

2018

Supplement to
Annual Reports and Resolutions
Volume 2

159th Annual Session
Honolulu, Hawaii
October 19–22, 2018

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American Dental Association
211 East Chicago Avenue
Chicago, Illinois 60611

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Dental Education, Science and Related Matters

Resolution No. 5 New

Report: N/A Date Submitted: August 2018

Submitted By: Council on Dental Education and Licensure

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: Organizational Capacity-Obj. 6: Role and responsibility of the tripartite clearly defined and agreed upon

How does this resolution increase member value: See Background

1 AMENDMENT TO THE ADA POLICY ON PROMOTION OF FREEDOM OF MOVEMENT FOR DENTAL 2 HYGIENISTS

3 **Background:** The Council on Dental Education and Licensure (CDEL) reviewed the ADA Policy on
4 Promotion of Freedom of Movement for Dental Hygienists (*Trans.*1990:550) and recommends the
5 amendments presented in Resolution 5 to reflect current terminology and protocols used by state dental
6 boards which are the regulatory agencies responsible for licensure matters. The proposed revisions also
7 urge that dental hygienists licensed in good standing in one state be considered eligible for licensure in
8 another state without requiring another clinical examination.

9 Resolution

10 **5. Resolved**, that the ADA Policy, Promotion of Freedom of Movement for Dental Hygienists
11 (*Trans.*1990:550) be amended as follows (additions underscoring; deletions ~~stricken~~):

12 Promotion of Freedom of Movement for Dental Hygienists (*Trans.*1990:550)

13 **Resolved**, that the state boards of dentistry ~~dental examiners and the American Association of~~
14 ~~Dental Boards~~ be urged to give consideration to the profession's ongoing need for dental
15 hygienists and ~~be encouraged to~~ develop licensure mobility pathways mechanisms under which
16 dental hygienists licensed in good standing in one state may be licensed for practice in another
17 state ~~without completing an additional clinical examination. in which they may now reside, with~~
18 ~~previous education, licensure and clinical experience used as a substitute for current~~
19 ~~requirements, and be it further~~

20 **Resolved**, that the eligibility requirements for dentists as outlined in the Association's Guidelines
21 for Licensure (*Trans.*1976:919; 1977:923; 1989:529) be taken into consideration, where
22 applicable, in establishing eligibility requirements for dental hygienists.
23
24

25
26 **BOARD RECOMMENDATION: Vote Yes.**

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

Resolution No. 6 New

Report: N/A Date Submitted: August 2018

Submitted By: Council on Dental Education and Licensure

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: Organizational Capacity-Obj. 6: Role and responsibility of the tripartite clearly defined and agreed upon

How does this resolution increase member value: See Background

1 **AMENDMENT OF ADA POLICY ON EXAMINATIONS FOR ALLIED DENTAL (NON-DENTIST)** 2 **PERSONNEL**

3 **Background:** In accord with Resolution 170H-2012, Regular Comprehensive Policy Review
4 (*Trans.*2012:370), the Council on Dental Education and Licensure recommends that the policy,
5 Examinations for Allied Dental (Non-Dentist) Personnel (*Trans.*2010:595), be amended to reflect current
6 terminology and protocols used by state dental boards. The Council urges the Association to maintain
7 policy opposing the examination of allied dental personnel (e.g., dental therapists or dental hygienists) for
8 licensure purposes together with dentist candidates, and to urge state dental boards to require the
9 separate examinations.

10 **Resolution**

11 **6. Resolved**, that the Policy on Examinations for Allied Dental (Non-Dentist) Personnel
12 (*Trans.*2010:595) be amended as follows (additions are underscored; deletions are ~~stricken~~):

13 **Resolved**, that the ADA ~~House of Delegates~~ strongly urges ~~encourages~~ state dental boards
14 ~~testing agencies~~ to require examine examination of candidates for dental licensure separately
15 from candidates for allied dental (non-dentist) licensure.

16 **BOARD RECOMMENDATION: Vote Yes.**

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

Resolution No. 7 New

Report: N/A Date Submitted: August 2018

Submitted By: Council on Dental Education and Licensure

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: Organizational Capacity-Obj. 6: Role and responsibility of the tripartite clearly defined and agreed upon

How does this resolution increase member value: See Background

AMENDMENT TO THE GOVERNANCE MANUAL REGARDING COUNCIL ON DENTAL EDUCATION AND LICENSURE APPOINTMENTS AND VACANCIES

Background: The Council on Dental Education and Licensure has noted that the former ADA *Bylaws* and current ADA **Governance Manual** do not clearly address the process for outside organizations, i.e., the American Association of Dental Boards (AADB) and the American Dental Education Association (ADEA), to make direct appointments to the Council. Further, managing a vacancy occurring when an AADB or ADEA appointee's term concludes early is not clearly stated.

Accordingly, the Council recommends that the Composition and Vacancy provisions in Chapter VIII of the **Governance Manual** be amended and urges the House of Delegates to adopt the resolution below. A two-thirds vote in the affirmative is required for the resolution to be approved.

Resolution

7. Resolved, that Chapter VIII. COUNCILS, Sections A.1.a.i. Nominations and F. Vacancy of the *Governance and Organizational Manual* be amended as follows (additions underscored):

CHAPTER VIII. COUNCILS

A. Members, Selections, Nominations and Elections.

1. Composition. The composition of the councils of this Association shall be as follows:

- a. Council on Dental Education and Licensure. The Council on Dental Education and Licensure shall be composed of seventeen (17) members selected as follows:

i. Nominations.

- (a) Eight (8) members shall be nominated by the Board of Trustees on a rotational system by trustee district from the active, life or retired members of this Association, no one of whom shall be a full-time member of a faculty of a school of dentistry, a current dental examiner or member of a state or regional testing agency, state board of dentistry or jurisdictional dental licensing agency.* These members shall be elected by the House of Delegates.

- 1 (b) Four (4) members who are active, life or retired members of this
2 Association shall be selected by the American Association of Dental
3 Boards from the active membership of that body, no one of whom
4 shall be a member of a faculty of a school of dentistry. These
5 members shall not require the approval of the House of Delegates
6 for appointment.
7
- 8 (c) Four (4) members who are active, life or retired members of this
9 Association shall be selected by the American Dental Education
10 Association from its active membership. These members shall hold
11 positions of professorial rank in dental schools accredited by the
12 Commission on Dental Accreditation and shall not be current dental
13 examiners or members of any state or regional testing agency, state
14 board of dentistry or jurisdictional dental licensing agency. These
15 members shall not require the approval of the House of Delegates
16 for appointment.
- 17 (d) One (1) new dentist member recommended by the New Dentist
18 Committee and nominated by the Board of Trustees.

19 * * *

20 F. Vacancy. In the event of a vacancy in the membership of any Council, except a member
21 of the Council on Dental Education and Licensure selected by an organization other than this
22 Association, the President shall appoint a member of the Association possessing the same
23 qualifications as established by the *Bylaws* or this *Governance Manual* for the previous
24 member, to fill such vacancy until a successor is elected by the next House of Delegates for
25 the remainder of the unexpired term. In the event such vacancy involves a member of the
26 Council on Dental Education and Licensure who was selected by an organization other than
27 this Association, such other organization shall appoint a successor. The appointed member
28 shall possess the same qualifications as those possessed by the previous member of the
29 Council. In the event such vacancy involves the chair of the council, the President shall have
30 the power to appoint an *ad interim* chair. In the event it is the current recipient of the Gold
31 Medal Award for Excellence in Dental Research who cannot serve on the Council on
32 Scientific Affairs, the President, in consultation with the Board of Trustees, shall have the
33 power to appoint a prominent research scientist who shall serve until the award is bestowed
34 on the next honoree. If the term of the vacated council position has less than fifty percent
35 (50%) of a full term remaining at the time the successor member is appointed or elected, the
36 successor member shall be eligible for election to a new term. If fifty percent (50%) or more
37 of the vacated term remains to be served at the time of the appointment or election, the
38 successor member shall not be eligible for another term.

39 **BOARD RECOMMENDATION: Vote Yes.**

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

Resolution No. 8 New

Report: N/A Date Submitted: August 2018

Submitted By: Council on Dental Education and Licensure

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: Organizational Capacity-Obj. 6: Role and responsibility of the tripartite clearly defined and agreed upon

How does this resolution increase member value: See Background

POLICY ON STATE DENTAL BOARD RECOGNITION OF THE NATIONAL COMMISSION ON RECOGNITION OF DENTAL SPECIALTIES AND CERTIFYING BOARDS

Background: The 2017 ADA House of Delegates established the National Commission on Recognition of Dental Specialties and Certifying Boards (National Commission or NCRDSCB) and charged the National Commission with the responsibility of recognizing dental specialties and specialty certifying boards, based on the ADA Requirements for Recognition of Dental Specialties and National Certifying Boards for Dental Specialists. The Council on Dental Education and Licensure recommends that the ADA have policy in support of this new agency urging state dental boards to recognize the National Commission. The ADA has similar policy statements urging state dental boards to recognize the Commission on Dental Accreditation, the Joint Commission on National Dental Examinations and the Commission for Continuing Education Provider Recognition.

The Council on Dental Education and Licensure recommends adoption of the following resolution:

Resolution

State Dental Board Recognition of the National Commission on Recognition of Dental Specialties and Certifying Boards

8. Resolved, that the American Dental Association urges all state dental boards to recognize the National Commission on Recognition of Dental Specialties and Certifying Boards as the agency responsible for the recognition of dental specialties and dental specialty certifying boards.

BOARD RECOMMENDATION: Vote Yes.

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

Resolution No. 9 NewReport: N/A Date Submitted: August 2018Submitted 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 the tripartite clearly defined and agreed upon

How does this resolution increase member value: See Background

**RESCISSION OF POLICIES RELATED TO RECOGNITION OF DENTAL SPECIALTIES AND
CERTIFYING BOARDS**

Background: The 2017 ADA House of Delegates adopted Resolution 30H-2017, establishing the National Commission on Recognition of Dental Specialties and Certifying Boards (National Commission or NCRDSCB) and charging the agency with the responsibility of recognizing dental specialties and specialty certifying boards based on the ADA Requirements for Recognition of Dental Specialties and National Certifying Boards for Dental Specialists. At its inaugural meeting in May 2018, the National Commission adopted verbatim the ADA statements recognizing each of the nine ADA-recognized dental specialties, their sponsoring organizations and certifying boards as well as the ADA policy related to the periodic review of the dental specialties.

Because of the National Commission's actions and in accord with Resolution 170H-2012, Regular Comprehensive Policy Review, the Council on Dental Education and Licensure has reviewed all of the Association's policies related to the dental specialties. The Council recommends that the Association's statements recognizing the dental specialties, their sponsoring organizations and certifying boards be rescinded because such recognition is now the purview of the National Commission and to avoid confusion and redundancy. Further, the Council recommends rescission of the policy, Periodic Review of Dental Specialty Education and Practice (*Trans.*2001:468; 2011:465) because this activity is now managed by the National Commission as reflected in its own policy statement.

Accordingly, the Council recommends that the House review and approve the rescission of the following policy statements related to recognition of dental specialties and certifying boards.

Resolution

9. Resolved, that the following ADA policy statements related to recognition of dental specialties and certifying boards be rescinded:

- Certifying Board in Oral and Maxillofacial Pathology (*Trans.*1950:29; 2015:255)
- Recognition of Oral and Maxillofacial Pathology as a Dental Specialty (*Trans.*1987:510; 2015:255)
- Certifying Board in Oral and Maxillofacial Radiology (*Trans.*2015:256)
- Recognition of Oral and Maxillofacial Radiology as a Dental Specialty (*Trans.*1999:898; 2015:256)
- Certifying Board in Oral and Maxillofacial Surgery (*Trans.*2015:256)

1 Recognition of Oral and Maxillofacial Surgery as a Dental Specialty (*Trans.*1990:554;
2 2015:256)
3 Specialty of Oral and Maxillofacial Surgery (*Trans.*1990:549)
4 Certifying Board in Pediatric Dentistry (*Trans.*2015:257)
5 Recognition of Pediatric Dentistry as a Dental Specialty (*Trans.*1990:549; 2015:257)
6 Certifying Board in Periodontics (*Trans.*2015:258)
7 Recognition of Periodontics as a Dental Specialty (*Trans.*1988:490; 2015:257)
8 Certifying Board in Prosthodontics (*Trans.*2015:258)
9 Recognition of Prosthodontics as a Dental Specialty (*Trans.*1987:510; 2015:258)
10 Certifying Board in Orthodontics and Dentofacial Orthopedics (*Trans.*1950:189; 2015:257)
11 Recognition of Orthodontics and Dentofacial Orthopedics as a Dental Specialty
12 (*Trans.*1989:519; 2015:257)
13 Certifying Board in Endodontics (*Trans.*1964:251; 2015:255)
14 Recognition of Endodontics as a Dental Specialty (*Trans.*1963:244; 2015:254)
15 Certifying Board in Dental Public Health (*Trans.*1951:180; 2015:254)
16 Recognition of Dental Public Health as a Dental Specialty (*Trans.*1986:512; 2015:254)
17 Periodic Review of Dental Specialty Education and Practice (*Trans.*2001:468; 2011:465)

18 **BOARD RECOMMENDATION: Vote Yes.**

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

WORKSHEET ADDENDUM POLICIES TO BE RESCINDED

Certifying Board in Oral and Maxillofacial Pathology (*Trans.*1950:29; 2015:255)

Resolved, that the American Dental Association approves the American Board of Oral and Maxillofacial Pathology as the national certifying board for the specialty of oral and maxillofacial pathology.

Recognition of Oral and Maxillofacial Pathology as a Dental Specialty (*Trans.*1987:510; 2015:255)

Resolved, that oral and maxillofacial pathology is a dental specialty recognized by the American Dental Association and sponsored by the American Academy of Oral and Maxillofacial Pathology.

Certifying Board in Oral and Maxillofacial Radiology (*Trans.*2015:256)

Resolved, that the American Dental Association approves the American Board of Oral and Maxillofacial Radiology as the national certifying board for the specialty of oral and maxillofacial radiology.

Recognition of Oral and Maxillofacial Radiology as a Dental Specialty (*Trans.*1999:898; 2015:256)

Resolved, that oral and maxillofacial radiology is a dental specialty recognized by the American Dental Association and sponsored by the American Academy of Oral and Maxillofacial Radiology.

Certifying Board in Oral and Maxillofacial Surgery (*Trans.*2015:256)

Resolved, that the American Dental Association approves the American Board of Oral and Maxillofacial Surgery as the national certifying board for the specialty of oral and maxillofacial surgery.

Recognition of Oral and Maxillofacial Surgery as a Dental Specialty (*Trans.*1990:554; 2015:256)

Resolved, that oral and maxillofacial surgery is a dental specialty recognized by the American Dental Association and sponsored by the American Association of Oral and Maxillofacial Surgeons.

Specialty of Oral and Maxillofacial Surgery (*Trans.*1990:549)

Resolved, that the following definition of the specialty of oral and maxillofacial surgery be adopted:

Oral and maxillofacial surgery is the specialty of dentistry which includes the diagnosis, surgical and adjunctive treatment of diseases, injuries and defects involving both the functional and aesthetic aspects of the hard and soft tissues of the oral and maxillofacial region.

Certifying Board in Pediatric Dentistry (*Trans.*2015:257)

Resolved, that the American Dental Association approves the American Board of Pediatric Dentistry as the national certifying board for the specialty of pediatric dentistry.

Recognition of Pediatric Dentistry as a Dental Specialty (*Trans.*1990:549; 2015:257)

Resolved, that pediatric dentistry is a dental specialty recognized by the American Dental Association and sponsored by the American Academy of Pediatric Dentistry.

Certifying Board in Periodontics (*Trans.*2015:258)

Resolved, that the American Dental Association approves the American Board of Periodontology as the national certifying board for the specialty of periodontics.

Recognition of Periodontics as a Dental Specialty (*Trans.*1988:490; 2015:257)

Resolved, that periodontics is a dental specialty recognized by the American Dental Association and sponsored by the American Academy of Periodontology.

Certifying Board in Prosthodontics (*Trans.*2015:258)

Resolved, that the American Dental Association approves the American Board of Prosthodontics as the national certifying board for the specialty of prosthodontics.

Recognition of Prosthodontics as a Dental Specialty (*Trans.*1987:510; 2015:258)

Resolved, that prosthodontics is a dental specialty recognized by the American Dental Association and sponsored by the American College of Prosthodontists.

Certifying Board in Orthodontics and Dentofacial Orthopedics (*Trans.*1950:189; 2015:257)

Resolved, that the American Dental Association approves the American Board of Orthodontics as the national certifying board for the specialty of orthodontics and dentofacial orthopedics.

Recognition of Orthodontics and Dentofacial Orthopedics as a Dental Specialty (*Trans.*1989:519; 2015:257)

Resolved, that orthodontics and dentofacial orthopedics is a dental specialty recognized by the American Dental Association and sponsored by the American Association of Orthodontists.

Certifying Board in Endodontics (*Trans.*1964:251; 2015:255)

Resolved, that the American Dental Association approves the American Board of Endodontics as the national certifying board for the specialty of endodontics.

Recognition of Endodontics as a Dental Specialty (*Trans.*1963:244; 2015:254)

Resolved, that endodontics is a dental specialty recognized by the American Dental Association and sponsored by the American Association of Endodontists.

Certifying Board in Dental Public Health (*Trans.*1951:180; 2015:254)

Resolved, that the American Dental Association approves the American Board of Dental Public Health as the national certifying board for the specialty of dental public health.

Recognition of Dental Public Health as a Dental Specialty (*Trans.*1986:512; 2015:254)

Resolved, that dental public health is a dental specialty recognized by the American Dental Association and sponsored by the American Association of Public Health Dentistry.

Periodic Review of Dental Specialty Education and Practice (*Trans.*2001:468; 2011:465)

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

Resolved, that the Council report the results of the reviews to the House of Delegates.

Resolution No. 10 New

Report: N/A Date Submitted: August 2018

Submitted By: Joint Commission on National Dental Examinations

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: Not Applicable

AMENDMENT OF THE JOINT COMMISSION ON NATIONAL DENTAL EXAMINATIONS STANDING RULES

Background: The ADA *Bylaws* state that the Joint Commission on National Dental Examinations (JCNDE) is to provide and conduct written examinations, exclusive of clinical demonstrations, for the purpose of assisting state boards in determining qualifications of dentists and dental hygienists who seek licensure to practice in any state or other jurisdiction of the United States. The current resolution involves proposed changes to the *Rules*, to update the term “test construction committees” to “test construction team,” and to revise procedures associated with test constructor term limits.

Based on feedback from prior Commissioners and the experiences of staff, DTS is transitioning from the term “test construction committees” to “test construction team.” The latter better reflects the role of test constructors in the test development process. DTS also seeks to modify test constructor term limits. The JCNDE occasionally loses certain highly qualified test constructors due to term limits, while simultaneously the position these constructors previously held remain vacant due to the inability to find an appropriately qualified replacement. DTS intends to maintain the current practice from an operational perspective, but requests language concerning term limits be removed from the *Standing Rules*. This would provide DTS the flexibility needed to avoid losing certain extremely strong test constructors, particularly in situations where few reasonable alternatives exist.

The Joint Commission recommends that the following resolution be adopted by the 2018 House of Delegates:

Resolution

10. Resolved, that the *Standing Rules of the Joint Commission on National Dental Examinations* be revised as indicated in Appendix 1 (additions underscored; deletions ~~stricken~~).

BOARD RECOMMENDATION: Vote Yes.

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

Appendix No. 1

**Proposed Changes to the Standing Rules of the
Joint Commission on National Dental Examinations**

STANDING RULES

October 20178

A publication of the Joint Commission on National Dental Examinations
American Dental Association Building
211 East Chicago Avenue
Chicago, Illinois 60611-2637

1 The Joint Commission on National Dental Examinations operates within the limits imposed by four
2 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 4. Standing Rules of the Joint Commission on National Dental Examinations
- 8

9 Subject to constraints defined in these documents, the Joint Commission is free to establish its own
10 policies and procedures for the conduct of its business. Such policies and procedures as have been
11 adopted are compiled here.

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28	Availability	8

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 a 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, 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 an election.

ROLES OF COMMITTEES

The following four Joint Commission standing committees meet in conjunction with the annual meeting of the Joint Commission:

- 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.

1 Assignments

2 Assignment of topics to specific committees is the responsibility of the Joint Commission Chair, but this
3 responsibility may be delegated in part or in total to the Secretary. Listed and discussed below are
4 examples of topics that are typically assigned to each committee.

5 A topic may be assigned to more than one committee. In addition, provided that it completes its assigned
6 items, a committee may consider a topic assigned to a different committee.

7 Committee on Administration

8 This committee's responsibility relates to administration and operations for all National Board
9 Examinations. Specific topics to be considered include:

- 10
11 a. Examination security, including procedures for examination administration
12 b. Examination regulations
13 c. Joint Commission Bylaws and Standing Rules
14 d. Finances, including an annual comparison of income and expenses
15

16 Committee on Dental Hygiene

17
18 This committee's responsibility relates primarily to the National Board Dental Hygiene Examination.
19 Specific topics to be considered include:

- 20
21 a. Examination content and specifications
22 b. Test construction procedures, including nomination of test constructors and establishment of
23 qualification requirements
24 c. Information circulated to publicize or explain the testing program
25 d. Portions of Examination Regulations that affect dental hygiene candidates
26 e. Matters pertaining to finances, ADA and Joint Commission Bylaws, and Joint
27 Commission Standing Rules that affect the National Board Dental Hygiene
28 Examination

29 Committee on Examination Development

30 This committee's responsibility relates primarily to the National Board Dental Examinations. Specific
31 topics to be considered include:

- 32 a. Examination content and specifications
33 b. Test construction procedures, including nomination of test constructors and establishment of
34 qualification requirements
35 c. Information circulated to publicize or explain the testing program
36 d. Portions of Examination Regulations that affect dental candidates
37 e. Matters pertaining to finances, ADA and Joint Commission Bylaws, and Joint
38 Commission Standing Rules that affect the National Board Dental Examinations

39 Committee on Research and Development

40 This committee's responsibility relates to all National Board Examinations. Topics considered by
41 this committee include any research and development activities related to the 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 following are three exceptions:

- a. A decision about the manner in which a committee approaches its assignment. For example, a change in the personal data form for potential test constructors need not be reported.
- b. Identification of background materials requested 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 provided to all Commissioners and all committee members. Exceptions include, for example, the following: 1) information about a nominee to a test construction committee team is provided only to the committee charged with screening nominees and 2) technical reports containing sensitive information (e.g., involving matters of test security) that are provided as background for the Committee on Research and Development.

Committee reports are provided to the Joint Commission electronically. 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, 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 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

The Joint Commission selects consultants to serve on its Test Construction ~~Committees~~ Teams. A test constructor is appointed for a one-year term and may be reappointed ~~to four consecutive terms~~. To be considered for appointment, candidates must possess appropriate qualifications and must submit a completed personal data form. Test constructor qualifications are published in the following document: JCNDE Test Construction Teams Committees and Member Selection Criteria. ~~Test constructors who have completed five years of service on a committee team will not be considered for reappointment to the same committee team.~~

DETECTION OF IRREGULARITIES BASED ON FORENSIC ANALYSES

The Joint Commission is responsible for protecting the integrity of National Board Examination results. One method involves forensic analyses of candidate performance to detect irregularities and aberrant response patterns. Candidate's 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 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, 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 JCNDE may consider an appeal.

Requests for an appeal pertaining to test results must be initiated within 30 days of receiving test results or, in the case of withheld results, within 30 days of receiving written notice that results are being withheld. In the event that the JCNDE has given notice that previously released 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 results until such time as the appeal is decided or the time for submitting a request for appeal has expired. In the interim, no results will be reported. 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, at his/her sole discretion, may 1) grant the appeal, 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 results, the Chair 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 appeals to another member of the Joint Commission.

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 JCNDE may consider a change in 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 JCNDE action within 60 days after receipt of the written request for an appeal.

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

1 partiality or bias which might interfere with objectivity in decision-making with respect to policy, or the
2 evaluation of candidate appeals.

3
4 The Joint Commission strives to avoid conflicts of interest and the appearance of conflicts in decisions
5 regarding examination policy or individual candidate appeals. Potential conflicts of interest for
6 Commissioners include, but are not limited to:

- 7
- 8 • A professional or personal relationship or an affiliation with the individual or an organization
9 that may create a conflict or the appearance of a conflict.
 - 10 • Being an officer or administrator in a dental education program, testing agency, or board of
11 dentistry with related decision-making influence regarding a candidate for National Board
12 certification.

13 To safeguard the objectivity of the Joint Commission, it is the responsibility of any Commissioner to
14 disclose any potential conflicts. Any member with a direct conflict of interest must recuse himself/herself
15 from the decision making process regarding candidate appeals, or from discussions involving policies that
16 impact the fairness and impartiality of the JCNDE's examination programs.

17 18 **SIMULTANEOUS SERVICE POLICY** 19

20 A member of the Joint Commission on National Dental Examinations—including its standing and ad-hoc
21 committees—may not simultaneously serve as a principal officer of another organization that has a role in
22 appointing a member of the Joint Commission, including the American Dental Education Association,
23 American Association of Dental Boards, American Dental Association, and the American Dental
24 Hygienists' Association, nor may a member of the JCNDE simultaneously serve as a principal officer of a
25 clinical testing agency.¹ When such a conflict is revealed at the time of appointment, the appointing
26 organization will be informed that the conflict exists and requested to select another individual for
27 membership on the Joint Commission. When such a conflict arises during the term of a current
28 commissioner, the commissioner will be asked to resolve the conflict by resigning from one of the
29 conflicting appointments. In the event that the member resigns from the Joint Commission, the appointing
30 organization will appoint another individual to complete the unfinished term, as specified by the American
31 Dental Association (ADA) Bylaws and ADA Standing Rules for Councils and Commissions.

32 33 **ASSISTANCE TO OTHER AGENCIES** 34

35 One of the duties of the Joint Commission is to serve as a resource for the dental profession in the area
36 of developing written examinations for licensure. This charge is fulfilled by providing assistance to state
37 boards of dentistry and to national and international dental organizations. This policy statement describes
38 limitations on availability.

39 40 **Availability**

41 Operation of the National Board Examinations is the Joint Commission's primary charge. Assistance is
42 provided to state boards of dentistry or national dental organizations only upon request and only if the
43 Joint Commission possesses the resources to fulfill the request.

44 If the Joint Commission is forced to select agencies to receive assistance, highest priority will be given to
45 state boards of dentistry that accept National Board results. For dental organizations in the U.S. and its
46 territories, assistance is limited to consultation and sharing general information about Joint Commission
47 policies and procedures. Requests for testing services will be referred to the ADA Department of Testing
48 Services or other organizations or individuals that provide such services.

¹ This requirement applies to appointments made after 2016.

Resolution No. 11 NewReport: N/A Date Submitted: August 2018Submitted 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 the tripartite clearly defined and agreed upon

How does this resolution increase member value: See Background

AMENDMENT TO CRITERIA FOR RECOGNITION OF INTEREST AREAS IN GENERAL DENTISTRY

Background: In accordance with Resolution 170H-2012, Regular Comprehensive Policy Review (*Trans.*2012:370), which requires Councils to review all policies a minimum of once every five years, the ADA Policy on Criteria for Recognition of Interest Areas in General Dentistry has been reviewed by the Council on Dental Education and Licensure. The Council believes that an editorial revision to Criterion 1 of the *Criteria* is necessary to reference the National Commission on Recognition of Dental Specialties and Certifying Boards as the agency responsible for the recognition of dental specialties and certifying boards, rather than the ADA.

Accordingly, the Council on Dental Education and Licensure recommends adoption of the following resolution:

Resolution

11. Resolved, that the ADA Policy on Criteria for Recognition of Interest Areas in General Dentistry (*Trans.*2010:579) be amended as follows (additions underscoring; deletions ~~stricken~~):

Criteria for Recognition of Interest Areas in General Dentistry

1. The existence of a well-defined body of established evidence-based scientific and clinical dental knowledge underlying the general dentistry area - knowledge that is in large part distinct from, or more detailed than, that of other areas of general dentistry education and practice and any of the ~~ADA-recognized dental specialties~~ recognized by the National Commission on Recognition of Dental Specialties and Certifying Boards.

Elements to be addressed:

- Definition and scope of the general dentistry area
 - Educational goals and objectives of the general dentistry area
 - Competency and proficiency statements for the general dentistry education area
 - Description of how scientific dental knowledge in the area is substantive and distinct from other general dentistry areas
2. The body of knowledge is sufficient to educate individuals in a distinct advanced education area of general dentistry, not merely one or more techniques.

Elements to be addressed:

- Identification of distinct components of biomedical, behavioral and clinical science in the advanced education area
- Description of why this area of knowledge is a distinct education area of general dentistry, rather than a series of just one or more techniques
- Documentation demonstrating that the body of knowledge is unique and distinct from that in other education areas accredited by the Commission on Dental Accreditation
- Documentation of the complexity of the body of knowledge of the general dentistry area by identifying specific advanced techniques and procedures, representative samples of curricula from existing programs, textbooks and journals

3. The existence of established advanced educational programs with structured curricula, qualified faculty and enrolled individuals for which accreditation by the Commission on Dental Accreditation can be a viable method of quality assurance.

Elements to be addressed:

- Description of the historical development and evolution of educational programs in the area of advanced training in general dentistry
- A listing of the current operational programs in the advanced general dentistry training area, identifying for each, the:
 - a. Sponsoring institution;
 - b. Name and qualifications of the program director;
 - c. Number of full-time and part-time faculty (define part-time for each program);
 - d. Curriculum (course outlines, student competencies, class schedules);
 - e. Outcomes assessment method;
 - f. Minimum length of the program;
 - g. Certificate and/or degree awarded upon completion;
 - h. Number of enrolled individuals per year for at least the past five years*; and
 - i. Number of graduates per year for at least the past five years.***If the established education programs have been in existence less than five years, provide information since their founding.*
- Documentation on how many programs in the education area would seek voluntary accreditation review, if available

4. The education programs are the equivalent of at least one 12-month full-time academic year in length. The programs must be academic programs sponsored by an institution accredited by an agency recognized by the United States Department of Education or accredited by the Joint Commission on Accreditation of Healthcare Organizations or its equivalent rather than a series of continuing education experiences.

