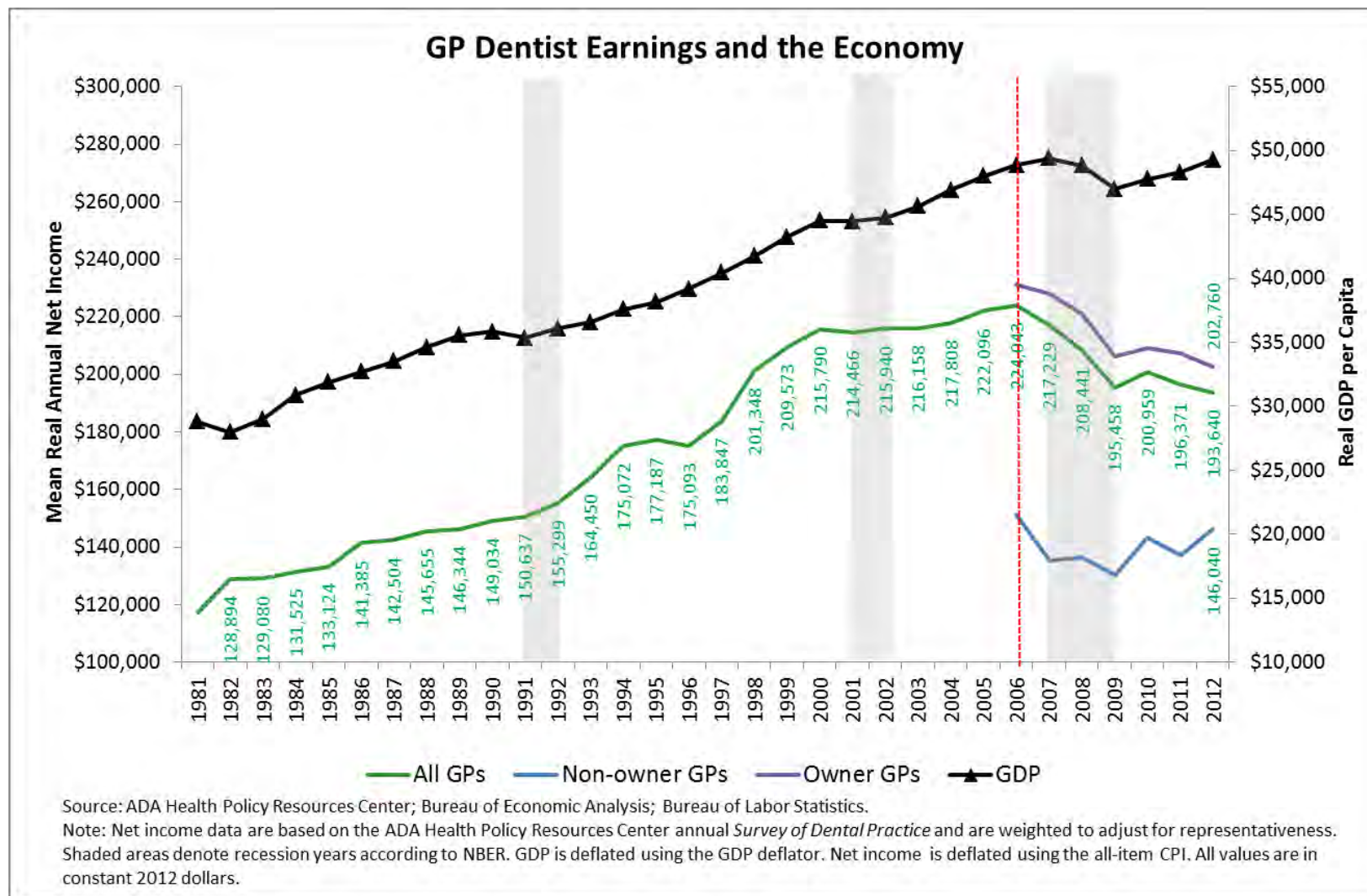


Figure 2. Ratio of Debt to Income, According to Occupation.

Although it seems unlikely that we're in a bubble market for medical education, we may already be in one for veterinary medicine. That bubble will burst when potential students recognize that the costs of training aren't matched by later returns. Then the optometry bubble may burst, followed by the pharmacy and dentistry bubbles. At the extreme, we will march down the debt-to-income-ratio ladder, through psychiatrists to cardiologists to orthopedists . . . until no one is left but the MBAs.

Dentist Earnings



Student Debt

COVER STORY

Educational debt and intended employment choice among dental school seniors

Tanya Wanchek, PhD, JD; Sean Nicholson, PhD; Marko Vujicic, PhD; Adriana Menezes, Anthony Ziebert, DDS, MS

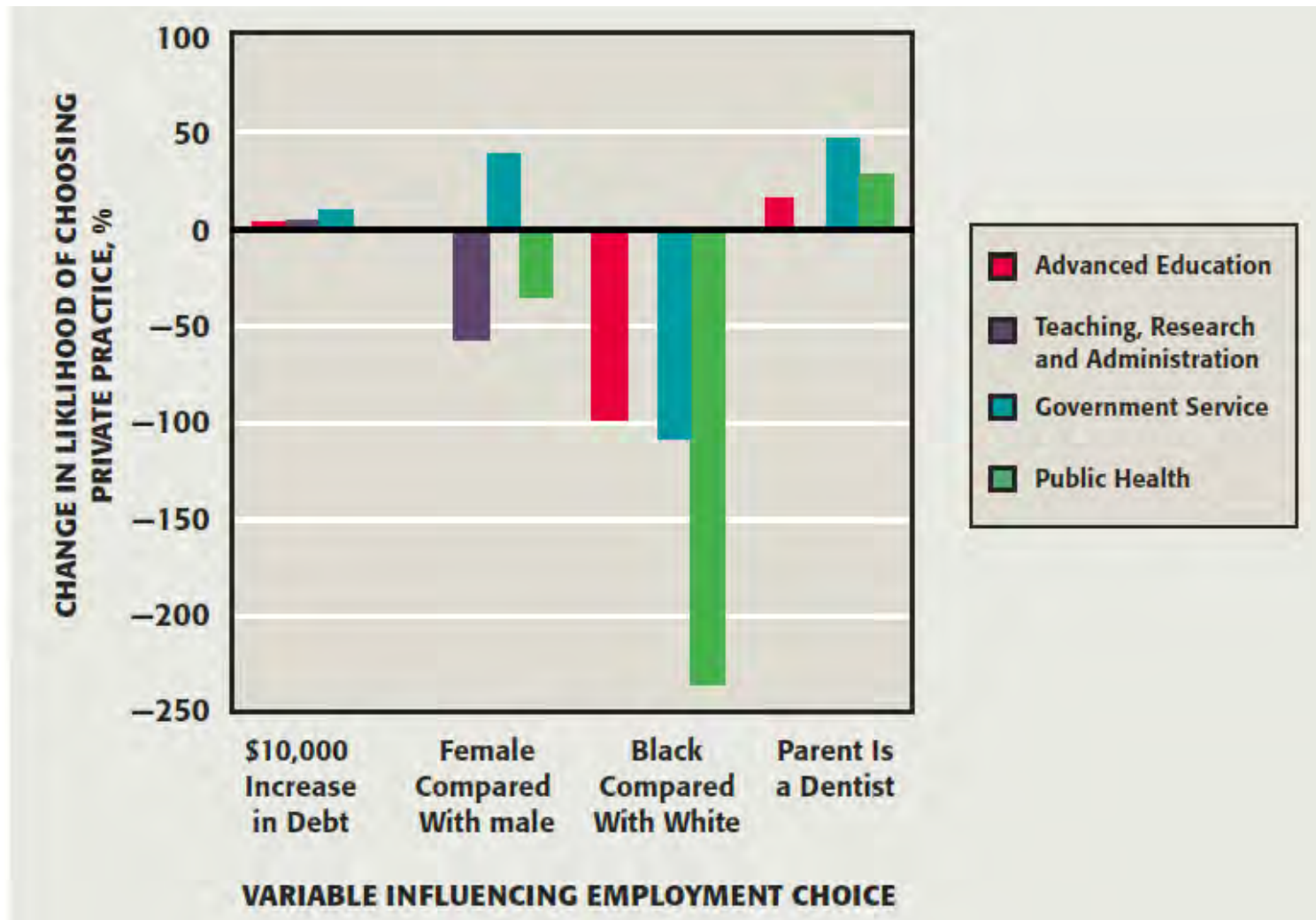
Dental school students' debt levels are rising. The average educational debt of graduating dental school seniors, including both dental school debt and prior educational debt, rose from \$122,000 in 2004 to \$179,000 in 2011 according to calculations we performed by using data from the ADEA [American Dental Education Association] Survey of Dental School Seniors. Dentists' income has not risen as rapidly over the same period. As a result, average edu-

ABSTRACT

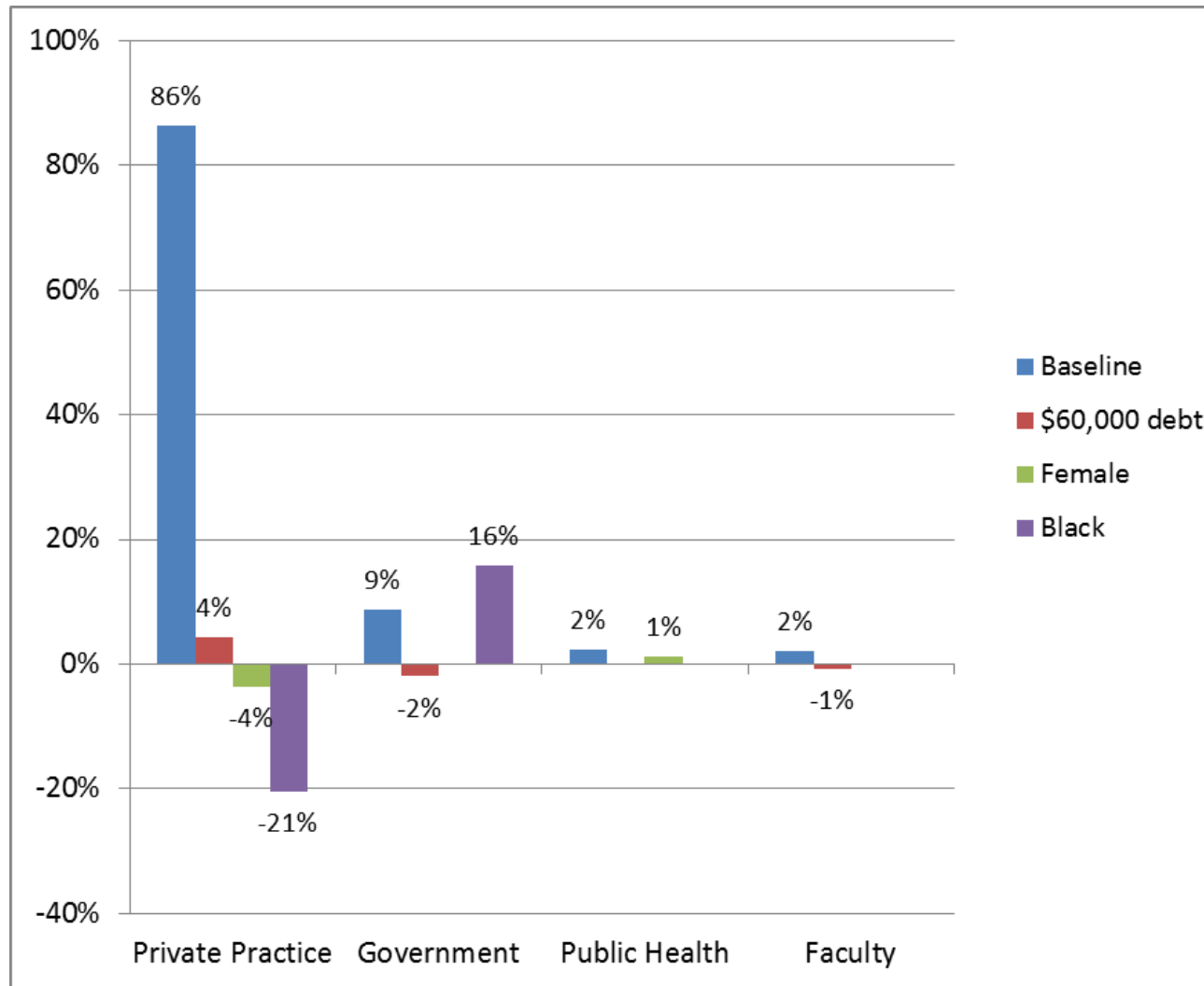
Background. The authors examine the association between educational debt and dental school seniors' intended activity after graduation.

Methods. The authors used multinomial logit regression analysis to estimate the relationship between dental educational debt and intended activity after graduation, controlling for potentially confounding variables. They used data from the 2004 through 2011 ADEA [American Dental Education Association] Survey of Dental School Seniors.

Student Debt



Student Debt



Student Debt

- The probability that a female dentist **owns her practice** is 22 percentage points lower than a male dentist.
- Whites are much more likely to **own a practice** than Hispanics (by 12.9 percentage points), Asians (by 18.0 percentage points), and blacks (by 19.4 percentage points).
- Females and non-whites are **more willing to accept poor patients** than males and whites.
- Debt does not affect ownership or willingness to accept poor patients

Student Debt

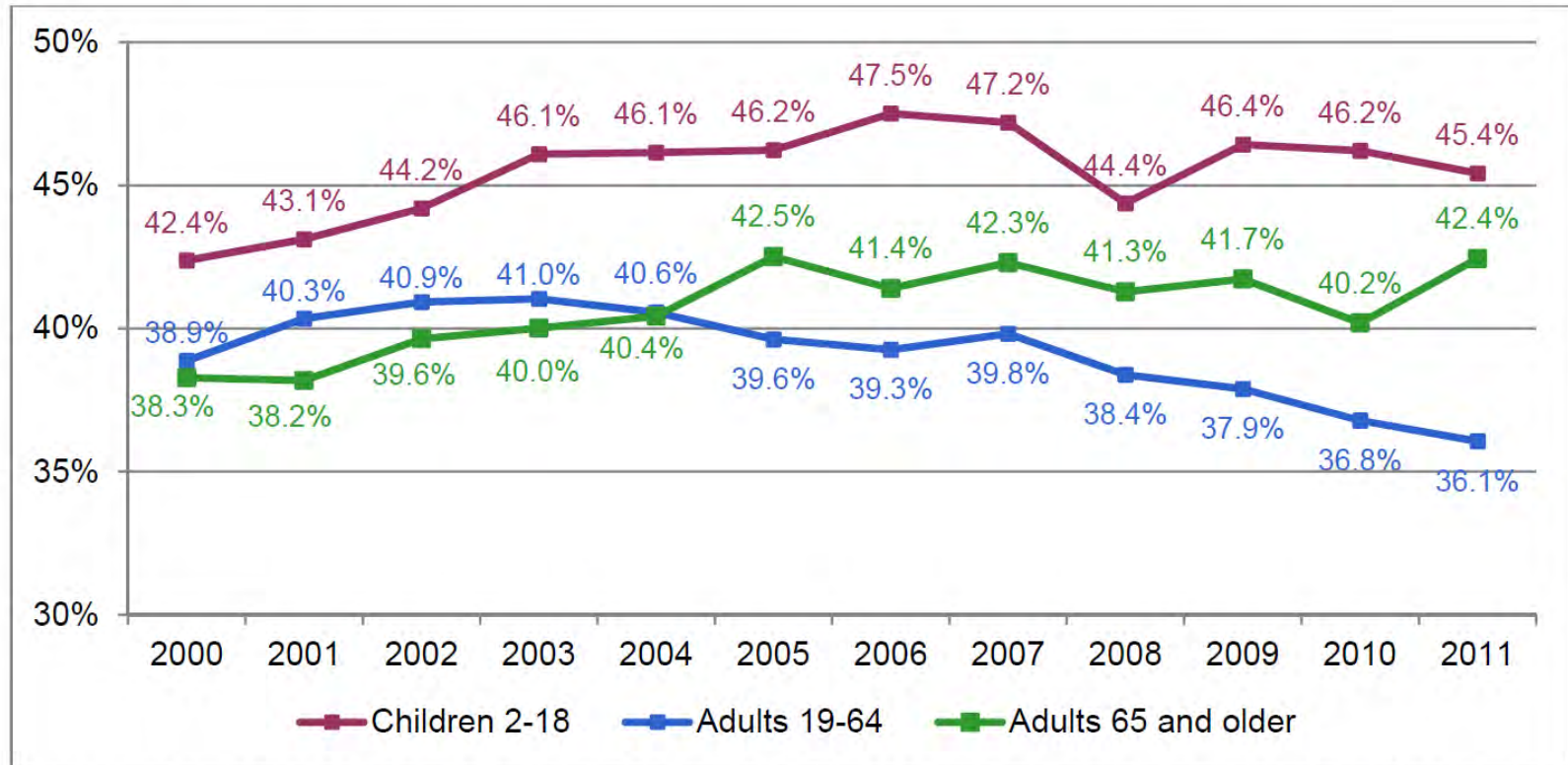
- Education debt has an impact on some career choices.
- The magnitude of this effect is fairly small, especially when compared to the impact of personal characteristics like gender, race, and whether a parent is a dentist.
- Preliminary results from subsequent research suggest that the impact of education debt is even smaller once you control for endogeneity.

A Look Forward...