Elements to be addressed:

- Evidence of the minimum length of the program for full-time students
- Evidence that a certificate and/or degree is awarded upon completion of the program
- Programs' recruitment materials (e.g., bulletin, catalogue)
- Other evidence that the programs are bona fide higher education experiences, rather than a series of continuing education courses (e.g., academic calendars, schedule of classes, and syllabi that address scope, depth and complexity of the higher education experience, formal approval or acknowledgment by the parent institution that the courses or curricula in the education area meet the institution's academic requirements for advanced education)

- 1
2 5. The competence of the graduates of the advanced education programs is important to the
3 health care of the general public.
4

5 Elements to be addressed:
6

- 7 • Description of the need for appropriately trained individuals in the general dentistry area
8 to ensure quality health care for the public
9 • Description of current and emerging trends in the general dentistry education area
10 • Documentation that dental health care professionals currently provide health care
11 services in the identified area
12 • Evidence that the area of knowledge is important and significant to patient care and
13 dentistry
14 • Documentation that the general dentistry programs comply with the ADA *Principles of*
15 *Ethics and Code of Professional Conduct*, as well as state and federal regulations
16

17 **BOARD RECOMMENDATION: Vote Yes.**

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

Resolution No. 12 New

Report: N/A Date Submitted: August 2018

Submitted By: Council on Dental Education and Licensure

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: Organizational Capacity-Obj. 6: Role and responsibility of the tripartite clearly defined and agreed upon

How does this resolution increase member value: See Background

AMENDMENT TO THE POLICY: REQUIREMENTS FOR BOARD CERTIFICATION

Background: The Council on Dental Education and Licensure (CDEL) reviewed the ADA Policy statement on Requirements for Board Certification and believes that the first resolved clause is redundant with the ADA Policy *Requirements for Recognition of Dental Specialties and National Certifying Boards for Dental Specialists* (*Trans.*2001:470; 2004:313; 2009:443; 2013:328) and should be amended as presented in Resolution 12.

Resolution

12. Resolved, that the ADA Policy on Requirements for Board Certification (*Trans.*1975:690) be amended as follows (deletions ~~stricken~~):

~~**Resolved**, that candidates for board certification who graduated after January 1, 1967 must have successfully completed an accredited advanced specialty program, and be it further~~

Resolved, that candidates for board certification who completed the prescribed length of education for board certification in a program of an institution then listed by the Council on Dental Education and Licensure prior to 1967 and who have announced ethically limitation of practice in one of the recognized dental specialties are considered educationally eligible.

BOARD RECOMMENDATION: Vote Yes.

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

Resolution No. 13 NewReport: N/A Date Submitted: August 2018Submitted 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 the tripartite clearly defined and agreed upon

How does this resolution increase member value: See Background

**AMENDMENT TO THE REQUIREMENTS FOR RECOGNITION OF DENTAL SPECIALTIES AND
NATIONAL CERTIFYING BOARDS FOR DENTAL SPECIALISTS**

Background: In accordance with Resolution 170H-2012, Regular Comprehensive Policy Review (*Trans.*2012:370) which requires Councils to review all policies a minimum of once every five years, the ADA's Policy on Requirements for Recognition of Dental Specialties and National Certifying Boards for Dental Specialists were reviewed in 2018 by the Council on Dental Education and Licensure. The Council believes that housekeeping revisions to the Requirements for Recognition are necessary due to the establishment of the National Commission on Recognition of Dental Specialties and Certifying Boards by the 2017 ADA House of Delegates. Additionally, proposed revisions related to Requirements 3, 4 and 6 are recommended to provide further clarification on the intent of the Requirements. The proposed amendments are presented in the resolution below. A clean version of the document with all proposed revisions is presented for informational purposes in Appendix 1.

Accordingly, the Council on Dental Education and Licensure recommends adoption of the following resolution:

Resolution

13. Resolved, that the ADA Policy on ADA Requirements for Recognition of Dental Specialties and National Certifying Boards for Dental Specialists (*Trans.*2001:470; 2004:313; 2009:443; 2013:328) be amended as follows (additions underscoring; deletions ~~stricken~~):

Introduction

A specialty is an area of dentistry that has been formally recognized by the ~~American Dental Association~~ National Commission on Recognition of Dental Specialties and Certifying Boards as meeting the "Requirements for Recognition of Dental Specialties" specified in this document. Dental specialties are recognized ~~by the Association~~ to protect the public, nurture the art and science of dentistry, and improve the quality of care. It is the Association's belief that the needs of the public are best served if the profession is oriented primarily to general practice. Specialties are recognized in those areas where advanced knowledge and skills are essential to maintain or restore oral health.¹

Not all areas in dentistry will satisfy the requirements for specialty recognition. However, the public

¹ Association policies regarding ethical announcement of specialization and limitation of practice are contained in the *ADA Principles of Ethics and Code of Professional Conduct*.

and profession benefit substantially when non-specialty groups develop and advance areas of interest through education, practice and research. The contributions of such groups are acknowledged by the profession and their endeavors are encouraged.

The sponsoring organization must submit to the ~~Council on Dental Education and Licensure~~ National Commission on Recognition of Dental Specialties and Certifying Boards a formal application which demonstrates compliance with all the requirements for specialty recognition. ~~The Council will submit its recommendation for approval or denial of the proposed specialty to the Association's House of Delegates.~~

Following ~~approval~~ recognition of a specialty by the National Commission on Recognition of Dental Specialties and Certifying Boards ~~House of Delegates~~, the sponsoring organization must establish a national board for certifying diplomates in accordance with the "Requirements for National Certifying Boards for Dental Specialists" may be established as specified in this document. ~~Additionally, the Commission on Dental Accreditation develops educational requirements and establishes an accreditation program for advanced educational programs in the specialty. The Council on Dental Education and Licensure and the sponsoring organization monitors the administrative standards and operation of the certifying board.~~

Requirements for Recognition of Dental Specialties

A sponsoring organization seeking specialty recognition for an area must document that the discipline satisfies all the requirements specified in this section.

- (1) In order for an area to become and/or remain recognized as a dental specialty, it must be represented by a sponsoring organization: (a) whose membership is reflective of that proposed or recognized dental specialty; (b) in which the privileges to hold office and to vote on any issue related to the specialty are reserved for dentists who either have completed an CODA-accredited advanced education program accredited by the Commission on Dental Accreditation in that proposed or recognized specialty or have sufficient experience in that specialty as deemed appropriate by the sponsoring organization and its certifying board; and (c) that demonstrates the ability to establish a certifying board.
- (2) A proposed specialty must be a distinct and well-defined field which requires unique knowledge and skills beyond those commonly possessed by dental school graduates as defined by the predoctoral accreditation standards.² Commission on Dental Accreditation's Accreditation Standards for Dental Education Programs.
- (3) The scope of the proposed specialty requires advanced knowledge and skills that: (a) as a whole, are separate and distinct from the knowledge and skills sets required to practice in any recognized dental specialty or combination of recognized dental specialties; and (b) cannot be accommodated through minimal modification of a recognized dental specialty ~~or combination of recognized dental specialties~~.
- (4) The specialty applicant must document scientifically, by valid and reliable statistical evidence/studies, that it: (a) actively contributes to new knowledge in the field; (b) actively contributes to professional education; (c) actively contributes to research needs of the profession; and (d) provides oral health services in the field of study for the public; all each of which the specialty candidate must demonstrate would are currently not being be satisfactorily met by general practitioners or dental specialists except for the contributions of the specialty applicant.

² Predoctoral accreditation standards are contained in the Commission on Dental Accreditation's document Accreditation Standards for Dental Education Programs.

(5) A proposed specialty must directly benefit some aspect of clinical patient care.

(6) Formal advanced education programs of at least two years ~~beyond the predoctoral dental curriculum as defined~~ accredited by the Commission on Dental Accreditation must exist to provide the special knowledge and skills required for practice of the proposed specialty.

Requirements for National Certifying Boards for Dental Specialists³

In order to become, and remain, eligible for recognition by the ~~American Dental Association~~ National Commission on Recognition of Dental Specialties and Certifying Boards as a national certifying board for a dental specialty, the specialty shall have a sponsoring ~~or parent~~ organization that meets all of the elements of Requirement (1) of the Requirements for Recognition of Dental Specialties. A close working relationship shall be maintained between the ~~parent~~ sponsoring organization and the certifying board. Additionally, the following requirements must be fulfilled.

Organization of Boards:

(1) Each Board shall have no less than five or more than 12 voting directors designated on a rotation basis in accordance with a method approved by the ~~Council on Dental Education and Licensure~~ National Commission on Recognition of Dental Specialties and Certifying Boards. Although the ~~Council~~ Commission does not prescribe a single method for selecting directors of boards, members may not serve for more than a total of nine years. Membership on the board shall be in accordance with a prescribed method endorsed by the sponsoring organization. All board directors shall be diplomates of that board and only the ~~parent~~ sponsoring organizations of boards may establish additional qualifications if they so desire.

(2) Each board shall submit in writing to the ~~Council on Dental Education and Licensure~~ National Commission on Recognition of Dental Specialties and Certifying Boards a program sufficiently comprehensive in scope to meet the requirements established by the American Dental Association for the operation of a certifying board. This statement should include evidence of sponsorship of the board by a national organization that meets all the elements of Requirement (1) of the Requirements for Recognition of Dental Specialties.

(3) Each board shall submit to the ~~Council on Dental Education and Licensure~~ National Commission on Recognition of Dental Specialties and Certifying Boards evidence of adequate financial support to conduct its program of certification.

(4) Each 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. Consultants who participate in clinical examinations should be diplomates.

Operation of Boards:

(1) Each board shall certify qualified dentists as diplomates only in the special area of dental practice approved by the ~~American Dental Association~~ National Commission on Recognition of Dental Specialties and Certifying Boards for such certification. No more than one board shall be recognized ~~by the Association~~ for the certification of diplomates in a single area of practice.

(2) Each board, except by waiver of the ~~Council on Dental Education and Licensure~~ National Commission on Recognition of Dental Specialties and Certifying Boards, shall give at least one examination in each calendar year and shall announce such examination at least six months in advance.

(3) Each board shall maintain a current list of its diplomates.

³-Amended by the 1992 ADA House of Delegates.

(4) Each board shall submit annually to the ~~Council on Dental Education and Licensure~~ National Commission on Recognition of Dental Specialties and Certifying Boards data relative to its financial operations, applicant admission procedures, and examination content and results thereof. Examination procedures and results should follow the Standards for Educational Psychological Testing, including validity and reliability evidence. A diplomate may, upon request, obtain a copy of the annual technical and financial reports of the board.

(5) Each board shall encourage its diplomates to engage in lifelong learning and continuous quality improvement.

(6) Each board shall provide periodically to the ~~Council on Dental Education and Licensure~~ National Commission on Recognition of Dental Specialties and Certifying Boards evidence of its examination and certification of a significant number of additional dentists in order to warrant its continuing approval by the ~~American Dental Association~~ National Commission on Recognition of Dental Specialties and Certifying Boards.

(7) Each board shall bear full responsibility for the conduct of its program, the evaluation of the qualifications and competence of those it certifies as diplomates, and the issuance of certificates.

(8) Each board shall require an annual registration fee from each of its diplomates intended to assist in supporting financially the continued program of the board.

Certification Requirements:

~~(1) Each board shall use, in the evaluation of its candidates, standards of education and experience approved by the Commission on Dental Accreditation.~~

~~(2)~~ (1) Each board shall require, for eligibility for certification as a diplomate, the successful completion of an advanced education ~~educational~~ program accredited by the Commission on Dental Accreditation of two or more academic years in length, as specified by the Commission.⁴

Although desirable, the period of advanced study need not be continuous, nor completed within successive calendar years. An advanced educational program equivalent to two academic years in length, successfully completed on a part-time basis over an extended period of time as a graduated sequence of educational experience not exceeding four calendar years, may be considered acceptable in satisfying this requirement. Short continuation and refresher courses and teaching experience in specialty departments in dental schools will not be accepted in meeting any portion of this requirement.

Each board may establish an exception to the qualification requirement of completion of an advanced specialty education program accredited by the Commission on Dental Accreditation for the unique candidate who has not met this requirement *per se*, but can demonstrate to the satisfaction of the certifying board, equivalent advanced specialty education. A certifying board must petition the ~~Council on Dental Education and Licensure~~ National Commission on Recognition of Dental Specialties and Certifying Boards for permission to establish such a

⁴ The following interpretation for educational eligibility was provided by the 1975 House of Delegates of the American Dental Association (*Trans.*1975: 690) and amended by 2009 House of Delegates. (*Trans.*2009:443)

Candidates for board certification who graduated after January 1, 1967, must have successfully completed an accredited advanced specialty program. Candidates for board certification who completed the prescribed length of education for board certification in a program of an institution then listed by the Council on Dental Education and Licensure prior to 1967, and who have announced ethically limitation of practice in one of the recognized dental specialties, are considered educationally qualified.

1 policy. If granted, the provisions of the certifying board's policy shall be reported to the House
2 of Delegates in the Annual Report of the Council on Dental Education and Licensure.

3 ~~(3)~~ (2) Each board shall establish its minimum requirements for years of practice in the area for
4 which it grants certificates. The years of advanced education in this area may be accepted
5 toward fulfillment of this requirement.

6 ~~(4)~~ (3) Each board, in cooperation with its sponsoring parent organization, shall prepare and
7 publicize its recommendations on the educational program and experience requirements which
8 candidates will be expected to meet.

9 **Founding Boards and Waivers**

10 ~~Members of a founding board in an area of practice not recognized previously by the American Dental~~
11 ~~Association shall be exempt from certifying examination. Newly recognized boards may petition the~~
12 ~~Council on Dental Education and Licensure for permission to waive the formal education~~
13 ~~requirements for candidates who apply for examination. If granted, the provisions of the waiver shall~~
14 ~~be reported to the House of Delegates in the Annual Report of the Council on Dental Education and~~
15 ~~Licensure.~~

16 **BOARD RECOMMENDATION: Vote Yes.**

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

Appendix 1

**Proposed Revisions (Clean Copy) to
Requirements for Recognition of Dental Specialties and National Certifying
Boards for Dental Specialists****Requirements for Recognition of Dental Specialties and National Certifying Boards for Dental
Specialists (*Trans.2001:470; 2004:313; 2009:443; 2013:328*)**

Introduction

A specialty is an area of dentistry that has been formally recognized by the National Commission on Recognition of Dental Specialties and Certifying Boards as meeting the "Requirements for Recognition of Dental Specialties" specified in this document. Dental specialties are recognized to protect the public, nurture the art and science of dentistry, and improve the quality of care. It is the Association's belief that the needs of the public are best served if the profession is oriented primarily to general practice. Specialties are recognized in those areas where advanced knowledge and skills are essential to maintain or restore oral health.¹

Not all areas in dentistry will satisfy the requirements for specialty recognition. However, the public and profession benefit substantially when non-specialty groups develop and advance areas of interest through education, practice and research. The contributions of such groups are acknowledged by the profession and their endeavors are encouraged.

The sponsoring organization must submit to the National Commission on Recognition of Dental Specialties and Certifying Boards a formal application which demonstrates compliance with all the requirements for specialty recognition.

Following recognition of a specialty by the National Commission on Recognition of Dental Specialties and Certifying Boards, a national board for certifying diplomates in accordance with the "Requirements for National Certifying Boards for Dental Specialists" may be established as specified in this document.

Requirements for Recognition of Dental Specialties

A sponsoring organization seeking specialty recognition for an area must document that the discipline satisfies all the requirements specified in this section.

- (1) In order for an area to become and/or remain recognized as a dental specialty, it must be represented by a sponsoring organization: (a) whose membership is reflective of that proposed or recognized dental specialty; (b) in which the privileges to hold office and to vote on any issue related to the specialty are reserved for dentists who either have completed an advanced education program accredited by the Commission on Dental Accreditation in that proposed or recognized specialty or have sufficient experience in that specialty as deemed appropriate by the sponsoring organization and its certifying board; and (c) that demonstrates the ability to establish a certifying board.
- (2) A proposed specialty must be a distinct and well-defined field which requires unique knowledge and skills beyond those commonly possessed by dental school graduates as defined by the Commission on Dental Accreditation's Accreditation Standards for Dental Education Programs.
- (3) The scope of the proposed specialty requires advanced knowledge and skills that: (a) as a whole, are separate and distinct from the knowledge and skills sets required to practice in any recognized dental

¹ Association policies regarding ethical announcement of specialization and limitation of practice are contained in the *ADA Principles of Ethics and Code of Professional Conduct*.

specialty; and (b) cannot be accommodated through minimal modification of a recognized dental specialty.

- (4) The specialty applicant must document scientifically, by valid and reliable statistical evidence/studies, that it: (a) actively contributes to new knowledge in the field; (b) actively contributes to professional education; (c) actively contributes to research needs of the profession; and (d) provides oral health services in the field of study for the public; each of which the specialty candidate must demonstrate would not be satisfactorily met except for the contributions of the specialty applicant.
- (5) A proposed specialty must directly benefit some aspect of clinical patient care.
- (6) Formal advanced education programs of at least two years accredited by the Commission on Dental Accreditation must exist to provide the special knowledge and skills required for practice of the proposed specialty.

Requirements for National Certifying Boards for Dental Specialists

In order to become, and remain, eligible for recognition by the National Commission on Recognition of Dental Specialties and Certifying Boards as a national certifying board for a dental specialty, the specialty shall have a sponsoring organization that meets all of the elements of Requirement (1) of the Requirements for Recognition of Dental Specialties. A close working relationship shall be maintained between the sponsoring organization and the certifying board. Additionally, the following requirements must be fulfilled.

Organization of Boards:

- (1) Each Board shall have no less than five or more than 12 voting directors designated on a rotation basis in accordance with a method approved by the National Commission on Recognition of Dental Specialties and Certifying Boards. Although the Commission does not prescribe a single method for selecting directors of boards, members may not serve for more than a total of nine years. Membership on the board shall be in accordance with a prescribed method endorsed by the sponsoring organization. All board directors shall be diplomates of that board and only the sponsoring organizations of boards may establish additional qualifications if they so desire.
- (2) Each board shall submit in writing to the National Commission on Recognition of Dental Specialties and Certifying Boards a program sufficiently comprehensive in scope to meet the requirements established by the American Dental Association for the operation of a certifying board. This statement should include evidence of sponsorship of the board by a national organization that meets all the elements of Requirement (1) of the Requirements for Recognition of Dental Specialties.
- (3) Each board shall submit to the National Commission on Recognition of Dental Specialties and Certifying Boards evidence of adequate financial support to conduct its program of certification.
- (4) Each 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. Consultants who participate in clinical examinations should be diplomates.

Operation of Boards:

- (1) Each board shall certify qualified dentists as diplomates only in the special area of dental practice approved by the National Commission on Recognition of Dental Specialties and Certifying Boards for such certification. No more than one board shall be recognized for the certification of diplomates in a single area of practice.
- (2) Each board, except by waiver of the National Commission on Recognition of Dental Specialties and Certifying Boards, shall give at least one examination in each calendar year and shall announce such examination at least six months in advance.
- (3) Each board shall maintain a current list of its diplomates.

- (4) Each board shall submit annually to the National Commission on Recognition of Dental Specialties and Certifying Boards data relative to its financial operations, applicant admission procedures and examination content, and results including examination validity and reliability evidence. Examination procedures and results should follow the Standards for Educational Psychological Testing, including validity and reliability evidence. A diplomate may, upon request, obtain a copy of the annual technical and financial reports of the board.
- (5) Each board shall encourage its diplomates to engage in lifelong learning and continuous quality improvement.
- (6) Each board shall provide periodically to the National Commission on Recognition of Dental Specialties and Certifying Boards evidence of its examination and certification of a significant number of additional dentists in order to warrant its continuing approval by the National Commission on Recognition of Dental Specialties and Certifying Boards.
- (7) Each board shall bear full responsibility for the conduct of its program, the evaluation of the qualifications and competence of those it certifies as diplomates, and the issuance of certificates.
- (8) Each board shall require an annual registration fee from each of its diplomates intended to assist in supporting financially the continued program of the board.

Certification Requirements:

- (1) Each board shall require, for eligibility for certification as a diplomate, the successful completion of an advanced education program accredited by the Commission on Dental Accreditation of two or more academic years in length, as specified by the Commission.

Although desirable, the period of advanced study need not be continuous, nor completed within successive calendar years. An advanced educational program equivalent to two academic years in length, successfully completed on a part-time basis over an extended period of time as a graduated sequence of educational experience not exceeding four calendar years, may be considered acceptable in satisfying this requirement. Short continuation and refresher courses and teaching experience in specialty departments in dental schools will not be accepted in meeting any portion of this requirement.

Each board may establish an exception to the qualification requirement of completion of an advanced specialty education program accredited by the Commission on Dental Accreditation for the unique candidate who has not met this requirement *per se*, but can demonstrate to the satisfaction of the certifying board, equivalent advanced specialty education. A certifying board must petition the National Commission on Recognition of Dental Specialties and Certifying Boards for permission to establish such a policy.
- (2) Each board shall establish its minimum requirements for years of practice in the area for which it grants certificates. The years of advanced education in this area may be accepted toward fulfillment of this requirement.
- (3) Each board, in cooperation with its sponsoring organization, shall prepare and publicize its recommendations on the educational program and experience requirements which candidates will be expected to meet.

Resolution No. 15 New

Report: N/A Date Submitted: August 2018

Submitted By: Council on Dental Education and Licensure

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: Organizational Capacity-Obj. 6: Role and responsibility of the tripartite clearly defined and agreed upon

How does this resolution increase member value: See Background

RESCISSION OF POLICY: CERTIFICATION IN UNRECOGNIZED PRACTICE AREAS

Background: The 2017 ADA House of Delegates adopted Resolution 30H-2017, establishing the National Commission on Recognition of Dental Specialties and Certifying Boards (National Commission or NCRDSCB) and charging the agency with the responsibility of recognizing dental specialties and specialty certifying boards, based on the ADA Requirements for Recognition of Dental Specialties and National Certifying Boards for Dental Specialists (*Trans.*2001:470; 2004:313; 2009:443; 2013:328). At its inaugural meeting in May 2018, the National Commission adopted verbatim the ADA statements recognizing each of the nine ADA-recognized dental specialties, their sponsoring organizations and certifying boards as well as the ADA policy related to the periodic review of the dental specialties.

Because of the National Commission's actions and in accord with Resolution 170H-2012, Regular Comprehensive Policy Review, the Council on Dental Education and Licensure has reviewed all of the Association's policies related to the dental specialties. Accordingly, the Council recommends rescission of the policy, Certification in Unrecognized Practice Areas because the policy is outdated and contrary to the Principles of Ethics and Code of Professional Conduct, Advisory Opinion 5.H. Announcement of Specialization and Limitation of Practice.

Accordingly, the Council recommends that the House review and approve the rescission of the policy statement on certification in unrecognized practice areas.

Resolution

15. Resolved, that the ADA policy on Certification in Unrecognized Practice Areas (*Trans.*1957:360) be rescinded.

BOARD RECOMMENDATION: Vote Yes.

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

**WORKSHEET ADDENDUM
POLICY TO BE RESCINDED**

Certification in Unrecognized Practice Areas (*Trans.1957:360*)

Resolved, that the certification of diplomates by certifying boards representing areas of practice not formally recognized as specialties by the American Dental Association be disapproved.

Resolution No. 17 New

Report: N/A Date Submitted: August 2018

Submitted By: Council on Dental Education and Licensure

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: Organizational Capacity-Obj. 6: Role and responsibility of the tripartite clearly defined and agreed upon

How does this resolution increase member value: See Background

AMENDMENT TO THE POLICY: NUMBER OF SPECIALTY AREAS OF DENTAL PRACTICE

Background: In accordance with Resolution 170H-2012, Regular Comprehensive Policy Review (*Trans.*2012:370) which requires Councils to review all policies a minimum of once every five years, the policy, Number of Specialty Areas of Dental Practice, has been reviewed by the Council on Dental Education and Licensure. The Council believes that the intent of the policy is to support the ADA Requirements for Recognition of Dental Specialties and National Certifying Boards for Dental Specialists and document the Association's position that dental specialists perform services acquired by formal advanced education and training beyond those commonly possessed by general dentists. The number of specialty areas is not relevant.

Accordingly, the Council on Dental Education and Licensure recommends adoption of the following resolution:

Resolution

17. Resolved, that the Number of Specialty Areas of Dental Practice (*Trans.*1995:633) be amended as follows (additions underscoring; deletions ~~stricken~~):

~~Number of Specialty Areas of Dental Practice~~

Resolved, that the ~~number of specialty~~ number of specialty areas of dental practice meet the ADA's "Requirements for Recognition of Dental Specialties" ~~be limited to that which will~~ to assure the public of the competence of the dentist who holds himself/herself out to the public as a specialist who performs services which require formal advanced education, training and skills beyond those commonly possessed by the general practitioner.

BOARD RECOMMENDATION: Vote Yes.

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

Resolution No. 21 New

Report: N/A Date Submitted: August 2018

Submitted By: Council on Dental Education and Licensure

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: Organizational Capacity-Obj. 6: Role and responsibility of the tripartite clearly defined and agreed upon

How does this resolution increase member value: See Background

RESCISSION OF POLICY: USE OF THE TERM "SPECIALTY"

Background: In accord with Resolution 170H-2012, Regular Comprehensive Policy Review (*Trans.* 2012: 370), the Council on Dental Education and Licensure has reviewed all of the Association's policies related to the dental specialties. The Council recommends rescission of the policy, Use of the Term "Specialty," because the policy is outdated. The recognition of dental specialties is the responsibility of the National Commission on Recognition of Dental Specialties and Certifying Boards. Further, the policy is contrary to the *Principles of Ethics and Code of Professional Conduct*, Advisory Opinion 5.H. Announcement of Specialization and Limitation of Practice.

Accordingly, the Council recommends that the House review and approve the rescission of the policy statement on use of the term "specialty."

Resolution

21. Resolved, that the ADA Policy on Use of the Term "Specialty" (*Trans.* 1957:360) be rescinded.

BOARD RECOMMENDATION: Vote Yes.

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

WORKSHEET ADDENDUM
POLICY TO BE RESCINDED

Use of the Term “Specialty” (*Trans.1957:360*)

Resolved, that the use of the term “specialty” by any group which does not represent a specialty formally recognized by the American Dental Association be disapproved.

Resolution No. 22 New

Report: N/A Date Submitted: August 2018

Submitted By: Council on Dental Education and Licensure

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: Organizational Capacity-Obj. 6: Role and responsibility of the tripartite clearly defined and agreed upon

How does this resolution increase member value: See Background

1 RESCISSION OF POLICY ON DUAL DEGREED DENTISTS

2 **Background:** In accord with Resolution 170H-2012, Regular Comprehensive Policy Review
 3 (*Trans.*2012:370), the Council on Dental Education and Licensure has conducted a two-year
 4 comprehensive review of Association policies on dental licensure. During its consideration of the policy,
 5 Dual Degreed Dentists (*Trans.*2003:367; 2012:464), the Council noted that all 53 jurisdictions include
 6 legal provisions for licensure of dentist-physicians in state statutes. Thus, over the fifteen years since this
 7 policy was first adopted, states have enacted laws regarding the licensure of dentists degreed as both
 8 dentists and physicians. Therefore, the Council believes this policy is obsolete and recommends that the
 9 House approve the rescission of the policy statement on dual degreed dentists.

10 Resolution

11 **22. Resolved,** that the ADA Policy on Dual Degreed Dentists (*Trans.*2003:367; 2012:464) be
 12 rescinded.

13 BOARD RECOMMENDATION: Vote Yes.

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

WORKSHEET ADDENDUM
POLICY TO BE RESCINDED

Policy on Dual Degreed Dentists (*Trans.*2003:367; 2012:464)

Resolved, that in order to protect the health, welfare and safety of the public, the American Dental Association believes that individuals who possess both a medical degree and a dental degree and elect to practice dentistry should be required to obtain a dental license issued by the jurisdiction in which they practice, and that oversight for their practice of dentistry should fall under the purview of their state dental practice act and their state boards of dentistry.

Resolution No. 23 New

Report: N/A Date Submitted: August 2018

Submitted By: Joint Commission on National Dental Examinations

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

AMENDMENT OF THE JOINT COMMISSION ON NATIONAL DENTAL EXAMINATIONS BYLAWS

Background: The American Dental Association (ADA) *Bylaws* state that the Joint Commission on National Dental Examinations (JCNDE) is to provide and conduct written examinations, exclusive of clinical demonstrations, for the purpose of assisting state boards in determining qualifications of dentists and dental hygienists who seek licensure to practice in any state or other jurisdiction of the United States.

Based on feedback from prior Commissioners and the experiences of staff, DTS is transitioning from the term “test construction committees” to “test construction team.” The latter better reflects the role of test constructors in the test development process. The proposed changes to these Bylaws implement this change in terminology.

The JCNDE recommends that the following resolution be adopted by the 2018 House of Delegates:

Resolution

23. Resolved, that the *Bylaws of the Joint Commission on National Dental Examinations* be revised as indicated in Appendix 1 (additions underscored; deletions ~~stricken~~).

BOARD RECOMMENDATION: Vote Yes.

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

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Appendix No. 1
Proposed Changes to the Bylaws of the
Joint Commission on National Dental Examinations

JOINT COMMISSION ON NATIONAL DENTAL EXAMINATIONS

BYLAWS

~~June 2017~~October 2018

A publication of the Joint Commission on National Dental Examinations
American Dental Association
211 East Chicago Avenue
Chicago, Illinois 60611

1 The Joint Commission on National Dental Examinations is governed by four documents. In order of
2 precedence, they are:

- 3
- 4 *Bylaws of the American Dental Association*
- 5 *Bylaws of the Joint Commission on National Dental Examinations*
- 6 *Standing Rules for Councils and Commissions*
- 7 *Standing Rules of the Joint Commission on National Dental Examinations*
- 8

9 Joint Commission *Bylaws*, which follow, are consistent with but more comprehensive than ADA *Bylaws*.

10
11 Joint Commission *Bylaws* were adopted in 1980 and amended since. Additional modifications may be
12 made by the ADA House of Delegates without prior notification.

ARTICLE I. PURPOSE

The purposes of the Joint Commission on National Dental Examinations are:

- A. To provide and conduct written examinations, exclusive of clinical demonstrations, for the purpose of assisting state boards in determining qualifications of dentists who seek licensure to practice in any state, district or dependency of the United States, which recognizes the National Board Examinations.
- B. To provide and conduct written examinations, exclusive of clinical demonstrations, for the purpose of assisting state boards in determining qualifications of dental hygienists who seek licensure to practice in any state, district or dependency of the United States, which recognizes the National Board Examinations.
- C. To make rules and regulations for the conduct of National Board Examinations and for National Board Certification.
- D. To serve as a resource for the dental profession in the development of written examinations.

ARTICLE II. BOARD OF COMMISSIONERS**Section 1. Legislative and Management Body**

The legislative and management body of the Joint Commission on National Dental Examinations shall be the Board of Commissioners.

Section 2. Composition

The Board of Commissioners shall consist of fifteen (15) Commissioners to be selected as follows:

- A. Six (6) Commissioners who are active, life or retired members of the American Dental Association shall be selected by the American Association of Dental Boards from its active membership no one of whom is a member of a faculty of an accredited dental school.
 - 1. For the purpose of these Bylaws, the active membership of the American Association of Dental Boards is defined as all active members (members who currently serve on state boards), all individual active members (members who formerly served on state boards) and all life members of that Association.
- B. Three (3) Commissioners who are active, life or retired members of the American Dental Association and who hold professorial rank at accredited dental schools shall be selected by the American Dental Education Association from its active membership, no one of whom is a member of a state board of dentistry.
- C. Three (3) Commissioners shall be selected by the American Dental Association from its active, life and retired members, no one of whom is a faculty member of an accredited dental school or a member of a state board of dentistry.
- D. One (1) Commissioner shall be selected by the American Dental Hygienists' Association from its active membership.

1 E. One (1) Commissioner shall be selected by the American Student Dental Association from its
2 active membership.

3
4 F. One (1) Commissioner shall be elected as a public representative by the Board of
5 Commissioners, but such public representative shall not be a dentist, a dental hygienist, a
6 dental student, a dental hygiene student or a faculty member of an accredited dental school
7 or dental hygiene program.

8 **Section 3. Term of Office**

9
10 The term of office of a Commissioner shall be four (4) years except that the Commissioner selected by
11 the American Student Dental Association shall serve a term of one (1) year.

12
13 A. The Commissioner selected by the American Student Dental Association may be selected
14 one (1) year in advance and may attend meetings of the Board of Commissioners as an
15 observer before his or her term begins.

16
17 The tenure of a Commissioner shall be limited to one (1) term. Terms of Commissioners shall begin and
18 end with adjournment of the closing session of the annual meeting of the House of Delegates of the
19 American Dental Association in the appropriate year.

20 **Section 4. Powers**

21
22
23 A. The Board of Commissioners shall be vested with full power to conduct all business of the
24 Joint Commission on National Dental Examinations subject to laws of the state of Illinois, the
25 *Bylaws of the American Dental Association* and these *Bylaws*.

26
27 B. The Board of Commissioners shall have the power to establish rules and regulations to
28 govern its organization and procedure provided that such rules and regulations are consistent
29 with the *Bylaws of the American Dental Association* and with these *Bylaws*.

30 **Section 5. Duties**

31
32 A. Examination Development and Administration: The Board of Commissioners shall:

- 33
34 1. Develop, publish and periodically review specifications for National Board Examinations.
35
36 2. Appoint consultants with appropriate qualifications to assist in the construction of National
37 Board Examinations.
38
39 3. Develop, publish and periodically review rules and regulations for the fair and orderly
40 administration of National Board Examinations.
41
42 4. Cause National Board Examinations to be administered at least annually at locations
43 throughout the United States.
44
45 5. Cause results from National Board Examinations to be reported in a timely fashion to
46 candidates and/or their schools and to state boards identified by candidates.
47
48 6. Cause a permanent record of National Board Examination results to be maintained so
49 that such results may be reported to individuals or institutions identified by candidates.
50
51 7. Protect the security of National Board Examinations and the integrity of National Board
52 Examination results.

1 B. Liaison: The Board of Commissioners shall:

- 2
- 3 1. Submit an annual report of the activities and future plans of the Joint Commission on
- 4 National Dental Examinations to appropriate officials of the American Association of
- 5 Dental Boards, the American Dental Education Association, the American Dental
- 6 Association, the American Dental Hygienists' Association, and the American Student
- 7 Dental Association.
- 8
- 9 2. Conduct an annual forum for representatives of state boards of dentistry for the purposes
- 10 of providing information about and receiving recommendations for National Board
- 11 Examinations.
- 12

13 C. Financial Management: The Board of Commissioners shall:

- 14
- 15 1. Submit annually to the Board of Trustees of the American Dental Association an
- 16 appropriation request for the next year.
- 17
- 18 2. Control allocated funds in a manner consistent with the budgetary policy of the American
- 19 Dental Association.
- 20
- 21 3. Monitor the relationship between expenses for National Board Examinations and income
- 22 from examination fees and recommend to the Board of Trustees of the American Dental
- 23 Association such changes in fees as needed to avoid either profit or loss.
- 24

25 D. Miscellaneous: The Board of Commissioners shall monitor these *Bylaws* for consistency with

26 the *Bylaws of the American Dental Association*. When or if a conflict exists, the Board of

27 Commissioners shall describe such conflict in its annual report to sponsoring associations

28 and recommend changes to achieve conformity.

29 **Section 6. Meetings**

- 30
- 31 A. Regular Meetings: There shall be one (1) regular meeting of the Board of Commissioners
- 32 each year.
- 33
- 34 B. Special Meetings: A special meeting of the Board of Commissioners may be called at any
- 35 time by the Chair of the Joint Commission on National Dental Examinations. The Chair shall
- 36 call a special meeting at the request of nine (9) of the fifteen (15) members of the Board of
- 37 Commissioners. Members of the Board of Commissioners shall be notified at least ten (10)
- 38 days in advance of the convening of a special meeting.

39 **Section 7. Quorum**

40

41 A majority of voting members of the Board of Commissioners shall constitute a quorum.

42

43 **ARTICLE III. COMMITTEES**

44

45 **Section 1. Committee on Dental Hygiene**

46

47 The Joint Commission on National Dental Examinations shall have a standing Committee on Dental

48 Hygiene.

49

- 50 A. Composition: The Committee on Dental Hygiene shall be composed of eight (8) members to
- 51 be selected as follows:

1. One (1) Commissioner appointed by the Chair who is a representative of the American Association of Dental Boards.
 2. One (1) Commissioner appointed by the Chair who is a representative of the American Dental Education Association.
 3. One (1) Commissioner appointed by the Chair who is a representative of the American Dental Association.
 4. One (1) Commissioner who is the representative of the American Dental Hygienists' Association plus three (3) additional dental hygienists who are selected by the American Dental Hygienists' Association. Of the four (4) dental hygienist members, two (2) members shall be faculty members of accredited dental hygiene programs and two (2) members shall represent practicing dental hygienists.
 5. One (1) dental hygiene student who is selected by the American Dental Hygienists' Association.
- B. Meetings: The Committee on Dental Hygiene shall have one (1) regular meeting each year. This meeting shall precede the regular, annual meeting of the Board of Commissioners. Special meetings of the Committee on Dental Hygiene shall be convened at the request of the Board of Commissioners or at the request of a majority of Committee members subject to approval by the Board of Commissioners.
- C. Duties: The Committee on Dental Hygiene shall consider matters related to the National Board Dental Hygiene Examination.

Section 2. Test Construction ~~Committee~~ Team

The Joint Commission on National Dental Examinations shall establish and convene regular meetings of such ~~committees~~ teams as are necessary to construct National Board Examinations.

Section 3. Other Committees

The Chair, with the advice and consent of the Board of Commissioners, may appoint such other committees as are necessary to ensure the orderly functioning of the business of the Joint Commission on National Dental Examinations. Excluding test construction teams ~~committees~~, each committee will include at least one (1) Commissioner who is a representative of the American Association of Dental Boards, one (1) Commissioner who is a representative of the American Dental Education Association, and one (1) Commissioner who is a representative of the American Dental Association.

Section 4. Authority

Decisions of committees shall be subject to approval by the Board of Commissioners.

ARTICLE IV. OFFICERS

Section 1. Chair

- A. Eligibility: The Chair of the Joint Commission on National Dental Examinations shall be a dentist who is a member of the Board of Commissioners.

1 B. Election: The Vice Chair of the Joint Commission on National Dental Examinations shall
2 become Chair at the end of his or her term as Vice Chair. If the Vice Chair is unable or
3 unwilling to serve as Chair, then the Chair shall be elected by the Board of Commissioners
4 during its regular, annual meeting. The term of the Chair shall be one (1) year beginning and
5 ending with adjournment of the closing session of the annual meeting of the House of
6 Delegates of the American Dental Association.

7
8 C. Duties: The Chair of the Joint Commission on National Dental Examinations shall:
9

- 10 1. Appoint members and chairmen of such committees as are necessary for the orderly
11 conduct of business except as otherwise provided in these *Bylaws*.
- 12
- 13 2. Circulate or cause to be circulated an announcement and an agenda for each regular or
14 special meeting of the Board of Commissioners.
- 15
- 16 3. Preside during meetings of the Board of Commissioners.
- 17
- 18 4. Prepare or supervise the preparation of an annual report of the Joint Commission on
19 National Dental Examinations.
- 20
- 21 5. Prepare or supervise the preparation of an annual appropriation request for the Joint
22 Commission on National Dental Examinations.
- 23
- 24 6. Represent the Joint Commission on National Dental Examinations during sessions of the
25 House of Delegates of the American Dental Association.
- 26

27 **Section 2. Vice Chair**

- 28
- 29 A. Eligibility: The Vice Chair of the Joint Commission on National Dental Examinations shall be
30 a dentist who is a member of the Board of Commissioners.
- 31
- 32 B. Election: The Vice Chair of the Joint Commission on National Dental Examinations shall be
33 elected by the Board of Commissioners during its regular, annual meeting. The term of the
34 Vice Chair shall be one (1) year beginning and ending with adjournment of the closing
35 session of the annual meeting of the House of Delegates of the American Dental Association.
- 36
- 37 C. Duties: The Vice Chair of the Joint Commission on National Dental Examinations shall assist
38 the Chair in the performance of his or her duties.
- 39

40 **Section 3. Secretary:**

- 41
- 42 A. Appointment: The Secretary of the Joint Commission on National Dental Examinations shall
43 be an employee of the American Dental Association selected by the Executive Director of
44 that Association.
- 45
- 46 B. Evaluation: The performance of the Secretary may be evaluated by the Board of
47 Commissioners. If the Board of Commissioners exercises this option, written evaluation
48 including recommendations signed by the Chair shall be forwarded to the Executive Director
49 of the American Dental Association.
- 50
- 51 C. Duties: The Secretary of the Joint Commission on National Dental Examinations shall:
52
- 53 1. Keep minutes of meetings of the Board of Commissioners.

2. Be the custodian of records of the Joint Commission on National Dental Examinations.

3. Manage the office and staff of the Joint Commission on National Dental Examinations.

ARTICLE V. MISCELLANEOUS

Section 1. Financial Records

Financial records of the Joint Commission on National Dental Examinations shall be maintained by the American Dental Association in a manner consistent with accepted principles of accounting. Such financial records shall be available on reasonable notice for inspection by a representative or agent of the American Association of Dental Boards, the American Dental Education Association, the American Dental Hygienists' Association or the American Student Dental Association.

Section 2. Additional Rules

The rules contained in the current edition of the *American Institute of Parliamentarians Standard Code of Parliamentary Procedure* shall govern the deliberations for the Board of Commissioners in all instances where they are applicable and not in conflict with the *Bylaws of the American Dental Association*, these *Bylaws* or previously established rules and regulations of the Board of Commissioners.

Section 3. Vacancy

In the event of a vacancy in the office of a Commissioner, the following procedures shall be employed:

- A. In the event that the Commissioner was selected by an association, such association shall select a successor who possesses the qualifications established by these *Bylaws* to complete the unexpired term.
- B. In the event that the Commissioner was the public representative, the Board of Commissioners shall elect a successor who possesses the qualifications established by these *Bylaws* to complete the unexpired term.
- C. In the event the vacancy involves the Chair, the Vice Chair shall immediately assume all duties of the Chair.
- D. In the event the vacancy involve the Vice Chair, a meeting of the Joint Commission shall be convened to select a new Vice Chair.

ARTICLE VI. AMENDMENT

These *Bylaws* may be amended only by majority vote of the House of Delegates of the American Dental Association.

Resolution No. 26 New

Report: N/A Date Submitted: August 2018

Submitted By: Council on Dental Education and Licensure

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: Organizational Capacity-Obj. 6: Role and responsibility of the tripartite clearly defined and agreed upon

How does this resolution increase member value: See Background

COMPREHENSIVE POLICY ON DENTAL LICENSURE

Background: In accord with Resolution 170H-2012, Regular Comprehensive Policy Review (*Trans.*2012:370), the Council on Dental Education and Licensure conducted a two-year comprehensive review of the Association's 17 policies related to dental licensure. The Council identified redundancies and lengthy explanations within these policy statements and concluded that new succinct yet comprehensive policy related to: (1) general principles for dental licensure, (2) initial licensure, (3) the curriculum integrated format clinical examination (4) graduates of non-CODA accredited dental education programs, (5) licensure by credentials, and (6) licensure by credentials for dentists who are not graduates of CODA-accredited dental schools, should be developed to replace 12 of the current policies. In doing so, the Council paid careful attention to the salient points stated in current policies, particularly those related to public protection, ensuring that these key positions remain in the proposed new policy. To illustrate this, Appendix 1 is a crosswalk analysis of key themes in current policy to the applicable sections of the proposed policy.

General Principles: The first section of the proposed policy statement is a series of statements on the Association's general principles regarding dental licensure, reflecting the important concepts and positions noted in the following current policy statements: Policy on One Standard of Competency (*Trans.*2003:369; 2012:463), Policy on Dental Licensure (*Trans.*1998:720; 2003:341), Position Statement on Federal Intervention in Licensure (*Trans.*1975:187, 718; 2012:468), Dental Practice by Unqualified Persons (*Trans.*1959:207), and Eliminating Use of Patients in Board Examinations (*Trans.*2005:336; 2013:351). The Council believes that with adoption of the proposed new policy, these current policy statements should be rescinded.

Initial Licensure: This second section urges states to accept a common core of requirements for initial licensure. It reflects the important concepts and positions noted in the current policy statement, Guidelines for Licensure (*Trans.*1976:919; 1977:923; 1989:529; 1992:632; 1999:938; 2000:401; 2003:340; 2012:464). Further, the Council recommends rescission of several other licensure policies, given that licensure pathways have evolved and changed, i.e., Monitoring Clinical Dental Licensure Examinations (*Trans.*2005:333; 2012:462), Clinical Licensure Examinations in Dental Schools (*Trans.*2003:368; 2012:462), and Acceptance of Results of Regional Boards (*Trans.*1992:630; 2001:468; 2012:468). The Council believes that with the adoption of the proposed new policy, these current policies should be rescinded.

Curriculum Integrated Format Clinical Examinations: This section of the proposed policy addresses the curriculum integrated format clinical examination, currently administered by some of the clinical testing agencies and recognized by state dental boards. The important concepts and positions noted in current policy statements, Definition of Curriculum Integrated Format (*Trans.*2007:389) and Clinical Licensure Examinations in Dental Schools (*Trans.*2003:368; 2012:462), are reflected in this section of the new policy statement. The Council believes that with the adoption of the new proposed policy, the two current policies on this subject should be rescinded.

Licensing Graduates of Non-accredited Programs: This paragraph of the proposed policy addresses initial licensure of graduates of non-CODA accredited dental education programs and the educational credentials that should be required by state dental boards to determine eligibility for initial licensure. The concepts and positions noted in the current policy Licensure of Graduates of Nonaccredited Dental Programs (*Trans.*1984:539; 2012:477) are reflected in this new statement. The Council believes that with the adoption of the new policy, the current policy Licensure of Graduates of Nonaccredited Dental Programs (*Trans.*1984:539; 2012:477) should be rescinded.

Licensure by Credentials: This section urges state dental boards to have provisions regarding licensure by credentials (or endorsement or reciprocity) to license and credential experienced dentists who are already licensed in good standing in another state. The important concepts and positions noted in the current policy statements, Endorsement of Recommendations of the ADA Guidelines for Licensure by Credentials (*Trans.*1992:628; 2009:447; 2012:464) and the Guidelines for Licensure (*Trans.*1976:919; 1977:923; 1989:529; 1992:632; 1999:938; 2000:401; 2003:304; 2012:464) are reflected in this new statement. The Council believes that with the adoption of the new policy, the Endorsement of Recommendations of the ADA Guidelines for Licensure by Credentials and Guidelines for Licensure should be rescinded.

Licensure by Credentials for Graduates of Non-accredited Programs: The final paragraph of the new policy statement regards licensure by credentials for experienced dentists who were licensed in one or more states prior to the requirement for graduation from a CODA-accredited dental education program. These concepts and positions are noted in the current policy statement, Guidelines for Licensure (*Trans.*1976:919; 1977:923; 1989:529; 1992:632; 1999:938; 2000:401; 2003:340; 2012:464) and are reflected in this new proposed policy). The Council believes that with the adoption of the new policy, the Guidelines for Licensure, should be rescinded as previously noted.

Resolution

26. Resolved, that the Comprehensive Policy on Dental Licensure be adopted:

COMPREHENSIVE POLICY ON DENTAL LICENSURE

General Principles

- One standard of competency for dental licensure must be in place in order to provide quality oral health care to the public.
- Provisions for freedom of movement across state lines for all dental professionals should exist to facilitate the provision of quality oral health care to the public.
- Federal licensure and federal intervention in the state dental licensure system are strongly opposed.
- Efforts of unlicensed and unqualified persons to gain a right to serve the public directly in the field of dental practice are strongly opposed.

- Elimination of patients in the clinical licensure examination process is strongly supported to address ethical concerns, including those identified in the ADA Council on Ethics, Bylaws and Judicial Affairs statement entitled Ethical Considerations When Using Patients in the Examination Process (*Reports* 2008:103). State dental societies and dental boards are urged to work toward acceptance of valid and reliable clinical assessments that do not require single-encounter performance of procedures on patients.
- The state boards of dentistry in each state or licensure jurisdiction are the sole licensure and regulating authorities for all dentists and allied dental personnel.
- State dental boards are encouraged to require verification of completion of continuing dental education as a condition for re-registration of dental licenses.
- Dentists identified as deficient through properly constituted peer review mechanisms should undergo assessment and corrective competency-based education and such provisions should be included in laws, rules and regulations.

Initial Licensure

States are urged to accept the following common core of requirements for initial licensure:

1. Completion of a DDS or DMD degree from a university-based dental education program accredited by the Commission on Dental Accreditation.
2. Successful passage of the National Board Dental Examination, a valid and reliable written cognitive test.
3. A determination of clinical competency for the beginning practitioner, which may include:
 - Acceptance of clinical examination results from any clinical testing agency; or
 - Graduation from CODA-accredited PGY-1 program, that is, a residency program at least one year in length at a CODA-accredited clinically-based postdoctoral general dentistry and/or successful completion of at least one year of a specialty residency program; or
 - Completion of a portfolio-type examination (such as employed by the California Dental Board) or similar assessment, that uses the evaluation mechanisms currently applied by the dental schools to assess student competence; or
 - An Objective Structured Clinical Examination (OSCE), that is, a valid and reliable non-patient based examination consisting of multiple, standardized stations that require candidates to use their clinical knowledge and skills to successfully complete one or more dental problem-solving tasks.

Curriculum Integrated Format Clinical Examination

A Curriculum Integrated Format (CIF) clinical examination addresses ethical concerns associated with single encounter patient-based examinations currently administered by dental clinical testing agencies. A CIF provides candidates opportunities to successfully complete independent "third-party" clinical assessments on patients of record prior to

1 graduation from a dental education program accredited by the Commission on Dental
2 Accreditation. The curriculum integrated format, as defined below, should only be
3 employed as a licensure examination until a non-patient based licensure examination is
4 developed that protects the public and meets psychometric standards. The Association
5 believes that the following CIF provisions must be required by state boards of dentistry
6 and incorporated by testing agencies for protection of the patient:
7

- 8 • A CIF examination must be performed by candidates on patients of record within an
9 appropriately sequenced treatment plan.
- 10
- 11 • The competencies assessed by the clinical examining agency must be selected
12 components of current dental education program curricula and reflective of current
13 dental practice.
- 14
- 15 • All portions of the CIF examination must be available at multiple times within each
16 institution during dental school to ensure that patient care is accomplished within an
17 appropriate treatment plan and to allow candidates to remediate and retake prior to
18 graduation any portions of the examination which they have not successfully
19 completed.

20 **Graduates of Non-CODA Accredited Dental Education Programs**

21
22 For initial licensure in dentistry, international graduates of non-CODA accredited dental
23 education programs should possess the following educational credentials: 1) completion
24 of a university-based dental education program accredited by the Commission on Dental
25 Accreditation (CODA) leading to a DDS or DMD degree or 2) graduation from a
26 postgraduate program in general dentistry accredited by the Commission on Dental
27 Accreditation.

28 **Licensure by Credentials**

29
30 States should have provisions for licensure of dentists who demonstrate they are
31 currently licensed in good standing and also have not been the subject of final or
32 pending disciplinary action in any state or jurisdiction in which they have been licensed.
33 This should also apply to experienced, internationally-trained dentists, who have been
34 licensed in a U.S. jurisdiction, and who may or may not have graduated from a CODA-
35 accredited dental school.

36
37 Appropriate credentials may include:

- 38 • DDS or DMD degree from a dental education program accredited by the
39 Commission on Dental Accreditation
- 40 • Specialty certificate/master's degree from accredited program
- 41 • Specialty Board certification
- 42 • GPR/AEGD certificate from accredited program
- 43 • Current license in good standing
- 44 • Passing grade on an initial clinical licensure exam, unless initial license was granted
45 via completion of PGY1, Portfolio examination, or other state-approved pathway for
46 assessment of clinical competency.
- 47 • Documentation of completion of continuing education

For dentists who hold a current dental license in good standing in any jurisdiction, state dental boards should:

- Accept pathways that allow for licensure without completing an additional clinical examination, e.g., by credentials, reciprocity, and/or endorsement.
- Consider participation in licensure compacts
- Implement specialty licensure by credentials and/or specialty licensure to facilitate licensure portability of dental specialists.
- Make provisions available for a limited or volunteer license for dentists who wish to provide services without compensation to critical needs populations within a state in which they are not already licensed.
- Make provisions available for limited teaching permits for faculty members at teaching facilities and dental programs accredited by the Commission on Dental Accreditation.

Licensure by Credentials for Dentists Who Are Not Graduates of CODA-Accredited Dental Education Programs

State dental societies and dental boards are strongly encouraged to grant the same benefits of licensure mobility to U.S. currently-licensed dentists who were licensed by their respective jurisdictions prior to state implementation of the requirement for graduation from a CODA-accredited dental school with a DDS or DMD degree.

And be it further,

Resolved, that the following ADA policy statements on Dental Licensure be rescinded:

Policy on One Standard of Competency (*Trans.*2003:369; 2012:463)
Acceptance of Results of Regional Boards (*Trans.*1992:630; 2001:468; 2012:468)
Position Statement on Federal Intervention in Licensure (*Trans.*1975:187, 718; 2012:468)
Dental Practice by Unqualified Persons (*Trans.*1959:207)
Eliminating Use of Patients in Board Examinations (*Trans.*2005:336; 2013:351)
Policy on Dental Licensure (*Trans.*1998:720; 2003:341)
Guidelines for Licensure (*Trans.*1976:919; 1977:923; 1989:529; 1992:632; 1999:938; 2000:401; 2003:340; 2012:464)
Monitoring Clinical Dental Licensure Examinations (*Trans.*2005:333; 2012:462)
Definition of Curriculum Integrated Format (*Trans.*2007:389)
Clinical Licensure Examinations in Dental Schools (*Trans.*2003:368; 2012:462)
Policy on Licensure of Graduates of Nonaccredited Dental Programs (*Trans.*1984:539; 2012:477)
Endorsement of Recommendations of the ADA Guidelines for Licensure by Credentials (*Trans.*1992:628; 2009:447; 2012:464)

BOARD RECOMMENDATION: Vote Yes.

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

Resolution No. 26S-1

Report: NA Date Submitted: October 2018

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

How does this resolution increase member value: See Background

COMPREHENSIVE POLICY ON DENTAL LICENSURE

The following amendment to Resolution 26 (Worksheet:4047) was adopted by the Second Trustee District and transmitted on October 11, 2018, by Dr. Mark J. Feldman, executive director, New York State Dental Association.

Background: New York is a PGY1 state and we do not recognize any clinical examination. The Curriculum Integrated Format exam (CIF) is one we support for those students who need to take a clinical exam for licensure elsewhere as it satisfies the ethical considerations of patient testing. In addition, we support freedom of movement and accept licensure by credentials from all states following two years of licensure. We appreciate CDEL's attempt to place all policies on licensure in one document but feel it needs amending to accurately reflect current ADA policy on patient testing and freedom of movement.

Line 32 (Worksheet:4048) lists a clinical examination as an acceptable determination of clinical competency without specifying if it uses patients or not. Current ADA policy only recommends the use of patients if the CIF is used. Then (Worksheet:4049), lines 2-4, specifies that the CIF exam should only be used until a non-patient based examination is available. This creates two problems: First, this implies that once a non-patient exam is available the CIF should not be used but a clinical exam (that could involve patients) is still listed as an acceptable determination of clinical competence on (Worksheet:4048). Second, freedom of movement is not served well until the non-patient based exam is at least accepted by a majority of states as currently exists with the CIF exam given by at least one testing agency.

We believe that the document would be clearer and more reflective of ADA policy, if the statement about the CIF exam were moved forward to apply to all clinical exams and we add in that the format should not be abandoned until a non-patient exam is widely accepted to conform to the principle of freedom of movement.

Resolution

26S-1. Resolved, that the Comprehensive Policy on Dental Licensure be adopted (additions underscored; deletions stricken):

General Principles

- One standard of competency for dental licensure must be in place in order to provide quality oral health care to the public.
- Provisions for freedom of movement across state lines for all dental professionals should exist to facilitate the provision of quality oral health care to the public.
- Federal licensure and federal intervention in the state dental licensure system are strongly opposed.
- Efforts of unlicensed and unqualified persons to gain a right to serve the public directly in the field of dental practice are strongly opposed.
- Elimination of patients in the clinical licensure examination process is strongly supported to address ethical concerns, including those identified in the ADA Council on Ethics, Bylaws and Judicial Affairs statement entitled Ethical Considerations When Using Patients in the Examination Process (*Reports* 2008:103). State dental societies and dental boards are urged to work toward acceptance of valid and reliable clinical assessments that do not require single-encounter performance of procedures on patients.
- The state boards of dentistry in each state or licensure jurisdiction are the sole licensure and regulating authorities for all dentists and allied dental personnel.
- State dental boards are encouraged to require verification of completion of continuing dental education as a condition for re-registration of dental licenses.
- Dentists identified as deficient through properly constituted peer review mechanisms should undergo assessment and corrective competency-based education and such provisions should be included in laws, rules and regulations.

Initial Licensure

States are urged to accept the following common core of requirements for initial licensure:

1. Completion of a DDS or DMD degree from a university-based dental education program accredited by the Commission on Dental Accreditation.
2. Successful passage of the National Board Dental Examination, a valid and reliable written cognitive test.
3. A determination of clinical competency for the beginning practitioner, which may include:
 - Acceptance of clinical examination results from any clinical testing agency; If the clinical examination involves the use of patients it should use the curriculum integrated format as defined in this document and only be employed as a licensure examination until a non-patient based licensure examination is

developed that protects the public and meets psychometric standards and is accepted by a majority of States or

- Graduation from CODA-accredited PGY-1 program, that is, a residency program at least one year in length at a CODA-accredited clinically-based postdoctoral general dentistry and/or successful completion of at least one year of a specialty residency program; or
- Completion of a portfolio-type examination (such as employed by the California Dental Board) or similar assessment, that uses the evaluation mechanisms currently applied by the dental schools to assess student competence; or
- An Objective Structured Clinical Examination (OSCE), that is, a valid and reliable non-patient based examination consisting of multiple, standardized stations that require candidates to use their clinical knowledge and skills to successfully complete one or more dental problem-solving tasks.

Curriculum Integrated Format Clinical Examination

A Curriculum Integrated Format (CIF) clinical examination addresses ethical concerns associated with single encounter patient-based examinations currently administered by dental clinical testing agencies. A CIF provides candidates opportunities to successfully complete independent “third-party” clinical assessments on patients of record prior to graduation from a dental education program accredited by the Commission on Dental Accreditation. ~~The curriculum integrated format, as defined below, should only be employed as a licensure examination until a non-patient based licensure examination is developed that protects the public and meets psychometric standards.~~ The Association believes that the following CIF provisions must be required by state boards of dentistry and incorporated by testing agencies for protection of the patient:

- A CIF examination must be performed by candidates on patients of record within an appropriately sequenced treatment plan.
- The competencies assessed by the clinical examining agency must be selected components of current dental education program curricula and reflective of current dental practice.
- All portions of the CIF examination must be available at multiple times within each institution during dental school to ensure that patient care is accomplished within an appropriate treatment plan and to allow candidates to remediate and retake prior to graduation any portions of the examination which they have not successfully completed.

Graduates of Non-CODA Accredited Dental Education Programs

For initial licensure in dentistry, international graduates of non-CODA accredited dental education programs should possess the following educational credentials: 1) completion of a university-based dental education program accredited by the Commission on Dental Accreditation (CODA) leading to a DDS or DMD degree or 2) graduation from a postgraduate program in general dentistry accredited by the Commission on Dental Accreditation.

Licensure by Credentials

States should have provisions for licensure of dentists who demonstrate they are currently licensed in good standing and also have not been the subject of final or pending disciplinary action in any state or jurisdiction in which they have been licensed. This should also apply to experienced, internationally-trained dentists, who have been licensed in a U.S. jurisdiction, and who may or may not have graduated from a CODA-accredited dental school.

Appropriate credentials may include:

- DDS or DMD degree from a dental education program accredited by the Commission on Dental Accreditation
- Specialty certificate/master's degree from accredited program
- Specialty Board certification
- GPR/AEGD certificate from accredited program
- Current license in good standing
- Passing grade on an initial clinical licensure exam, unless initial license was granted via completion of PGY1, Portfolio examination, or other state-approved pathway for assessment of clinical competency.
- Documentation of completion of continuing education

For dentists who hold a current dental license in good standing in any jurisdiction, state dental boards should:

- Accept pathways that allow for licensure without completing an additional clinical examination, e.g., by credentials, reciprocity, and/or endorsement.
- Consider participation in licensure compacts
- Implement specialty licensure by credentials and/or specialty licensure to facilitate licensure portability of dental specialists.
- Make provisions available for a limited or volunteer license for dentists who wish to provide services without compensation to critical needs populations within a state in which they are not already licensed.
- Make provisions available for limited teaching permits for faculty members at teaching facilities and dental programs accredited by the Commission on Dental Accreditation.