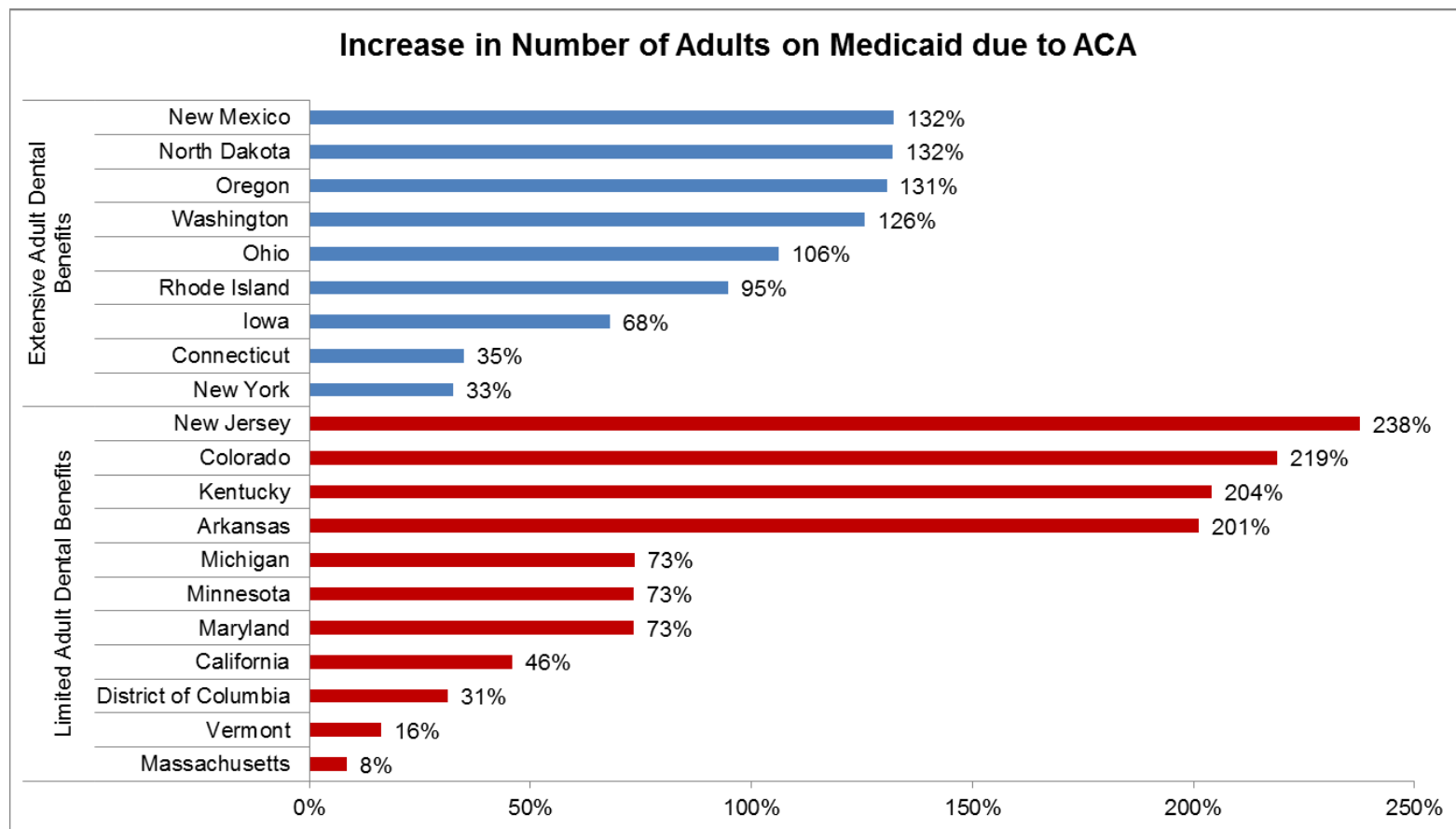
Shift in Demand for Dental Care

Figure 1: Percentage of the Population with a Dental Visit in the Year, 2000-2011



Source: Medical Expenditure Panel Survey, AHRQ. **Notes:** Changes are statistically significant at the 5% level for children ages 2-18 (2000-2011), at the 1% level for adults ages 19-64 (2003-2011), and at the 1% level for adults ages 65 and over (2000-2011).

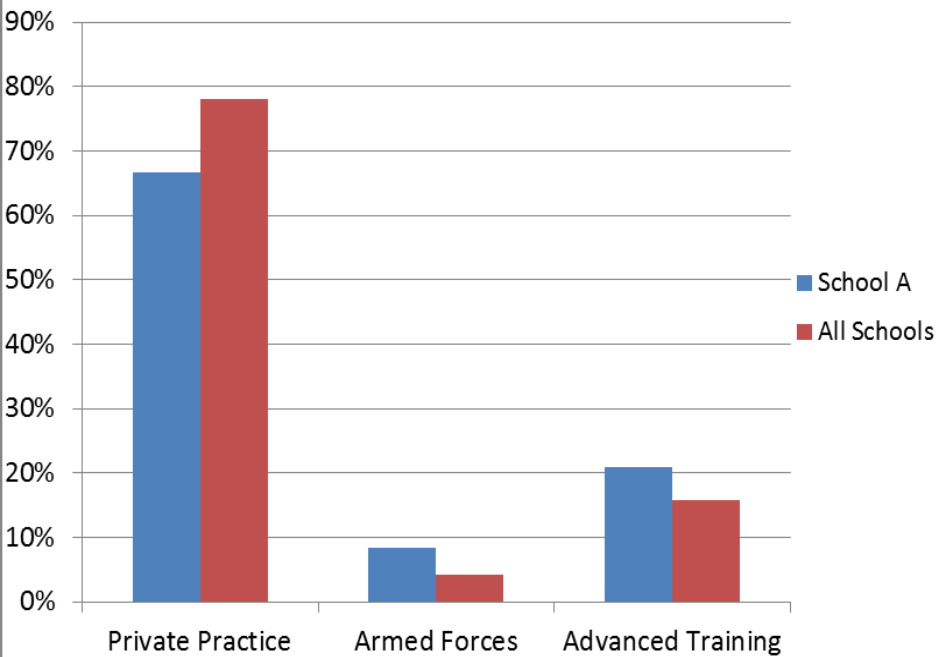
Medicaid Expansion



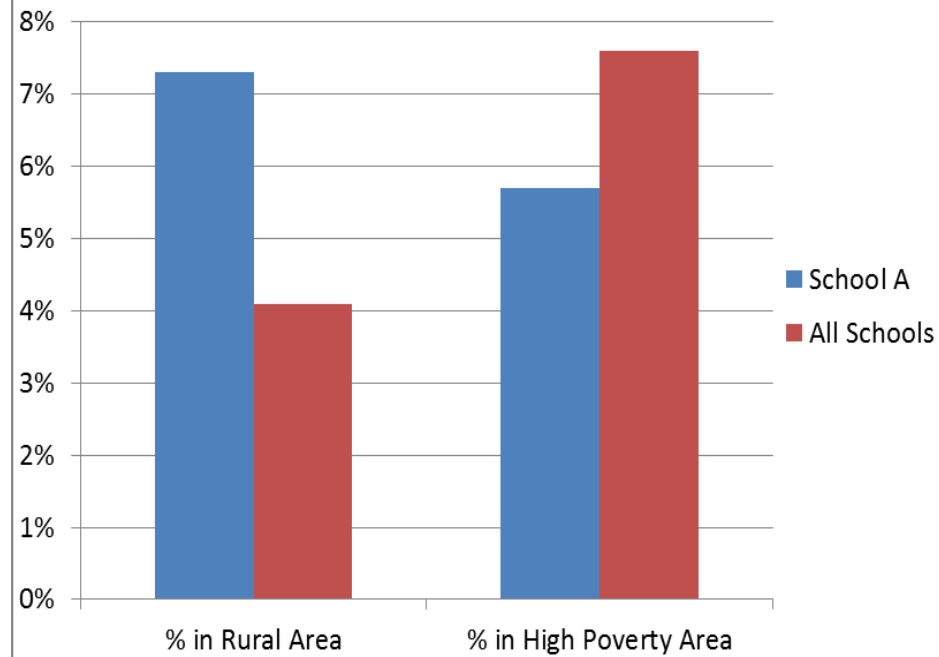
Source: ADA Health Policy Resources Center analysis of State Medicaid Policies, Kaiser Family Foundation. **Notes:** We examined the Medicaid benefits offered by each state to determine the type of dental benefits provided to enrolled adults. States typically post benefits information on their state Medicaid website, or in a statement of benefits. We classified each state's adult Medicaid dental benefits into one of four categories: extensive dental benefits, limited dental benefits, emergency dental benefits, and no dental benefits. While there is no clearly defined, well-established method for classifying adult Medicaid dental benefits, these categories are consistent with previous methodology developed by the ADA. We calculated the potential percentage change in adults eligible for Medicaid by dividing the number of adults potentially eligible for Medicaid in 2014 as determined by the Kaiser Family Foundation by the number of adults enrolled in Medicaid in 2010, by state.

Medicaid Expansion

What is your Primary Occupation?



Where do you Practice?



Moving from Volume to Value

THE BIG IDEA

The Strategy That Will Fix Health Care

Providers must lead the way in making value the overarching goal by Michael E. Porter and Thomas H. Lee

Organizations that progress rapidly in adopting the value agenda will reap huge benefits, even if regulatory change is slow.

The Value Agenda

The strategic agenda for moving to a high-value health care delivery system has six components. They are interdependent and mutually reinforcing. Progress will be greatest if multiple components are advanced together.





Increased Care Coordination



ADA American Dental Association¹
America's leading advocate for oral health

Health Policy Resources Center Research Brief

Accountable Care Organizations Present Key Opportunities for the Dental Profession

Author: Marko Vujicic, Ph.D.; Kamyar Nasseh, Ph.D.

Key Messages

- Dental care is not generally included as a core component within today's Accountable Care Organizations (ACOs). Where dental services are incorporated, it is mainly only at the level of facilitated referral or co-location.
- One key reason is that existing ACOs focus on Medicare populations and Medicare does not include dental benefits. There is also a perception that most dental providers and plans are accustomed to providing care according to frequency limits defined by dental insurance policies rather than a patient's dental risk profile.
- ACOs could help bridge the gap between oral and general health care, improve coordination of care, and help reduce overall health care costs. They also provide an opportunity to re-examine the role of oral care providers within the health care team. Since dental care for children is an essential health benefit under the Affordable Care Act, the most immediate opportunities are with the pediatric population.

Introduction

The health care system in the U.S. is on the verge of major reform. The Affordable Care Act (ACA) aims to improve the health of the population, enhance the patient experience of care (including quality, access, and reliability) and reduce, or at least control, the cost of care¹. A key aspect of the reforms is a sea change in how health care is delivered and financed. Today's system of loosely affiliated health care providers each paid primarily fee-for-service (FFS) is expected to give way to a much more coordinated delivery model that rewards providers for improvements in health outcomes and efficiency.

Accountable Care Organizations (ACOs) are designed to align provider incentives with

The ADA Health Policy Resources Center (HPRC) is a thought leader and recognized authority on critical policy issues facing the dental profession. Through unbiased, innovative, empirical research, HPRC helps dentists and policy makers make informed decisions that affect dental practices, the public and the profession.

Who We Are
HPRC's interdisciplinary team of health economists, statisticians, and analysts has extensive expertise in policy research in dentistry and regularly collaborates with researchers in academia, the dental industry and consulting firms.

Contact Us
Contact the Health Policy Resources Center for more information on products and services at hprc@ada.org or call 312.440.2328.

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April 2013

Increased Care Coordination

Tomorrow's health care environment will provide an opportunity to re-examine the role of oral care providers within the health care system.

Marko Vujicic, PhD; Hilton Israelson, DDS; James Antoon, DMD; Roger Kiesling, DDS; Thomas Paumier, DDS; Mark Zust, DDS

GUEST EDITORIAL

A profession in transition

Dentistry is a profession in transition. Important economic, demographic and political forces are colliding to reshape the practice environment for America's dentists. To better understand the potential changes on the horizon, the American Dental Association (ADA) recently carried out a comprehensive, future-oriented analysis of the dental care sector as part of the 2015-2020 strategic plan development process.¹ This first-of-its-kind analysis drew on research carried out by health care consulting firm Diringer and Associates, various external consultants and the ADA's Health Policy Resources Center. Researchers investigated a wide variety of topics over a period of several months. To help identify the most pressing environmental factors that need to guide the ADA's strategic plan and to assist in a "what does it all mean for dentistry" discussion, a group of external thought leaders with diverse backgrounds and perspectives were asked to share their insights at a two-day conference. The full report, *A Profession in Transition*,² was released in August 2013. This is an executive summary of the key findings.

One of the most important findings is that utilization of dental care is declining among working-age adults, particularly the young and the poor, and that this trend is unrelated to the recent economic downturn.

LOOKING BACK

Several important structural changes have occurred in the dental care sector in recent years. Structural changes are those that are driven by changes in the underlying behaviors of various groups—including patients, dentists and payers—and are distinct from cyclical changes that are driven simply by economic cycles.

One of the most important findings is that utilization of dental care is

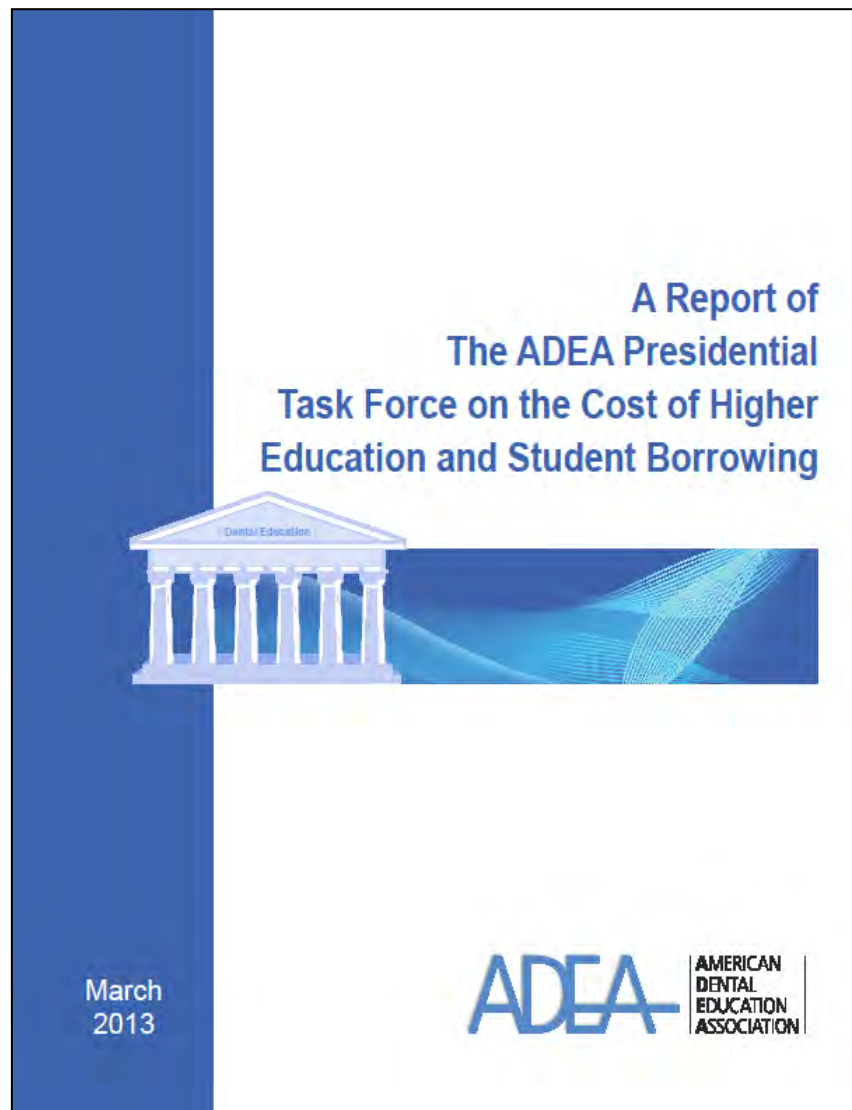
Dental Economics & Dental Student Indebtedness

Cecile A. Feldman, DMD, MBA

Dean and Professor

Rutgers School of Dental Medicine

June 20, 2014



Goals

- Describe a model current market forces influencing dental education costs and student borrowing
- Explain trends in dental education costs
- Explain trends in student borrowing
- Initiatives which can be undertaken to address these issues

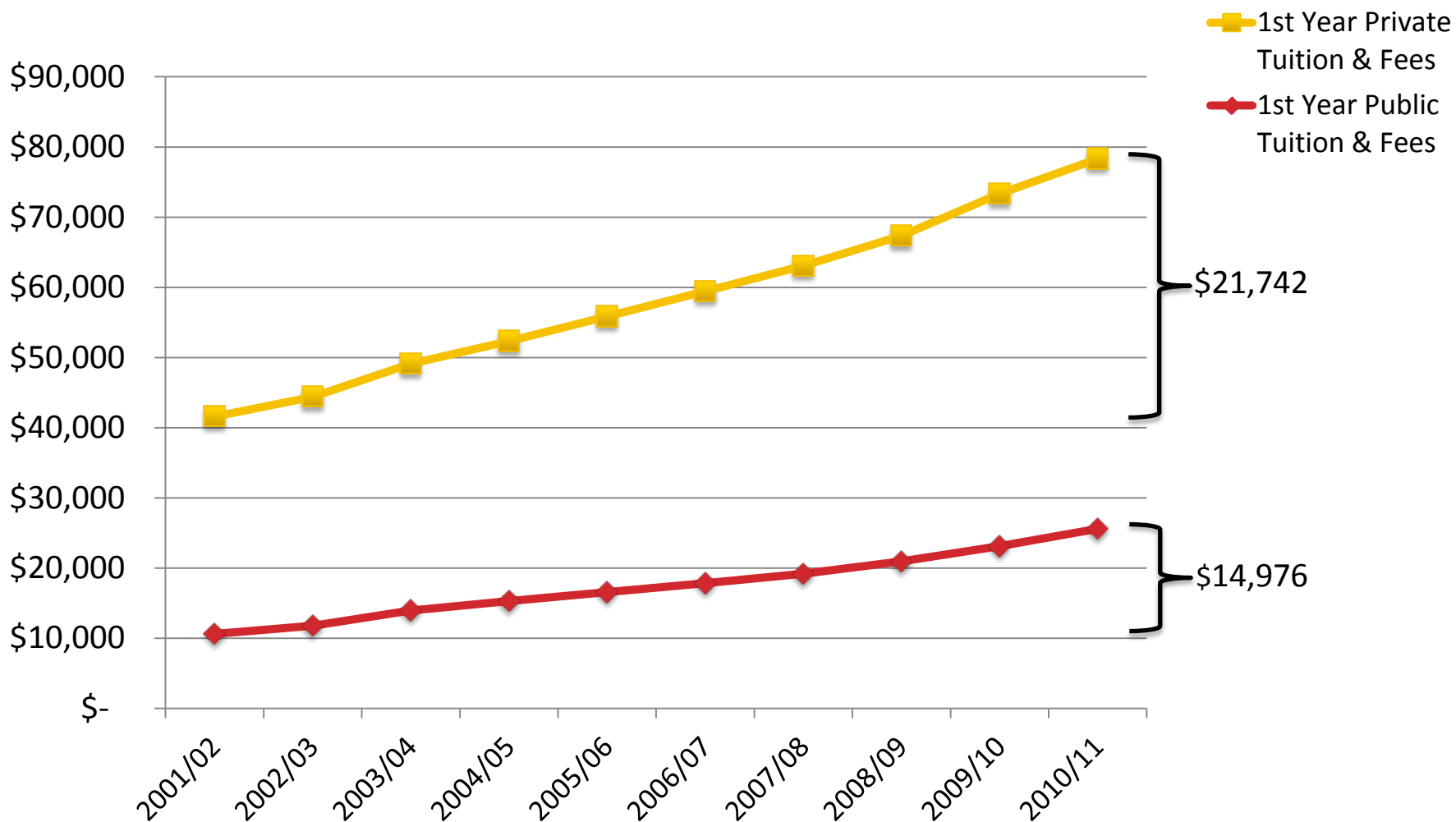
Student Expense Budget

RSDM Class 2017: 2013-2014

	In-State Own Residence	In-State Living with Parents	Out-of-State Own Residence	Out-of-State Living with Parents
Tuition	\$35,823	\$35,823	\$57,479	\$57,479
Books & Supplies	\$12,261	\$12,261	\$12,261	\$12,261
Fees	\$2,782	\$2,782	\$2,782	\$2,782
Personal	\$4,010	\$4,010	\$4,010	\$4,010
Transportation	\$4,230	\$4,230	\$4,230	\$4,230
Room and Board	\$13,860	\$3,540	\$13,860	\$3,540
TOTAL	\$72,966	\$62,646	\$94,622	\$84,302