Licensure by Credentials for Dentists Who Are Not Graduates of CODA-Accredited Dental Education Programs

State dental societies and dental boards are strongly encouraged to grant the same benefits of licensure mobility to U.S. currently-licensed dentists who were licensed by their respective jurisdictions prior to state implementation of the requirement for graduation from a CODA-accredited dental school with a DDS or DMD degree.

and be if further,

Resolved, that the following ADA policy statements on Dental Licensure be rescinded:

Policy on One Standard of Competency (*Trans.*2003:369; 2012:463)
Acceptance of Results of Regional Boards (*Trans.*1992:630; 2001:468; 2012:468)

1 Position Statement on Federal Intervention in Licensure (*Trans.*1975:187, 718;
2 2012:468)
3 Dental Practice by Unqualified Persons (*Trans.*1959:207)
4 Eliminating Use of Patients in Board Examinations (*Trans.*2005:336; 2013:351)
5 Policy on Dental Licensure (*Trans.*1998:720; 2003:341)
6 Guidelines for Licensure (*Trans.*1976:919; 1977:923; 1989:529; 1992:632; 1999:938;
7 2000:401; 2003:340; 2012:464)
8 Monitoring Clinical Dental Licensure Examinations (*Trans.*2005:333; 2012:462)
9 Definition of Curriculum Integrated Format (*Trans.*2007:389)
10 Clinical Licensure Examinations in Dental Schools (*Trans.*2003:368; 2012:462)
11 Policy on Licensure of Graduates of Nonaccredited Dental Programs (*Trans.*1984:539;
12 2012:477)
13 Endorsement of Recommendations of the ADA Guidelines for Licensure by Credentials
14 (*Trans.*1992:628; 2009:447; 2012:464)

15 **BOARD RECOMMENDATION: Received after the September 2018 Board of Trustees meeting.**

RESCINDED POLICY CROSSWALK ANALYSIS

The policies noted below are recommended for rescission. Important concepts and positions within these policies that should be retained by the Association are reflected in the proposed Comprehensive Policy on Dental Licensure. The retained concepts are shaded below and crosswalked to the relevant section of the proposed Comprehensive Policy on Dental Licensure [noted within brackets].

Policy on One Standard of Competency (Trans.2003:369; 2012:463)

Resolved, that it is the policy of the Association that there is one standard of competency for licensure in order to provide quality oral health care to the public. [Resolution 26, Worksheet: 4047, General Principles, first bullet]

Acceptance of Results of Regional Boards (Trans.1992:630; 2001:468; 2012:468)

Resolved, that the Association supports efforts to create substantial similarities in the administration, content and scoring of the dental and dental hygiene clinical examinations by continuing to encourage state boards of dentistry to accept a common core of requirements [Resolution 26, Worksheet: 4048, Initial Licensure, first paragraph] and guidelines for clinical examinations, so as to increase acceptance of results by state boards of any state or regional examination, and be it further

Resolved, that the ADA encourage constituent societies in those states that participate in regional boards to promote to their state's licensing agency the acceptance, with appropriate review of credentials, of the clinical examination results of each regional board for the purpose of licensure in their state, and thereby facilitate freedom of movement for dental professionals [Resolution 26, Worksheet: 4047, General Principles, second bullet].

Position Statement on Federal Intervention in Licensure (Trans.1975:187, 718; 2012:468)

The American Dental Association has repeatedly recorded its support for the principle of dental licensure at the individual state level and its opposition for placing this important function under federal control. The purpose of this statement is to identify the reasons underlying the Association's position.

A basic premise of the Association's position is that American dentistry has reached a level of quality and availability not matched elsewhere in the world. The system of state licensure has been an important factor in dentistry's development. Therefore, the Association would oppose replacement of the state licensure system. In the opinion of the Association, federal control of dental licensure would not only fail to solve existing problems involving delivery of dental care to the public, but also could be expected to create new problems.

Maldistribution: One of the most widely recognized and most complex problems facing dentistry involves the distribution of dentists throughout the country. Typically, inner city and rural areas have difficulty attracting dentists. Some proponents of abandoning the state licensure system believe that federal licensure would help alleviate the distribution problem. Presumably, federal licensure would eliminate red tape for dentists moving from one state to another. Then, underserved areas might be able to attract dentists from other states.

Although the Association recognizes the maldistribution problem, it does not believe federal licensure to be a potential solution. A review of dentist-population ratios by county and state indicates greater

variance within states than among states. Currently, nothing impedes a dentist licensed in a state from moving to an underserved area in the same state. Since this has not occurred, it is doubtful that dentists from other states would flock to these underserved areas.

Mobility of Dentists: Even though not important as a solution to maldistribution of dentists, the Association is committed to seeking a mechanism that would allow competent practitioners to relocate in a different state with a minimum of inconvenience. This goal is not incompatible with the system of state licensure. Licensing a dentist licensed in another state on the basis of his or her credentials meeting specific professional criteria is one mechanism currently being vigorously pursued. In considering various alternatives, however, the Association has maintained the position that each state should retain sufficient safeguards to ensure that any dentist granted a license in the state is competent to serve the people of the state. Any lesser condition would fail to provide adequate public protection.

Experimentation: The current state-based licensure system is composed of 53 jurisdictions, each attempting to develop the most effective system possible for regulating the practice of dentistry. When new systems or regulations are proposed, initial evaluation must, of necessity, be based on supposition. Because hard evidence about new proposals is seldom available, new proposals usually evoke mixed reactions. Although few new ideas gain majority approval quickly on a national level, many are approved by one or more states. Experience of these states forms a basis for other states to make a higher quality decision about the proposal within a relatively short time. In a sense, a few states provide a controlled experiment for the majority. Examples of this process can be found in acceptance of National Board scores, development of the concept of licensure by credentials, growth of regional clinical testing services and assignment of duties to dental auxiliary personnel.

Influence on the Dental Curriculum: Dental education programs have a responsibility to graduate individuals capable of practicing dentistry. Since meeting licensure requirements is a prerequisite to practice, dental education programs also prepare students to pass licensure examinations. Consequently, the agency that establishes licensure standards can have an influence over dental curriculums. Under the state licensure system this influence is shared among 53 jurisdictions, and thus moderated. With a single federal agency setting standards, the influence of licensure examinations might become excessive and virtually dictate the content and emphasis for all dental curriculums. This centralization would tend to make a static situation that would inhibit evolution and change. Also, the cooperation that has developed among educators, examiners and the practicing profession at the state level has been effective in dealing with the relationship between licensure requirements and the dental curriculum. The same degree of cooperation could not be expected at the federal level.

Enforcement: Licensure involves more than issuing licenses to candidates who qualify. Regulatory agencies also must ensure that licensed dentists maintain competence and practice in accordance with the law. It is in this policing function that federal licensure seems most inadequate. To be most effective, regulatory responsibility should be placed at the lowest level of government capable of performing the functions—in this instance, the state, through its board of dentistry.

Summary: For the reasons cited, the American Dental Association strongly opposes federal licensure and federal intervention in the state licensing system. [Resolution 26, Worksheet: 4047, General Principles, third bullet]

Dental Practice by Unqualified Persons (*Trans.1959:207*)

Resolved, that the efforts of untrained and unqualified persons to gain a limited or unqualified right to serve the public directly in the field of dental practice be opposed [Resolution 26, Worksheet: 4047, General Principles, fourth bullet] as detrimental to the health, safety and welfare of the public.

Eliminating Use of Patients in Board Examinations (*Trans.*2005:336; 2013:351)

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

Resolved, that the Association recognizes that ethical considerations, including those identified in the ADA Council on Ethics, Bylaws and Judicial Affairs statement entitled *Ethical Considerations When Using Patients in the Examination Process* (Reports 2008:103), may arise from the use of patients in the clinical licensure examination process, **[Resolution 26, Worksheet: 4048, General Principles, fifth bullet]** even though the clinical examination process is itself ethical, and be it further

Resolved, that the ADA supports the elimination of patients in the clinical licensure examination process **[Resolution 26, Worksheet: 4048, General Principles, fifth bullet]** with the exception of the curriculum integrated format, as defined by the ADA, within dental schools, and be it further

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

Policy on Dental Licensure (*Trans.*1998:720; 2003:341)

The following policies of the American Dental Association were adopted with the knowledge, understanding and agreement that they are guidelines for each individual state and are to be implemented at the discretion of each constituent society and state board of dental examiners.

The American Dental Association recommends:

1. that the state board of dentistry in each state should be the sole licensing and regulating authority for all dental personnel, including dental specialists; **[Resolution 26, Worksheet: 4048, General Principles, sixth bullet]**
2. that each state continue to require of all candidates for licensure satisfactory performance on the National Board Dental Examinations, Parts I and II; **[Resolution 26, Worksheet: 4048, Initial Licensure section]**
3. that each state accepts satisfactory performance on National Board examinations as a requirement of satisfactory performance on a written examination for licensure; **[Resolution 26, Worksheet: 4048, Initial Licensure section]**
4. that each state continue to require of all candidates for initial licensure satisfactory performance on an individual state or regional clinical examination, or successful completion of a postgraduate program in general dentistry that contains competency assessments or in an ADA recognized dental specialty at least one year in length that is accredited by the ADA Commission on Dental Accreditation; **[Resolution 26, Worksheet: 4048, Initial Licensure section]**
5. that each state consider active participation in regional clinical examinations; **[Resolution 26, Worksheet: 4048, Initial Licensure section]**
6. that each state consider requiring dentists to maintain records to show evidence of continuing education as a condition for re-registration of their licenses; **[Resolution 26, Worksheet: 4048, General Principles, seventh bullet]**
7. that states consider including in their practice acts provisions to require for licensure maintenance, proof of remedial study for those dentists identified through properly constituted peer review mechanisms as being deficient; and **[Resolution 26, Worksheet: 4048, General Principles, eighth bullet]**

8. that state dental associations, state boards of dentistry and dental schools work in close cooperation to provide supplemental education opportunities for those dentists who lack clinical proficiency but are otherwise eligible for a dental license.

Guidelines for Licensure (*Trans.*1976:919; 1977:923; 1989:529; 1992:632; 1999:938; 2000:401; 2003:340; 2012:464)

Dental licensure is intended to ensure that only qualified individuals provide dental treatment to the public. Among qualifications deemed essential are satisfactory theoretical knowledge of basic biomedical and dental sciences and satisfactory clinical skill. It is essential that each candidate for an initial license be required to demonstrate these attributes on examination, a written examination for theoretical knowledge and a clinical examination for clinical skill. The clinical examination requirement may also be met by successful completion of a postgraduate program in general dentistry that contains competency assessments or in an ADA recognized dental specialty, at least one year in length, which is accredited by the Commission on Dental Accreditation. **[Resolution 26, Worksheet: 4048, Initial Licensure section]** These guidelines suggest alternate mechanisms for evaluating the theoretical knowledge and clinical skill of an applicant for licensure who holds a dental license in another jurisdiction. Requiring a candidate who is seeking licensure in several jurisdictions to demonstrate his or her theoretical knowledge and clinical skill on separate examinations for each jurisdiction seems unnecessary duplication.

Licensure by Examination: Written examination programs conducted by the Joint Commission on National Dental Examinations have achieved broad recognition by state boards of dentistry. **[Resolution 26, Worksheet: 4048, Initial Licensure section]** National Board dental examinations are conducted in two parts. Part I covers basic biomedical sciences; Part II covers dental sciences. It is recommended that satisfactory performance on Part II of the National Board dental examinations within five years prior to applying for a state dental license be considered adequate testing of theoretical knowledge. National Board regulations require a candidate to pass Part I before participating in Part II. Consequently, this recommendation excludes Part I only from the time limit.

No clinical examination has achieved as broad recognition as have National Board written examinations. Clinical examinations used for dental licensure are conducted by individual state boards of dentistry and by regional clinical testing services. It is recommended that satisfactory performance within the last five years on any state or regional clinical examination at least equivalent in quality and difficulty to the state's own clinical examination be considered adequate testing for clinical skill **[Resolution 26, Worksheet: 4048, Initial Licensure section]** provided that the candidate for licensure:

- a. is currently licensed in another jurisdiction. **[Resolution 26, Worksheet: 4049, Licensure by Credentials, first paragraph]**
- b. has been in practice since being examined.
- c. is endorsed by the state board of dentistry in the state of his or her current practice.
- d. has not been the subject to final or pending disciplinary action in any state in which he or she is or has been licensed.
- e. has not failed the clinical examination of the state to which he or she is applying within the last three years.

Licensure by Credentials: The American Dental Association believes that an evaluation of a practicing dentist's theoretical knowledge and clinical skill based on his or her performance record can provide as much protection to the public as would an evaluation based on examination. Issuing a license using a performance record in place of examinations is termed licensure by credentials.

All candidates for licensure by credentials are required to fulfill basic education and practice requirements. Further, it is recommended that licensure by credentials be available only to a candidate who:

- a. has graduated from a dental program accredited by the Commission on Dental Accreditation, or has completed a supplementary predoctoral education program of at least two academic years in an accredited dental program and has been certified by the dean of an accredited dental program as having achieved the same level of didactic and clinical competence as expected of a graduate of the school, or has completed an educational experience that is recognized by the respective state dental board as equivalent to the above. **[Resolution 26, Worksheet: 4049, Licensure by Credentials, second paragraph]**
- b. is currently licensed **[Resolution 26, Worksheet: 4049, Licensure by Credentials, first paragraph]** by a licensing jurisdiction in a state, the District of Columbia, the Commonwealth of Puerto Rico or a dependency of the United States.
- c. has been in practice or full-time dental education immediately prior to applying.
- d. is endorsed by the state board of dentistry in the state of current practice.
- e. has not been the subject of final or pending disciplinary action **[Resolution 26, Worksheet: 4049, Licensure by Credentials, first paragraph]** in any state in which he or she is or has been licensed.
- f. has not failed the clinical examination of the state to which he or she is applying within the last three years.

Additional criteria to determine the professional competence of a licensed dentist could include:

- g. Information from the National Practitioner Data Bank and/or the AADB Clearinghouse for Board Actions.
- h. Questioning under oath.
- i. Results of peer review reports from constituent societies and/or federal dental services.
- j. Substance abuse testing/treatment.
- k. Background checks for criminal or fraudulent activities.
- l. Participation in continuing education.
- m. A current certificate in cardiopulmonary resuscitation.
- n. Recent patient case reports and/or oral defense of diagnosis and treatment plans.
- o. No physical or psychological impairment that would adversely affect the ability to deliver quality dental care.
- p. Agreement to initiate practice in the credentialing jurisdiction within a reasonable period of time to ensure that licensure is based on credentials that are current at the time practice is initiated.
- q. Proof of professional liability coverage and that such coverage has not been refused, declined, canceled, nonrenewed or modified.

Alternate ways that current theoretical knowledge might be documented follow. It is recommended that for a candidate who meets eligibility requirements for licensure by credentials, these methods be considered as possible alternatives to the written examination requirement.

1. Successful completion of an accredited advanced dental education program in the last ten years.
2. A total of at least 180 hours of acceptable, formal scientific continuing education in the last ten years, with a maximum credit of 60 hours for each two-year period.
3. Successful completion of a recognized specialty board examination in the last ten years.
4. Teaching experience of at least one day per week or its equivalent in an accredited dental education program for at least six of the last ten years.

Possible documentation for current clinical skill appears in the following list. Provided that eligibility requirements for licensure by credentials are met, it is recommended that these methods be considered as possible alternatives to satisfactory performance on a clinical examination.

1. Successful completion of an accredited advanced education program in general dentistry or general practice residency within the last ten years.
2. Successful completion of an accredited dental specialty education program in a clinical discipline within the last ten years.

3. A total of at least 180 hours of acceptable clinically-oriented continuing education in the last ten years, with a maximum credit of 60 hours for each two-year period.
4. Clinical teaching of at least one day per week or its equivalent in an accredited dental education program, including a hospital-based advanced dental education program, for at least six of the last ten years.
5. Presenting case histories of patients treated by the candidate in the last five years, with preoperative and postoperative radiographs, covering procedures required on the state clinical examination, for discussion with the state board.

Licensure by Credentials for Internationally Trained Dentists: It is ADA policy that internationally trained dentists, who were licensed by their respective jurisdictions prior to implementation of the requirement of a two-year supplementary education program in an accredited dental school, be granted the same benefits of freedom of movement as any other member of the Association. **[Resolution 26, Worksheet: 4050, Licensure by Credentials for Dentists Who are Not Graduates of CODA-Accredited Dental Education Programs, first paragraph]**

Specialty Licensure: The American Dental Association urges constituent dental societies and state dental boards to implement specialty licensure by credentials and/or specialty licensure **[Resolution 26, Worksheet: 4050, Licensure by Credentials, tenth bullet]** as a top priority. The Association urges states to consider the following provisions regarding specialty licensure by credentials:

- a. All specialists should be required to have passed a state dental board approved general dentistry examination and have an entry-level dental license issued by a state or a U.S. territory before being eligible to be credentialed or to take a specialty examination in another state.
- b. Specialists should not be required to pass an additional general dentistry examination when applying for a license to practice the specialty.
- c. Specialists who have passed a specialty licensure examination in another state should be granted licensure by credentials without further clinical examination.
- d. States should be urged to enact provisions by which a dental specialist licensed in another jurisdiction may be issued a license by credentials to allow the specialist who holds diplomate status from an ADA-recognized dental specialty certifying board or who has completed an advanced specialty education program accredited by the Commission on Dental Accreditation to practice the specific specialty.
- e. Specialists who hold diplomate status from an ADA-recognized dental specialty certifying board or who have completed an advanced specialty education program accredited by the Commission on Dental Accreditation and meet all other state requirements for licensure should not be required to take any additional general dentistry examinations.
- f. Specialty licensure examinations and criteria for credentialing should be reviewed annually for reliability and validity and updated regularly to protect the public.

Volunteer Licensure: The ADA supports and encourages volunteerism by members. The *Principles of Ethics and Code of Professional Conduct* require members to recognize the obligation to help those who may not have access to care. A limited or volunteer license by credentials should be available to dentists who wish to provide services to indigent or critical needs populations within a state without compensation. **[Resolution 26, Worksheet: 4050, Licensure by Credentials, eleventh bullet]** Often, the expense of initial licensure, licensure renewal and liability insurance prevent many dentists from volunteering services. The Association urges states to consider the following provisions regarding limited/volunteer licensure for dentists:

1. Allow dentists to provide services to indigent or critical needs populations within a state without compensation.
2. Waive any associated fees for limited or volunteer licenses so long as the dentist continues to provide services without compensation.

3. Grant sovereign immunity for dentists when providing services to indigent or critical needs patients without compensation.
4. Require the same standards for education and training as for initial licensure in that jurisdiction.

Monitoring Clinical Dental Licensure Examinations (Trans.2005:333; 2012:462)

Resolved, that the appropriate agency of the ADA continue to monitor activities of the clinical testing agencies and report annually to the House of Delegates on its findings, and be it further

Resolved, that the ADA supports the use of testing practices in the development, administration and scoring of licensing examinations that produce results which are reliable and with the highest validity possible. **[Resolution 26, Worksheet: 4048, Initial Licensure section]**

Definition of Curriculum Integrated Format (Trans.2007:389)

Resolved, that the American Dental Association adopt the following definition:

Curriculum Integrated Format: An initial clinical licensure process that provides candidates an opportunity to successfully complete an independent “third party” clinical assessment prior to graduation from a dental education program accredited by the ADA Commission on Dental Accreditation.

If such a process includes patient care as part of the assessment, it should be performed by candidates on patients of record, whenever possible, within an appropriately sequenced treatment plan. The competencies assessed by the clinical examining agency should be selected components of current dental education program curricula.

All portions of this assessment are available at multiple times within each institution during dental school to ensure that patient care is accomplished within an appropriate treatment plan and to allow candidates to remediate and retake any portions of the assessment which they have not successfully completed. **[Resolution 26, Worksheets: 4048 and 4049, Curriculum Integrated Format Clinical Examination section]**

Clinical Licensure Examinations in Dental Schools (Trans.2003:368; 2012:462)

Resolved, that the Association encourages all dental licensing agencies to collaborate with dental educators to offer a clinical licensing examination on patients within dental schools using a curriculum integrated format, and be it further

Resolved, that these examinations be given frequently enough within each institution to allow candidates to remediate and retake any portions of the examination that they have not completed successfully.

[Resolution 26, Worksheet: 4049, Curriculum Integrated Format Clinical Examination, third bullet]

Policy on Licensure of Graduates of Nonaccredited Dental Programs (Trans.1984:539; 2012:477)

The United States has a long and proud tradition of affording opportunities to immigrants. The American Dental Association fully supports application of this principle in dentistry, but not at the expense of the standards of dental practice in this country. State licensure is a critical element in preserving that standard of practice and for the protection of citizens of the state.

Although licensing provisions vary among U.S. licensing jurisdictions, all jurisdictions have the same three types of requirements: an educational requirement, a written examination requirement and a clinical examination requirement. The traditional educational requirement is graduation from a pre-doctoral dental education program accredited by the Commission on Dental Accreditation (CODA).

In the absence of accreditation, an educational requirement for dental licensure has limited significance. The Association questions whether written and clinical examinations alone provide sufficient verification of competence to serve the purpose of licensure. Thus, the ADA believes that any graduate of a nonaccredited pre-doctoral dental education program should be required to obtain supplementary education in an accredited pre-doctoral dental education program prior to licensure. **[Resolution 26, Worksheet: 4049, Graduates of Non-CODA Accredited Dental Education Programs, first paragraph]** The amount of additional training needed by graduates of nonaccredited pre-doctoral dental education programs may vary. While some flexibility is needed, the licensure process requires well-defined minimum standards. Recommended minimum educational standards for licensure of a graduate of a nonaccredited pre-doctoral dental education program are:

1. Completion of an accredited supplementary predoctoral education program. **[Resolution 26, Worksheet: 4049, Graduates of Non-CODA Accredited Dental Education Programs, first paragraph]** A supplementary education program of at least two academic years is required.
2. Certification by the dean of the accredited dental school that the candidate has achieved the same level of didactic and clinical competence as expected of a graduate of the program.

Endorsement of Recommendations of the ADA Guidelines for Licensure by Credentials **(Trans.1992:628; 2009:447; 2012:464)**

Resolved, that the ADA actively endorse and urge all dental licensing jurisdictions to utilize the ADA Guidelines for Licensure by Credentials, **[Resolution 26, Worksheet: 4049, Licensure by Credentials section]** and be it further

Resolved, that the ADA Council on Dental Education and Licensure monitor the use of these recommendations by the dental licensing jurisdictions and report annually to the House of Delegates.

WORKSHEET ADDENDUM
POLICIES TO BE RESCINDED

Policy on One Standard of Competency (*Trans.*2003:369; 2012:463)

Resolved, that it is the policy of the Association that there is one standard of competency for licensure in order to provide quality oral health care to the public.

Acceptance of Results of Regional Boards (*Trans.*1992:630; 2001:468; 2012:468)

Resolved, that the Association supports efforts to create substantial similarities in the administration, content and scoring of the dental and dental hygiene clinical examinations by continuing to encourage state boards of dentistry to accept a common core of requirements and guidelines for clinical examinations, so as to increase acceptance of results by state boards of any state or regional examination, and be it further

Resolved, that the ADA encourage constituent societies in those states that participate in regional boards to promote to their state's licensing agency the acceptance, with appropriate review of credentials, of the clinical examination results of each regional board for the purpose of licensure in their state, and thereby facilitate freedom of movement for dental professionals.

Position Statement on Federal Intervention in Licensure (*Trans.*1975:187, 718; 2012:468)

The American Dental Association has repeatedly recorded its support for the principle of dental licensure at the individual state level and its opposition for placing this important function under federal control. The purpose of this statement is to identify the reasons underlying the Association's position.

A basic premise of the Association's position is that American dentistry has reached a level of quality and availability not matched elsewhere in the world. The system of state licensure has been an important factor in dentistry's development. Therefore, the Association would oppose replacement of the state licensure system. In the opinion of the Association, federal control of dental licensure would not only fail to solve existing problems involving delivery of dental care to the public, but also could be expected to create new problems.

Maldistribution: One of the most widely recognized and most complex problems facing dentistry involves the distribution of dentists throughout the country. Typically, inner city and rural areas have difficulty attracting dentists. Some proponents of abandoning the state licensure system believe that federal licensure would help alleviate the distribution problem. Presumably, federal licensure would eliminate red tape for dentists moving from one state to another. Then, underserved areas might be able to attract dentists from other states.

Although the Association recognizes the maldistribution problem, it does not believe federal licensure to be a potential solution. A review of dentist-population ratios by county and state indicates greater variance within states than among states. Currently, nothing impedes a dentist licensed in a state from moving to an underserved area in the same state. Since this has not occurred, it is doubtful that dentists from other states would flock to these underserved areas.

Mobility of Dentists: Even though not important as a solution to maldistribution of dentists, the Association is committed to seeking a mechanism that would allow competent practitioners to relocate in a different state with a minimum of inconvenience. This goal is not incompatible with the system of state licensure. Licensing a dentist licensed in another state on the basis of his or her credentials meeting specific professional criteria is one mechanism currently being vigorously pursued. In considering various alternatives, however, the Association has maintained the position that each state should retain sufficient

safeguards to ensure that any dentist granted a license in the state is competent to serve the people of the state. Any lesser condition would fail to provide adequate public protection.

Experimentation: The current state-based licensure system is composed of 53 jurisdictions, each attempting to develop the most effective system possible for regulating the practice of dentistry. When new systems or regulations are proposed, initial evaluation must, of necessity, be based on supposition. Because hard evidence about new proposals is seldom available, new proposals usually evoke mixed reactions. Although few new ideas gain majority approval quickly on a national level, many are approved by one or more states. Experience of these states forms a basis for other states to make a higher quality decision about the proposal within a relatively short time. In a sense, a few states provide a controlled experiment for the majority. Examples of this process can be found in acceptance of National Board scores, development of the concept of licensure by credentials, growth of regional clinical testing services and assignment of duties to dental auxiliary personnel.

Influence on the Dental Curriculum: Dental education programs have a responsibility to graduate individuals capable of practicing dentistry. Since meeting licensure requirements is a prerequisite to practice, dental education programs also prepare students to pass licensure examinations. Consequently, the agency that establishes licensure standards can have an influence over dental curriculums. Under the state licensure system this influence is shared among 53 jurisdictions, and thus moderated. With a single federal agency setting standards, the influence of licensure examinations might become excessive and virtually dictate the content and emphasis for all dental curriculums. This centralization would tend to make a static situation that would inhibit evolution and change. Also, the cooperation that has developed among educators, examiners and the practicing profession at the state level has been effective in dealing with the relationship between licensure requirements and the dental curriculum. The same degree of cooperation could not be expected at the federal level.

Enforcement: Licensure involves more than issuing licenses to candidates who qualify. Regulatory agencies also must ensure that licensed dentists maintain competence and practice in accordance with the law. It is in this policing function that federal licensure seems most inadequate. To be most effective, regulatory responsibility should be placed at the lowest level of government capable of performing the functions—in this instance, the state, through its board of dentistry.

Summary: For the reasons cited, the American Dental Association strongly opposes federal licensure and federal intervention in the state licensing system.

Dental Practice by Unqualified Persons (*Trans.1959:207*)

Resolved, that the efforts of untrained and unqualified persons to gain a limited or unqualified right to serve the public directly in the field of dental practice be opposed as detrimental to the health, safety and welfare of the public.

Eliminating Use of Patients in Board Examinations (*Trans.2005:336; 2013:351*)

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

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

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

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

Policy on Dental Licensure (*Trans.*1998:720; 2003:341)

The following policies of the American Dental Association were adopted with the knowledge, understanding and agreement that they are guidelines for each individual state and are to be implemented at the discretion of each constituent society and state board of dental examiners.

The American Dental Association recommends:

1. that the state board of dentistry in each state should be the sole licensing and regulating authority for all dental personnel, including dental specialists;
2. that each state continue to require of all candidates for licensure satisfactory performance on the National Board Dental Examinations, Parts I and II;
3. that each state accepts satisfactory performance on National Board examinations as a requirement of satisfactory performance on a written examination for licensure;
4. that each state continue to require of all candidates for initial licensure satisfactory performance on an individual state or regional clinical examination, or successful completion of a postgraduate program in general dentistry that contains competency assessments or in an ADA recognized dental specialty at least one year in length that is accredited by the ADA Commission on Dental Accreditation;
5. that each state consider active participation in regional clinical examinations;
6. that each state consider requiring dentists to maintain records to show evidence of continuing education as a condition for re-registration of their licenses;
7. that states consider including in their practice acts provisions to require for licensure maintenance, proof of remedial study for those dentists identified through properly constituted peer review mechanisms as being deficient; and
8. that state dental associations, state boards of dentistry and dental schools work in close cooperation to provide supplemental education opportunities for those dentists who lack clinical proficiency but are otherwise eligible for a dental license.

Guidelines for Licensure (*Trans.*1976:919; 1977:923; 1989:529; 1992:632; 1999:938; 2000:401; 2003:340; 2012:464)

Dental licensure is intended to ensure that only qualified individuals provide dental treatment to the public. Among qualifications deemed essential are satisfactory theoretical knowledge of basic biomedical and dental sciences and satisfactory clinical skill. It is essential that each candidate for an initial license be required to demonstrate these attributes on examination, a written examination for theoretical knowledge and a clinical examination for clinical skill. The clinical examination requirement may also be met by successful completion of a postgraduate program in general dentistry that contains competency assessments or in an ADA recognized dental specialty, at least one year in length, which is accredited by the Commission on Dental Accreditation. These guidelines suggest alternate mechanisms for evaluating the theoretical knowledge and clinical skill of an applicant for licensure who holds a dental license in another jurisdiction. Requiring a candidate who is seeking licensure in several jurisdictions to demonstrate his or her theoretical knowledge and clinical skill on separate examinations for each jurisdiction seems unnecessary duplication.

Licensure by Examination: Written examination programs conducted by the Joint Commission on National Dental Examinations have achieved broad recognition by state boards of dentistry. National Board dental examinations are conducted in two parts. Part I covers basic biomedical sciences; Part II covers dental sciences. It is recommended that satisfactory performance on Part II of the National Board dental examinations within five years prior to applying for a state dental license be considered adequate testing of theoretical knowledge. National Board regulations require a candidate to pass Part I before participating in Part II. Consequently, this recommendation excludes Part I only from the time limit.

No clinical examination has achieved as broad recognition as have National Board written examinations. Clinical examinations used for dental licensure are conducted by individual state boards of dentistry and by regional clinical testing services. It is recommended that satisfactory performance within the last five years on any state or regional clinical examination at least equivalent in quality and difficulty to the state's own clinical examination be considered adequate testing for clinical skill provided that the candidate for licensure:

- a. is currently licensed in another jurisdiction.
- b. has been in practice since being examined.
- c. is endorsed by the state board of dentistry in the state of his or her current practice.
- d. has not been the subject to final or pending disciplinary action in any state in which he or she is or has been licensed.
- e. has not failed the clinical examination of the state to which he or she is applying within the last three years.

Licensure by Credentials: The American Dental Association believes that an evaluation of a practicing dentist's theoretical knowledge and clinical skill based on his or her performance record can provide as much protection to the public as would an evaluation based on examination. Issuing a license using a performance record in place of examinations is termed licensure by credentials.

All candidates for licensure by credentials are required to fulfill basic education and practice requirements. Further, it is recommended that licensure by credentials be available only to a candidate who:

- a. has graduated from a dental program accredited by the Commission on Dental Accreditation, or has completed a supplementary predoctoral education program of at least two academic years in an accredited dental program and has been certified by the dean of an accredited dental program as having achieved the same level of didactic and clinical competence as expected of a graduate of the school, or has completed an educational experience that is recognized by the respective state dental board as equivalent to the above.
- b. is currently licensed by a licensing jurisdiction in a state, the District of Columbia, the Commonwealth of Puerto Rico or a dependency of the United States.
- c. has been in practice or full-time dental education immediately prior to applying.
- d. is endorsed by the state board of dentistry in the state of current practice.
- e. has not been the subject of final or pending disciplinary action in any state in which he or she is or has been licensed.
- f. has not failed the clinical examination of the state to which he or she is applying within the last three years.

Additional criteria to determine the professional competence of a licensed dentist could include:

- g. Information from the National Practitioner Data Bank and/or the AADB Clearinghouse for Board Actions.
- h. Questioning under oath.
- i. Results of peer review reports from constituent societies and/or federal dental services.
- j. Substance abuse testing/treatment.
- k. Background checks for criminal or fraudulent activities.
- l. Participation in continuing education.
- m. A current certificate in cardiopulmonary resuscitation.
- n. Recent patient case reports and/or oral defense of diagnosis and treatment plans.
- o. No physical or psychological impairment that would adversely affect the ability to deliver quality dental care.
- p. Agreement to initiate practice in the credentialing jurisdiction within a reasonable period of time to ensure that licensure is based on credentials that are current at the time practice is initiated.
- q. Proof of professional liability coverage and that such coverage has not been refused, declined, canceled, nonrenewed or modified.

1 Alternate ways that current theoretical knowledge might be documented follow. It is recommended that for
2 a candidate who meets eligibility requirements for licensure by credentials, these methods be considered
3 as possible alternatives to the written examination requirement.

- 4 1. Successful completion of an accredited advanced dental education program in the last ten years.
- 5 2. A total of at least 180 hours of acceptable, formal scientific continuing education in the last ten years,
6 with a maximum credit of 60 hours for each two-year period.
- 7 3. Successful completion of a recognized specialty board examination in the last ten years.
- 8 4. Teaching experience of at least one day per week or its equivalent in an accredited dental education
9 program for at least six of the last ten years.

10 Possible documentation for current clinical skill appears in the following list. Provided that eligibility
11 requirements for licensure by credentials are met, it is recommended that these methods be considered
12 as possible alternatives to satisfactory performance on a clinical examination.

- 13 1. Successful completion of an accredited advanced education program in general dentistry or general
14 practice residency within the last ten years.
- 15 2. Successful completion of an accredited dental specialty education program in a clinical discipline
16 within the last ten years.
- 17 3. A total of at least 180 hours of acceptable clinically-oriented continuing education in the last ten
18 years, with a maximum credit of 60 hours for each two-year period.
- 19 4. Clinical teaching of at least one day per week or its equivalent in an accredited dental education
20 program, including a hospital-based advanced dental education program, for at least six of the last
21 ten years.
- 22 5. Presenting case histories of patients treated by the candidate in the last five years, with preoperative
23 and postoperative radiographs, covering procedures required on the state clinical examination, for
24 discussion with the state board.

25
26 **Licensure by Credentials for Internationally Trained Dentists:** It is ADA policy that internationally
27 trained dentists, who were licensed by their respective jurisdictions prior to implementation of the
28 requirement of a two-year supplementary education program in an accredited dental school, be granted
29 the same benefits of freedom of movement as any other member of the Association.

30
31 **Specialty Licensure:** The American Dental Association urges constituent dental societies and state
32 dental boards to implement specialty licensure by credentials and/or specialty licensure as a top priority.
33 The Association urges states to consider the following provisions regarding specialty licensure by
34 credentials:

- 35 a. All specialists should be required to have passed a state dental board approved general dentistry
36 examination and have an entry-level dental license issued by a state or a U.S. territory before being
37 eligible to be credentialed or to take a specialty examination in another state.
- 38 b. Specialists should not be required to pass an additional general dentistry examination when applying
39 for a license to practice the specialty.
- 40 c. Specialists who have passed a specialty licensure examination in another state should be granted
41 licensure by credentials without further clinical examination.
- 42 d. States should be urged to enact provisions by which a dental specialist licensed in another jurisdiction
43 may be issued a license by credentials to allow the specialist who holds diplomate status from an
44 ADA-recognized dental specialty certifying board or who has completed an advanced specialty
45 education program accredited by the Commission on Dental Accreditation to practice the specific
46 specialty.
- 47 e. Specialists who hold diplomate status from an ADA-recognized dental specialty certifying board or
48 who have completed an advanced specialty education program accredited by the Commission on
49 Dental Accreditation and meet all other state requirements for licensure should not be required to
50 take any additional general dentistry examinations.
- 51 f. Specialty licensure examinations and criteria for credentialing should be reviewed annually for
52 reliability and validity and updated regularly to protect the public.

Volunteer Licensure: The ADA supports and encourages volunteerism by members. The *Principles of Ethics and Code of Professional Conduct* require members to recognize the obligation to help those who may not have access to care. A limited or volunteer license by credentials should be available to dentists who wish to provide services to indigent or critical needs populations within a state without compensation. Often, the expense of initial licensure, licensure renewal and liability insurance prevent many dentists from volunteering services. The Association urges states to consider the following provisions regarding limited/volunteer licensure for dentists:

1. Allow dentists to provide services to indigent or critical needs populations within a state without compensation.
2. Waive any associated fees for limited or volunteer licenses so long as the dentist continues to provide services without compensation.
3. Grant sovereign immunity for dentists when providing services to indigent or critical needs patients without compensation.
4. Require the same standards for education and training as for initial licensure in that jurisdiction.

Monitoring Clinical Dental Licensure Examinations (Trans.2005:333; 2012:462)

Resolved, that the appropriate agency of the ADA continue to monitor activities of the clinical testing agencies and report annually to the House of Delegates on its findings, and be it further

Resolved, that the ADA supports the use of testing practices in the development, administration and scoring of licensing examinations that produce results which are reliable and with the highest validity possible.

Definition of Curriculum Integrated Format (Trans.2007:389)

Resolved, that the American Dental Association adopt the following definition:

Curriculum Integrated Format: An initial clinical licensure process that provides candidates an opportunity to successfully complete an independent "third party" clinical assessment prior to graduation from a dental education program accredited by the ADA Commission on Dental Accreditation.

If such a process includes patient care as part of the assessment, it should be performed by candidates on patients of record, whenever possible, within an appropriately sequenced treatment plan. The competencies assessed by the clinical examining agency should be selected components of current dental education program curricula.

All portions of this assessment are available at multiple times within each institution during dental school to ensure that patient care is accomplished within an appropriate treatment plan and to allow candidates to remediate and retake any portions of the assessment which they have not successfully completed.

Clinical Licensure Examinations in Dental Schools (Trans.2003:368; 2012:462)

Resolved, that the Association encourages all dental licensing agencies to collaborate with dental educators to offer a clinical licensing examination on patients within dental schools using a curriculum integrated format, and be it further

Resolved, that these examinations be given frequently enough within each institution to allow candidates to remediate and retake any portions of the examination that they have not completed successfully.

Policy on Licensure of Graduates of Nonaccredited Dental Programs (*Trans.*1984:539; 2012:477)

The United States has a long and proud tradition of affording opportunities to immigrants. The American Dental Association fully supports application of this principle in dentistry, but not at the expense of the standards of dental practice in this country. State licensure is a critical element in preserving that standard of practice and for the protection of citizens of the state.

Although licensing provisions vary among U.S. licensing jurisdictions, all jurisdictions have the same three types of requirements: an educational requirement, a written examination requirement and a clinical examination requirement. The traditional educational requirement is graduation from a pre-doctoral dental education program accredited by the Commission on Dental Accreditation (CODA).

In the absence of accreditation, an educational requirement for dental licensure has limited significance. The Association questions whether written and clinical examinations alone provide sufficient verification of competence to serve the purpose of licensure. Thus, the ADA believes that any graduate of a nonaccredited pre-doctoral dental education program should be required to obtain supplementary education in an accredited pre-doctoral dental education program prior to licensure. The amount of additional training needed by graduates of nonaccredited pre-doctoral dental education programs may vary. While some flexibility is needed, the licensure process requires well-defined minimum standards. Recommended minimum educational standards for licensure of a graduate of a nonaccredited pre-doctoral dental education program are:

1. Completion of an accredited supplementary predoctoral education program. A supplementary education program of at least two academic years is required.
2. Certification by the dean of the accredited dental school that the candidate has achieved the same level of didactic and clinical competence as expected of a graduate of the program.

Endorsement of Recommendations of the ADA Guidelines for Licensure by Credentials (*Trans.*1992:628; 2009:447; 2012:464)

Resolved, that the ADA actively endorse and urge all dental licensing jurisdictions to utilize the ADA Guidelines for Licensure by Credentials

Resolved, that the ADA Council on Dental Education and Licensure monitor the use of these recommendations by the dental licensing jurisdictions and report annually to the House of Delegates.

Resolution No. 14 New

Report: NA Date Submitted: September 2018

Submitted By: Board of Trustees

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: Organizational Capacity-Obj. 6: Role and responsibility of the tripartite clearly defined and agreed upon

How does this resolution increase member value: Not Applicable

PROPOSED CHANGES TO THE GOVERNANCE MANUAL WITH RESPECT TO APPOINTMENT OF AD INTERIM CHAIRS OF COMMISSIONS

Background: The Board of Trustees and the Commission on Dental Accreditation (CODA) created an ADA/CODA Relationship Workgroup¹ to further consider the governance and financial relationship of CODA to the ADA. The Workgroup has met annually since 2014. The Workgroup was established to maintain an open line of communication between the American Dental Association and Commission on Dental Accreditation and, in doing so, to improve the relationship regarding finances and governance, and educate each organization in the process.

Related to the governance oversight, the Workgroup has been engaged in discussions for the past four years regarding the recognition criteria of the United States Department of Education that require “Clear and effective controls against conflict of interest, or the appearance of conflict of interest...” [USDE Criteria §602.15(a)(6)]. In particular, the Workgroup has been evaluating provisions within the ADA governance documents that may increase the risk for a formal complaint by a community of interest to the USDE in the area of conflict of interest.

Proposal: Based on input from the Workgroup, the Board of Trustees believes that the provision in the *Governance and Organizational Manual* of the American Dental Association (*ADA Governance Manual*) requiring the Board to appoint an *ad interim* chair in the event of a vacancy in the chair of any commission should be changed to allow each commission to select its own *ad interim* chair, just as it may select its own chair. Accordingly, the Board proposes for the House’s consideration the following resolution.

Resolution

14. Resolved, that CHAPTER IX. COMMISSIONS, Section G. Vacancy, of the *Governance and Organizational Manual* of the American Dental Association be amended as indicated (additions are underlined; deletions are ~~stricken~~):

¹ Members of the 2017-2018 Workgroup include: Dr. Robert Bitter (8th district trustee, Co-Chair), Dr. William Leffler (CODA, Co-Chair), Dr. Raymond Cohlma (12th district trustee), Dr. Loren Feldner (CODA), Dr. Steven Friedrichsen (CODA), Dr. Chad Gehani (2nd district trustee), Dr. Jeffery Hicks (CODA), Dr. Billie Sue Kyger (7th district trustee), and Dr. Roy Thompson (6th district trustee).

1 CHAPTER IX. COMMISSIONS

2
3 ****4 D. Chairs. Commissions shall elect their own chairs. To be eligible to serve as chair of a
5 commission, the commission member must be an active, life or retired member of this
6 Association.
7

8 ****

9 G. Vacancy: In the event of a vacancy in the office of a member of a commission, the
10 following procedure shall be followed:
11

- 12 1. In the event the member of a commission whose office is vacant is or was a
-
- 13 member of and as appointed or elected by this Association, the President of
-
- 14 this Association shall appoint a member of this Association to fill that
-
- 15 vacancy. The appointed member shall possess the same qualifications as
-
- 16 established in this Governance Manual for the previous member, and the
-
- 17 appointed member shall fill the vacancy until a successor is elected by the
-
- 18 next House of Delegates of this Association for the remainder of the
-
- 19 unexpired term.
-
- 20 2. In the event the member of a commission whose office is vacant was
-
- 21 selected by an organization other than this Association, such other
-
- 22 organization shall appoint a successor. The appointed member shall
-
- 23 possess the same qualifications as those possessed by the previous
-
- 24 member of the commission.
-
- 25 3. In the event such vacancy involves the chair of a commission,
- the
-
- 26
- commission shall select an *ad interim* chair according to its rules, provided
-
- 27
- that the eligibility requirements for chair found in Section D of this chapter
-
- 28
- shall be satisfied. ~~the President of this Association shall have the power to~~
-
- 29
- ~~appoint an ad interim chair, except as otherwise provided in the Bylaws or~~
-
- 30
- ~~this Governance Manual.~~
-
- 31 4. If the term of the vacated office of a member of a commission has less than
-
- 32 fifty percent (50%) of a full four-year term remaining at the time the
-
- 33 successor member is appointed or elected to fill the vacancy, the successor
-
- 34 member shall be eligible for election to a new four-year term. If fifty percent
-
- 35 (50%) or more of the vacated term remains to be served at the time of the
-
- 36 appointment or election of a successor member to fill the vacancy, the
-
- 37 successor member shall not be eligible for another term.

38 **BOARD RECOMMENDATION: Vote Yes.**39 **BOARD VOTE: UNANIMOUS.**

Resolution No. 14S-1 Amendment

Report: NA Date Submitted: October 2018

Submitted By: Eleventh 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: Organizational Capacity-Obj. 6: Role and responsibility of the tripartite clearly defined and agreed upon

How does this resolution increase member value: Not Applicable

**AMENDMENT TO RESOLUTION 14: PROPOSED CHANGES TO THE GOVERNANCE MANUAL
WITH RESPECT TO APPOINTMENT OF AD INTERIM CHAIRS OF COMMISSIONS**

The following amendment to Resolution 14 (Worksheet:4066) was adopted by the Eleventh Trustee District and transmitted on October 4, 2018, by Dr. **Brian Bryan** Edgar, past president, Washington State Dental Association.

Background: The Eleventh Trustee District appreciates the efforts of the ADA/CODA Relationship Workgroup and the Board of Trustees in considering proposed changes to improve the arms-length relationship between the ADA and commissions and is sensitive to the risk of a formal complaint against the ADA in the area of potential conflicts of interest. With regards to selecting an *ad interim* chair with the former method of appointment by the ADA Board, the approach of the original resolution may be in conflict with the legal definition of *ad interim* as this resolution is intended.

By definition an officer *ad interim* is a person appointed (emphasis added) to fill a position that is temporarily open or to perform the functions of a particular position during the absence or temporary incapacity of the individual who regularly fulfills these duties (Source: West's Encyclopedia of American Law, edition 2).

To resolve this conflict, the Eleventh District proposes that a different method be used which still preserves the autonomy of the commissions selecting their own chairs without conflict of interest as is the intent of the original resolution. We propose that each commission in this situation with a vacancy in chair position automatically select the already elected vice chair, if that member is willing to accept the nomination to the chair position. As this alternate approach was developed, it became apparent that it offers advantages over the approach in the original resolution. First, the time lag of the Commission(s) to select a new chair will be eliminated. The duties of chair of a commission requires daily performance of tasks for the commission that will be disrupted the least. Secondly, the commission in selecting a new vice chair will not be rushed to make this selection. Lastly the vice chair already meets the qualifications of Section D of CHAPTER IX. COMMISSIONS of the *Bylaws* as prescribed in the original resolution.

Resolution

14S-1. Resolved, that CHAPTER IX. COMMISSIONS, Section G. Vacancy, of the Governance and Organizational Manual of the American Dental Association be amended as indicated (additions underlined; deletions ~~stricken~~):

CHAPTER IX. COMMISSIONS

D. Chairs. Commissions shall elect their own chairs. To be eligible to serve as chair of a commission, the commission member must be an active, life or retired member of this Association.

G. Vacancy: In the event of a vacancy in the office of a member of a commission, the following procedure shall be followed:

1. In the event the member of a commission whose office is vacant is or was a member of and as appointed or elected by this Association, the President of this Association shall appoint a member of Association to fill that vacancy. The appointed member shall possess the same qualifications as established in this Governance Manual for the previous member, and the appointed member shall fill the vacancy until a successor is elected by the next House of Delegates of this Association for the remainder of the unexpired term.

2. In the event the member of a commission whose office is vacant was selected by an organization other than this Association, such other organization shall appoint a successor. The appointed member shall possess the same qualifications as those possessed by the previous member of the commission.

3. In the event such vacancy involves the chair of a commission, the commission shall select the previously elected vice-chair as chair. ~~the President of this Association shall have the power to appoint an ad interim chair, except as otherwise provided in the Bylaws or this Governance Manual. The commission shall then select a new vice chair.~~

4. If the term of the vacated office of a member of a commission has less than fifty percent (50%) of a full four-year term remaining at the time the successor member is appointed or elected to fill the vacancy, the successor member shall be eligible for election to a new four-year term. If fifty percent (50%) or more of the vacated term remains to be served at the time of the appointment or election of a successor member to fill the vacancy, the successor member shall not be eligible for another term.

BOARD RECOMMENDATION: Received too late for Board comment.

Resolution No. 16 New

Report: NA Date Submitted: September 2018

Submitted By: Board of Trustees

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: Organizational Capacity-Obj. 6: Role and responsibility of the tripartite clearly defined and agreed upon

How does this resolution increase member value: Not Applicable

CODA AUTHORITY TO ADOPT RULES REGARDING THE CONDUCT OF ITS MEETINGS

Background: The Board of Trustees and the Commission on Dental Accreditation (CODA) created an ADA/CODA Relationship Workgroup¹ to further consider the governance and financial relationship of CODA to the ADA. The Workgroup has met annually since 2014. The Workgroup was established to maintain an open line of communication between the American Dental Association and Commission on Dental Accreditation and, in doing so, to improve the relationship regarding finances and governance, and educate each organization in the process.

Related to the governance oversight, the Workgroup has been engaged in discussions for the past four years regarding the recognition criteria of the United States Department of Education that require "Clear and effective controls against conflict of interest, or the appearance of conflict of interest..." [USDE Criteria §602.15(a)(6)]. In particular, the Workgroup has been evaluating provisions within the ADA governance documents that may increase the risk for a formal complaint by a community of interest to the USDE in the area of conflict of interest.

Proposal: This report relates solely to a procedural matter which the Board believes should be addressed to help CODA operate in an efficient manner, to avoid unnecessary ADA oversight. The proposed changes are all to the *Governance and Organizational Manual* of the American Dental Association (*ADA Governance Manual*).

Specifically, the Board asks the House to consider changes to grant CODA authority to establish its own rules regarding the conduct of its meetings, including rules relating to quorum. In order to make clear that Department of Education criteria relating to accreditation of CODA are satisfied, the Board proposes amending the *ADA Governance Manual* to allow CODA to conduct its meetings pursuant to rules created by itself.

¹ Members of the 2017-2018 Workgroup include: Dr. Robert Bitter (8th district trustee, Co-Chair), Dr. William Leffler (CODA, Co-Chair), Dr. Raymond Cohlma (12th district trustee), Dr. Loren Feldner (CODA), Dr. Steven Friedrichsen (CODA), Dr. Chad Gehani (2nd district trustee), Dr. Jeffery Hicks (CODA), Dr. Billie Sue Kyger (7th district trustee), and Dr. Roy Thompson (6th district trustee).

Resolution

16. Resolved, that Chapter IX. COMMISSIONS, Section H. Meetings of Commissions, of the *Governance and Organizational Manual* of the American Dental Association be amended as indicated (additions are underlined; deletions are ~~stricken~~):

H. Meetings of Commissions. ~~Each commission~~ The Joint Commission on National Dental Examinations, the Commission on Continuing Education Provider Recognition, and the National Commission on Recognition of Dental Specialties and Certifying Boards shall hold at least one regular meeting annually, provided that funds are available in the budget for that purpose and unless otherwise directed by the Board of Trustees. Meetings may be held at the Headquarters Building, the Washington Office or from multiple remote locations through the use of a conference telephone or other communications equipment by means of which all members can communicate with each other. Such meetings shall be conducted in accordance with rules and procedures established by the Board of Trustees. The Commission on Dental Accreditation shall conduct meetings in accordance with rules and procedures pursuant to the Rules of the Commission on Dental Accreditation.

and be it further

Resolved, that Chapter IX.COMMISSIONS, Section I.QUORUM, of the *Governance and Organizational Manual* of the American Dental Association, be amended as indicated (additions are underscored; deletions are ~~stricken~~):

I. Quorum. A majority of the members of the Joint Commission on National Dental Examinations, the Commission on Continuing Education Provider Recognition, and the National Commission on Recognition of Dental Specialties and Certifying Boards ~~any commission~~ shall constitute a quorum. Quorum requirements for the Commission on Dental Accreditation shall be as stated in the Rules of the Commission on Dental Accreditation.

BOARD RECOMMENDATION: Vote Yes.

BOARD VOTE: UNANIMOUS.

Resolution No. 20 New

Report: NA Date Submitted: September 2018

Submitted By: Board of Trustees

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: Organizational Capacity-Obj. 6: Role and responsibility of the tripartite clearly defined and agreed upon

How does this resolution increase member value: Not Applicable

AMENDMENT TO THE ADA BYLAWS AND GOVERNANCE MANUAL ON CONFLICT OF INTERESTS AND CODA

Background: The Board of Trustees and the Commission on Dental Accreditation (CODA) created an ADA/CODA Relationship Workgroup¹ to further consider the governance and financial relationship of CODA to the ADA. The Workgroup has met annually since 2014. The Workgroup was established to maintain an open line of communication between the American Dental Association and Commission on Dental Accreditation and, in doing so, to improve the relationship regarding finances and governance, and educate each organization in the process.

Related to the governance oversight, the Workgroup has been engaged in discussions for the past four years regarding the recognition criteria of the United States Department of Education that require "Clear and effective controls against conflict of interest, or the appearance of conflict of interest..." [USDE Criteria §602.15(a)(6)]. In particular, the Workgroup has been evaluating provisions within the ADA governance documents that may increase the risk for a formal complaint by a community of interest to the USDE in the area of conflict of interest.

Proposal: Based on input from the Workgroup, the Board has come to understand that the Commission on Dental Accreditation (CODA) has its own policies and procedures relating to conflict of interest which are required as part of its recognition by the Department of Education. Given this, the Board believes that it should not be the final arbiter of what constitutes a conflict of interest within the work of CODA. Accordingly, the Board proposes the following amendment to the ADA *Bylaws* and the *Governance and Organizational Manual* of the American Dental Association for the consideration of the House of Delegates.

¹ Members of the 2017-2018 Workgroup include: Dr. Robert Bitter (8th district trustee, Co-Chair), Dr. William Leffler (CODA, Co-Chair), Dr. Raymond Cohlma (12th district trustee), Dr. Loren Feldner (CODA), Dr. Steven Friedrichsen (CODA), Dr. Chad Gehani (2nd district trustee), Dr. Jeffery Hicks (CODA), Dr. Billie Sue Kyger (7th district trustee), and Dr. Roy Thompson (6th district trustee).

Resolution

20. Resolved that the ADA *Bylaws*, Chapter V. BOARD OF TRUSTEES, *Section 80. DUTIES*, Duty "M", be amended as indicated (additions are underscored):

M. Render a final judgment on what constitutes a conflict of interest except with respect to the work of the Commission on Dental Accreditation.

and be it further

Resolved, that Chapter XVII. Conflict of Interests (final sentence), of the *Governance and Organizational Manual* of the American Dental Association be amended as follows (additions are underscored):

The Board of Trustees shall render a final judgment on what constitutes a conflict of interest except with respect to the work of the Commission on Dental Accreditation.

BOARD RECOMMENDATION: Vote Yes.

BOARD VOTE: UNANIMOUS.

Resolution No. 37 New

Report: N/A Date Submitted: August 2018

Submitted By: Commission on Dental Accreditation

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: Organizational Capacity-Obj. 6: Role and responsibility of the tripartite clearly defined and agreed upon

How does this resolution increase member value: Not Applicable

**REVISION OF THE RULES OF THE COMMISSION ON DENTAL ACCREDITATION:
TERMINOLOGY CHANGES RELATED TO ADVANCED EDUCATION PROGRAMS**

Background: In summer 2018, the Commission on Dental Accreditation (CODA) directed that the *Rules of the Commission on Dental Accreditation* be revised to align with the Commission's changes to terminology related to advanced education programs. The change in CODA's terminology related to advanced education programs will become effective January 1, 2019. Appendix 1 includes the proposed revisions, with additions underscored and deletions ~~stricken~~.

In accordance with ADA *Bylaws*, Chapter IX Commissions, Section 30, Duties, the Commission may submit amendments to its *Rules* to the ADA House of Delegates for approval by majority vote.

Resolution

37. Resolved, that the *Rules* of the Commission on Dental Accreditation be amended as presented in Appendix 1.

BOARD RECOMMENDATION: Vote Yes.

BOARD VOTE: UNANIMOUS.

Appendix 1

2. Rules of the Commission on Dental Accreditation:

Article I. MISSION

The Commission on Dental Accreditation serves the public and profession by developing and implementing accreditation standards that promote and monitor the continuous quality and improvement of dental education programs.

Adopted August 5, 2016

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, Residents and Fellows of the American Dental Education Association, one (1) dentist for each ADA-recognized dental specialty who is board certified in the respective ~~special~~ discipline-specific area of practice and is selected by each of the following organizations: American Academy of Oral and Maxillofacial Pathology, American Academy of Oral and Maxillofacial Radiology, American Academy of Pediatric Dentistry, American Academy of Periodontology, American Association of Endodontists, American Association of Oral and Maxillofacial Surgeons, American Association of Orthodontists, American Association of Public Health Dentistry, American College of Prosthodontics, ~~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, the American Society of Dentist Anesthesiologists, the American Academy of Oral Medicine, and the American Academy of Orofacial Pain 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.

1 Section 3. TERM OF OFFICE: The term of office of the members of the Board of Commissioners shall
2 be one four (4) year term except that the member jointly selected by the American Dental Education
3 Association and the American Student Dental Association shall serve only one two (2) year term.
4

5 Section 4. POWERS:
6

7 A. The Board of Commissioners shall be vested with full power to conduct all business of the
8 Commission subject to the laws of the State of Illinois, these *Rules* and the *Constitution and*
9 *Bylaws* of the American Dental Association.
10

11 B. The Board of Commissioners shall have the power to establish rules and regulations not
12 inconsistent with these *Rules* to govern its organization and procedures.
13

14 Section 5. DUTIES:
15

16 A. The Board of Commissioners shall prepare a budget at its winter meeting each year for
17 carrying on the activities of the Commission for the ensuing fiscal year and shall submit said
18 budget to the Board of Trustees of the American Dental Association for funding in accordance
19 with Chapter XIV of the *Bylaws* of the American Dental Association.
20

21 B. The Board of Commissioners shall submit an annual report of the Commission's activities to
22 the House of Delegates of the American Dental Association and interim reports, on request,
23 to the Board of Trustees of the American Dental Association.
24

25 C. The Board of Commissioners shall appoint special committees of the Commission for the
26 purpose of performing duties not otherwise assigned by these *Rules*.
27

28 D. The Board of Commissioners shall appoint consultants to assist in developing accreditation
29 standards and conducting accreditation evaluations, including on-site reviews of predoctoral,
30 advanced dental educational and allied dental educational programs and to assist with other
31 duties of the Commission from time to time as needed.
32

33 Section 6. MEETINGS:
34

35 A. REGULAR MEETINGS: There shall be two (2) regular meetings of the Board of
36 Commissioners each year.
37

38 B. SPECIAL MEETINGS: Special meetings of the Board of Commissioners may be called at
39 any time by the Chairman of the Commission. The Chairman shall call such meetings on
40 request of a majority of the voting members of the Board provided at least ten (10) days
41 notice is given to each member of the Board in advance of the meeting. No business shall be
42 considered except that provided in the call unless by unanimous consent of the members of
43 the Board present and voting.
44

45 C. LIMITATION OF ATTENDANCE DURING MEETINGS: In keeping with the confidential
46 nature of the deliberations regarding the accreditation status of individual educational
47 programs, a portion of the meetings of the Commission, and its committees shall be
48 designated as confidential, with attendance limited to members, the American Dental
49 Association Trustee Liaison, selected staff of the Commission and affiliated or other
50 accreditors as the Commission deems appropriate. During this part of the meeting, only
51 confidential accreditation actions may be considered.
52

53 Section 7. QUORUM: A majority of the voting members of the Board of Commissioners shall constitute
a quorum.

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 dental 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~~ advanced dental education 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.~~ The representative for advanced dental education disciplines of advanced education in general dentistry, dental anesthesiology, general practice residency, oral medicine, and orofacial pain will be jointly selected by the disciplines' sponsoring organizations. 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 tracked mail or courier service signature required, 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.

1 When a hearing to provide supplemental information is desired, a written request is to be
2 made to the Director of the Commission thirty (30) days prior to the meeting. The chairman
3 and the Director of the Commission determine the disposition of the request and inform the
4 requestor of the date, hour and amount of time which will be allocated for the hearing.