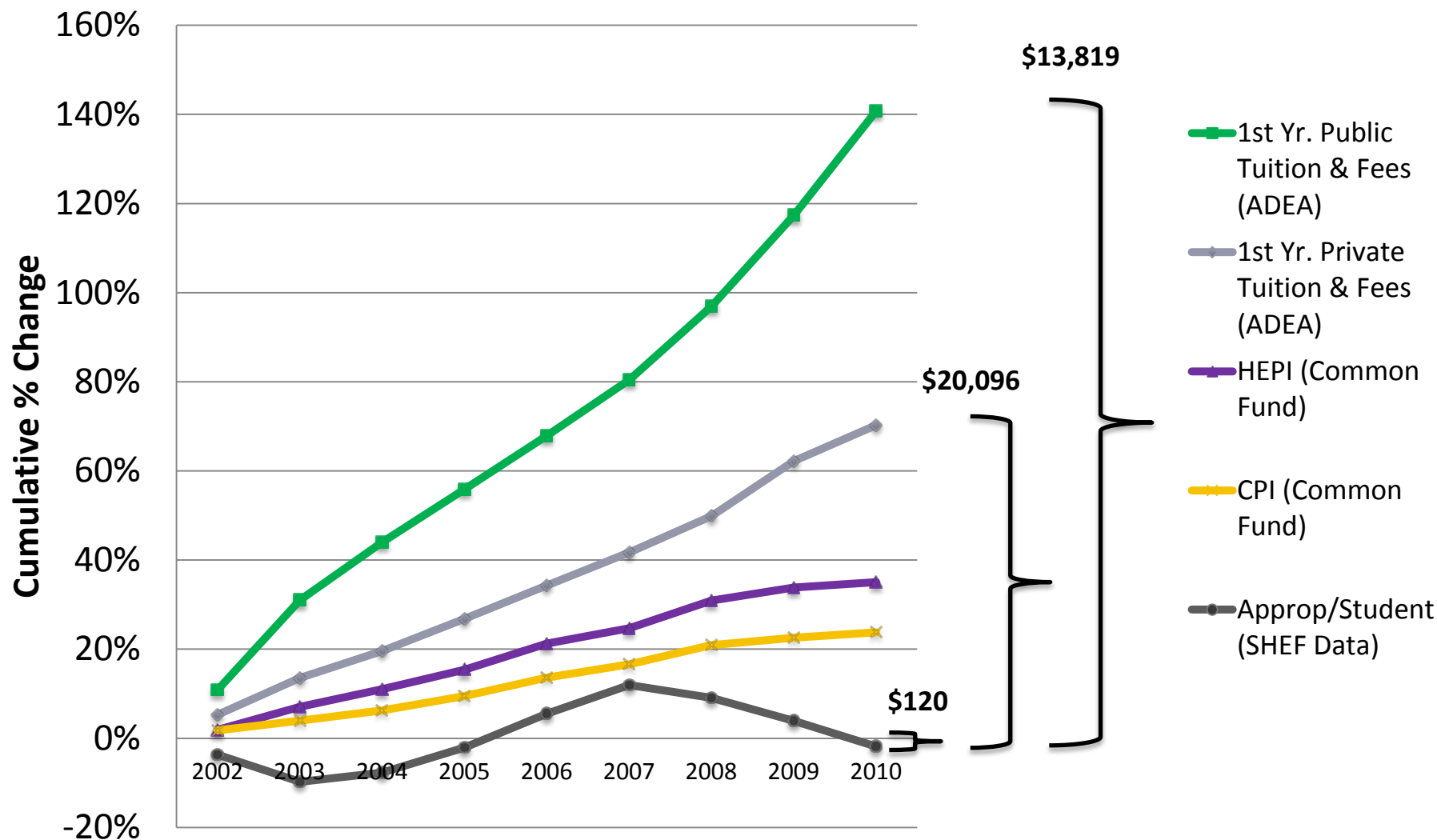
1st Year Tuition & Fees

(Nominal \$ - Not Adjusted)

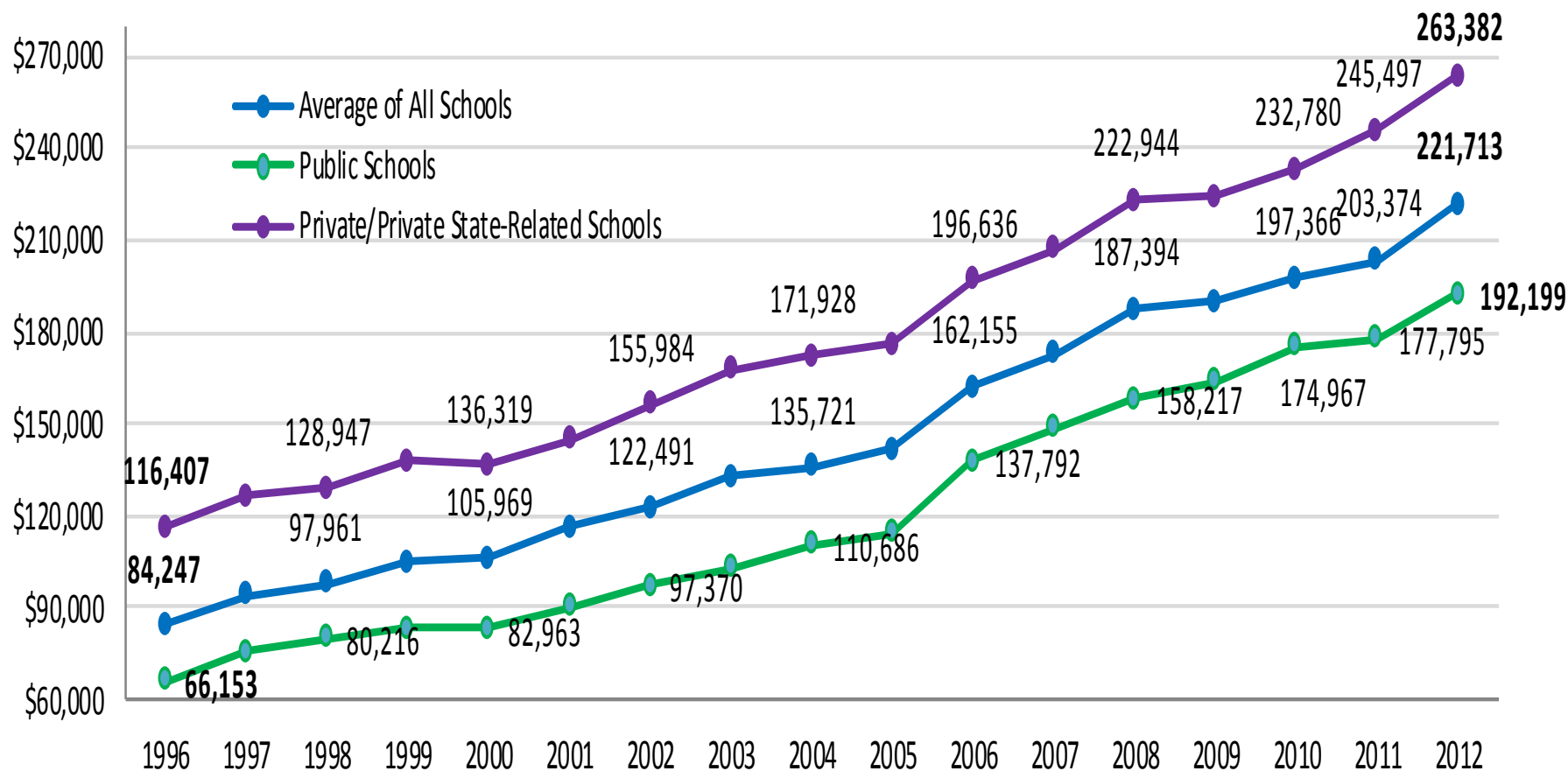


Cumulative % Change in 1st Yr. Tuition & Fees between 2002 and 2010

(Based upon Nominal \$ - not adjusted)



Borrowers: Average Educational Debt Among Graduating Students with Debt by Type of School, 1996-2012 (Current Dollars)



Source: American Dental Education Association, Survey of Dental School Seniors

Note: Educational debt is the sum of undergraduate debt and dental school debt of only those respondents who have debt.

What is considered manageable student debt?

- Total educational debt at graduation should not exceed total salary**

	1996	2011	% Change
Student Debt			
Public	\$94,840	\$177,795	87.47%
Private	\$166,866	\$245,497	47.10%
ADA REPORTED GP Net Income	\$171,143	\$192,392	12.15%
Debt/Income Ratio			
Public	55.29%	97.29%	67.15%
Private	92.41%	127.60%	31.16%

Note: \$142,7000 – US Department of Labor Median Dentist Income for 2012

- Monthly loan payments should not exceed 8-12% of gross income**

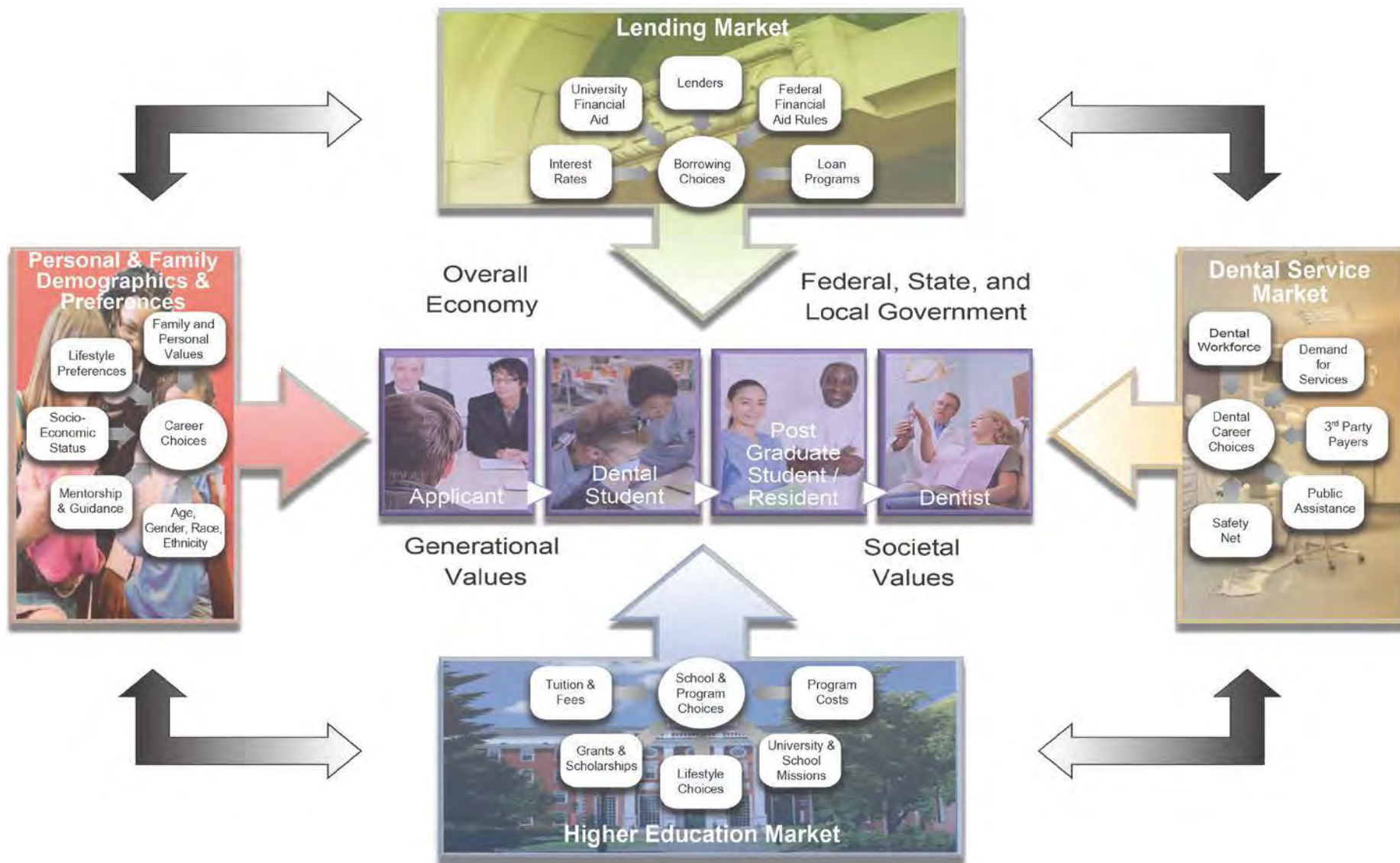
Recommendations for Lowering Dental Education Costs and Reducing Student Borrowing

1. Promote financial literacy and ensure that the highest quality financial aid services and counseling are available to prospective and current students, residents, and fellows.
2. Continue to pursue funding for scholarships from stakeholder communities.
3. Continue to promote mission alignment with resource management in academic dental institutions.
4. Explore alternative dental education models.
5. Enhance advocacy partnerships with other dental organizations.
6. Continue to take a leadership role in representing the interests of ADEA's membership on issues related to the cost of dental education and student borrowing.
 - a. Loan Repayment/Forgiveness Programs
 - b. GME and THCGME (Teaching Health Center GME)
 - c. FQHCs

Suggestions for Future Research

1. Conduct more extensive trend analyses of available cost and borrowing data.
2. Establish data sharing agreements among various stakeholders.
3. Refine ADEA and CODA surveys so they provide information that supports planning, policy, and decision making associated with the cost of dental education and dental student borrowing.
4. Encourage both local and national qualitative research that examines the status of students' educational loans.
5. Conduct a national study to identify the costs of implementing alternative educational models, especially IPE.
6. Examine implications of rising debt among allied dental students.

Student borrowing is a complicated issue because it is a complicated system.



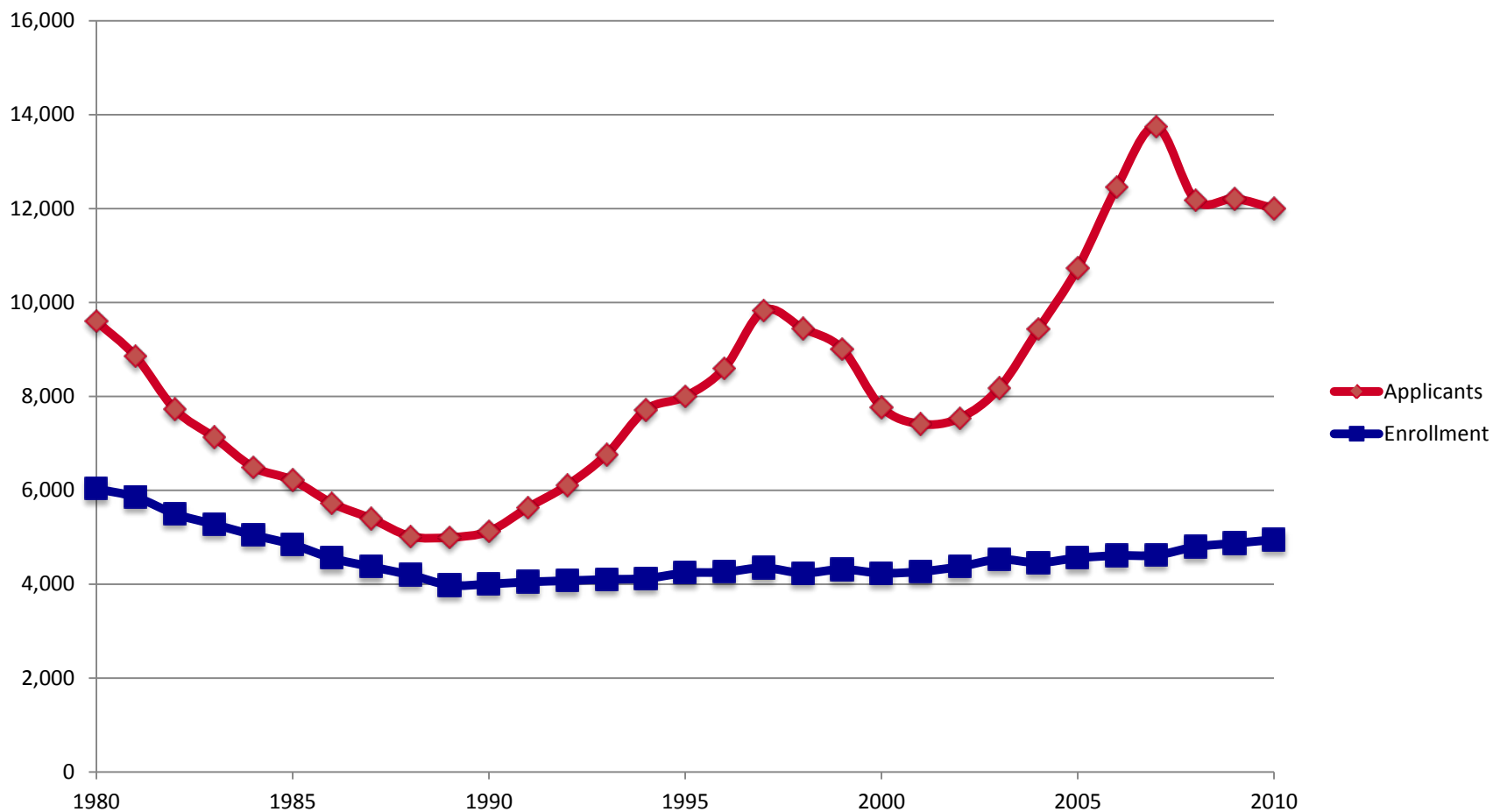
Student borrowing is a complicated issue because it is a complicated system.



Student borrowing is a complicated issue because it is a complicated system.