5 Section 4. APPEAL: In the event the final decision of the Board of Commissioners is a denial or
6 withdrawal of accreditation, the educational program shall be informed of this decision within fourteen (14)
7 days following the Commission meeting. Within fourteen (14) days after receipt of the final decision of the
8 Board of Commissioners, the educational program may appeal the decision of the Board of
9 Commissioners by filing a written appeal with the Director of the Board of Commissioners. The filing of an
10 appeal shall automatically stay the final decision of the Board of Commissioners. The Appeal Board of
11 the Commission shall convene and hold its hearing within sixty (60) days after the appeal is filed. The
12 educational program filing the appeal may be represented by legal counsel and shall be given the
13 opportunity at such hearing to offer evidence and argument in writing or orally or both tending to refute or
14 overcome the findings and decision of the Board of Commissioners. No new information regarding
15 correction of the deficiencies may be presented with the exception of review of new financial information if
16 all of the following conditions are met: (i) The financial information was unavailable to the institution or
17 program until after the decision subject to appeal was made. (ii) The financial information is significant
18 and bears materially on the financial deficiencies identified by the Commission. The criteria of
19 significance and materiality are determined by the Commission. (iii) The only remaining deficiency cited
20 by the Commission in support of a final adverse action decision is the institution's or program's failure to
21 meet the Commission's standard pertaining to finances. An institution or program may seek the review of
22 new financial information described in this section only once and any determination by the Commission
23 made with respect to that review does not provide a basis for an appeal. The educational program need
24 not appear in person or by its representative at the appellate hearing. The Appeal Board may make the
25 following decisions: to affirm, amend, remand, or reverse the adverse actions of the Commission. A
26 decision to affirm, amend, or reverse the adverse action is implemented by the Commission. In a
27 decision to remand the adverse action for further consideration, the Appeal Board will identify specific
28 issues that the Commission must address. The Commission must act in a manner consistent with the
29 Appeal Board's decisions or instructions. The Appeal Board shall advise the appellant educational
30 program of the Appeal Board's decision in writing by tracked mail or courier service signature required.
31 The decision rendered by the Appeal Board shall be final and binding. In the event the educational
32 program does not file a timely appeal of the Board of Commissioners' findings and decision, the Board of
33 Commissioners' decision shall become final.

34 Section 5. HEARING AND APPEAL COSTS: If a hearing is held before the Board of Commissioners,
35 the costs of the Commission respecting such hearing shall be borne by the Commission. If an appeal is
36 heard by the Appeal Board, the costs of the Commission respecting such appeal shall be shared equally
37 by the Commission and the appellant educational program filing the appeal except in those instances
38 where equal sharing would cause a financial hardship to the appellant. However, each educational
39 program shall bear the cost of its representatives for any such hearing or appeal.

40 Article V. OFFICERS

41 Section I. OFFICERS: The officers of the Commission shall be a Chair, Vice-Chair and a Director and
42 such other officers as the Board of Commissioners may authorize. The Chair and Vice-Chair shall be
43 elected by the members of the Commission. The Chair and Vice-Chair shall be active, life or retired
44 member of the American Dental Association.

45 Section 2. DUTIES: The duties of the officers are as follows:

46 A. CHAIR: The Chair shall preside at all meetings of the Board of Commissioners.

- 1 B. VICE-CHAIR: If the Chair is unable to attend any given meeting of the Board of
2 Commissioners, the Vice-Chair shall preside at the meeting. If the Vice-chair is unable to
3 attend the meeting, the other members of the Board of Commissioners present and voting
4 shall elect by majority vote an acting chair for the purpose of presiding at that meeting only.
- 5 C. DIRECTOR: The Director shall keep the minutes of the meetings of the Board of
6 Commissioners, prepare an agenda for each meeting, see that all notices are duly given in
7 accordance with the provisions of these *Rules* or as required by law, be the custodian of the
8 Commission's records, and in general shall perform all duties incident to the office of Director.

9 Article VI. MISCELLANEOUS

10 The rules contained in the current edition of "The American Institute of Parliamentarians Standard Code of
11 Parliamentary Procedure (AIPSC)" shall govern the deliberations of the Board of Commissioners and
12 Appeal Board in all instances where they are applicable and not in conflict with the *Rules* or the previously
13 established rules and regulations of the Board of Commissioners.

14 Article VII. AMENDMENTS

15 These *Rules* may be amended at any meeting of the Board of Commissioners by majority vote of the
16 members of the Board present and voting subject to the subsequent approval of the House of Delegates
17 of the American Dental Association.

18 Revised: 8/17; 1/17; 8/15; 8/10, 10/02, 10/97, 10/87, 11/82; Reaffirmed: 8/12

19 Adopted by the Commission on Dental Accreditation, February 1, 2002. Approved by the ADA House of
20 Delegates, October 2002. Revisions adopted by the Commission on Dental Accreditation, August 2010.
21 Approved by the ADA House of Delegates, October 2010. Revision of Mission Statement adopted by the
22 Commission on Dental Accreditation, August 2012. Approved by the ADA House of Delegates, October
23 2012. Revisions adopted by the Commission on Dental Accreditation, August 2015. Approved by the ADA
24 House of Delegates, November 2015. Revision of Mission Statement adopted by the Commission on
25 Dental Accreditation, August 2016. Approved by the ADA House of Delegates, October 2016. Revision to
26 Article IV, Section IV (comma placement), adopted by the Commission on Dental Accreditation, August
27 2017.

Resolution No. 39 New

Report: NA Date Submitted: September 2018

Submitted By: Board of Trustees

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: Organizational Capacity-Obj. 6: Role and responsibility of the tripartite clearly defined and agreed upon

How does this resolution increase member value: Not Applicable

1 COMMISSION ANNUAL REPORTS

2 **Background:** The Board of Trustees and the Commission on Dental Accreditation (CODA) created an
3 ADA/CODA Relationship Workgroup¹ to further consider the governance and financial relationship of
4 CODA to the ADA. The Workgroup has met annually since 2014. The Workgroup was established to
5 maintain an open line of communication between the American Dental Association and Commission on
6 Dental Accreditation and, in doing so, to improve the relationship regarding finances and governance, and
7 educate each organization in the process.

8 Related to the governance oversight, the Workgroup has been engaged in discussions for the past four
9 years regarding the recognition criteria of the United States Department of Education that require "Clear
10 and effective controls against conflict of interest, or the appearance of conflict of interest..." [USDE
11 Criteria §602.15(a)(6)]. In particular, the Workgroup has been evaluating provisions within the ADA
12 governance documents that may increase the risk for a formal complaint by a community of interest to the
13 USDE in the area of conflict of interest.

14 **Proposal:** The ADA provides to each council and commission an annual report template calling for
15 specific information. That template requires the report to focus on work that furthers the ADA Strategic
16 Plan. The Board believes that the required annual report format does not comport to the missions of the
17 Commissions, each of which has a mission that is distinctly related to its area of responsibility and not
18 necessarily related to the overall strategic plan of the ADA. The Board believes that each Commission
19 should be free to submit an annual report to the Association that contains information the Commission
20 feels is relevant to its work.

21 The Board believes that each commission should decide what information to report to the Association in
22 light of each commission's mission. Likewise, the Board believes that each commission with the exception
23 of CODA should continue to submit an annual report to the House of Delegates. As for CODA, because
24 of the many mechanisms it has for communicating information, the Board does not believe it should be
25 required to submit a report in conjunction with meetings of the House of Delegates. Specifically, the
26 Board notes that CODA provides information to the ADA and its other communities of interest in an effort
27 to be transparent related to its activities, including but not limited to: 1) distributing CODA's public meeting
28 materials on its website, 2) distributing the summary of major actions following each CODA meeting; 3)
29 distributing the minutes of each meeting on CODA's website; 4) disseminating public accreditation actions

¹ Members of the 2017-2018 Workgroup include: Dr. Robert Bitter (8th district trustee, Co-Chair), Dr. William Leffler (CODA, Co-Chair), Dr. Raymond Cohlma (12th district trustee), Dr. Loren Feldner (CODA), Dr. Steven Friedrichsen (CODA), Dr. Chad Gehani (2nd district trustee), Dr. Jeffery Hicks (CODA), Dr. Billie Sue Kyger (7th district trustee), and Dr. Roy Thompson (6th district trustee).

to the Board of Trustees and posting accreditation actions on CODA's website; 5) publishing CODA Alerts and other announcements on CODA's website and by email to communities of interest; and 6) CODA's annual presentation to the ADA Board of Trustees, which typically occurs during the summer Board meeting.

Accordingly, the Board offers the following resolution for the House's consideration.

Resolution

39. Resolved, that Chapter IX, COMMISSIONS, *Section.30. DUTIES*, Subsection A. COMMISSION ON DENTAL ACCREDITATION, Duty "d" of the ADA *Bylaws* be amended as follows (deletions are ~~stricken~~):

Section 30. 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 and allied dental educational programs.
 - b. Accredite dental, advanced dental and 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.

and be it further

Resolved, that Chapter IX. COMMISSIONS, Section K. Annual Report and Budget, Paragraph 1. Annual Report, of the *Governance and Organizational Manual* of the Association be amended as follows (additions are underlined; deletions are ~~stricken~~):

K. Annual Report and Budget.

1. Annual Report. ~~Each commission~~ The Joint Commission on National Dental Examinations, the Commission on Continuing Education Provider Recognition, and the National Commission on Recognition of Dental Specialties and Certifying Boards shall submit, through the Executive Director, an annual report to the House of Delegates containing that information each commission deems to be appropriate and a copy thereof to the Board of Trustees. The Commission on Dental Accreditation shall publish an annual report containing that information it deems to be appropriate to its communities of interest according to a timeline of its choosing and pursuant to the Rules of the Commission on Dental Accreditation.

- 1 **BOARD RECOMMENDATION: Vote Yes.**
- 2 **BOARD VOTE: UNANIMOUS.**

Resolution No. 39S-1 Substitute

Report: NA Date Submitted: October 2018

Submitted By: Ninth 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: Organizational Capacity-Obj. 6: Role and responsibility of the tripartite clearly defined and agreed upon

How does this resolution increase member value: Not Applicable

1 COMMISSION ANNUAL REPORTS

2 The following substitute for Resolution 39 (Worksheet:4080) was adopted by the Ninth Trustee District
3 and transmitted on October 4, 2018, by Michelle Nichols-Cruz, governance manager, Michigan Dental
4 Association.

5 **Background:** The Ninth District believes that communication and transparency should continue between
6 the ADA and CODA.

7 Resolution

8
9 **39S-1. Resolved**, that Chapter IX, COMMISSIONS, *Section 30. DUTIES*, Subsection A.
10 COMMISSION ON DENTAL ACCREDITATION, Duty "d" of the ADA *Bylaws* be amended as
11 follows (additions are double underlined).

12 *Section 30. DUTIES:*

13
14 A. COMMISSION ON DENTAL ACCREDITATION. The duties of the Commission on
15 Dental Accreditation shall be to:

- 16 a. Formulate and adopt requirements and guidelines for the accreditation of
17 dental, advanced dental and allied dental educational programs.
- 18 b. Accredit dental, advanced dental and allied dental educational programs.
- 19 c. Provide a means for appeal from an adverse decision of the accrediting body of
20 the Commission to a separate and distinct body of the Commission whose
21 membership shall be totally different from that of the accrediting body of the
22 Commission.
- 23 d. Submit an annual report to the House of Delegates of this Association and
24 interim reports, on request, and the Commission's annual budget and report to the
25 Board of Trustees of the Association.
- 26 e. Submit the Commission's articles of incorporation and rules and amendments
27 thereto to this Association's House of Delegates for approval by majority vote
28

1 and be it further

2 **Resolved**, that Chapter IX. COMMISSIONS, Section K. Annual Report and Budget, Paragraph 1.
3 Annual Report, of the *Governance and Organizational Manual* of the Association be amended as
4 follows (additions are double underlined; deletions are ~~stricken~~):

5 K. Annual Report and Budget.

- 6
- 7 1. Annual Report. ~~Each commission~~ The Joint Commission on National Dental Examinations,
8 the Commission on Continuing Education Provider Recognition, and the National
9 Commission on Recognition of Dental Specialties and Certifying Boards shall submit,
10 through the Executive Director, an annual report to the House of Delegates containing that
11 information each commission deems to be appropriate and a copy thereof to the Board of
12 Trustees. The Commission on Dental Accreditation shall publish an annual report
13 containing that information it deems to be appropriate to its communities of interest
14 according to a timeline of its choosing and pursuant to the Rules of the Commission on
15 Dental Accreditation. CODA will transmit its annual report to the ADA Board of Trustees
16 and the ADA House of Delegates.

17 **BOARD RECOMMENDATION: Received After the September 2018 Board of Trustees meeting.**

Resolution No. 40 New

Report: NA Date Submitted: September 2018

Submitted By: Board of Trustees

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: Organizational Capacity-Obj. 6: Role and responsibility of the tripartite clearly defined and agreed upon

How does this resolution increase member value: Not Applicable

PROPOSED CHANGES TO THE BYLAWS AND GOVERNANCE MANUAL WITH RESPECT TO CODA AND HIRING CONSULTANTS

Background: The Board of Trustees and the Commission on Dental Accreditation (CODA) created an ADA/CODA Relationship Workgroup¹ to further consider the governance and financial relationship of CODA to the ADA. The Workgroup has met annually since 2014. The Workgroup was established to maintain an open line of communication between the American Dental Association and Commission on Dental Accreditation and, in doing so, to improve the relationship regarding finances and governance, and educate each organization in the process.

Related to the governance oversight, the Workgroup has been engaged in discussions for the past four years regarding the recognition criteria of the United States Department of Education that require "Clear and effective controls against conflict of interest, or the appearance of conflict of interest..." [USDE Criteria §602.15(a)(6)]. In particular, the Workgroup has been evaluating provisions within the ADA governance documents that may increase the risk for a formal complaint by a community of interest to the USDE in the area of conflict of interest.

Proposal: This report relates solely to a procedural matter which the Board believes should be addressed to help CODA operate in an efficient manner, to avoid unnecessary ADA oversight. The proposed changes are to the ADA *Bylaws* and *Governance and Organizational Manual* of the American Dental Association (ADA *Governance Manual*).

Specifically, the Board asks the House to consider changes to grant CODA authority to appoint all its own consultants to assist CODA in making improvements to the entire accreditation program, for example, strategic planning facilitation and implementation; information technology needs evaluation; or best accreditation practices. It currently has the authority to appoint consultants only to assist in developing requirements and guidelines for the conduct of accreditation evaluations, including site visitations, of predoctoral, advanced dental education, and dental auxiliary educational programs.

¹ Members of the 2017-2018 Workgroup include: Dr. Robert Bitter (8th district trustee, Co-Chair), Dr. William Leffler (CODA, Co-Chair), Dr. Raymond Cohlma (12th district trustee), Dr. Loren Feldner (CODA), Dr. Steven Friedrichsen (CODA), Dr. Chad Gehani (2nd district trustee), Dr. Jeffery Hicks (CODA), Dr. Billie Sue Kyger (7th district trustee), and Dr. Roy Thompson (6th district trustee).

Resolution

40. Resolved, that the ADA *Bylaws*, Chapter V. BOARD OF TRUSTEES, Section 80. DUTIES, Duty "I," be amended as follows (additions underscored; deletion ~~stricken~~):

- I. ~~Except for as otherwise provided in these *Bylaws*, a~~Act upon commission and committee nominations for consultants as set forth in the *Governance and Organizational Manual of the American Dental Association*.

and be it further

Resolved, that Section E. Consultants, Advisers and Staff, Paragraph 1. Consultants and Advisers, of the *Governance and Organizational Manual* of the American Dental Association be amended as indicated (additions are underlined; deletions are ~~stricken~~):

CHAPTER IX. COMMISSIONS

E. Consultants, Advisers and Staff.

1. Consultants and Advisers.

a. The Commission on Dental Accreditation shall have the power to appoint consultants to assist in developing requirements and guidelines for conducting the accreditation program and accreditation evaluations, including site visitations, of predoctoral, advanced dental education, and allied dental education programs.

b. The Joint Commission on National Dental Examinations, the Commission on Continuing Education Provider Recognition, and the National Commission on Recognition of Dental Specialties and Certifying Boards, Each commission shall have the authority to nominate consultants and advisers in conformity with rules and regulations established by the Board of Trustees except as otherwise provided in the *Bylaws* or this *Governance Manual*. The Joint Commission on National Dental Examinations also shall select consultants to serve on the commission's test construction committees. ~~The Commission on Dental Accreditation shall have the power to appoint consultants to assist in developing requirements and guidelines for the conducting of accreditation evaluations, including site visitations, of predoctoral, advanced dental education, and dental auxiliary educational programs.~~ The Commission for Continuing Education Provider Recognition shall have the power to appoint consultants to assist in developing standards and procedures, conducting recognition reviews and conducting appeals.

BOARD RECOMMENDATION: Vote Yes.

BOARD VOTE: UNANIMOUS.

Resolution No. 41 New

Report: NA Date Submitted: September 2018

Submitted By: Board of Trustees

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: Organizational Capacity-Obj. 6: Role and responsibility of the tripartite clearly defined and agreed upon

How does this resolution increase member value: Not Applicable

1 **AMENDMENT TO RESOLUTION 1H-2013—SELF-ASSESSMENTS**

2 **Background:** The Board of Trustees and the Commission on Dental Accreditation (CODA) created an
3 ADA/CODA Relationship Workgroup¹ to further consider the governance and financial relationship of
4 CODA to the ADA. The Workgroup has met annually since 2014. The Workgroup was established to
5 maintain an open line of communication between the American Dental Association and Commission on
6 Dental Accreditation and, in doing so, to improve the relationship regarding finances and governance, and
7 educate each organization in the process.

8 Related to the governance oversight, the Workgroup has been engaged in discussions for the past four
9 years regarding the recognition criteria of the United States Department of Education that require "Clear
10 and effective controls against conflict of interest, or the appearance of conflict of interest..." [USDE
11 Criteria §602.15(a)(6)]. In particular, the Workgroup has been evaluating provisions within the ADA
12 governance documents that may increase the risk for a formal complaint by a community of interest to the
13 USDE in the area of conflict of interest.

14 **Proposal:** In 2013, the House passed Resolution 1H-2013 (*Trans.* 2013:339), which mandates each
15 Council and Commission to submit a self-assessment related to the agency's threshold issues, structure,
16 efficiencies, areas of responsibility, agenda review, and strategic direction. The Board proposes
17 exempting the Commission on Dental Accreditation (CODA) from this requirement. As an agency
18 recognized by the United States Department of Education (USDE), the Commission undergoes a
19 comprehensive and rigorous review of its structure, governance, financial stability, and accreditation
20 program by the USDE every five years. The Board believes that the Commission's ongoing recognition
21 by the USDE should serve as a measure of self and external assessment of the agency, and that CODA
22 should not be required to submit the ADA's self-assessment.

23 Accordingly, the Board proposes the following resolution:

¹ Members of the 2017-2018 Workgroup include: Dr. Robert Bitter (8th district trustee, Co-Chair), Dr. William Leffler (CODA, Co-Chair), Dr. Raymond Cohlmia (12th district trustee), Dr. Loren Feldner (CODA), Dr. Steven Friedrichsen (CODA), Dr. Chad Gehani (2nd district trustee), Dr. Jeffery Hicks (CODA), Dr. Billie Sue Kyger (7th district trustee), and Dr. Roy Thompson (6th district trustee).

Resolution

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

Resolved, that Resolution1H-2013 (*Trans.* 2013:339) be rescinded.

BOARD RECOMMENDATION: Vote Yes.

BOARD VOTE: UNANIMOUS.

**WORKSHEET ADDENDUM
POLICY TO BE RESCINDED****Council, Commission, and Committee Self-Assessments (*Trans.2013:339*)**

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

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

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

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

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

Resolution No. 42 New

Report: NA Date Submitted: September 2018

Submitted By: Board of Trustees

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: Organizational Capacity-Obj. 6: Role and responsibility of the tripartite clearly defined and agreed upon

How does this resolution increase member value: Not Applicable

1 **AUTHORITY OF CODA OVER ITS RULES AND ARTICLES**

2 **Background:** The Board of Trustees and the Commission on Dental Accreditation (CODA) created an
3 ADA/CODA Relationship Workgroup¹ to further consider the governance and financial relationship of
4 CODA to the ADA. The Workgroup has met annually since 2014. The Workgroup was established to
5 maintain an open line of communication between the American Dental Association and Commission on
6 Dental Accreditation and, in doing so, to improve the relationship regarding finances and governance, and
7 educate each organization in the process.

8 Related to the governance oversight, the Workgroup has been engaged in discussions for the past four
9 years regarding the recognition criteria of the United States Department of Education that require "Clear
10 and effective controls against conflict of interest, or the appearance of conflict of interest..." [USDE
11 Criteria §602.15(a)(6)]. In particular, the Workgroup has been evaluating provisions within the ADA
12 governance documents that may increase the risk for a formal complaint by a community of interest to the
13 USDE in the area of conflict of interest.

14 **Proposal:** The current ADA *Bylaws and Governance and Organizational Manual* of the American Dental
15 Association (ADA *Governance Manual*) require the Commission on Dental Accreditation (CODA) to
16 submit any changes to its Articles and Rules to the House of Delegates for approval. This requirement
17 poses a potential conflict, as CODA may be required to revise its Rules to address a United States
18 Department of Education (USDE) requirement, which may be in conflict with the Association's *Bylaws*.
19 Additionally, some aspects of CODA's accreditation program are documented within the CODA *Rules*,
20 and CODA must have sole authority to oversee the accreditation program without undue influence or the
21 appearance of undue influence from another agency, including modification of the accreditation
22 processes. The Board notes that the new National Commission on Recognition of Dental Specialties and
23 Certifying Boards was granted sole authority to revise its own Rules, at its initiation, during the October
24 2017 House of Delegates.

25 The Board believes that it is important that CODA have authority to revise its own Articles and Rules,
26 given the expectation by the USDE that CODA act autonomously in carrying out the accreditation
27 program. Accordingly, the Board offers the following resolution for the House's consideration.

¹ Members of the 2017-2018 Workgroup include: Dr. Robert Bitter (8th district trustee, Co-Chair), Dr. William Leffler (CODA, Co-Chair), Dr. Raymond Cohlma (12th district trustee), Dr. Loren Feldner (CODA), Dr. Steven Friedrichsen (CODA), Dr. Chad Gehani (2nd district trustee), Dr. Jeffery Hicks (CODA), Dr. Billie Sue Kyger (7th district trustee), and Dr. Roy Thompson (6th district trustee).

Resolution

42 Resolved, that Chapter IX. COMMISSIONS, *Section 30. DUTIES*, Subsection A. COMMISSION ON DENTAL ACCREDITATION, of the ADA *Bylaws* be amended by deletion of duty "e" in its entirety as follows (deletions are ~~stricken~~):

Section 30. DUTIES:

A. COMMISSION ON DENTAL ACCREDITATION. The duties of the Commission on Dental Accreditation shall be to:

~~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.~~

and be it further

Resolved, that Chapter IX. COMMISSIONS, *Section L. Power to Adopt Rules*, of the *Governance and Organizational Manual* of the American Dental Association be amended as follows (additions are underlined; deletions are ~~stricken~~):

L. 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 the ~~Commission on Dental Accreditation~~, Joint Commission on National Dental Examinations and Commission for Continuing Education Provider Recognition, 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 and the National Commission on Recognition of Dental Specialties and Certifying Boards shall have the power to adopt rules and amendments thereto pursuant to a two-thirds affirmative vote of the members present and voting. ~~The Commission on Dental Accreditation and The Commission for Continuing Education Provider Recognition~~ shall have the authority to make corrections in punctuation, grammar, spelling, name changes, gender references, and similar editorial corrections to their Rules which do not alter 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 adopting such editorial correction.

BOARD RECOMMENDATION: Vote Yes.

BOARD VOTE: UNANIMOUS.

Resolution No. 43 New

Report: NA Date Submitted: September 2018

Submitted By: Board of Trustees

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: Organizational Capacity-Obj. 6: Role and responsibility of the tripartite clearly defined and agreed upon

How does this resolution increase member value: Not Applicable

CODA AUTHORITY TO REMOVE COMMISSION MEMBERS

Background: The Board of Trustees and the Commission on Dental Accreditation (CODA) created an ADA/CODA Relationship Workgroup¹ to further consider the governance and financial relationship of CODA to the ADA. The Workgroup has met annually since 2014. The Workgroup was established to maintain an open line of communication between the American Dental Association and Commission on Dental Accreditation and, in doing so, to improve the relationship regarding finances and governance, and educate each organization in the process.

Related to the governance oversight, the Workgroup has been engaged in discussions for the past four years regarding the recognition criteria of the United States Department of Education that require "Clear and effective controls against conflict of interest, or the appearance of conflict of interest..." [USDE Criteria §602.15(a)(6)]. In particular, the Workgroup has been evaluating provisions within the ADA governance documents that may increase the risk for a formal complaint by a community of interest to the USDE in the area of conflict of interest.

Proposal: Based on input from the Workgroup, the Board believes that a change to the *Governance and Organizational Manual* of the American Dental Association (*ADA Governance Manual*) is needed to give the Commission on Dental Accreditation authority to remove one of its members. The only mechanism currently available to the Commission to remove a Commission Board Member who has demonstrated a significant conflict of interest or breach of fiduciary responsibility is through provisions of the *ADA Governance Manual*, by a hearing and vote of the ADA Board of Trustees, or through a hearing and a vote of the ADA Council on Ethics, Bylaws and Judicial Affairs (CEBJA).

The Board believes that this mechanism for potential removal of a CODA commissioner for cause presents a significant perceived conflict of interest, as all dentist members of the Commission are required to be ADA members and especially if the Commission member to be removed has been directly appointed by the Association. The ADA's objectivity in these circumstances could be called into question by the Commission's communities of interest.

¹ Members of the 2017-2018 Workgroup include: Dr. Robert Bitter (8th district trustee, Co-Chair), Dr. William Leffler (CODA, Co-Chair), Dr. Raymond Cohlma (12th district trustee), Dr. Loren Feldner (CODA), Dr. Steven Friedrichsen (CODA), Dr. Chad Gehani (2nd district trustee), Dr. Jeffery Hicks (CODA), Dr. Billie Sue Kyger (7th district trustee), and Dr. Roy Thompson (6th district trustee).

Accordingly, the Board believes that the Commission should have authority to discipline its own members and proposes the following resolution for the House's consideration.

Resolution

43. Resolved, that Chapter IX. COMMISSIONS, Section B. Removal for Cause, of the *Governance and Organizational Manual* of the Association be amended by adding a new paragraph 1 and by renumbering and amending the existing unnumbered paragraph to read as follows (additions are underlined; deletions are ~~stricken~~):

B. Removal for Cause.

1. The Commission on Dental Accreditation shall have the sole authority to remove a Commission on Dental Accreditation member for cause pursuant to the Rules of the Commission on Dental Accreditation.
2. The Board of Trustees may remove a ~~commission~~ member of the Joint Commission on National Dental Examinations, the Commission on Continuing Education Provider Recognition, and the National Commission on Recognition of Dental Specialties and Certifying Boards 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. 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.

BOARD RECOMMENDATION: Vote Yes.

BOARD VOTE: UNANIMOUS.

Resolution No. 43S-1 Substitute

Report: NA Date Submitted: October 2018

Submitted By: Ninth 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: Organizational Capacity-Obj. 6: Role and responsibility of the tripartite clearly defined and agreed upon

How does this resolution increase member value: Not Applicable

CODA AUTHORITY TO REMOVE COMMISSION MEMBERS

The following substitute for Resolution 43 (Worksheet:4090) was adopted by the Ninth Trustee District and transmitted on October 4, 2018, by Michelle Nichols-Cruz, governance manager, Michigan Dental Association.

Background: In light of the separation of CODA and the ADA, communication becomes more paramount. The Ninth District feels that in regards to providing more transparency and accountability to the membership of the ADA, CODA should notify the ADA Board of Trustees when a CODA Commission member is removed for cause.

Resolution

43S-1. Resolved, that Chapter IX. COMMISSIONS, Section B. Removal for Cause, of the *Governance and Organizational Manual* of the Association be amended by addition (addition is double underlined; deletions are stricken):

B. Removal for Cause.

1. The Commission on Dental Accreditation shall have the sole authority to remove a Commission on Dental Accreditation member for cause pursuant to the Rules of the Commission on Dental Accreditation. The Commission on Dental Accreditation shall provide notice to the ADA Board of Trustees once the Commission acts to remove a members for cause.

2. The Board of Trustees may remove a ~~commission~~ member of the Joint Commission on National Dental Examinations, the Commission on Continuing Education Provider Recognition, and the National Commission on Recognition of Dental Specialties and Certifying Boards 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. Prior to issuance of the decision of the Board of Trustees, no commission member shall be

1 excused from attending any meeting of a commission unless there is an opportunity to be
2 heard or compelling reasons exist which are specified in writing by the Board of Trustees.
3

4 **BOARD RECOMMENDATION: Received after the September 2018 Board of Trustees meeting.**

Resolution No. 52 New

Report: N/A Date Submitted: September 2018

Submitted By: Council on Scientific Affairs

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

**REVISION TO THE COUNCIL ON SCIENTIFIC AFFAIRS' AREA OF RESPONSIBILITY FOR
RESEARCH AGENDA DEVELOPMENT**

Background: To streamline CSA operations and improve the ADA's advocacy for oral health research, the Council on Scientific Affairs (CSA) submits a proposed resolution to update CSA's area of responsibility pertaining to research agenda development, as presented in the *ADA Governance and Organizational Manual*. The proposal aims to focus CSA's area of responsibility on "identification of intramural and extramural priorities for dental research," in an effort to define internally-directed research priorities as well as more focused priorities to inform ADA advocacy efforts with external funding agencies and organizations.

Rationale for Updating CSA's Area of Responsibility for Research Agenda Development: In recent CSA self-assessments and strategic discussions, the Council has taken a detailed look at the overall effectiveness and impact of the ADA Research Agenda, which CSA has developed (for approval by the Board of Trustees) over the past two decades. Currently, the CSA is responsible for publishing a Research Agenda every two years. Council members consistently opine that the Research Agenda has limited effectiveness and impact on the dental research enterprise. Many CSA members admit being completely unaware of the ADA Research Agenda prior to joining the Council, which underscores the limited impact of this document.

The CSA feels the Research Agenda has minimal, if any, direct influence on the oral health research priorities of the National Institute of Dental and Craniofacial Research (NIDCR), dental schools or other research organizations. Additionally, the name itself, ADA Research Agenda, may improperly imply that the ADA offers direct funding for studies addressing the goals and objectives presented in the Research Agenda, although this has not been true for at least the past decade.

Based on these findings, the Council approved forwarding a recommendation to the 2018 House of Delegates to revise CSA's research-focused area of responsibility, as defined in the *ADA Governance and Organizational Manual*. Specifically, this proposed revision would shift the focus of this area of responsibility away from "promulgation of a biennial research agenda," and move it directly and more accurately toward "identification of intramural and extramural priorities for dental research."