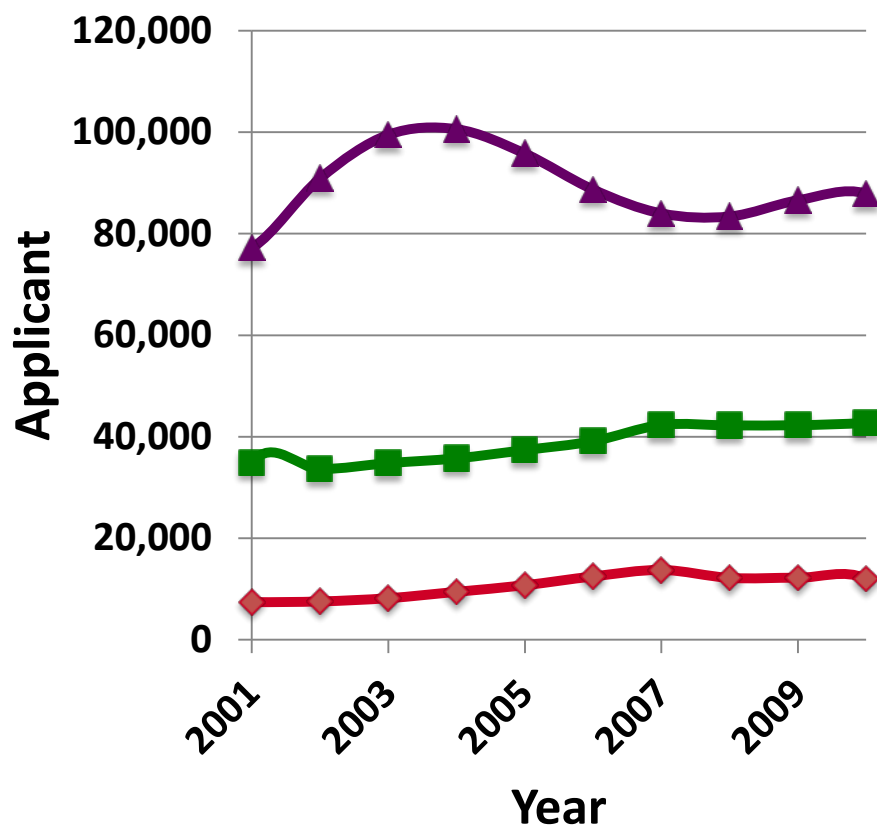


Dental School Applicants and 1st Year Enrollment

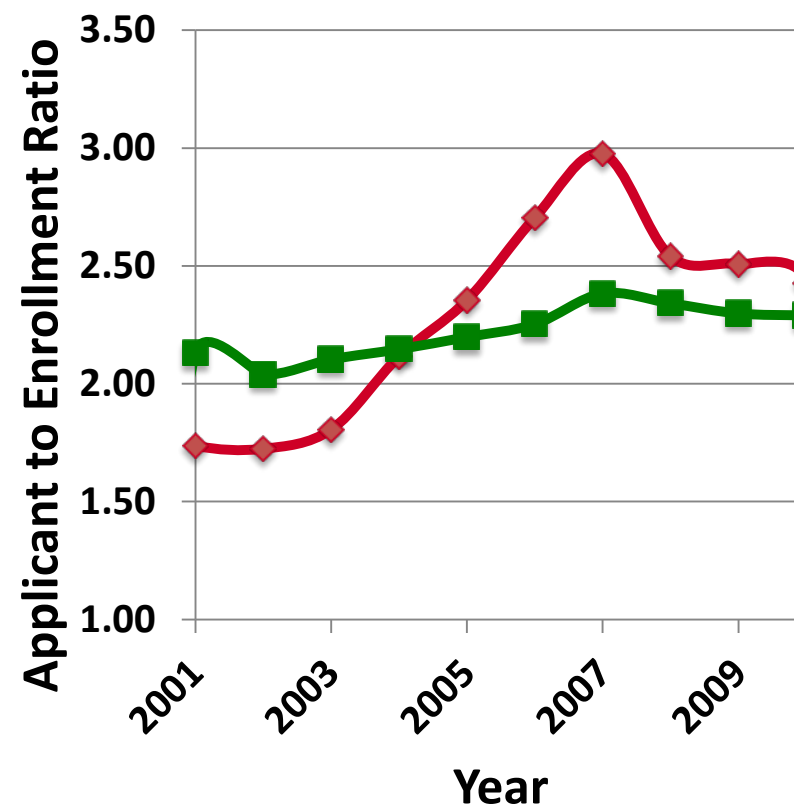


Applicants & Applicant to Enrollment Ratio

Applicants

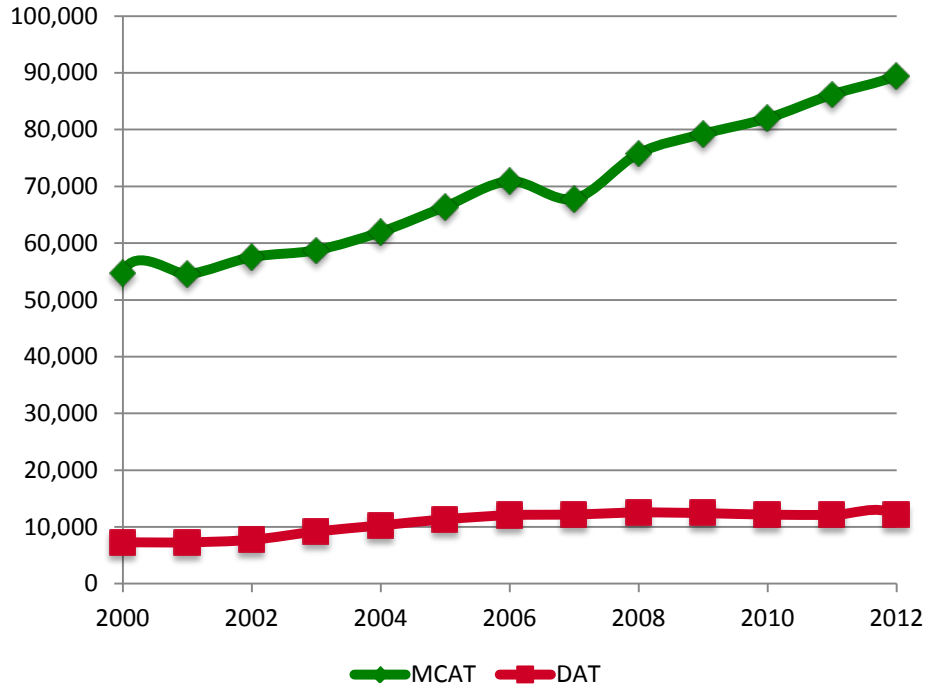


Applicant to Enrollment Ratio

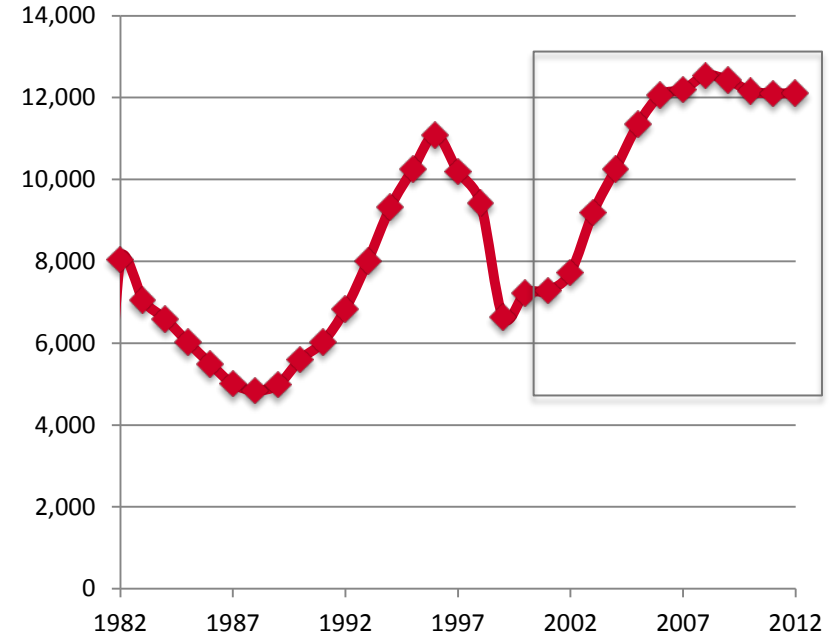


MCAT and DAT Trends

MCAT and DAT Tests



DAT



Student borrowing is a complicated issue because it is a complicated system.



Repayment Options

- Normal Payback
- Consolidation
 - Interest rate is the weighted average of the interest rates of the loans included in the consolidation
 - Rounded up to the next one-eighth of one percent
- Loan Repayment/Forgiveness Options
- Income Based Repayment/Pay As You Earn
 - **Is this a game changer?**

Uncertain Repayment Universe

Public Service Loan Forgiveness

- Will eligibility requirements change?
- What career plans change?

Income-Driven Repayment

- Will the plan be available for my entire career?
- Will forgiveness be available?
- Is this the best financial plan?

However, ...

- Recent financial aid changes for graduate/professional students
 - Especially benefit students going to high cost programs
- Media attention points to unintended consequences
 - Graduate/professional students benefit more than any other group under income-driven plans

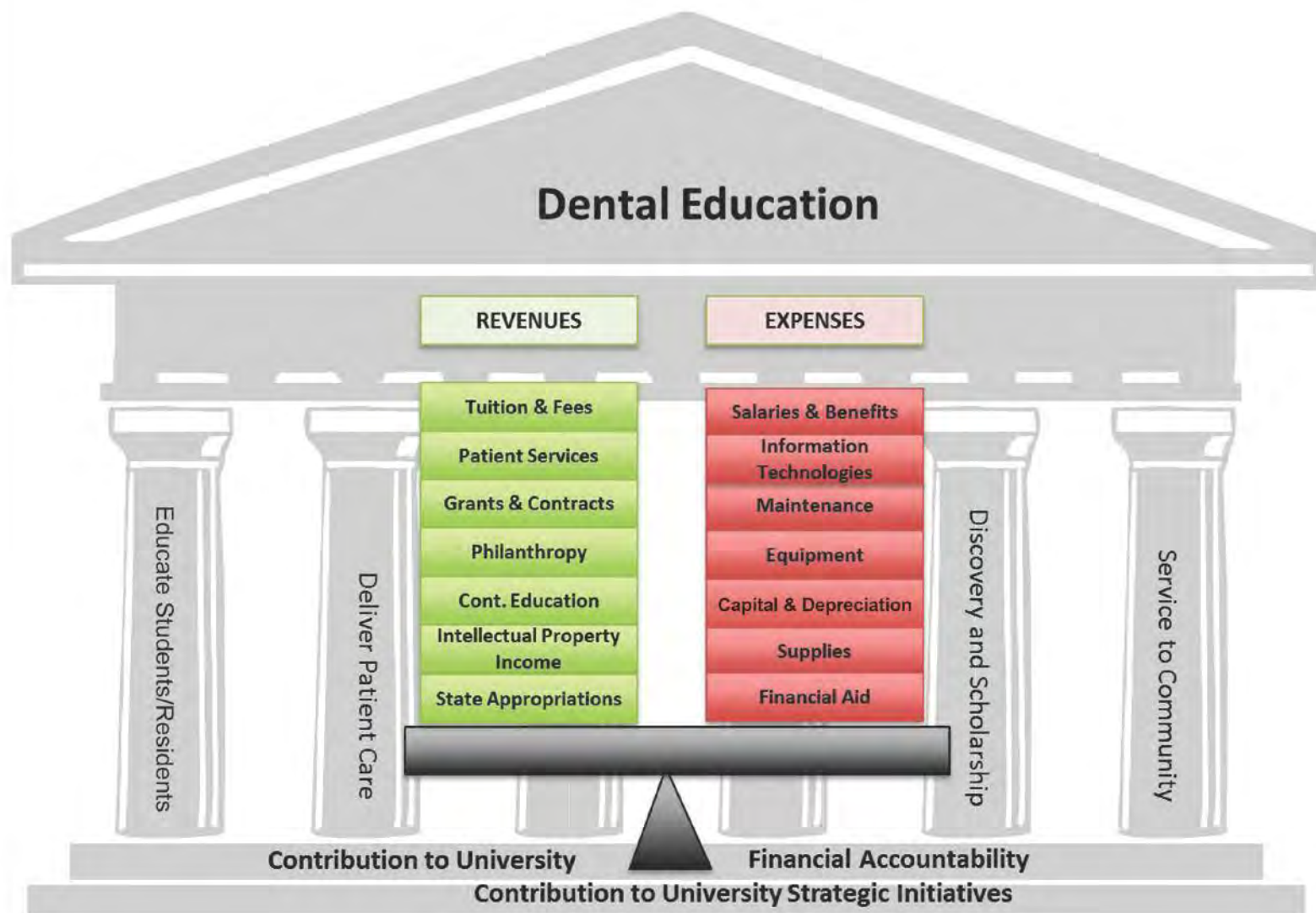
Student borrowing is a complicated issue because it is a complicated system.



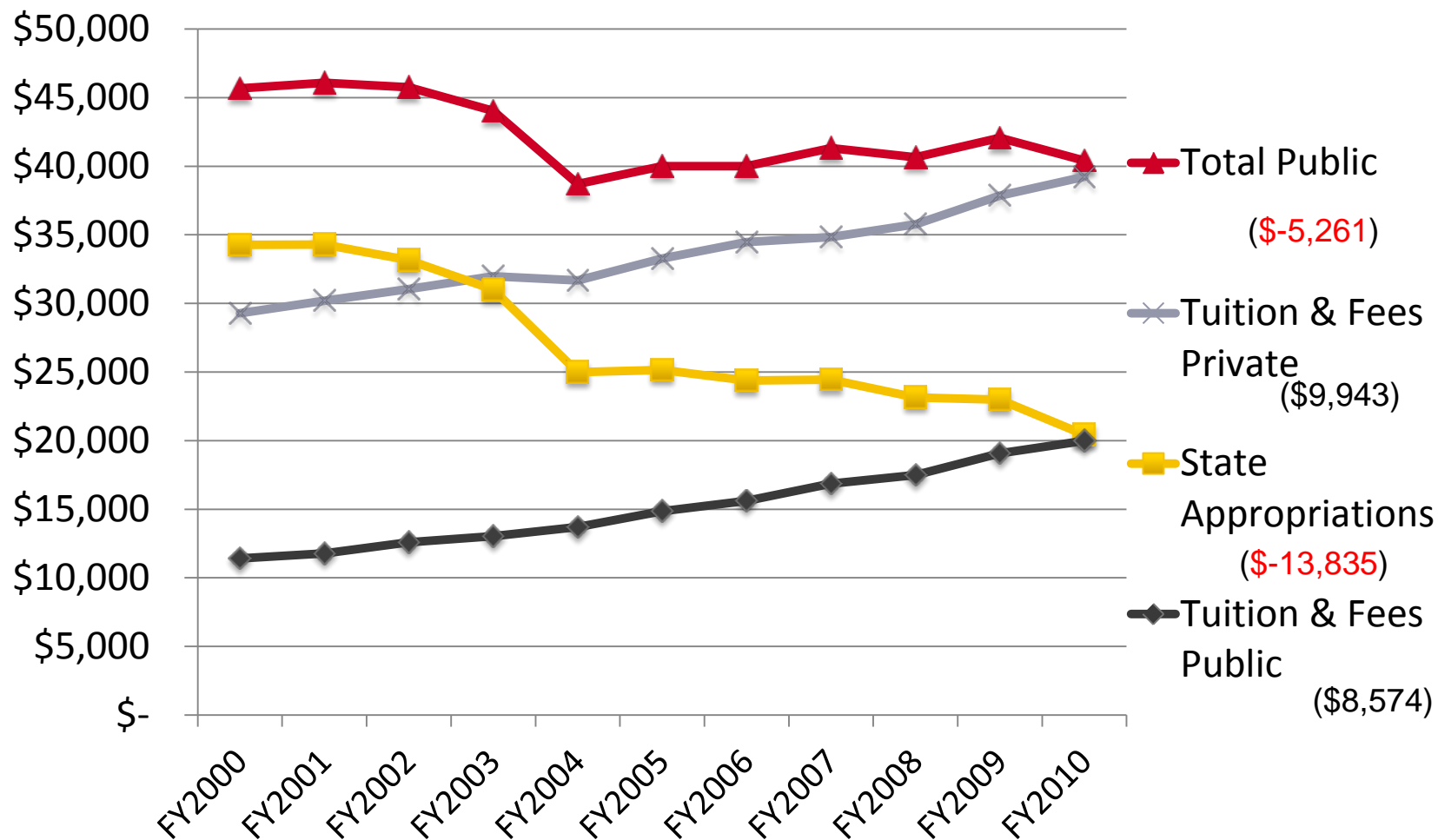
Student borrowing is a complicated issue because it is a complicated system.



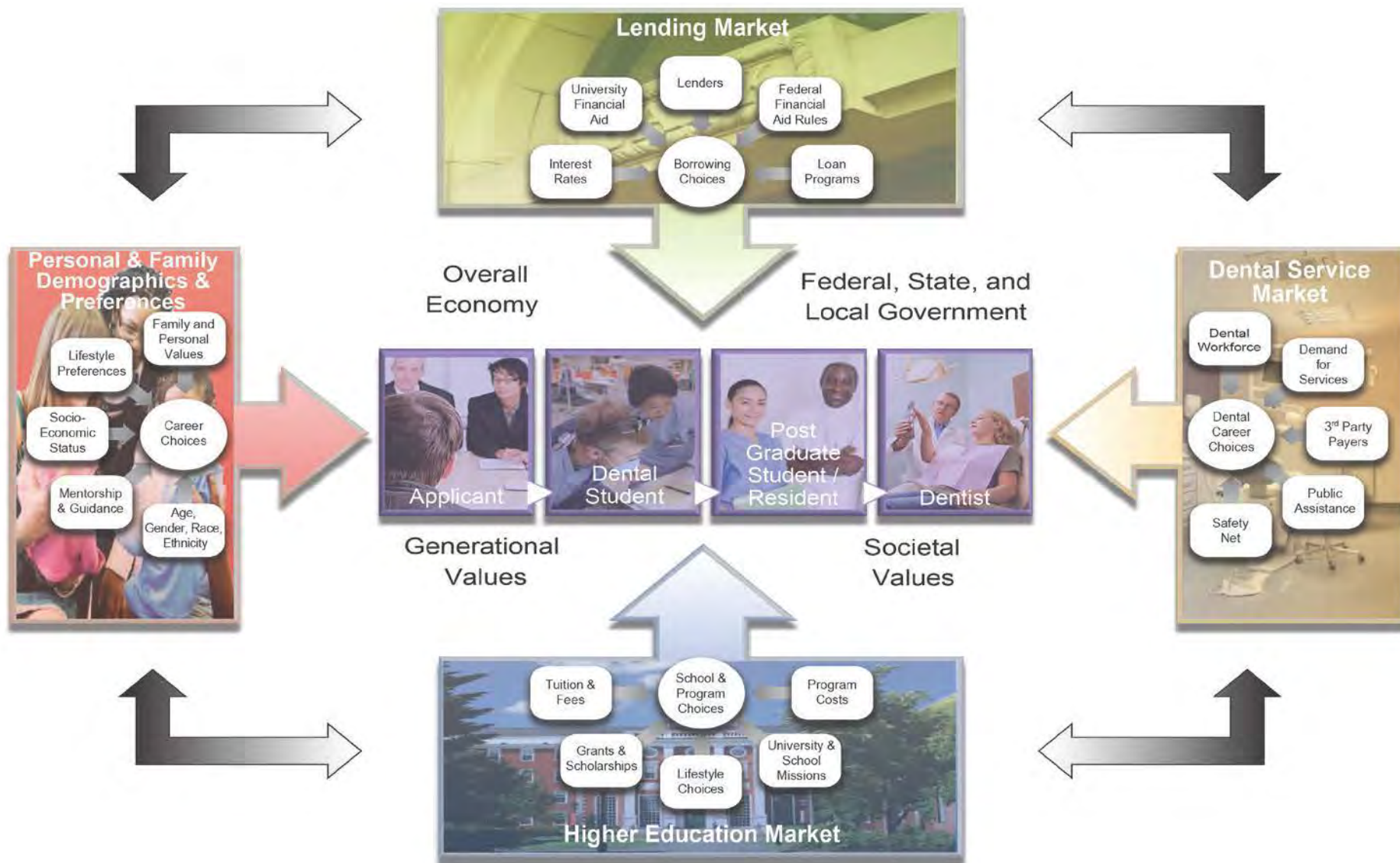
Complexity of Dental Education Finances



Tuition, Fees & State Appropriations per DDSE (2000 Constant Dollars)



Student borrowing is a complicated issue because it is a complicated system.

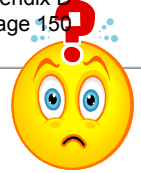


Literature Review

- Not many studies
 - Few in existence have methodological issues
- JADA 2014;145(5):428-434
 - Methods
 - Based on ADEA Senior Survey
 - Based on BEST GUESS of students about what they WILL do next year.
 - Need to look at ACTUAL employment and long term career earnings
 - Findings
 - Level of student indebtedness has less of an impact as compared to race, gender and parent being a dentist
 - Conclusions drawn based upon a \$10,000 increase in student debt
 - As increase has been much greater, Impact may be understated
 - Interesting Points
 - If the increase in supply of dentists is not met with a comparable increase in demand for dental services, then wage gains will be further limited and will exacerbate the declining ROI for dental education

Implications of a Decrease in ROI

- Should we expect a decrease in applications?
 - If so, at what level is the decrease significant?
- Will more graduates be seeking practice opportunities and not other career options including public service or academic careers?
- What will the affect be on post-graduate/specialty programs?
 - Higher debt pushes students into immediate practice so they can start repaying loans sooner vs. higher debt pushes students into specialties so that they defer loans as long as possible and have higher incomes
 - Lots of repayment options
- Will graduates be less willing to treat Medicaid patients and work in underserved areas?
 - Little data to support this hypothesis



Key Outstanding Questions

- Does cost of dental education and/or student borrowing influence student choice?
 - Who chooses dentistry as a career?
 - Who goes on to post graduate training? What type of post graduate program?
 - What career path they pursue?
 - Willingness to treat low income, underserved patients?
- How has the ROI changed?
 - Limited recent data?
 - What are the implications of this change?
 - What is the critical point in which dentistry is no longer a desired profession?
 - NOTE – It still is
- What is the impact of new loan repayment programs/options?
 - May be a game changer with “pay as you earn” options with loan forgiveness at the end
 - Involves developing a very sophisticated strategy

Questions?



Thank You



Borrowers: Seniors' immediate plans upon graduation in selected years 1980–2011, by percentage of total respondents for each year

Immediate Plans	1980	1985	1990	2000	2005	2008	2011
Solo Private Practice	17.3%	9.4%	5.8%	5.5%	3.7%	3.1%	
Partner Group	9.8%	14.3%	12.0%	9.5%	6.1%	6.7%	
Associate/Employed	29.9%	34.4%	31.3%	36.5%	41.8%	40.6%	
Total Private Practice	57.0%	58.1%	49.1%	51.5%	51.6%	50.4%	49.2%
Government Service	14.5%	10.3%	11.6%	11.0%	6.1%	5.9%	9.4%
Teaching/Research/ Administration	1.3%	0.9%	1.0%	0.5%	0.8%	0.8%	0.3%
Advanced Education	18.3%	23.6%	33.4%	34.1%	38.6%	39.6%	36.8%
Unsure/Other	8.9%	7.2%	4.9%	2.9%	3.0%	3.3%	4.1%



Borrowers: Seniors' long-term plans upon graduation in selected years 1990–2008, by percentage of total respondents for each year

Immediate Plans	1990	1995	2000	2005	2008
Solo Private Practice	37.7%	42.1%	37.6%	36.5%	34.2%
Partner Group	43.4%	38.9%	49.2%	50.8%	48.9%
Associate/Employed	NA	4.1%	3.5%	3.2%	6.4%
Total Private Practice	81.1%	85.1%	90.3%	90.5%	89.5%
Government Service	NA	NA	1.8%	1.0%	1.2%
Teaching/Research/Administration	NA	NA	2.2%	1.8%	1.9%
Unsure/Other	18.9%	10.6%	6.2%	5.7%	5.8%

ADA Stakeholder Meeting

Scope and Aims of a Proposed Comprehensive Study of the Current Dental Education Models

Research and Scholarship

Laurie K. McCauley, DDS, MS, PhD

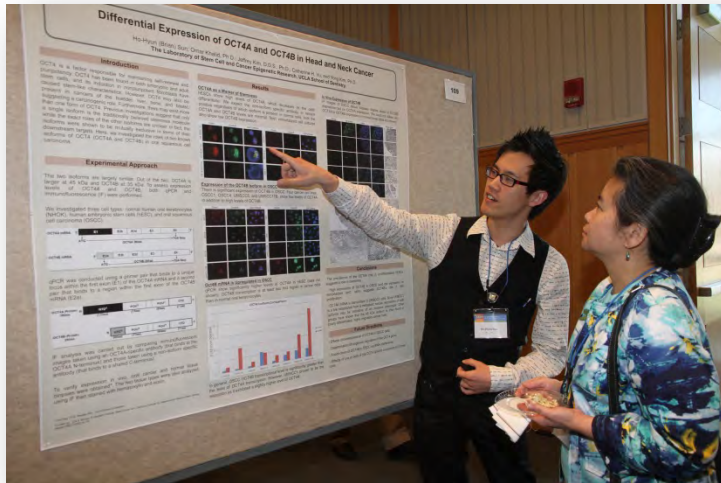


SCHOOL OF DENTISTRY
UNIVERSITY OF MICHIGAN

Research & Scholarship Talking Points

- What is the current status of research and scholarship activities of dental schools?
- What are the NIH funding trends?
- What does the shift to team science and interdisciplinary research mean for how NIH funds for oral health are granted? Where is dental research being conducted?

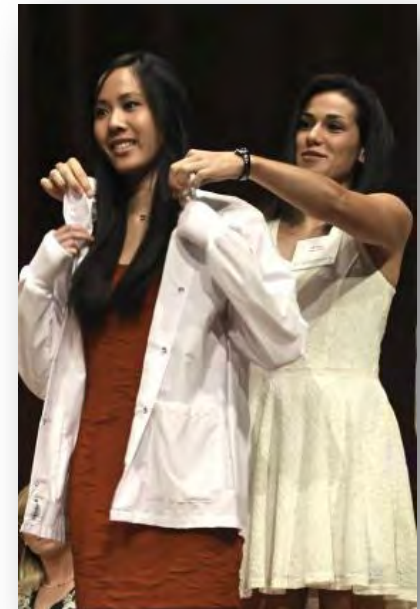
Professional Reflection



Per Kjeldsen

Is the core mission of dentistry to be a learned profession grounded in research?

Or do are we becoming more and more like a trade?





Per Kjeldsen

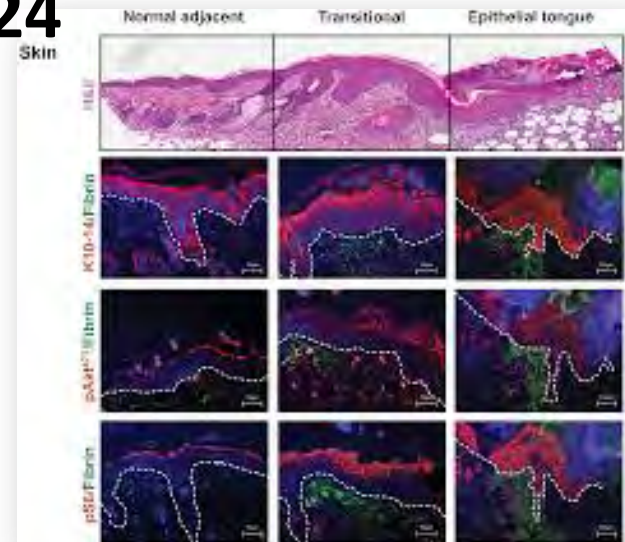


Per Kjeldsen

Through the research we are doing and communicating now, we should be changing the way patients will be treated in 2024



***Patient benefit
as a primary goal***



Most agree that we want to develop critical thinking skills in our students



These skills may be best learned through experiential engagement in research

DISCOVERY!

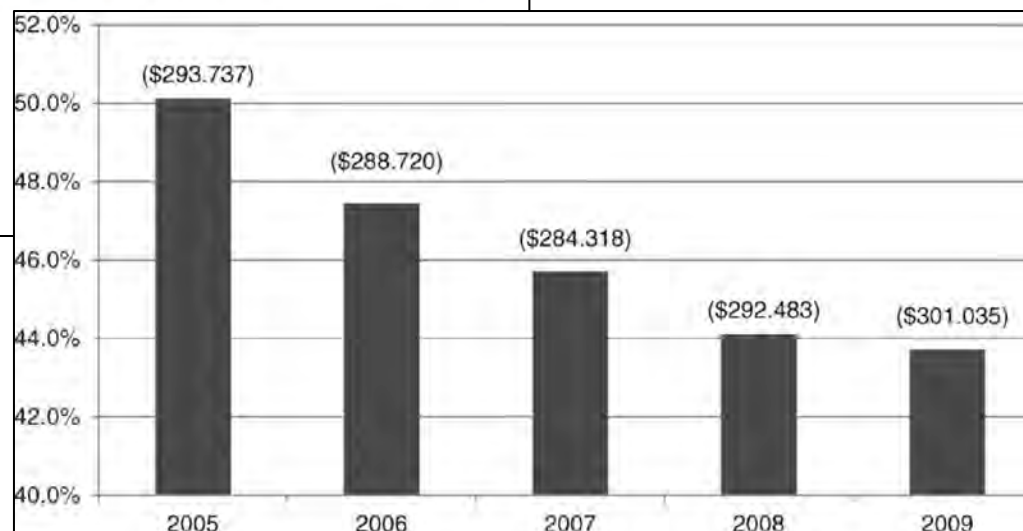
Martin Taubman, Editor

J.A. Lipton^{1*} and D.F. Kinane²

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J Dent Res 90(3):283-288, 2011

Total NIH Support to US Dental Schools, 2005-2009



PERSPECTIVE

P.J. Polverini

Professor and Dean, University of Michigan School of Dentistry, 1011 N. University, Ann Arbor, MI 48109-1078, USA; neovas@umich.edu

J Dent Res 90(3):281-282, 2011

Shaping the Future of the Dental Profession through Research and Discovery

There has been discussion – but insufficient action!

Predoctoral Dental Education

U.S. Dental Students' Attitudes Toward Research and Science: Impact of Research Experience

Shaina Devi Holman; Mateusz S. Wietecha; Angela Gullard; Jon M.B. Peterson, D.M.D.

Abstract: This study aimed to provide a first nationwide assessment of dental students' attitudes toward the importance of research and its integration into the dental curriculum. For this purpose, the American Association for Dental Research National Student Research Group developed an online survey that was distributed to 89 percent of U.S. dental students in May 2012. The survey consisted of twenty-one Likert-type items divided into three groups: importance of research in dentistry, barriers to research involvement, and exposure to research in the dental curriculum. There were 733 responses (3.9 percent response rate), including students in all stages of education representing fifty-eight out of sixty-one dental schools. Age and race/ethnic distributions corresponded with U.S. dental school enrollees. Results showed that 63 percent of respondents had conducted research before matriculation, and of the 34 percent that participated in research during dental school, only 27 percent were newcomers. Respondents strongly agreed that scientific research enabled their progress in dentistry. Inadequate time in the curriculum was an obstacle they perceived to research involvement during dental school. Respondents agreed that dental curricula emphasize evidence-based practices but may be inadequately teaching biostatistics and research methodologies. Students with research experience tended to have stronger positive opinions about the importance of research in dental education. Efforts to foster research in schools have been well received by students, but several issues remain for enriching dental education through greater involvement of students in research.

Journal of Dental Education ■ Volume 78, Number 3

2014

High distribution: 89%

Low response rate: 3.9%
733 responses 58/61 schools

63% pre-dent research
34% during dental school

"Scientific research enabled progress in dentistry"

Obstacle: inadequate time

Guest Editorial

Why Integrating Research and Scholarship into Dental Education Matters

Peter J. Polverini, D.D.S., D.M.Sc.

"As we migrate toward a more collaborative care environment A similarly collaborative approach is long overdue in the research community"

"Research and scholarship should also be considered an essential experiential learning opportunity"

STANDARD 6 – RESEARCH PROGRAM

6-1 Research, the process of scientific inquiry involved in the development and dissemination of new knowledge, must be an integral component of the purpose/mission, goals and objectives of the dental school

6-2 The dental school faculty, as appropriate to meet the school's purpose/mission, goals and objectives, must engage in research or other forms of scholarly activity

6-3 Dental education programs must provide opportunities, encourage, and support student participation in research and other scholarly activities mentored by faculty

STANDARD 6 – RESEARCH PROGRAM

Intent:

The dental education program should provide students with opportunities to experience research including, but not limited to, biomedical, translational, educational, epidemiologic and clinical research. Such activities should align with clearly defined research mission and goals of the institution. The dental education program should introduce students to the principles of research and provide elective opportunities beyond basic introduction, including how such research is conducted and evaluated, and where appropriate, conveyed to patients and other practitioners, and applied in clinical settings.

CODA Citations

(January, 2007 – October 2012)