The Council concluded that its expertise is better suited to recommending priorities that can influence other existing or proposed national dental research agendas, rather than through development of a separate, and perhaps competing, ADA Research Agenda. The Council also agreed that CSA should provide advice, perspective, and suggestions on intramural research priorities for the Science Institute (e.g., the Center for Evidence-Based Dentistry, Department of Scientific Information, ADA Seal of Acceptance Program, Product Evaluations Program, and the Department of Research and Standards).

The Council also recommended establishing a three-year review cycle for identifying “intramural and extramural priorities for dental research,” which would help ensure that all CSA members have an opportunity to provide input on these priorities during their respective terms of service on the Council.

The Council continues to support the goals and objectives presented in the ADA Research Agenda for 2017-2018. Consistent with the current Research Agenda, the Council’s current programs are prioritizing efforts to address core oral diseases (caries, periodontal disease, oral cancer), and, through the development of clinical practice guidelines and translational science, to enhance dental practice and improve patient outcomes.

Upon House approval of this proposed revision, the Council would work in close collaboration with appropriate consultants to develop a list of intramural and extramural research priorities for 2019-2022. The Council plans to continue its efforts to support and promote oral health research priorities that are most relevant to ADA members to improve oral health outcomes.

The following resolution is presented for House consideration.

Resolution

52. Resolved, that the ADA *Governance and Organizational Manual*, Chapter VIII.COUNCILS, Section K. AREAS OF RESPONSIBILITY, Subsection 10. COUNCIL ON SCIENTIFIC AFFAIRS, paragraph a, be amended as follows (additions underscored; deletions ~~stricken~~):

a. Science and scientific research, including:

i. Evidence-based dentistry;

ii. Evaluation of professional products;

iii. ~~Promulgation~~ Identification of a biennial intramural and extramural priorities for dental research every three yearsagenda; and

iv. Promotion of student involvement in dental research.

BOARD RECOMMENDATION: Vote Yes.

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

Resolution No. 53 NewReport: N/A Date Submitted: September 2018Submitted By: Council on Scientific AffairsReference Committee: C (Dental Education, Science and Related Matters)Total Net Financial Implication: NoneNet 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

HUMAN PAPILLOMAVIRUS (HPV) VACCINATION FOR THE PREVENTION OF INFECTION WITH HPV TYPES ASSOCIATED WITH OROPHARYNGEAL CANCER

Background: In accordance with the Council's charge to propose recommendations for Association policy, this report presents a multi-ADA council proposal that recommends adoption of a new Association policy statement addressing human papillomavirus (HPV) vaccination for the prevention of infection with HPV types associated with oropharyngeal cancer.

Rationale for the Proposed Policy: Reducing the burden of oral and oropharyngeal cancer has been a long-standing clinical issue for the dental profession, given the challenging nature of identifying cancerous or precancerous lesions in the oral cavity at earlier stages. This issue became increasingly significant in recent years with the emergence of extensive evidence that established oral infection with human papillomavirus (HPV) as a risk factor for oropharyngeal cancer.

CSA review of considerations regarding HPV-related oropharyngeal cancer began in the mid-2000s, which prompted the development and adoption of a CSA statement on the topic in spring 2009 (this CSA statement was updated and readopted in 2012). The Council's initial statement on HPV-associated oropharyngeal cancer aimed to educate dentists and the public about the growing incidence of this form of cancer, and to expand awareness that oropharyngeal cancer is associated with a sexually transmitted virus. CSA-appointed expert panels also addressed HPV-related oropharyngeal cancer in the 2010 evidence-based clinical recommendations on oral cancer screening, and in 2017 through an updated evidence-based guideline on the evaluation of potentially malignant disorders in the oral cavity (published in the October 2017 issue of *JADA*).

In February 2018, CSA established an *ad hoc* HPV Workgroup to develop an evidence-based background report and proposed policy statement regarding HPV vaccination and the relationship between HPV and oropharyngeal cancer. The HPV Workgroup was chaired by a CSA member and included one member each from the Council on Advocacy for Access and Prevention (CAAP) and the Council on Dental Practice (CDP), as well as three subject-matter experts.

ADA Council Activities Related to HPV

Council on Scientific Affairs: In spring 2018, the Council approved an HPV Workgroup report titled *Evidence Brief on Oropharyngeal Cancer and HPV Infection, Disease and Prevention*, which reviews the research evidence on this clinical issue (see Appendix). Primary "take-home" messages from the *Evidence Brief* are summarized below:

- 1 • The Centers for Disease Control and Prevention (CDC) estimates that, each year, 11.7 of every
- 2 100,000 adults are diagnosed with an HPV-associated cancer; of these, approximately 40% are
- 3 oropharyngeal squamous cell carcinomas.
- 4 • Incidence rates for oropharyngeal cancer have been increasing over the last three decades.
- 5 • Persistent HPV infection is the leading cause of oropharyngeal cancer in the United States, with
- 6 70% to 80% of oropharyngeal cancers attributable to HPV.
- 7 • Observational studies find that HPV vaccination is associated with a >90% reduction in oral HPV
- 8 infection.
- 9 • HPV type 16 (HPV-16) is responsible for more than 90% of oropharyngeal cancer and all
- 10 commercially produced HPV vaccines to date protect against HPV-16.
- 11 • Current evidence indicates that the HPV vaccine is safe and effective for the prevention of HPV
- 12 infection and for cancer prevention.
- 13 • Compared with vaccination rates for other adolescent vaccines, the HPV vaccine is underutilized
- 14 in the United States.
- 15 • The single best predictor of HPV vaccination is a recommendation from a health care
- 16 professional; receipt of quality information from a professional association is associated with
- 17 delivery of higher quality recommendations regarding HPV vaccination among medical
- 18 professionals.

19 Based on these findings, the HPV Workgroup developed a draft policy statement that emphasized the
20 important role of the HPV vaccine for cancer prevention. The Workgroup agreed that the proposed policy
21 should support efforts of the ADA, along with state and local dental societies, to support current CDC
22 recommendations for use of the HPV vaccine, and to advocate for research to improve understanding of
23 the natural history of oral HPV infection, transmission risks, screening and testing protocols.

24 *Council on Dental Practice:* In November 2017, CDP addressed this topic through the formation of an *ad*
25 *hoc* subcommittee to investigate raising awareness of oropharyngeal cancer and studying the feasibility
26 of dentists performing HPV vaccination in their offices. The CDP subcommittee conducted a literature
27 search and found that there are several factors dentists should consider if administering the HPV vaccine
28 in clinical practice:

- 29 • Outreach: dentists commonly perform recall visits every six months, which provides opportunity to
- 30 discuss health issues with adolescents aged 11-12 years.
- 31 • Acceptability: trust/preference among parents and patients.
- 32 • Feasibility: professional training, additional refrigerated storage capacity, documentation and
- 33 reimbursement.

34 CDP agreed with its HPV Subcommittee's findings that dentists would face many challenges if they
35 decided to administer the HPV vaccine in their dental practice. Major roadblocks include staff training,
36 dentist training, expanding the scope of practice, vaccine storage, regulatory compliance and finances.
37 The costs involved to purchase, train staff, document and store the vaccine is significant, and adequate
38 reimbursement is questionable. Separate storage of the vaccine would also be necessary, which was
39 seen as problematic.

40 CDP concluded that a dentist's responsibility at this time is to discuss preventive care with patients, and
41 that ADA's focus should be to provide tools to members to educate their patients, parents, and guardians
42 on the health consequences of HPV infection in the oral cavity and to discuss HPV vaccination as a
43 potential way to prevent oropharyngeal cancer. CDP also presented these comments as part of its
44 participation with the HPV Workgroup's policy-development process.

45 *Council on Advocacy for Access and Prevention:* In November 2017, CAAP's Prevention Subcommittee
46 discussed the importance of HPV vaccination as a preventive measure against development of
47 oropharyngeal cancer. At its January 2018 meeting, CAAP approved a resolution to encourage dentists to
48 have discussions with their patients, guardians, children or teenage patients regarding the importance of

HPV vaccination. At this meeting, CAAP also referred this resolution to CSA, which was working on this clinical issue.

Conclusion: At its June 2018 meeting, CSA reviewed comments from CAAP and CDP on the proposed HPV policy statement, and after review, the Council approved the proposed policy statement. CAAP and CDP approved the proposed policy in July 2018.

CSA, CAAP, and CDP agree that the proposed policy provides a current basis for the use of the HPV vaccine and recommends adoption of the proposed resolution. Given that HPV vaccination is associated with dramatically reduced rates of HPV infection, HPV vaccination will serve to stem the increasing rates of HPV-related oropharyngeal cancer in the United States. Dentists have an important role as health care advocates to raise awareness among their patients about HPV-related oropharyngeal cancer, promote HPV vaccination of appropriately aged patients, and discuss the important role of the vaccine in cancer prevention with the parents/guardians of younger patients.

Upon adoption of the proposed policy, CSA, CAAP and CDP would encourage ADA support of continuing education programs for dentists, as well as for promotion of materials for dentists to use with their patients about HPV infection, HPV-associated oropharyngeal cancer, and cancer prevention. The Council also would continue to collaborate with external and internal agencies on this issue and communicate appropriate information to ADA members about HPV infection, HPV-associated cancer and HPV vaccination.

The following resolution is presented for the House of Delegates' consideration.

Resolution

53. Resolved, that the following ADA policy statement on Human Papillomavirus (HPV) Vaccination for the Prevention of Infection with HPV Types Associated with Oropharyngeal Cancer be adopted:

The American Dental Association:

(1) adopts the position that HPV vaccination of adolescents and young adults, as recommended by the CDC Advisory Committee on Immunization Practices, is a safe and effective intervention to decrease the burden of oral and oropharyngeal HPV infection;

(2) urges dentists, as well as local and state dental societies, to support the use of the HPV vaccine as recommended by the CDC Advisory Committee on Immunization Practices; and

(3) encourages appropriate external agencies to support research to improve understanding of the natural history of oral HPV infection, transmission risks, screening and testing.

BOARD RECOMMENDATION: Vote Yes.

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

Resolution No. 53S-1 AmendmentReport: N/A Date Submitted: October 2018Submitted By: 14th 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

SUBSTITUTION TO RESOLUTION 53: HUMAN PAPILLOMAVIRUS (HPV) VACCINATION FOR THE PREVENTION OF INFECTION WITH HPV TYPES ASSOCIATED WITH OROPHARYNGEAL CANCER

The following amendment to Resolution 53 (Worksheet: 4095) was adopted by the Fourteenth Trustee District and transmitted on October 19, 2018, by Robert Roda.

Background: New CDC guidelines have been published increasing the recommended age for HPV vaccination up to 45 years old.

(<https://www.fda.gov/NewsEvents/Newsroom/PressAnnouncements/ucm622715.htm>)

This is important information that needs to be transmitted to members and the creation of a patient brochure can help increase patient acceptance of HPV vaccination. Dentists need to be empowered to educate and communicate with patients and an ADA published brochure provides the means to deliver this information in an efficient and concise way.

Resolution 53 should be amended to incorporate this change (additions underscored; deletions ~~stricken~~):

Resolution

53S-1. Resolved, that the following ADA policy statement on Human Papillomavirus (HPV) Vaccination for the Prevention of Infection with HPV Types Associated with Oropharyngeal Cancer be adopted:

The American Dental Association:

(1) adopts the position that HPV vaccination of adolescents and ~~young~~ adults to age 45, as recommended by the CDC Advisory Committee on Immunization Practices, is a safe and effective intervention to decrease the burden of oral and oropharyngeal HPV infection;

(2) urges dentists, as well as local and state dental societies, to support the use of the HPV vaccine as recommended by the CDC Advisory Committee on Immunization Practices; and

(3) encourages appropriate external agencies to support research to improve understanding of the natural history of oral HPV infection, transmission risks, screening and testing.

1 and be it further,

2 **Resolved,** that a brochure for patients and practitioners based on this policy be prepared and
3 published with a target of inclusion in the September 2019 ADA catalog.

APPENDIX**Evidence Brief on Oropharyngeal Cancer and Human Papillomavirus (HPV) Infection, Disease and Prevention****Objective**

This evidence brief summarizes what is known about human papillomavirus (HPV) infection, specifically the impact of HPV infection on the epidemiology of oral and oropharyngeal cancer, as well as the safety and efficacy of the HPV vaccine for disease prevention.

Oral and Oropharyngeal Cancer

Cancers in the oral cavity and oropharynx have historically been combined and, together comprise the sixth most common type of cancer worldwide.¹ In the United States, an estimated 346,902 live with oral cavity and oropharynx cancer, and an estimated 51,540 cases of oral and oropharyngeal cancer will be diagnosed in 2018.² The anatomic locations of these cancers consist of the oral cavity (comprised of the lips, the anterior two-thirds of the tongue, buccal mucosa, gingiva, hard palate, retromolar pad, and floor of the mouth) and the oropharynx (comprised of the palatine tonsils, soft palate, base of the tongue, and lateral/posterior pharyngeal walls).¹ The most frequently diagnosed (affected) anatomic subsite is the tonsil (23.1% of cases), followed by the base of the tongue (18.4%) and the oral tongue (17.8%).¹ The vast majority of oral and oropharyngeal cancers are squamous cell carcinoma (SCC), which originates from the epithelial mucosal lining.

More recently, with the high incidence of HPV-associated oropharyngeal squamous cell carcinoma (HPVOSCC), the oral cavity and oropharynx have been recognized to represent two distinct anatomic sites and cancers from these sites are no longer classified together for epidemiological and public health purposes. This change has been reflected in the World Health Organization Classification of Head and Neck Tumors, fourth edition, released in 2017.³

Tobacco and alcohol (used alone or in combination) are associated with 75% to 85% of head and neck squamous cell carcinomas (HNSCC) in the United States, and continue to be the major risk factors for oral squamous cell carcinoma.^{4,5} The risk of oral cavity SCC increases in a dose-response manner with duration and amount of tobacco exposure, such that current cigarette smokers are estimated to have 10-fold higher risk than never-smokers.⁴ Heavy alcohol use is a risk factor as well, and has a synergistic effect with smoking.⁴ The proportion of US adults who currently smoke or have formerly smoked has significantly decreased since 1965, and oral cavity cancer incidence rates have correspondingly decreased since the mid-1980s.⁴

Decreasing oral cavity SCC incidence rates have been accompanied by a 50% decrease in tobacco- and alcohol-associated oropharyngeal SCC incidence from 1988-2004.^{1,6} However, the overall incidence of oropharyngeal SCC has risen over the past three decades and this is attributed to a 225% increase in HPVOSCC.⁶ HPVOSCC now represents 70% to 80% of oropharyngeal SCC in the United States and Western Europe, and in the United States, has now surpassed cervical cancer as the most common HPV-related cancer.⁷ The lingual and palatine tonsils, specifically, are hot-spots for HPV infection. In contrast, HPV is associated with oral SCC and oral epithelial dysplasia very rarely.^{8,9}

Biology and Natural History of HPV Infection

Human papillomavirus is a non-enveloped, double-stranded DNA virus with over 100 different genotypes isolated to date.¹⁰ It is the most common sexually transmitted infection in the United States, with a prevalence of 70 million and an incidence of 14 million cases a year.¹¹ Most (90%) mucosal HPV

infections, whether cervical or oral/oropharyngeal, resolve asymptotically within one to two years.¹² HPV types are categorized into “low-risk” or “high-risk” based on their oncogenic potential.¹³ Several HPV types are categorized as high-risk, including HPV type 16, which is estimated to be responsible for most (>90%) of oropharyngeal cancer.¹⁴

Persistent (non-clearing) infections with one of the high-risk HPV types can lead to cancer over many years. In addition to oropharyngeal and cervical SCC, high-risk HPV types are associated with vulvar, vaginal, penile, anal, and rectal carcinoma.¹⁵ Low-risk HPV types are associated with benign lesions including anogenital warts, papillomas and recurrent respiratory papillomatosis.^{10,15,16}

Epidemiology of HPV-Associated Precancerous and Cancerous Lesions

Overall, HPV is responsible for 5.2% of all cancers in the United States. The Centers for Disease Control and Prevention (CDC) estimates that, each year, 11.7 of every 100,000 adults are diagnosed with an HPV-associated cancer; of these, approximately 40% are oropharyngeal SCC.¹⁵ Sixty-three percent of oropharyngeal cancers in females and 72% in males are calculated to be attributable to HPV.¹⁵ The prevalence of oral/oropharyngeal HPV infection as detected in saliva is 6.9% among individuals age 14 to 69 years¹⁷⁻¹⁹ and is three-fold higher in men than women (11.5% vs 3.3%).²⁰

HPV Vaccination Safety and Efficacy

Historically, three HPV vaccines have been licensed for use in the United States.²¹ Evidence from clinical trials demonstrates the immunogenicity, safety, and efficacy of bivalent, quadrivalent, and nonavalent vaccines in the prevention of infection of the HPV types specific to each vaccine (see Box). Data from these trials were used by the CDC Advisory Committee on Immunization Practices (ACIP) to develop its recommended dosing schedule for HPV vaccination of males and females.²¹

Cervarix (HPV-2), a bivalent vaccine made by GlaxoSmithKline, protects against HPV types 16 and 18, which cause about 70% of all HPV-associated cancers in the United States¹⁵ and was licensed in 2006.¹⁵ The original Gardasil vaccine (HPV-4), made by Merck was licensed in 2009 and protects against HPV 16 and 18, as well as HPV 6 and 11 (which cause 90% of genital warts). The expanded Gardasil vaccine, HPV-9, was licensed in 2014, and is a nonavalent vaccine that protects against 7 oncogenic HPV types 16, 18, 31, 33, 45, 52, and 58 (which cause more than 90% of all HPV-associated cancers); and also protects against HPV 6 and 11.¹⁵ As of 2017, the expanded Gardasil vaccine (HPV-9) is the only HPV vaccine used in the United States.

The natural history of HPV-related cancers involves slow-growing tumors that usually require more than 10 years to develop into invasive disease. This reality necessitates that clinical trials use intermediate markers of disease outcomes.²² Cervical intraepithelial neoplasia (CIN) and vulvar intraepithelial neoplasia are commonly used in clinical trials as surrogate end points for these cancers. Clinical trials have demonstrated the efficacy of all three HPV vaccines against CIN or external genital lesions.²³⁻³⁴ While persistent oral HPV infections, oral precursor lesions, or oral cancer have not been the primary endpoints of any clinical trial to date, prevalence of oral HPV infection has been shown to be reduced in cohorts that received the vaccine.^{35,36} Observational studies have found that HPV vaccination is associated with a dramatic (>90%) reduction in oral infection with HPV strains associated with the majority of oropharyngeal cancers.³⁷⁻³⁹

Box. Immunogenicity, Safety, or Efficacy of HPV Vaccines: Evidence Tables

Evidence from clinical trials regarding immunogenicity, safety, and efficacy of bivalent, quadrivalent, and nonavalent vaccines in the prevention of infection of the HPV types specific to each vaccine was obtained through a search of ClinicalTrials.gov conducted on 2/26/2018 for all studies involving “Human Papillomavirus.” Studies meeting the inclusion criteria of human subjects, manuscript available in English, and a measure of immunogenicity, safety, or efficacy of an HPV vaccine are presented in Appendix 1.

Data from these trials were used by the CDC Advisory Committee on Immunization Practices (ACIP) to develop its recommended dosing schedule for HPV vaccination of males and females.²¹ Additionally, observational trials that explored HPV vaccine efficacy against oral, anogenital, or systemic HPV infection were identified through a search in GoogleScholar for “Human Papillomavirus” conducted on 2/26/2018. Those studies meeting the inclusion criteria of human subjects, manuscript available in English, and HPV infection are presented in Appendix 2.

CDC Recommendations for HPV Vaccination

Currently, the HPV vaccine is one of four vaccines that are recommended by the ACIP for routine immunization of adolescents and young adults. The others are tetanus, diphtheria, and acellular pertussis (Tdap) vaccine; meningococcal vaccine; and annual influenza vaccine.⁴⁰

The ACIP recommends:

1. Routine HPV vaccination for all boys and girls at age 11 or 12 years, and vaccination can be given starting at age 9 years.²¹
2. “Catch up” vaccination for females through age 26 and for males through age 21 who were not adequately vaccinated previously; these ages were chosen based on cost-effectiveness models.²¹
3. Males aged 22 through 26 years may also be vaccinated.²¹

HPV Vaccination Compliance

In 2016, the CDC estimates that 65.1% and 56.0% of boys and girls between 13 and 17 years of age had received one or more doses of the vaccine,⁴¹ while only 41.6% of females and 10.1% of males in the United States between 19 and 26 years of age had received at least one dose of HPV vaccine.⁴² Although there has been a trend of increased vaccination over time, HPV vaccine coverage remains below the Healthy People 2020 goal of achieving >80% coverage among 13 to 15 year-olds.⁴³

HPV vaccination is now well established to be safe and effective for cancer prevention. However, compared with use rates for other adolescent vaccines, HPV vaccine is underutilized in the United States contributing to the burden of disease.⁴² The single best predictor of HPV vaccination is healthcare provider recommendation.⁴⁴ Receipt of quality information from a professional association has been shown to be associated with delivery of higher quality recommendations regarding HPV vaccination among medical providers.⁴⁵ While the dental care setting is not well oriented for vaccine delivery due to logistics (e.g. cost

1 of the vaccine, vaccine refrigeration requirements, and reimbursement), the public perception of dentist as
 2 an honest and ethical profession⁴⁶ offers a valuable role in providing evidence-based information to
 3 appropriate patients and parents/guardians of patients advocating for HPV vaccination. A diverse and
 4 growing list of professional associations, patient advocacy groups, and governmental agencies have
 5 issued statements, have policies, and/or are actively engaged either alone or as part of the HPV
 6 Roundtable to increase HPV vaccination rates of adolescent and young adults.(see Table)

Table. Associations, Governmental Agencies, and Patient Advocate Groups Working to Increase HPV Vaccination among Adolescents and Young Adults

American Academy of Family Physicians
American Academy of Pediatric Dentistry
American Academy of Pediatric Dentists
American Academy of Pediatrics
American Cancer Society
Advisory Committee on Immunization Practices
American College of Obstetricians and Gynecologists
American Medical Association
American Pharmacists Association
Army Public Health Center
Centers for Disease Control and Prevention
Comprehensive Cancer Control National Partners Organization
Department of the Navy, Bureau of Medicine and Surgery
Head and Neck Cancer Alliance
Immunization Action Coalition
Indian Health Service
Infectious Diseases Society of America
National Association of Country and City Health Officials
National Association of Pediatric Nurse Practitioners
National Cancer Institute Designated Cancer Centers
National Association of School Nurses
National HPV Roundtable
Public Health Agency of Canada
Society for Adolescent Health and Medicine
World Health Organization

7 Conclusions

8 Given that HPV vaccination is associated with dramatically reduced rates of HPV infection, HPV
 9 vaccination may serve to stem the increasing rates of HPV-associated oropharyngeal cancer in the
 10 United States. Dentists can have an important role as healthcare advocates to educate their patients
 11 about the risk factors of oral and oropharyngeal cancer, raise awareness among their patients about
 12 HPV-associated oropharyngeal cancer, promote HPV vaccination of appropriately aged patients,
 13 and discuss the important role of the vaccine in cancer prevention with the parents/guardians of
 14 younger patients.

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Appendix 1. Clinical Trial Data Regarding Efficacy of HPV Vaccination Against HPV Infection, Precursor Lesions and HPV-associated Cancers

Clinical Trial (length of follow-up)	Years	Study population	Vaccine (HPV types)/ Control Group	Efficacy against HPV infection		Efficacy against HPV-related warts, precancerous lesions and cancer		Adverse event** risk difference (vaccine-control)
				Per-protocol efficacy	Intention to treat efficacy	Per-protocol efficacy	Intention to treat efficacy	
PATRICIA NCT00122681 (48 mo.) ²⁵	2004- 2006	18,644 women aged 15-25 from 14 countries	Bivalent (16/18)/ placebo	HPV 16/18 persistent infection: 91.4% (95% CI: 86.1-95.0)		CIN2*+ related to HPV 16 or 18: 92.9% (95% CI: 79.9-98.3) CIN3+ related to HPV 16 or 18: 80.0% (95% CI: 0.3-98.1)	CIN2+ related to HPV 16 or 18: 94.5% (95% CI: 86.2-98.4) CIN3+ related to HPV 16 or 18: 90.9% (95% CI: 60.8-99.1)	Serious event: 0%
CVT NCT00128661 (48 mo.) ²⁶	2004- 2010	7,466 women aged 18-25 in Costa Rica	Bivalent (16/18)/ Hep A vaccine	HPV 16/18 incident infections: 79.5% (95% CI: 74.0-84.0)		CIN2+: 89.8% (95% CI: 39.5-99.5)		Serious event: 0.7%
CVT NCT00128661 (48 mo.) ³⁵	2004- 2010	7,466 women aged 18-25 in Costa Rica	Bivalent (16/18)/ Hep A vaccine		oral HPV 16/18 Infection: 93.3% (95% CI: 62.5-99.7) cervical HPV 16/18 infection: 72.0% (95% CI: 63.0-79.1)			Not Reported
CVT NCT00128661 (48 mo.) ³⁶	2004- 2010	7,466 women aged 18-25 in Costa Rica	Bivalent (16/18)/ Hep A vaccine		HPV 16/18 at any site: 64.8% (95% CI: 54.8-72.8) oral HPV 16/18: 100% (95% CI: 60.5-100)			Not Reported
FUTURE I NCT00092521 (48 mo.) ²³	2002- 2006	5,455 women aged 16-24 from 16 countries	Quadrivalent (6,11,16,18)/ placebo			anogenital or vaginal lesions related to HPV 6,11,16,18: 100% (95% CI: 94- 100) cervical lesions related to HPV types 6,11,16,18: 100% (95% CI: 94-100)	external anogenital and vaginal lesions related to HPV 6,11,16,18: 73% (95% CI: 58-83) cervical lesions related to HPV 6,11,16,18: 55% (95% CI: 40-66)	Injection site: 9.4 (95% CI: 7.3-11.5) Systemic: 2.8 (95% CI: 0.2-5.5) Serious event: 0 (95% CI: -0.6-0.8)
FUTURE II NCT00092534 (48 mo.) ²⁴	2002- 2006	12,167 women aged 15-26 in 13 countries	Quadrivalent (6,11,16,18)/ placebo			cervical lesions related to HPV 16 or 18: 98% (95% CI: 86-100)	cervical lesions related to HPV 16 or 18: 44% (95% CI: 26- 58)	Injection site: 6.5 (95% CI: 1.4-11.7) Systemic: 1.4 (95% CI: -5.0-7.8) Serious event: 0 (95% CI: -0.1-0.2)

*CIN=cervical intraepithelial neoplasia. 2+=grade 2 or above. 3+=grade 3 or above.

**Events as defined by each study. Injection site adverse event: within first 5 days after vaccination, any incidents of pain, erythema, hypersensitivity, swelling. Systemic adverse event: within first 15 days after vaccination, any incidents of pyrexia, fever (during first 5 days). Serious adverse event: new onset autoimmune disease, new onset chronic diseases, medically significant conditions, death.

Appendix 1 (Continued).

Clinical Trial (length of follow-up)	Years	Study population	Vaccine (HPV types)/ Control Group	Efficacy against HPV infection		Efficacy against HPV-related warts, precancerous lesions and cancer		Adverse event** risk difference (vaccine- control)
				Per-protocol efficacy	Intention to treat efficacy	Per-protocol efficacy	Intention to treat efficacy	
NCT00090220 (48 mo.) ²⁷	2004- 2009	3,819 women aged 24-45	Quadrivalent (6,11,16,18)/ placebo	persistent infection with 6,11,16,18: 89.6% (95% CI: 79.3-95.4)	persistent infection with 6,11,16,18: 49.9% (95% CI: 35.5-59.9)	6,11,16,18-related CIN: 94.1% (95% CI: 62.5- 99.9) 6,11,16,18-related external genital lesion: 100% (95% CI: 30.8-100)	6,11,16,18-related CIN: 47.5% (95% CI: 616.3-67.7) 6,11,16,18-related external genital lesion: 8.5% (95% CI: -126.6-63.4)	Injection site: 12.5% Systemic: -0.8% Serious event: -0.1%
NCT00090285 (36 mo.) ²⁹	2009- 2017	4,065 men aged 16-26 from 18 countries	Quadrivalent (6,11,16,18)/ Placebo	persistent infection with 6,11,16,18: 85.6% (95% CI: 73.4- 92.9)	persistent infection with 6,11,16,18: 47.8% (95% CI:36.0-57.6)	external genital lesions related to HPV 6/11/16/18: 90.4% (95% CI:69.2-98.1)	external genital lesions related to HPV 6/11/16/18: 65.5% (95% CI: 45.8-78.6)	Injection site:5.0 (95% CI:2-8) Systemic:-0.2 (95% CI:-3.2-2.7) Serious event:-0.2 (-0.7-0.3)
NCT00090285 (36 mo.) ³⁰	2009- 2017	4,065 men aged 16-26 from 18 countries	Quadrivalent (6,11,16,18)/ Placebo			external genital lesions related to HPV 6/11/16/18: 81.5% (95% CI:58-93)	external genital lesions related to 10 additional HPV types: 67.1% (95% CI:-83.9-96.8)	Not Reported
NCT00090285 (36 mo.) ³³	2004- 2008	men aged 16- 26 from 7 countries	Quadrivalent (6,11,16,18)/ Placebo	persistent infection with 6,11,16,18: 94.9% (95% CI: 80.4-99.4)	persistent infection with 6,11,16,18: 59.4% (95% CI: 43.0-71.4)	Anal intraepithelial lesions: 77.5% (95% CI: 39.6-93.3)	Anal intraepithelial lesions: 27% (95% CI: - 1.1-45.6)	Injection site: -1.2% Systemic: -4.4% Serious: 0.7%
NCT00543543 (54 mo.) ²⁸	2007- 2013	14,215 women aged 16-26	Nonavalent (6,11,16,18,31, 3,45,52,58)/ Quadrivalent (6,11,16,18)	persistent infection with 31,33,45,52,58 : 96% (95% CI: 94.4-97.2)		high grade cervical, vulvar, or vaginal disease: 96.7% (95% CI: 80.9-99.8) CIN2+: 96.3% (95%: 79.5- 99.8)	high grade cervical, vulvar, or vaginal 0.7 (95% CI:-15.7-14.8)	Injection site: 5.8% Systemic: 0.9% Serious event: 0.7%
NCT00543543 (6 years) ³¹	2007- 2013	14,215 women aged 16-26	Nonavalent (6,11,16,18,31, 3,45,52,58)/ Quadrivalent (6,11,16,18)			high-grade cervical, vulvar and vaginal disease related to HPV 31, 33,45,52,58: 97.4% (95% CI: 85.0-99.9)		Serious event: 0%

*CIN=cervical intraepithelial neoplasia. 2+=grade 2 or above. 3+=grade 3 or above.