Standard 1 – Institutional Effectiveness

- Two (2) Non-Compliance Citations

Standard 2 – Educational Programs

- Forty-two (42) Non-Compliance Citations

Standard 3 – Faculty and Staff

- Four (4) Non-Compliance Citations

Standard 4 – Educational Support Services

- One (1) Non-Compliance Citation

Standard 5 – Patient Care Services

- Nine (9) Non-Compliance Citations

Standard 6 – Research Program

- Zero (0) Citations**

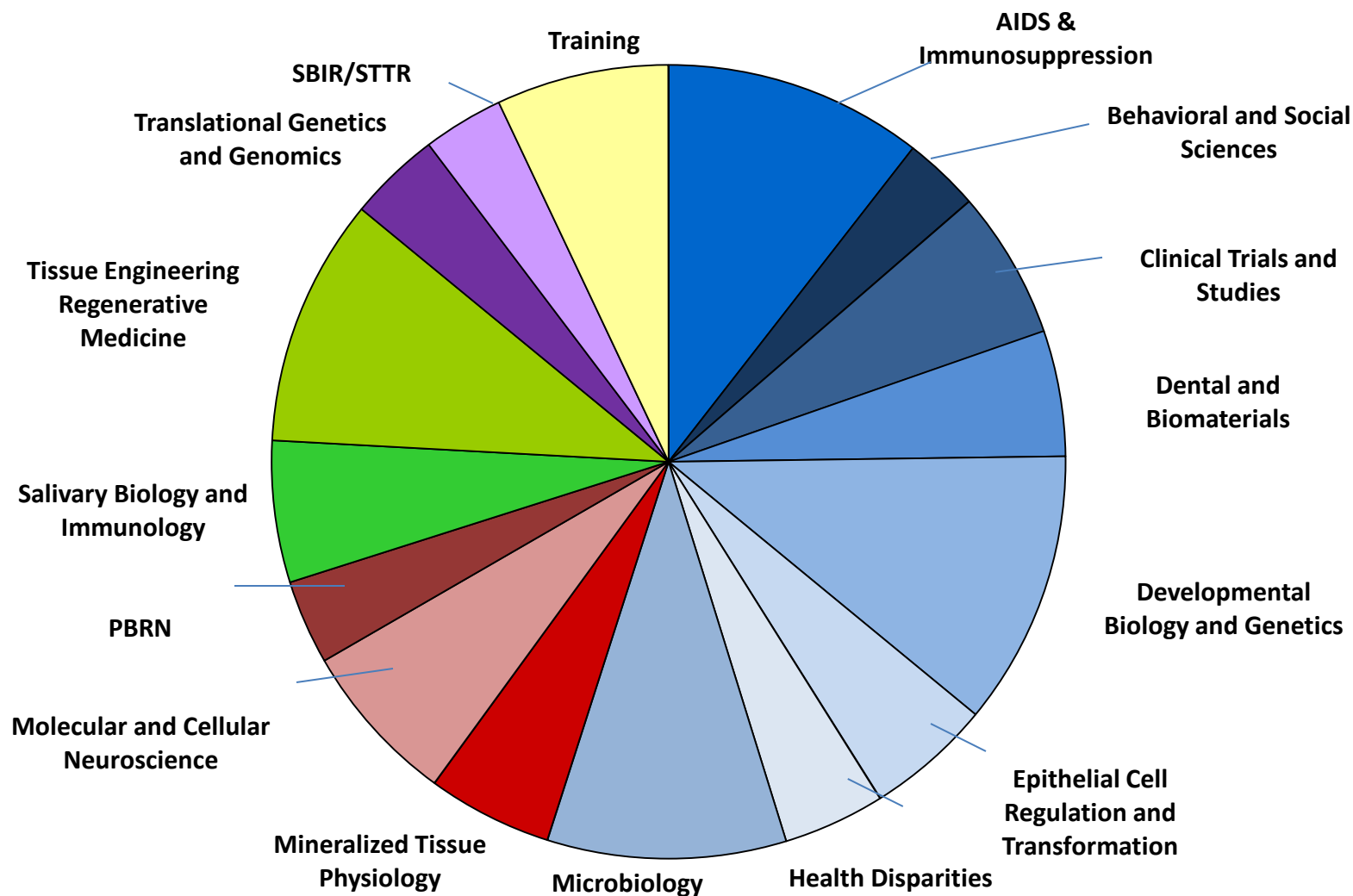
1997 – 2012

2 Citations for 6-2

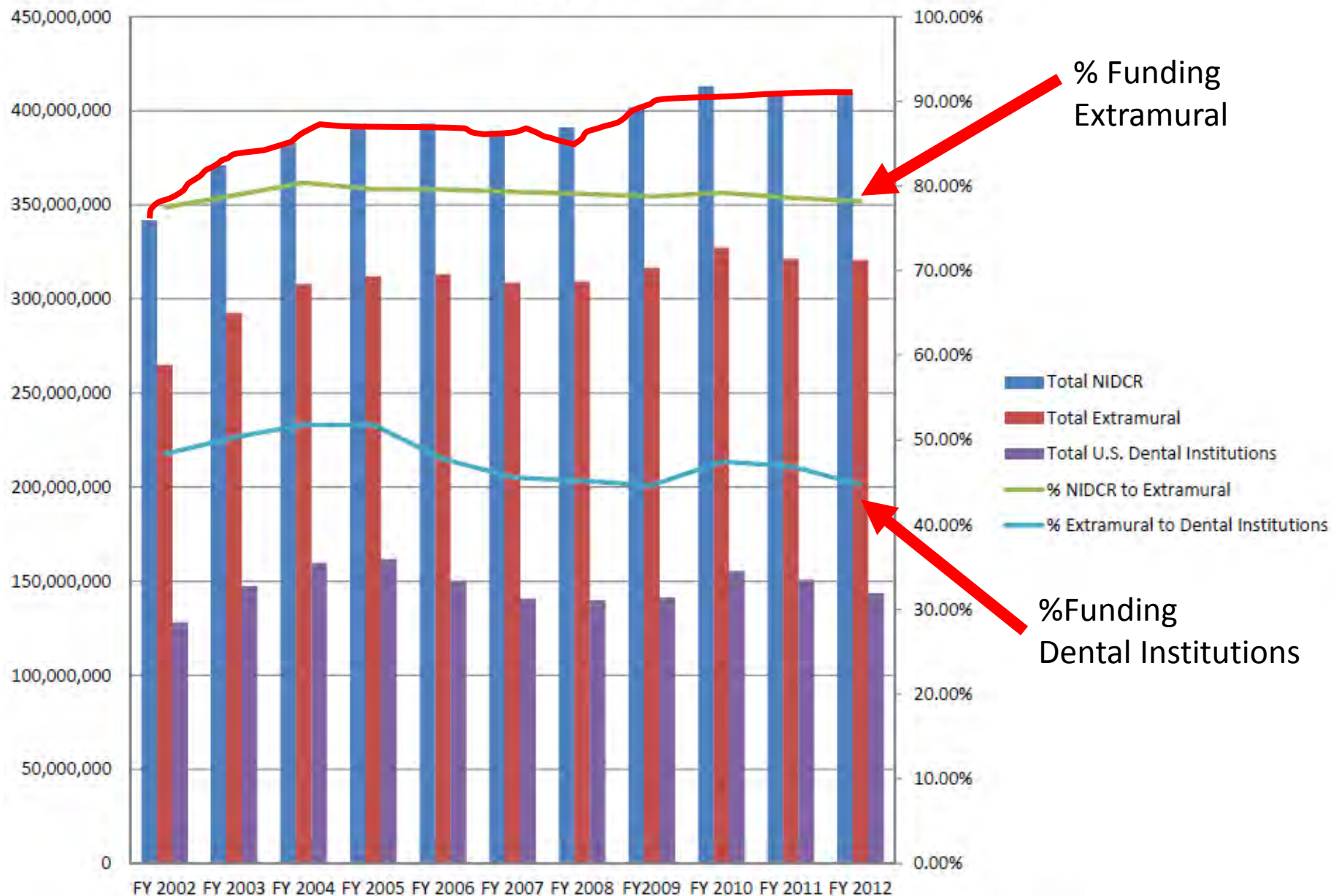


NIDCR EXTRAMURAL RESEARCH PORTFOLIO

(FY 2013 = \$300M)

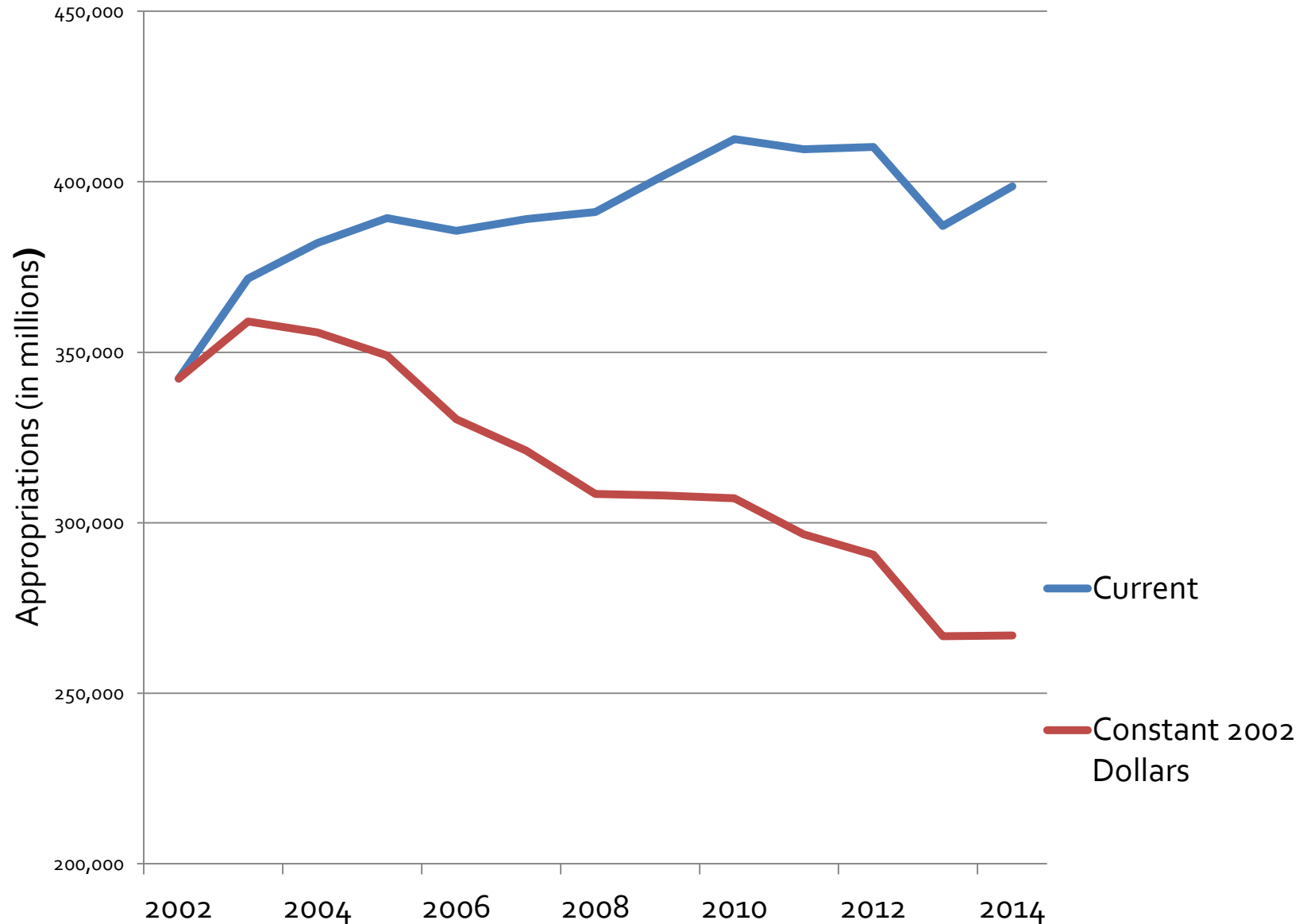


NIDCR Funding to Dental Institutions 2002 -2012



NIDCR Appropriations in Current and Constant Dollars

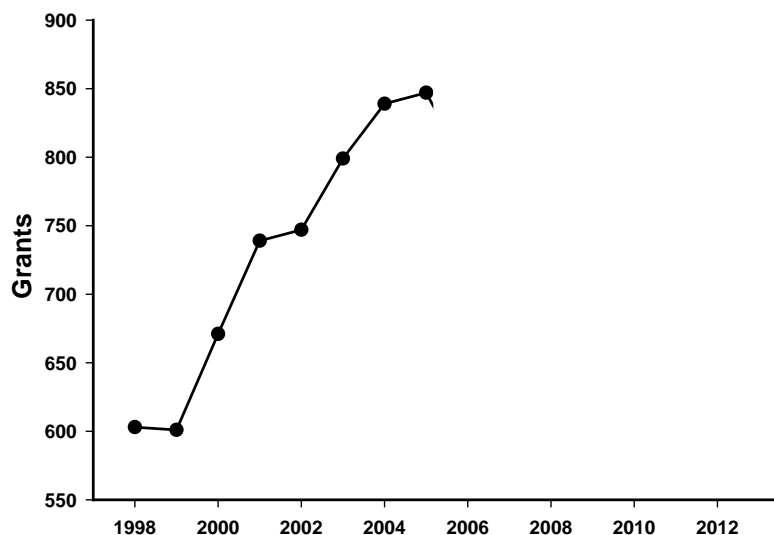
2002-2014



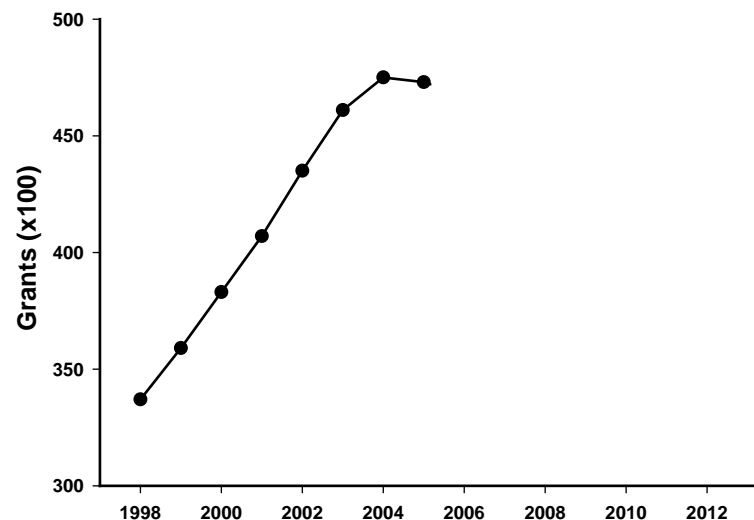
Purchasing power is 22% less than 2002

NIH Grants*: 1998-2013

NIDCR



NIH



*Includes: R,P,M,S,K,U series (excluding UC6), DP1, DP2, D42, G12.

NIDCR Awards for Early Career Training

Predoctoral

Institutional Training (T32, T90)

Individual Fellowships (F30, F31)

Diversity Supplements

NIH Summer Research Program (R25)

Postdoctoral

Institutional Training (T32, T90, R90)

Individual Fellowships (F32)

Career Development Awards (K08, K23)

Career Transition Awards (K22s and K99/R00)

Loan Repayment

Diversity Supplements

Junior Faculty

Institutional Training (K12)

Career Development Awards (K08, K23, K25)

Independent Scientist Award (K02)

Loan Repayment
Diversity Suppl.

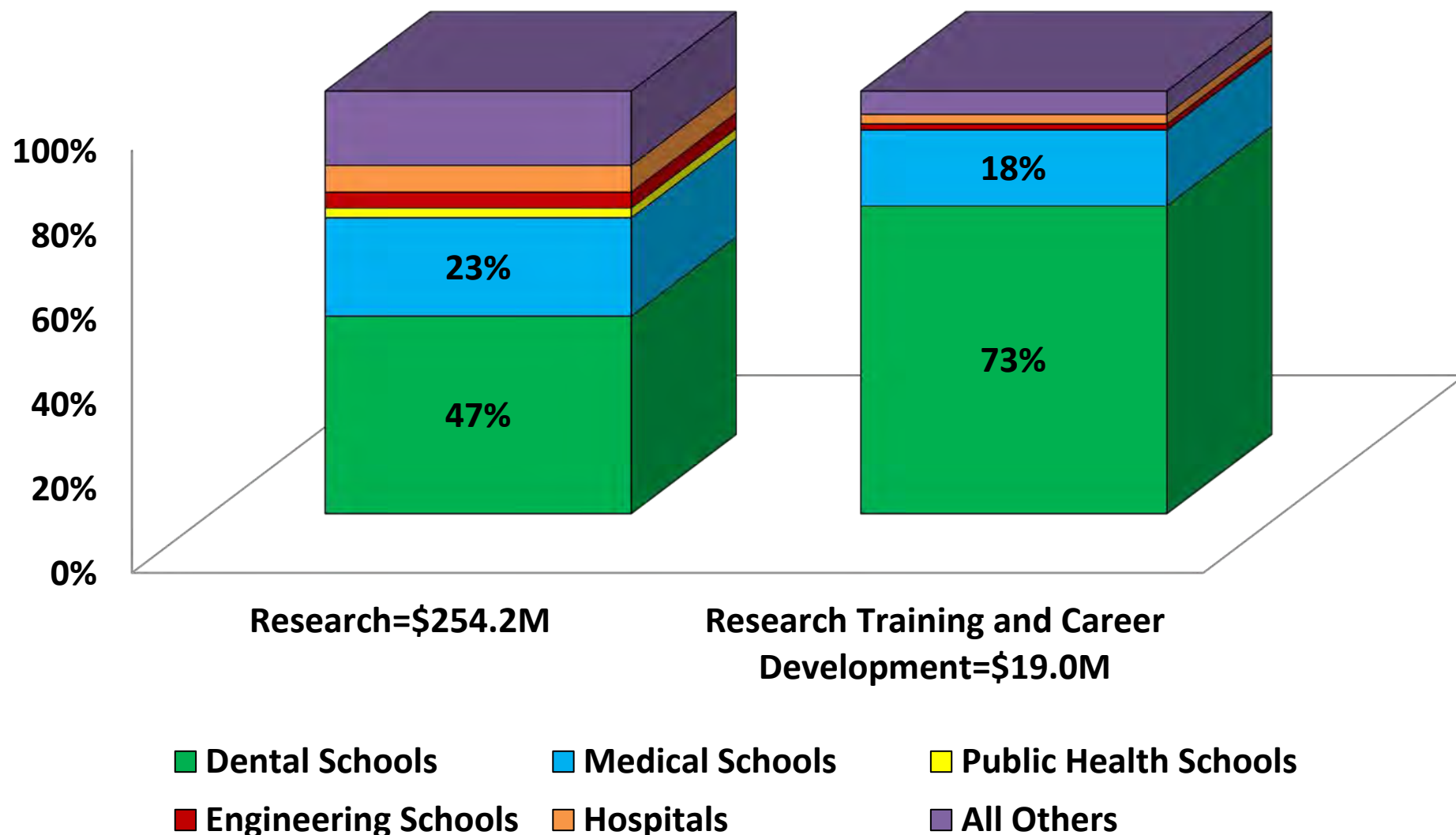
NIDCR SUPPORTS A FULL SPECTRUM OF RESEARCH TRAINING AND CAREER DEVELOPMENT AWARDS

Appendix D
Page 170

CAREER	GRADUATE/ DENTAL STUDENT	<ul style="list-style-type: none">• 92 Predoctoral Trainees (T32/T90)• 30 DDS-PhD Predoctoral Fellows (F30)• 49 PhD Predoctoral Fellows (F31)	<3/School
	POST DOCTORAL	<ul style="list-style-type: none">• 65 Postdoctoral Trainees (T32/T90/R90)• 17 Postdoctoral Fellows (F32)	
	EARLY	<ul style="list-style-type: none">• 5 Institutional Career Development Scholars (K12)• 18 Clinical Scientist Career Development Awards (K08)• 12 Patient-Oriented Career Development Awards (K23)	
	MIDDLE	<ul style="list-style-type: none">• 8 NIH Pathway to Independence Awards (K99)• 4 NIDCR Dentist Scientist Pathway to Independence Awards (K99)• 3 Independent Scientist Awards (K02)	
	SENIOR	<ul style="list-style-type: none">• 1 Individual Senior Fellow (F33)	

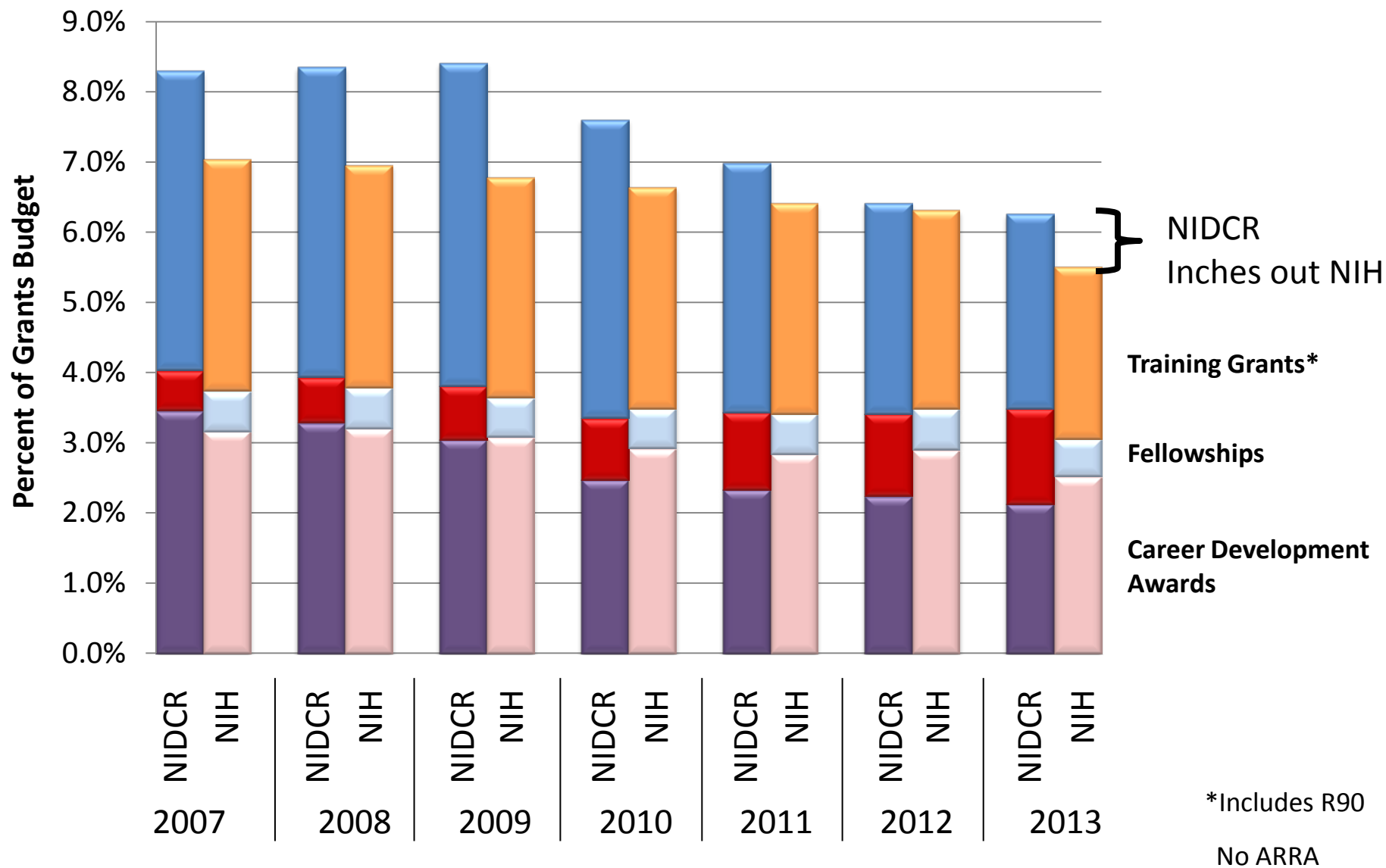


Proportion of FY2013 NIDCR Extramural Research and Training and Career Development Support by Type of Academic Institution





Career Development and Training Awards





Individual Research Training Awards

**High School
Student**

**College
Student**

**Predoctoral
Student**

**Postdoctoral
Fellow**

NIH Summer Internship Program

Research Training
for Dental or Dual
Degree Students

Summer Dental
Student Award

Medical Research
Scholars Program

Research Training for
Dentist Scientists

Individual Fellowships

Dental Clinical Research
Fellowship

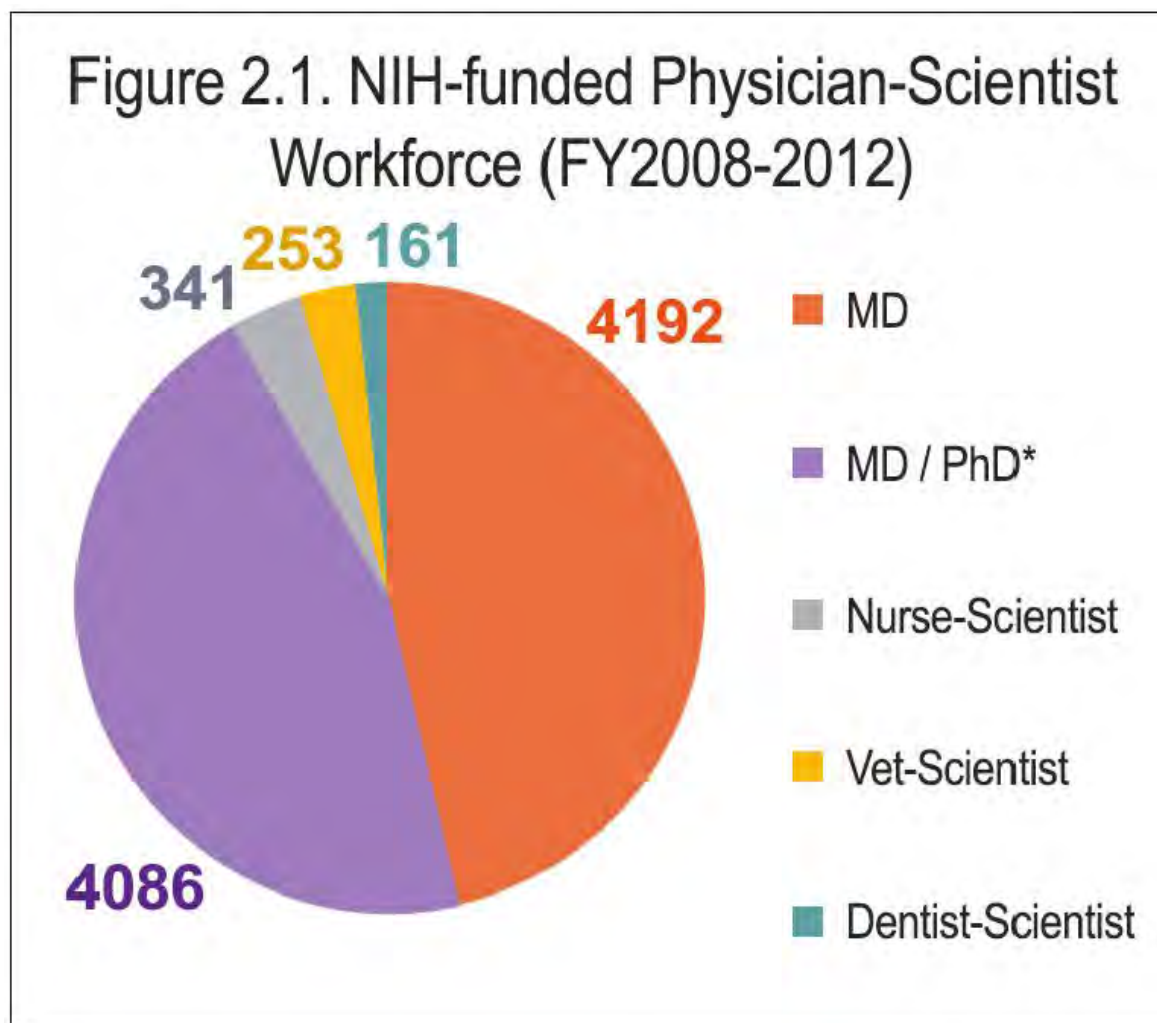
Career Transition Awards



Mission:

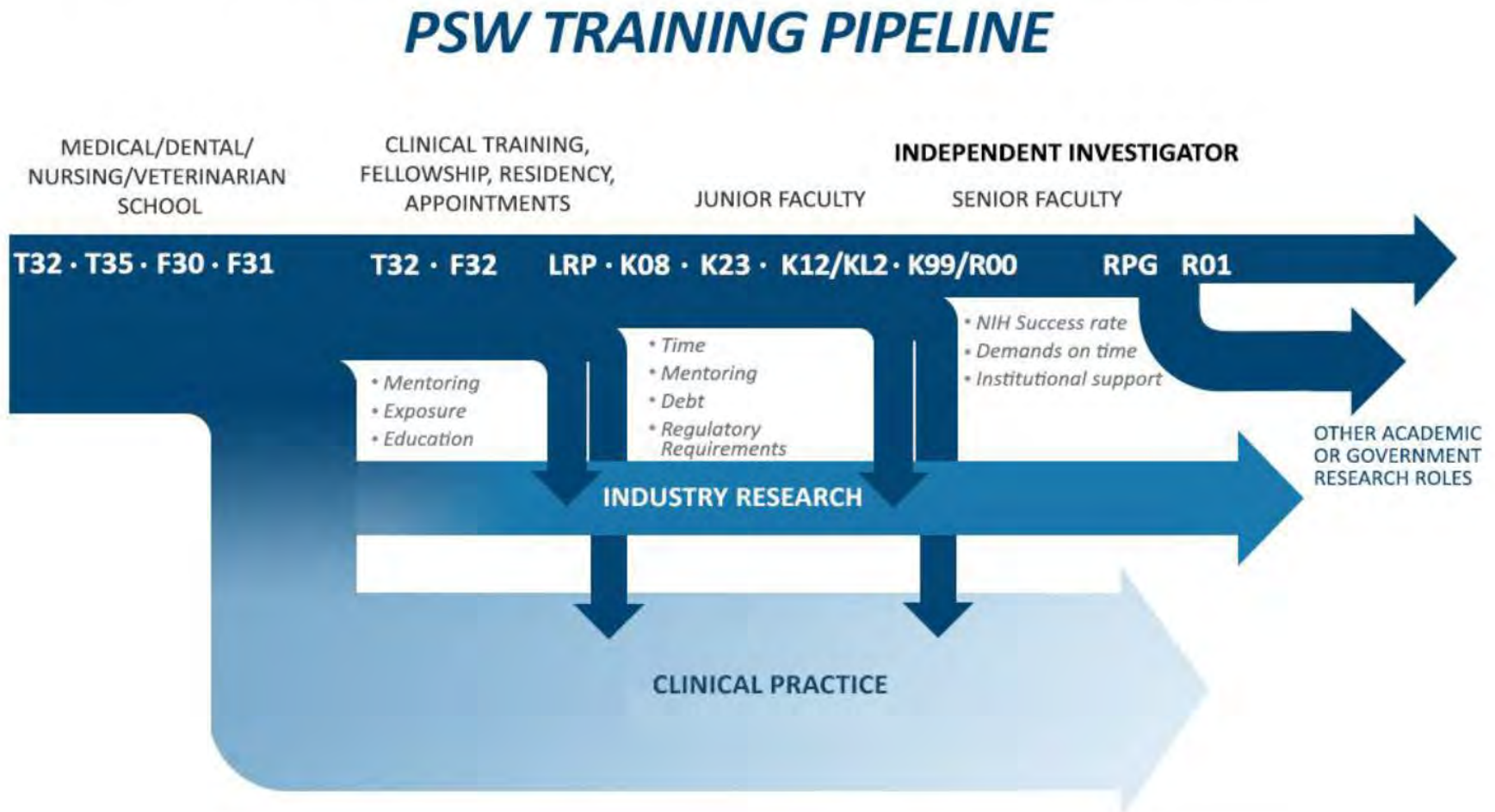
to improve oral, dental and
craniofacial health through research
and research training, and by sharing
science-based health information with
the public and health care
professionals.

Dentist-Scientists: A Small Piece of the Pie



NIH Physician-Scientist workforce working group report June 2014

Figure 2.2. NIH Support for the Physician-Scientist Pipeline¹²



Too many exit ramps?

NIH Physician-Scientist workforce working group report June 2014

What is the profile of a student who wants to engage in research?

Qualitative research²⁰ conducted with MD/PhD students identified one striking difference between these students and the general medical student population: the MD/PhD students almost universally made a decision to enter a research career well before they entered medical school, often as early as middle school and/or high school. They spoke of being exposed to grandparents or parents who were scientists, encountering physician-scientists during a health crisis of their own, or being excited by a high school biology teacher. They spoke of mentors they encountered during science courses in their undergraduate studies that convinced them that this career path was possible.

*NIH Physician-Scientist workforce working
group report June 2014*

Should we be admitting students who want to be clinicians and convince them to do research or should we identify students who want to do research and convince them to be clinicians?

Question 4: Appropriate level of Scholarship

- An emphasis on evidence based dentistry is best accomplished via experiential learning experiences in the orchestration of the scientific method
- Are we moving to a tiered system of research intensive vs. others in our schools?
- Cost of keeping a healthy mouth vs. the amount of \$ dental schools get from NIH
- Should students be required to do research in dental school?
- Who should be charged to determine the appropriate level of scholarship?
- Are schools accepting students based on their ability to pay or their ability to succeed in a complex system?
- How can we keep research in our institutions with decreasing funding for research?
- How will dental schools produce scientists capable of high quality research?
- What are the attributes of an ideal faculty member?
- With an increase in clinical teaching, how can junior faculty garner adequate time for scholarship?
- What is the mix of full and part time faculty and the impact on research?
- How can the dental community provide more effective advocacy for research support?
- How can we incentivize clinicians to engage in clinical research?

Acknowledgements



**NIDCR – Martha Somerman, Lynn King,
Margo Adesanya**

ADEA – Rick Valachovic, Eugene Anderson

AADR – Chris Fox



U Indiana - John Williams



Resolution No. 67 NewReport: N/A Date Submitted: September 2014Submitted By: Fourteenth Trustee DistrictReference Committee: C (Dental Education, Science and Related Matters)Total Net Financial Implication: None Net Dues Impact: _____Amount One-time _____ Amount On-going _____ FTE 0

ADA Strategic Plan Objective: Membership-Obj. 1: Leaders and Advocates in Oral Health

How does this resolution increase member value: See Background

EDUCATING CHILDREN AND PARENTS ABOUT THE DANGERS OF ORAL PIERCINGS

The following resolution was adopted by the Fourteenth Trustee District and transmitted on August 24, 2014, by Dr A.J. Smith, chair, Resolutions Committee.

Background: Over the past decade, an assortment of “body modifications”, such as piercings and tattoos has become increasingly more prevalent in society. These alterations are especially prolific among people in their teens and twenties. One of the more common piercing sites is the oral cavity.

Piercings in the oral cavity, such as tongue piercings, lip piercings, and cheek piercings are often deleterious to good oral health. Teeth can be damaged, periodontal tissues can be compromised, and infections may develop. Oftentimes, the individuals placing the piercings have little knowledge or understanding of the anatomy of the area they are working, much less the ability to manage any complications that might arise.

The ADA has taken a position advising against the placement and use of oral piercings, and has formulated pamphlets to educate people about the risks that can arise from piercings. However, a more concerted effort could be made to address the issue with children and their parents. Expanding our educational campaign could reach these children at a point where the information might have the most impact, before they are actually considering a procedure. Perhaps even incorporating it into age-appropriate materials and activities during National Children’s Dental Health Month and Give Kids a Smile.

Resolution

67. Resolved, that the ADA expand its educational program and prepare material on the dangers of oral piercing and intraoral tattoos, targeted toward younger children and their parents, and be it further

Resolved, that a report on this activity be presented to the 2015 House of Delegates.

BOARD COMMENT: The Board supports the concern regarding piercing and intraoral tattoos. While the ADA has an existing policy statement on intraoral piercing, inadequate info on the safety of oral tattoos is available. Furthermore, adolescents and young adults are the demographic population that typically engages in these activities. Accordingly, the Board recommends the following substitute resolution.

67B. Resolved, that the appropriate agency investigate the safety of intraoral tattoos, and be it further

1 **Resolved**, that the ADA expand its educational program and prepare material on the dangers of
 2 oral piercing and intraoral tattoos, that target younger children, young-adults, adolescents and
 3 their parents, and be it further

4 **Resolved**, that a report on this activity be presented to the 2015 House of Delegates.

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

6 **Vote: Resolution 67B**

BUCKENHEIMER	Yes	FEINBERG	Yes	KIESLING	Yes	STEVENS	Yes
COLE	Yes	GOUNARDES	Yes	KWASNY	Yes	SUMMERHAYS	Yes
CROWLEY	Yes	HAGENBRUCH	Yes	ROBERTS	Yes	YONEMOTO	Yes
DOW	Absent	ISRAELSON	Yes	SCOTT	Yes	ZENK	Yes
FAIR	Yes	JEFFERS	Yes	SHENKIN	Yes	ZUST	Yes

Resolution No. 68 New

Report: N/A Date Submitted: September 2014

Submitted By: Fourteenth Trustee District

Reference Committee: C (Dental Education, Science and Related Matters)

Total Net Financial Implication: None Net Dues Impact:

Amount One-time Amount On-going FTE 0

ADA Strategic Plan Objective: Membership-Obj. 1: Leaders and Advocates in Oral Health

How does this resolution increase member value: See Background

PROMOTION OF THE EVIDENCE REGARDING PREMEDICATION FOR PATIENTS WITH PROSTHESIS

The following resolution was adopted by the Fourteenth Trustee District and transmitted on August 24, 2014, by Dr A.J. Smith, chair, Resolutions Committee.

Background: Although evidence about the efficacy of pre-medicating patients with prosthetic joint replacements prior to dental treatment is lacking, the practice of recommending such premedication is prevalent. A systematic review published in 2012 with the ADA's backing concluded that best evidence does not justify the practice. Its continued prevalence creates clinical and ethical complications for dentists and fuels concerns about the injudicious over-prescription of antibiotics. Encouraging orthopedic surgeons to adopt practices justified by the evidence will improve the safety of providing dental care and enhance inter-professional cooperation. Members will appreciate the Association's leadership in clarifying a process consistent with the evidence.

Resolution

68. Resolved, that the ADA actively promote to appropriate medical organizations and practitioners the results of the 2012 systematic review regarding the efficacy of premedication prior to dental procedures performed on patients with prosthetic joint replacements, and be it further

Resolved, that a report on this activity be presented to the 2015 House of Delegates.

BOARD COMMENT: The Board was informed that ADA's Council on Scientific Affairs, in collaboration with the ADA's Center for Evidence-Based Dentistry, has updated the 2012 systematic review and guidelines to provide more clear recommendations for dentists and orthopedic surgeons on the appropriate use of prophylactic antibiotics for preventing prosthetic joint infections. The guideline was approved by the CSA and has been submitted to JADA. With this in mind, the following substitute resolution is proposed.

1 **68B. Resolved**, that the ADA actively promote to appropriate medical organizations and
2 practitioners the results of the 2014 systematic review regarding the efficacy of premedication
3 prior to dental procedures performed on patients with prosthetic joint replacements, and be it
4 further

5 **Resolved**, that a report on this activity be presented to the 2015 House of Delegates.

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

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

Resolution No. 69 NewReport: N/A Date Submitted: September 2014Submitted By: Fourteenth Trustee DistrictReference Committee: C (Dental Education, Science and Related Matters)Total Net Financial Implication: 69--\$189,645.37; 69B--\$0 Net Dues Impact: \$1.71Amount One-time 71,645.37 Amount On-going \$118,000 FTE 1

ADA Strategic Plan Objective: Membership-Obj. 1: Leaders and Advocates in Oral Health

How does this resolution increase member value: See Background

1 OPTIMIZING DENTAL HEALTH PRIOR TO SURGICAL/MEDICAL PROCEDURES AND TREATMENT

2 The following resolution was adopted by the Fourteenth Trustee District and transmitted on August 24,
3 2014, by Dr A.J. Smith, chair, Resolutions Committee.

4 **Background:** It cannot be denied that good overall health and wellness is not obtainable if the oral cavity
5 is not in a healthy state. Good oral health has been found to be a significant factor in reducing the impact
6 of many systemic conditions, including diabetes, heart disease, and strokes.

7 Optimizing dental health prior to surgical medical procedures should not be ignored. Prevention is usually
8 the simplest, least traumatic, and most economical method of limiting possible post-surgical
9 complications. Obtaining a dental examination and consultation should be routine for cancer patients
10 prior to head & neck radiation and chemotherapy, as well as organ transplant patients prior to surgery.
11 Developing a uniform policy related to pre-surgical dental health, specifying that the patient is free from
12 active oral infection, would minimize the possibility of post-surgical complications.

13 Resolution

14 **69. Resolved,** that the ADA develop evidence-based guidelines for physicians and surgeons to
15 eliminate the impact of untreated dental disease prior to complex medical or surgical procedures,
16 and be it further

17 **Resolved,** that a progress report be presented to the 2015 House of Delegates.

18
19 **BOARD COMMENT:** The Board agrees that there is a need to provide a cohesive policy statement and
20 additional research guidelines and/or critical summaries concerning the establishment of oral health prior
21 to invasive medical procedures. The Board also agrees that obtaining a dental examination and
22 consultation should be routine prior to initiation of surgical and complex medical treatment in patients with
23 very serious and potentially fatal systemic disease. However, the financial and resource impacts of this
24 resolution to develop evidence-based clinical practice guidelines would be considerable at over \$189K,
25 including over \$20K in volunteer travel expenses for 15 individuals to attend a three-day expert panel
26 meeting as well as 1 FTE position estimated at \$118K. For this reason, the Board is proposing the
27 following substitute resolution calling on the appropriate agencies to investigate what can be done and at
28 what cost.
29

69B. Resolved, that the ADA, through appropriate agencies, investigate the fiscal implication of the development of a policy statement and evidence-based guidelines for physicians and surgeons to eliminate the impact of untreated dental disease prior to complex medical or surgical procedures, and be it further

Resolved, that the same agencies investigate other approaches to address this issue that may accomplish the intent at lower cost, and be it further

Resolved, that a progress report be presented to the 2015 House of Delegates.

BOARD RECOMMENDATION: Vote Yes on the Substitute.

Vote: Resolution 69B

BUCKENHEIMER	Yes	FEINBERG	Yes	KIESLING	Yes	STEVENS	Yes
COLE	Yes	GOUNARDES	Yes	KWASNY	Yes	SUMMERHAYS	Yes
CROWLEY	Yes	HAGENBRUCH	Yes	ROBERTS	Yes	YONEMOTO	Yes
DOW	Absent	ISRAELSON	Yes	SCOTT	Yes	ZENK	Yes
FAIR	Yes	JEFFERS	Yes	SHENKIN	Yes	ZUST	Yes

Resolution No. 97 NewReport: CSA Supplemental Report 1 Date Submitted: September 2014Submitted By: Council on Scientific AffairsReference Committee: C (Dental Education, Science and Related Matters)Total Net Financial Implication: None Net Dues Impact: Amount One-time Amount On-going FTE 0

ADA Strategic Plan Objective: Membership-Obj. 1: Leaders and Advocates in Oral Health

How does this resolution increase member value: See Background

COUNCIL ON SCIENTIFIC AFFAIRS SUPPLEMENTAL REPORT 1
TO THE ADA HOUSE OF DELEGATES: DEFINITION OF ORAL HEALTH

Background: The Council on Scientific Affairs (CSA) is proposing a definition of oral health developed to provide a scientifically sound, clinically relevant foundation to meet the challenges and demands of multifaceted health care issues, research and educational models. After the CSA's Oral Health Subcommittee conducted a comprehensive review of the existing scientific literature and clinical studies, the CSA drafted a statement on oral health. The CSA sent its draft statement defining oral health to all pertinent ADA councils and internal committees for further review and input.

During its review process the CSA evaluated the full spectrum of health conditions associated with the oral cavity, including infections, inflammatory responses, neoplasms, injuries, birth defects, and dysfunctional conditions involving the oral and craniofacial region. The CSA also assessed the genetic predispositions, environmental conditions, psychosocial behaviors and other health-related factors which contribute to an individual's ability to eat, learn, communicate and socialize unhindered by pain, discomfort or embarrassment. Throughout the course of its review the Council considered the complex relationships of oral health to physical, mental and social development.

The draft definition was sent out for final review and feedback to 38 professional organizations and stakeholder groups. The CSA received favorable comments from a broad range of professional organizations and disciplines, including the Agency for Healthcare Research and Quality, American Academy of Oral & Maxillofacial Pathology, American Academy of Periodontology (AAP), American Association of Endodontists, American Association of Oral and Maxillofacial Surgeons (AAOMS), American College of Surgeons, American Dental Education Association, American Student Dental Association, Dental Trade Alliance, The Forsyth Institute, and University of Manchester (UK). The CSA also reviewed additional comments received from the Academy of General Dentistry, America's Health Insurance Plans, American College of Dentists, Delta Dental, Hispanic Dental Association, National Association of Dental Plans, National Dental Practice-Based Research Network, National Institute of Dental and Craniofacial Research and the World Health Organization.

After reviewing all of the comments it received from internal ADA and external professional agencies, the CSA reached a consensus on the definition of oral health. It has been designed to be a fluid definition to meet the current and evolving needs of dentists, dental patients, the dental profession, the ADA and allied health care organizations. The proposed definition is intended to provide a clinically relevant framework for risk assessment, prevention, disease management and treatment within the domain of oral health care and measurable health outcomes. Achieving a common understanding of the essential role of oral health to general health provides the opportunity for the ADA leadership and membership to continue to be at the forefront of health issues associated with the practice of dentistry.

Based on the profession's need for a definition of oral health, the scope and thorough process followed in its drafting, and the extensive review and feedback from ADA's internal agencies and external stakeholders, the Council urges the House to refrain from modifying or wordsmithing and to either approve the definition or return it to the Council. Accordingly, the Council on Scientific Affairs submits the following resolution.

Resolution

97. Resolved, that the following definition of oral health be adopted.

Oral health is a functional, structural, aesthetic, physiologic and psycho-social state of well-being and is essential to an individual's general health and quality of life.

BOARD RECOMMENDATION: Vote Yes.

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

Resolution No. None N/AReport: Board Report 12 Date Submitted: September 2014Submitted By: Board of TrusteesReference Committee: C (Dental Education, Science and Related Matters)Total Net Financial Implication: None Net Dues Impact: _____Amount One-time _____ Amount On-going _____ FTE 0

ADA Strategic Plan Objective: None

How does this resolution increase member value: See Background

1 **REPORT 12 OF THE BOARD OF TRUSTEES: ADA LIBRARY AND ARCHIVES ADVISORY BOARD**
 2 **ANNUAL REPORT**

3 **Background:** In November 2013, the ADA House of delegates approved the ADA Library and Archives
 4 Transition Plan. At its September meeting, the Board considered the appended Annual Report of the
 5 Library and Archives Advisory Board and voted to transmit it to the House of Delegates.

6 **BOARD RECOMMENDATION: Vote Yes.**

7 **Vote: Board Report 12:**

BUCKENHEIMER	Yes	FEINBERG	Yes	KIESLING	Yes	STEVENS	Yes
COLE	Yes	GOUNARDES	Yes	KWASNY	Yes	SUMMERHAYS	Yes
CROWLEY	Yes	HAGENBRUCH	Yes	ROBERTS	Yes	YONEMOTO	Yes
DOW	Absent	ISRAELSON	Yes	SCOTT	Yes	ZENK	Yes
FAIR	Yes	JEFFERS	Yes	SHENKIN	Yes	ZUST	Yes

Appendix 1

ADA Library & Archives Advisory Board

- Hagenbruch, Joseph, F., 2014, 8th district trustee, Chair
- Fair III, Julian, H., 2016, 16th district trustee
- Abt, Elliot, 2016, Council on Scientific Affairs
- Booth, H., Austin, 2016, Special Librarian
- Holm, Steven, J., 2016, Council on Dental Education and Licensure
- Mahler, Harvey, J., 2016, at-large Member
- Noraian, Kirk, W., 2015, Council on Scientific Affairs
- Sahota, D., Ruchi, 2016, at-large Member
- Sarrett, David C., 2017, Council on Dental Education and Licensure
- Gartman, Jeffrey, G., Director

Purpose

In November of 2013, the ADA House of Delegates approved the ADA Library & Archives Transition Plan.

This plan called for the creation of library volunteer oversight body, the ADA Library & Archives Advisory Board (LAAB). The responsibilities of this Board are as follows:

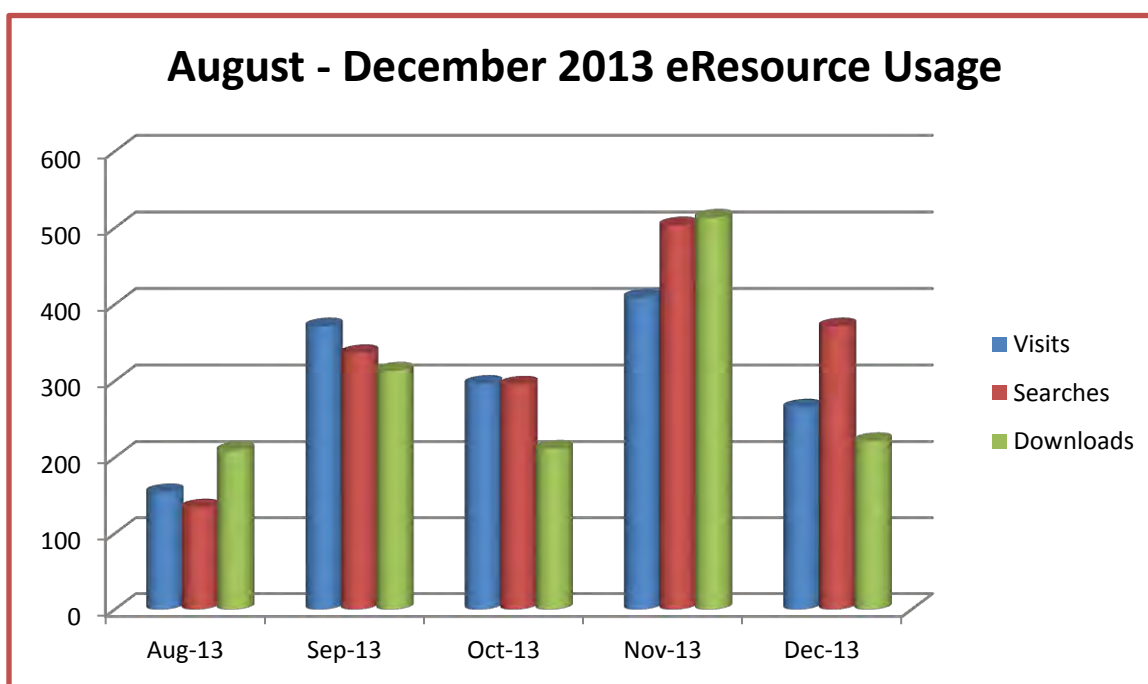
- Creating and developing the mission of the ADA library and a strategic plan for the ADA Library.
- Ensuring that the ADA library remains relevant to the ADA strategic plan.
- Providing input on the selection and hiring of a qualified library director, whenever the position becomes available.
- Providing input during the annual ADA budgeting process on library funding, priorities, and needs.
- Adopting policies and rules regarding library governance, assets and use; developing, approving, and codifying all policies, based on input from the library director and library staff; also delegating procedural work to the library director and library staff.
- Regularly planning and evaluating the library's service program.
- Evaluating annually the library facility to ensure it continues to meet ADA member and ADA staff needs.
- Launching a marketing plan for the promotion of the ADA library to ADA members; ADA component and constituent societies; the local dental and medical communities; and affiliated dental organizations.

- Conducting the business of the library in an open and ethical manner in compliance with all applicable laws and regulations and with respect for the institution, staff and public

Supporting the Strategic Plan: Activities, Results and Accomplishments

In support of Strategic Goal #1: Provide support to dentists so they may succeed and excel throughout their careers; the LAAB has done the following:

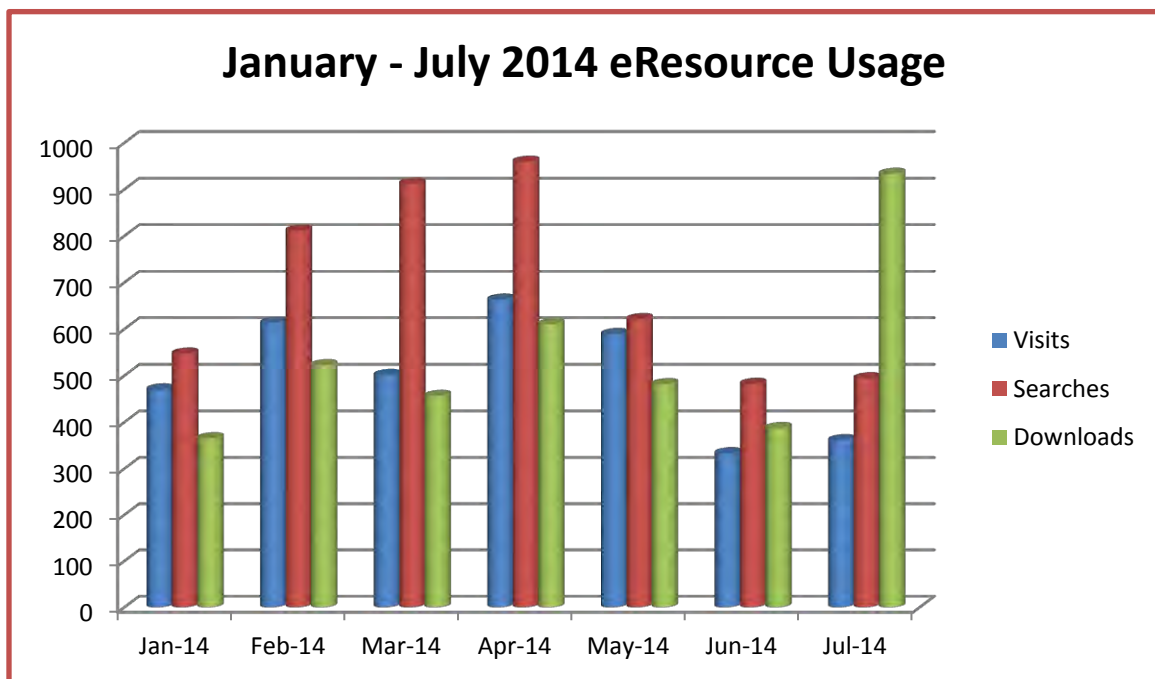
- Reviewed the implementation status of the electronic resources outlined in the Library & Archives transition Plan. The EBSCO A-to-Z List of online peer-reviewed journals and the DynaMed clinical tool are available for Members at ADA.Org. Access is available to 268 eJournals and 54 eBooks. Choices will be added to or subtracted from the list depending upon usage and need.



August – December 2013 eResource Usage

Month	Visits	Searches Done	Articles Downloaded
August 2013	154	134	209
September 2013	371	336	313
October 2013	296	295	211
November 2013	409	503	513

December 2013	265	371	221
Five Month Total	1495	1639	1467
Five Month Average	299	327	293



1

January – July 2014 eResource Usage

Month	Visits	Searches Done	Articles Downloaded
Jan 2014	470	547	365
Feb 2014	613	811	522
Mar 2014	501	912	456
Apr 2014	663	959	610
May 2014	589	621	481
Jun 2014	333	482	387
Jul 2014	361	494	933
Seven Month Total	3,530	4,826	3,754

Seven Month Average	504	689	536
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- The LAAB reviewed the 2013 and 2014 ADA Library & Archives budget, noting that there has been a \$500,000 reduction in expenses from the 2012 budget due to the reduction of 5 full-time and 3 part-time staff. The 2014 ADA Library & Archives budget reflects increased expenses due to the enhanced eResources. In 2013, the expenses for eResources were covered through money from the ADA contingency fund approved by the ADA Board of Trustees.
- The LAAB was informed that the Memorandum of Understanding (MOU) between the ADA Library & Archives and the Health Sciences Library at the University of Illinois at Chicago (UIC) was executed on June 27, 2014. The disposition of the deaccessioned books and ADA Member facility access was approved by both parties to the agreement. The MOU includes a five year window in which the ADA may retrieve its texts if the ADA so desires.
- The LAAB determined that members of the Canadian Dental Association, the British Dental Association, and the Australian Dental Association who are interested in accessing the eResources of the Library & Archives should be urged to become Affiliate Members of the ADA to ensure access to the eResources.
- The LAAB approved the ADA Library & Archives Communications Plan developed by the ADA Division of Communication. A key message is that the ADA Library & Archives is a 24x7, knowledge resource center committed to helping members succeed in their practice. There will be a special focus on marketing to new dentists and 4th year dental students. The plan will kick off at the 2014 ADA Annual Meeting.

Emerging Issues and Trends

All libraries are going through the process of maximizing resources through the expanded use of electronic and digital means of conveying information. The ADA Library & Archives are not immune from these rapid changes and must remain relevant to ADA Members and the profession. The LAAB is committed to:

- Providing efficient searching using current eResources and making the Library & Archives a knowledge resource center.
- Maintaining and developing a comprehensive collection of information resources for ADA members in various formats.
- Supporting evidence-based dentistry.
- Putting new success measures in place that emphasize impact on policy outcomes, impact on clinical practice, and research productivity of ADA members and staff.

Responses to House of Delegates Resolutions

Resolution 101H-2013 Composition of the ADA Library & Archives Advisory Board – urged the Board of Trustees to modify the composition of the ADA Library & Archives Advisory Board to include a public member who is a special librarian, and to consider that one of the two ADA at-large members of the Advisory Board appointed by the President preferably be a dental editor. The LAAB considered 4 nominees for the special librarian/public member position on the Board. Ms. H. Austin Booth, vice-provost for libraries at SUNY-Buffalo was selected by the Board of Trustees and appointed by the President to serve a two year term as the special librarian/public member.

1 **Policy Review**

2 The LAAB developed and approved the following policies in 2014:

3

- 4 • The ADA Library & Archives Electronic Resources Collection Development Policy.
- 5 • The ADA Archives Collection Policy.

6 This report is for informational purposes only.

Resolution No. 111 NewReport: N/A Date Submitted: October 2014Submitted By: Ninth Trustee DistrictReference Committee: C (Dental Education, Science and Related Matters)Total Net Financial Implication: None Net Dues Impact: _____Amount One-time _____ Amount On-going _____ FTE 0

ADA Strategic Plan Objective: Membership-Obj. 1: Leaders and Advocates in Oral Health

How does this resolution increase member value: See Background

TITLES AND DESCRIPTIONS OF CONTINUING EDUCATION COURSES

The following resolution was adopted by the Ninth Trustee District and submitted on October 10, 2014, by Dr. Curles Colbert, Michigan Dental Association.

Background: The intent of the new policy is to allow flexibility in titling courses while, at the same time, proclaiming emphatically the dentist as the only practitioner licensed by law to diagnose and treatment plan. Resolution 13 as written was more restrictive than the 1992 policy. Further it is essential any resolution put before the House reflect the varied disparate and continually changing laws of the individual fifty states. We therefore propose the following resolution.

Resolution

111. Resolved, that the policy entitled Titles and Descriptions of Continuing Education Courses be as follows:

Titles and Descriptions of Continuing Education Courses

Resolved, that continuing education course titles and descriptions should be structured such that the titles and descriptions do not explicitly or implicitly infer that attendees can perform procedures beyond their legal scope of practice, and be it further

Resolved, that the policy, Titles and Descriptions of Dental Hygiene Continuing Education Courses (*Trans.*1992:618) be rescinded.

**WORKSHET ADDENDUM
COUNCIL ON DENTAL EDUCATION AND LICENSURE
ADA POLICY TO BE RECINDED**

Dental Hygiene Program Titles and Descriptions (*Trans.*1992:618)

Resolved, that the American Dental Association opposes use of the terms “diagnosis” and “treatment planning” in the titles of continuing education courses for dental hygienists and descriptions of these courses that inappropriately imply the program content or prior education level of dental hygienists is sufficient to make the dental hygienist competent to render diagnosis of dental disease or treatment planning for dental patients, and be it further

Resolved, that the ADA communicate its position on this issue to the American Association of Dental Schools and the American Association of Dental Examiners, and be it further

Resolved, that constituent and component dental societies be asked to work with sponsors of continuing education and boards of dentistry to maintain appropriate use of terminology in continuing education program literature.