**Events as defined by each study. Injection site adverse event: within first 5 days after vaccination, any incidents of pain, erythema, hypersensitivity, swelling. Systemic adverse event: within first 15 days after vaccination, any incidents of pyrexia, fever (during first 5 days). Serious adverse event: new onset autoimmune disease, new onset chronic diseases, medically significant conditions, death.

Appendix 2. Efficacy of HPV Vaccination against Oral, Anogenital, or Systemic Infection (intention to treat analyses)

Data Source	Study population	Years	Vaccination	Source (serum vs anatomic sample)	Efficacy against oral infection	Efficacy against anogenital or systemic infection
NHANES 2011-14 data (49 mo.) ³⁷	US national sample	2011-2014	self-report of ≥ 1 dose of HPV vaccine through the age of 26 years/non-vaccinated	Oral fluid	Oral HPV: 88.2% (95% CI: 5.7-98.5) lower prevalence	
NHANES 2009-2014 data ³⁸	US national sample	2009-2014	self-report of HPV vaccination/non-vaccinated	Oral fluid		Vaccinated participants had significantly lower prevalence of quadrivalent vaccine types: 0.16 (95% CI: 0.04-0.68) compared to non-vaccinated prevalence of 1.47 (95% CI: 0.93-2.32)
Primary care clinics (11 years) ³²	Women aged 13-26	2006-2017	Quadrivalent (6,11,16,18) or Nonavalent (6,11,16,18,31,33,45,52,58)/ non-vaccinated	Cervicovaginal specimens		Prevalence of 6,11,16,18 types 82.8% lower among vaccinated (OR 0.12, 95% CI: 0.07-0.20) compared to non- vaccinated. Prevalence of 6,11,16,18,31,33,45,52,58 types 71.8% lower in vaccinated (OR 0.17, 95% CI: 0.16-0.44) compared to non-vaccinated.
NCT00786760 HPV Infection in Men (HIM) ¹²	1626 men aged 18-70 in Florida, Sao Paulo, or Morelos	2005-2019	None	Oral fluid	Rate of oral HPV acquisition was 5.6 per 1,000 person months. Rate of oral oncogenic HPV acquisition was 2.5 per 1,000 person months. Median duration of oral infections was 6.3 months.	

NCT01432574 Mid-Adult Men study (7 months) ³⁹	150 men aged 27-45 in Florida and Mexico	2012-2018	Quadrivalent (6, 11, 16, 18)/baseline level of infection	Oral fluid and serum	Antibodies for HPV-16 were detected in 93.2% of mouthwash specimens and 95.7% of sponge specimens; antibodies for HPV-18 were detected in 72.1% and 65.5%, respectively	
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Resolution No. 71 NewReport: N/A Date Submitted: September 2018Submitted By: Eighth Trustee DistrictReference Committee: C (Dental Education, Science and Related Matters)Total Net Financial Implication: \$505,500 Net Dues Impact: \$4.89Amount One-time \$85,500 Amount On-going \$420,000 FTE 3

ADA Strategic Plan Objective: Membership-Obj. 2: Net increase of 4,000 active licensed members by end of 2019

How does this resolution increase member value: See Background

ADA TASKFORCE ON DENTAL STUDENT DEBT

The following resolution was adopted by the Eighth Trustee District and transmitted on September 13, 2018, by Greg A. Johnson, executive director, Illinois State Dental Society.

Background: The level and management of student debt has become a critical issue for both private and public dental schools throughout the entire country. Its effect on dentistry is a multi-pronged challenge as the level of debt increases and the subsequent repayment requirements dictate what practice options are available to graduating dental students, as well as how this issue will affect the profession going forward into the future. Past ADA Board Report 13-2013 and its report from the ADA Stakeholder Meeting (June 19-20, 2014), titled *Defining the Scope and Aims of a Proposed Comprehensive Study of Current Dental Education Models*, looked in depth at educational models employed by dental schools around the country. It touched on the student debt issue, but student debt was not the major focus of the study.

While the ADA and ADEA may have accumulated a vast amount of information on dental student debt and its management, this information is scattered throughout the websites of various councils, commissions and institutes. The existence of these resources does not change the fundamental reality that many students must borrow vast sums of money to pay for a dental education. The ADA should create a Taskforce on Dental Student Debt devoted to approaching this issue from a new viewpoint, which would serve to amass existing information and focus the ADA on the specific topic of assisting dental students and new dentists with debt issues. The Taskforce would also develop new advocacy approaches to better address the causes of dental student debt in higher education.

Resolution

71. Resolved, that an ADA Taskforce on Dental Student Debt be established to study, identify and suggest sustainable, predictable and actionable options (financial and otherwise) to alleviate student debt burden and to develop a long-term strategy to promote and maintain a workable culture regarding the student debt burden designed to protect the dental profession, as well as and the public we serve, and be it further

Resolved, that the ADA Taskforce on Dental Student Debt include dental students (in their third or fourth year of dental school), new dentist(s) (dental school graduates no more than ten years out of dental or dental specialty school), dental educators from both public and private institutions, a certified financial planner(s), and ADA Trustee(s), appointed by the ADA President, and be it further

Resolved, that the ADA Taskforce on Dental Student Debt submit a report to the 2019 ADA House of Delegates.

BOARD COMMENT: The Board recognizes that dental student debt is a very serious issue, and notes that the Association has been addressing this important matter since 2010. There have been twelve resolutions addressing the topic, calling for actions on the student debt issue, including the formation of several Task Forces that have utilized outside consultants with expertise in student debt financing issues. The work of these Task Forces has resulted in new programs and ongoing initiatives such as: student loan consolidation at a lower interest rate via Laurel Road; successful advocacy efforts to reduce interest rates for federal student loans; continued efforts in advocating for federal and state student loan forgiveness programs; increased monitoring of student debt matters by HPI; adoption of strengthened CODA accreditation standards related to not only student loan financing of dental education, but also related to personal finances. The Board understands that there are also robust financial and debt planning tools available both on the ADA (through CPS) and ADEA websites. HPI has published 5 articles and 2 detailed reports on student debt and the costs of dental education, addressing the proposals suggested in this resolution.

The Board believes the Association continues to take numerous concrete actions and new programming to address the concern and help dental students manage their debt more effectively. The Board understands that this is a complicated matter which is beyond the control of the ADA; there are many factors that the Association cannot affect. For example, dental tuition is set at the institutional level, based on the cost of higher education and the competitive nature of dental school admission. The Board estimates that over the past 7 years, approximately \$500,000 has been spent studying, addressing and advocating for change on this matter. HPI continues to provide monitoring of dental student debt as part of its obligations to meet resolutions adopted by the House, and the ADA Division of Governmental Affairs continues to advocate for reform in higher education financing, especially in regards to dental schools.

For these reasons, the Board recommends that Resolution 71 not be adopted.

BOARD RECOMMENDATION: Vote No.

Vote: Resolution 71

ASAI	No	FISCH	No	KLEMMEDSON	No	ROBINSON	No
BITTER	Yes	GEHANI	No	KYGER	No	RODRIGUEZ	No
BLACK	No	HARRINGTON	No	MCDUGALL	No	SABATES	No
COHLMIA	No	HIMMELBERGER	No	MITCHELL	No	SHEPLEY	No
COLE	No	HUOT	No	NORBO	No	THOMPSON	Yes

Resolution No. 76 New

Report: N/A Date Submitted: September 2018

Submitted By: Fourteenth Trustee District

Reference Committee: C (Dental Education, Science and Related Matters)

Total Net Financial Implication: \$190,000 Net Dues Impact: \$1.84

Amount One-time \$190,000 Amount On-going FTE .5

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

How does this resolution increase member value: See Background

1 **REFINING CODA STANDARDS**

2 The following resolution as adopted by the Fourteenth Trustee District and transmitted on September 12,
3 2018, by Dr. Patsy Fujimoto, Fourteenth District Caucus Chair.

4 **Background:** CODA's accreditation standards assume that students in dental schools all start after
5 having had a common foundational education. This may not be the case, especially with regards to
6 international dental programs. Currently, we have an ill-defined explanation of an equivalent degree.
7 CODA standards specify what skills development must be attained in a dental program however the
8 standards are too generalized. This creates difficulty in establishing equivalence between dental
9 education programs and the evaluation of non-US/Canada trained dentists by the licensure examination
10 community.

11 It may be difficult for CODA to accredit international dental schools without significant expansion of
12 process and content compared to US and Canadian schools. A legitimate comparison of graduates of
13 international dental schools to US and Canadian graduates requires more than the attainment of CODA
14 accreditation.

15 Using educational parameters of greater granularity would significantly strengthen the meaning and
16 acceptability of equivalent degrees and help US/Canadian dental schools to calibrate their curriculums
17 and the educational experiences of their graduates. This can ensure maintenance of the US standard of
18 dental care and greater protection of US citizens.

19 **Resolutions**

20 **76. Resolved,** that the appropriate agency study the concept of equivalency as it pertains to
21 graduation from US/Canadian and international dental schools, and be it further

22 **Resolved,** that the appropriate agencies of the ADA develop parameters of greater detail than
23 outlined in CODA standards, to compare specific program content of US/Canada dental schools
24 compared to international dental schools.

25
26 **BOARD COMMENT:** The Board disagrees that the Association should play a role in defining equivalency
27 between dental education programs accredited by the Commission on Dental Accreditation (CODA) and
28 non-accredited international dental education programs at this time. According to state dental board
29 websites, California allows graduates of foreign dental schools to test for licensure, while Kansas and
30 Minnesota have provisions for equivalency review. The Board is unaware of any requests from the state
31 dental boards to develop equivalency guidelines.

1
2 The Board has concerns about developing equivalency guidelines that would be, in and of themselves,
3 less rigorous and less robust than the current process conducted through CODA. The Board notes that
4 there is long-standing ADA policy (State Board and Commission on Dental Accreditation Roles in
5 Candidate Evaluation for Licensure (*Trans.*2003:367), urging state boards of dentistry to continue to
6 support the role of CODA as the agency responsible for the evaluation of dental education programs.
7 CODA provides public protection and accountability, assuring prospective students and state licensing
8 agencies that accredited programs provide appropriate education, training and experience to adequately
9 prepare individuals for dental licensure and practice in the U.S. Further, the Board is aware that since
10 2006, international predoctoral dental education programs have been eligible to seek accreditation by
11 CODA. They are required to meet the same Accreditation Standards for Dental Education Programs as
12 the United States-based programs and follow the same rigorous process and procedures. However, they
13 must first undergo a multi-step process that involves detailed application and self-study, observation of
14 the Commission's accreditation process, and consultation with Commission staff, site reviewers, and the
15 Standing Committee on International Accreditation. If the consensus of the Standing Committee is that
16 the international program has the potential to achieve CODA accreditation, the program may elect to
17 submit an application for accreditation. To date, no international dental education program has been
18 accredited by CODA.

19 An "equivalency" study of the dental education curriculum, facilities, faculty, and resources of CODA-
20 accredited dental programs (assuming some of the schools would share) against the same components
21 of non-accredited international programs (assuming schools in some countries would share) if even
22 possible, would require consultant expertise beyond the current capacity of ADA resources. Because
23 international dental schools may pursue accreditation by CODA and because there is no documented
24 need for such guidelines by the few state dental boards with equivalency review licensure provisions, the
25 Board does not support this resolution.

26 **BOARD RECOMMENDATION: Vote No.**

27 **BOARD VOTE: UNANIMOUS.**

Resolution No. 77 New

Report: N/A Date Submitted: September 2018

Submitted By: Fourteenth Trustee District

Reference Committee: C (Dental Education, Science and Related Matters)

Total Net Financial Implication: \$10,000 Net Dues Impact: \$0.10

Amount One-time _____ Amount On-going _____ FTE 0.5

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

How does this resolution increase member value: See Background

1 **IS IDIOPATHIC PULMONARY FIBROSIS AN OCCUPATIONAL HAZARD OF DENTISTRY?**

2 The following resolution was adopted by the Fourteenth Trustee District and transmitted on September
3 12, 2018, by Dr. Patsy Fujimoto, Fourteenth District Caucus Chair.

4 **Background:** Idiopathic Pulmonary Fibrosis (IPF) is a type of lung disease that results in scarring
5 (fibrosis) of the lungs for an unknown reason. Over time, the scarring gets worse and it becomes hard
6 to take in a deep breath and the lungs cannot take in enough oxygen.

7 The CDC has reported that in the 21 years between September 1996 and June 2017, nine of the 894
8 patients who received treatment for IPF at a care center in Virginia were dental workers. Of those
9 patients, eight dentists and one technician, seven died of the disease. All of the eight dentists and the
10 dental technician were men. Five were white, one was black, and the race of the three others was
11 unknown. This cluster of IPF cases reinforces the need to understand further the occupational exposures
12 of dental personnel and the association between these exposures and the risk for developing IPF so that
13 strategies can be developed for prevention of potentially harmful exposures. This entity, IPF, has been
14 reported to effect dental professionals in the literature since the early 1980's yet nothing has been
15 reported in ADA literature, publications or warnings to dental learning institutions or our ADA websites.
16 Moreover we as an organization are obligated to protect our members to these health hazards such as
17 reinforcement and studying Personal Protective Equipment (PPE) and incorporating safe practices to
18 specific unidentified particulates, such as quality of masks and other equipment used and a detailed
19 comparison of particle sizes and clearly identifying the hazards involved in the pathology of IPF.

20 **Resolution**

21 **77. Resolved,** that the ADA task the Council on Scientific Affairs to monitor research regarding
22 the occupational hazards of developing Idiopathic Pulmonary Fibrosis in the dental setting, and
23 be it further

24 **Resolved,** that the Council on Scientific Affairs should provide a report on significant
25 developments with regards to IPF to the 2019 House of Delegates.

BOARD COMMENT: There is a need to better understand the relative risk of idiopathic pulmonary fibrosis (IPF) in dentistry. It is necessary that this research effort begin by engaging external experts and stakeholders, especially those with expertise in occupational health, pulmonary fibrosis, and respiratory toxicology. ADA Science Institute staff are already communicating with the National Institute for Occupational Safety and Health (NIOSH) and others on this issue. Any important developments will be communicated by staff to the Council on Scientific Affairs and the House of Delegates, as appropriate. The Board believes the issue is being addressed adequately by Science Institute staff and, therefore, does not require any House action at this time.

BOARD RECOMMENDATION: Vote No.

BOARD VOTE: UNANIMOUS.

References

1. <https://www.cdc.gov/mmwr/volumes/67/wr/mm6709a2.htm#suggestedcitation>
2. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1652029/>
3. <https://www.ncbi.nlm.nih.gov/pubmed/8032061/?i=75&from=/2090488/related>
4. [https://journal.chestnet.org/article/S0012-3692\(16\)31853-0/fulltext](https://journal.chestnet.org/article/S0012-3692(16)31853-0/fulltext)
5. <http://ijomeh.eu/pdf-2107-2342?filename=Pneumoconiosis%20and.pdf>

Resolution No. 78 NewReport: N/A Date Submitted: September 2018Submitted 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

SIMPLIFICATION OF CERP APPLICATION PROCESS FOR CODA ACCREDITED INSTITUTIONS

The following resolution was adopted by the Fourteenth Trustee District and transmitted on September 12, 2018, by Dr. Patsy Fujimoto, Fourteenth District Caucus Chair.

Background: Dental schools across the nation have limited resources to train new dental students. The effective and efficient use of existing resources is paramount to keep tuition as low as possible. Completion of a CERP application typically requires a minimum of 40 hours of staff time which detracts from the staff serving elsewhere to the benefit of students. As a CODA accredited institution, dental institutions are required to go through a rigorous examination process that includes applications and facility site visits. It stands to reason that if an institution can obtain CODA accreditation in order to prepare dental students for licensure and practice, they should also be capable of producing a continuing education course at that same high standard.

This resolution would reduce the time and effort needed for the CERP application process, thereby freeing dental school resources to be put to more effective use. However, since CCEPR still has associated administrative costs, CODA accredited institutions would still be required to pay the application and maintenance fees.

Resolution

78. Resolved, that the Commission for Continuing Education Provider Recognition be urged to simplify the application process for CODA accredited institutions seeking recognition as a CERP approved continuing dental education provider, and be it further

Resolved, that the Commission for Continuing Education Provider Recognition be urged to require CODA accredited institutions to pay the application fees and maintenance fees for their CERP recognition.

BOARD COMMENT: The Board appreciates the Fourteenth District's interest in simplifying the ADA CERP application process for dental schools that are accredited by CODA. However, the Board does not believe it is appropriate to urge the Commission for Continuing Education Provider Recognition to modify its processes for a specific group of continuing dental education (CE) providers.

The ADA House of Delegates established and charged CCEPR to establish continuing dental education standards and to approve providers that meet those standards. The CERP eligibility criteria, recognition standards and procedures are applied to all CE providers seeking CERP recognition, regardless of the

1 type of provider. Consistent application of standards, policies and procedures is a hallmark of any
2 accreditation process. CE providers that have achieved CERP recognition have all been required to
3 complete the same application processes and demonstrate compliance with the same set of standards.
4

5 Further, it should be noted that CODA is recognized by the US Department of Education to accredit
6 dental, advanced dental and allied dental education programs. CODA does not accredit the institutions
7 sponsoring these programs. CODA's scope and mission do not include the accreditation of continuing
8 dental education departments or programs, nor do the accreditation processes for dental and advanced
9 dental education programs include assessments of any CE components that may be affiliated with these
10 programs or their sponsoring institutions.
11

12 For these reasons, the Board recommends that Resolution 78 not be adopted.

13 **BOARD RECOMMENDATION: Vote No.**

14 **BOARD VOTE: UNANIMOUS.**

Resolution No. None N/AReport: Council on Scientific Affairs Report 1 Date Submitted: September 2018Submitted 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

**RESPONSE TO RESOLUTION 45-2017—CONSIDERATIONS FOR INCLUDING PH LEVEL
INFORMATION ON ORAL CARE PRODUCT LABELING**

Background: The Council proposes addressing Resolution 45-2017 by establishing an *ad hoc* task force of ADA staff and members of a dental standards subcommittee to develop a state-of-the-science report on pH in over-the-counter oral care products.

Scope: The 2017 House of Delegates considered Resolution 45-2017, which was referred, as amended (below), to the Council on Scientific Affairs (CSA) for further study and report to the 2018 HOD:

Resolved, that the ADA supports and encourages manufacturers to provide product labeling to include information on the pH level for over-the-counter ~~anti-caries and fluoride rinses~~ oral products available to the public for disease prevention and palliation.

This report, developed in consultation with the CSA Seal of Acceptance Program Subcommittee, was approved by the CSA and presents the Council's response to this referred resolution.

While the scope of Resolution 45-2017 could be interpreted to include many over-the-counter (OTC) products taken orally, this report will address pH considerations specific to OTC oral care products (e.g., toothpaste, mouthrinses, tooth whiteners, oral moisturizers). In short, the report will focus on OTC oral care products with either therapeutic claims (following regulations in the U.S. Food and Drug Administration's (FDA's) OTC drug monographs) or cosmetic claims (i.e., OTC products used for treatment of bad breath or at-home whitening).

CSA Discussions on Resolution 45-2017: Over-the-counter oral care products have variable pH levels for formulation-specific purposes (e.g., therapeutic effects, fluoride uptake, oral acceptability). At its February 2018 meeting, Council members emphasized that, based on the pH requirements in current ANSI/ADA standards,^{1,2} some fluoride-containing products perform much better at lower pH, and that lower pH in oral care products is not necessarily inappropriate. Additionally, some Council members expressed concern about patients "turning away" from oral care products if they were labelled with low pH because numerous research studies are available to support their safety and effectiveness.

Based on these product-related considerations, inter-individual variation (e.g., salivary composition/flow, biofilm acid tolerance) and the need for industry input for a comprehensive response to Resolution 45-2017, the Council recommended establishing an *ad hoc* task force to conduct a targeted search of the available research on pH in oral care products, including unpublished studies conducted by industry, and addressing these studies as part of a standards-related project proposal. This suggested approach was

originally proposed by an ADA/ANSI Workgroup on Oral Hygiene Products, which forwarded the suggestion to CSA as a proposal for collaboration.

Several considerations support this approach. Primarily, it will allow for participation by OTC product manufacturers and enable them to provide direct information on the pH values of oral care products/compositions in the current OTC marketplace. In early 2018, an ADA/ANSI Workgroup forwarded this proposed plan to CSA as a suggestion for collaboration.

In 2018, the Council weighed various considerations regarding the OTC oral care products and determined that the current “Drugs Facts” label for oral care products already presents sufficient information to support user safety for OTC oral products, including toothpastes, mouthrinses, home-use whitening products, oral moisturizers and other products. At any time the FDA deems that a specific use of an oral care product requires a warning label on product packaging, it has the authority to call upon manufacturers to conduct additional product testing to support their product’s data and therapeutic claims, in order to provide assurance of consumer safety according to intended use of the product. However, CSA members also noted that including pH levels or information on oral care product labels can be easily misunderstood and misinterpreted by consumers, due to the complex chemistry and formulations of oral therapeutic products.

The FDA has authority for enforcing regulatory requirements pertaining to OTC oral care product labeling and OTC active ingredients, and ensuring that companies adequately follow the [standard “Drug Facts” labeling format](#).⁴

The Council also recognizes the need for further research to better understand pH and the role it plays in conditions such as dental erosion, or in special patient cases such as head and neck cancer patients facing the effects of radiation-induced xerostomia.

Collaboration with the Standards Committee on Dental Products (SCDP): To address dental standards considerations related to Resolution 45-2017, the Council sent a letter to Dr. P.L. Fan, current chair of both SCDP Subcommittee 7 (Abrasive and Oral Devices) and Sub-Technical Advisory Group (TAG) 7—Oral Care Products (which are both affiliated with the SCDP), prior to their March 2018 meetings in Fort Lauderdale. This correspondence asked the standards committees to review the pH range and pH requirements that are presented in current ANSI/ADA standards for OTC oral products as a discussion item at the March 2018 meeting.

In response, several SCDP workgroup meetings in March 2018 included discussions to review considerations regarding acceptable pH ranges that are presented in ANSI/ADA standards for OTC oral products, specifically ANSI/ADA Standard 130 for Dentifrices¹ and ANSI/ADA Standard 116 for Oral Rinses² (note: pH considerations are included in both ANSI/ADA standards, and are therefore included in ADA Seal of Acceptance Program requirements).

In April 2018, under the direction of CSA chair, Dr. Paul Eleazer, the ADA Science Institute senior staff met by teleconference with Dr. Fan to discuss the convening of a task force to review current ANSI/ADA standards for OTC oral care products and develop a draft report to the profession on this topic. One model for this proposed state-of-the-science report is a 2016 article, which presents a comprehensive pH assessment of commercially available beverages in the United States.³

To provide a comprehensive response to Resolution 45-2017, ADA Science Institute staff will conduct a collaborative research project with OTC product manufacturers who currently participate in either Subcommittee 7, Oral Care Products, or Sub-Technical Advisory Group (TAG) 7—Oral Care Products, of the ADA Standards Committee on Dental Products (SCDP). This *ad hoc* ADA-SCDP task force includes representatives from the OTC oral care industry, including individuals who participate in meetings held by Sub-TAG 7, a primary standards committee for oral hygiene products. Furthermore, to address considerations that were raised at the 2017 ADA meeting, the proposed draft report from the *ad hoc* SCDP task force also will include pH considerations with prescription (non-OTC) oral rinses, such as chlorhexidine mouthwash.

The *ad hoc* ADA-SCDP task force held its first teleconference in May 2018 to discuss the proposed project and begin to develop a draft outline for the report.

In 2018, the Council and the ADA Science Institute continue to work on several projects that will integrate pH considerations into new educational resources for ADA members and the public (e.g., *Oral Health Topic* pages on ADA.org; a new drug therapeutic guide for dental clinicians; product information pages for ADA-Accepted products). The Council anticipates that the *ad hoc* SCDP task force will complete an initial draft report by the first quarter of 2019, with the goal of finalizing a draft report for publication in a peer-reviewed dental journal, preferably *JADA*, and submission for publication consideration by mid-2019.

Conclusion: In this context, the Council notes the following:

- The labeling of OTC products is a highly regulated process, and the FDA is recognized as having regulatory authority over prescription drugs and non-prescription (OTC) products that make therapeutic claims, including toothpaste, mouthrinse and other OTC oral products.⁴
- OTC oral care products have variable pH levels for formulation-specific purposes (e.g., therapeutic effects, fluoride uptake). These and other labeling considerations are overseen by the regulatory framework for OTC drug product labeling, under the FDA's regulatory authority.

The Council is not aware of significant (or emerging) safety concerns or product advisories (alerts) that would justify submitting a Citizen's Petition to include pH information on OTC product labels, which already have limited space to include required information on the standard "Drugs Facts" OTC label format. The Council also advises that including pH information on oral care products could produce unnecessary misunderstandings and misinterpretation by consumers.

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)

References

1. American National Standards Institute, American Dental Association. ANSI/ADA Standard No. 130 for Dentifrices. Chicago: American Dental Association; 2013.
2. American National Standards Institute, American Dental Association. ANSI/ADA Standard 116 for Oral Rinses. Chicago: American Dental Association; 2010.
3. Reddy A, Norris DF, Momeni SS et al. The pH of beverages in the United States. *JADA* 2016;147(4):255-263.
4. U.S. Food and Drug Administration. What does FDA regulate? March 28, 2018. Available at: <https://www.fda.gov/AboutFDA/Transparency/Basics/ucm194879.htm>. Accessed May 18, 2018.

Resolution No. None N/AReport: Board Report 7 Date Submitted: September 2018Submitted 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: Membership-Obj. 3: 10% increase in assessment of member value

How does this resolution increase member value: See Background

**REPORT 7 OF THE BOARD OF TRUSTEES: ADA LIBRARY AND ARCHIVES ADVISORY BOARD
ANNUAL REPORT**

Background: In November 2013, the ADA House of Delegates approved the ADA Library and Archives Transition Plan, including the establishment of a volunteer board to oversee operations of the ADA Library and Archives. An engaged and functioning advisory board is considered a best practice for library management. The ADA Library and Archives Advisory Board serves in an advisory capacity to the Board of Trustees.

At its September 2018 meeting, the Board of Trustees approved the appended Annual Report of the Library and Archives Advisory Board for transmittal to the 2018 House of Delegates.

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

Appendix 1

ADA Library & Archives Advisory Board

1 Asai, Rickland G., 2018, Board of Trustees, 11th District, chair
 2 Fisch, Judith, 2019, Board of Trustees, 1st District
 3 Eleazer, Paul, 2019, Alabama, Council on Scientific Affairs
 4 Parker, William, 2019, Florida, Council on Scientific Affairs
 5 Hammer, Christine, L., 2018, Maryland, at-large Member
 6 Korzeb, Jennifer, 2018, Massachusetts, Council on Dental Education and Licensure
 7 Miles, Maurice, 2019, Maryland, Council on Dental Education and Licensure
 8 Hayes, Mary, 2018, Illinois, at-large Member
 9 Booth, H. Austin, 2018, public member, special/dental librarian
 10
 11 Nickisch Duggan, Heidi, director
 12 Fleming, Anna, electronic resources & research services librarian
 13 Matlak, Andrea, archivist & metadata librarian
 14 O'Brien, Kelly, informationist
 15 Pontillo, Laura, coordinator

Areas of Responsibility as Set Forth in the *Bylaws or Governance and Organizational Manual of the American Dental Association*

18 The areas of responsibility for the ADA Library & Archives Advisory Board (LAAB) are as follows:

- 19
- 20 • Creating and developing the mission and strategic plan of the ADA Library & Archives.
- 21 • Ensuring that the ADA Library & Archives remain relevant to the ADA strategic plan.
- 22 • Providing input during the annual ADA budgeting process on library funding, priorities and needs.
- 23 • Adopting policies and rules regarding library governance, assets and use; developing, approving,
- 24 and codifying all policies, based on input from the library staff; also delegating procedural work to
- 25 the library staff.
- 26 • Regularly planning and evaluating the library's service program.
- 27 • Evaluating the library facility to ensure that it continues to meet ADA member and ADA staff
- 28 needs.
- 29 • Launching a marketing plan for the promotion of the ADA Library & Archives to ADA members;
- 30 ADA component and constituent societies; the local dental and medical communities; and
- 31 affiliated dental organizations.
- 32 • Conducting the business of the library in an open and ethical manner in compliance with all
- 33 applicable laws and regulations and with respect for the association, staff and public.

Advancing ADA Strategic Goals and Objectives: Agency Programs, Projects, Results and Success Measures

36 **Objective 1:** Grow Active, Full Dues Paying Membership

37
38 **Initiative/Program:** Scientific Support/Utilization of Library Content

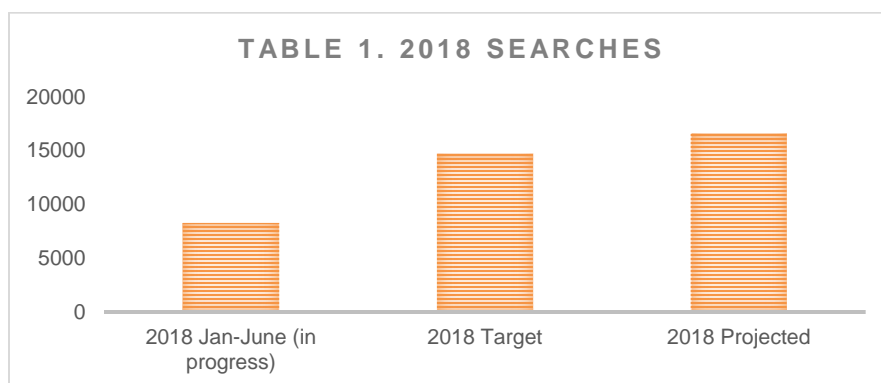
39
40 **Success Measure:** Increase the number of search sessions via electronic resources by 10% over 13,355
41 search sessions in 2017.

Target: 14,690

Range: 14,000—15,000

Outcome: On Target; likely to exceed.

Usage statistics from the first half of 2018 (January-June) show continued increased use of the Library's electronic resources (journals, databases, e-books). Projecting to the end of 2018, ADA members and staff are anticipated to conduct approximately 16,500 online searches (over the target of 14,690), as Members become more aware of the library's growing electronic resources (Table 1).



Objective 2: Grow Active, Full Dues Paying Membership

Initiative/Program: Scientific Support/Utilization of Library Content

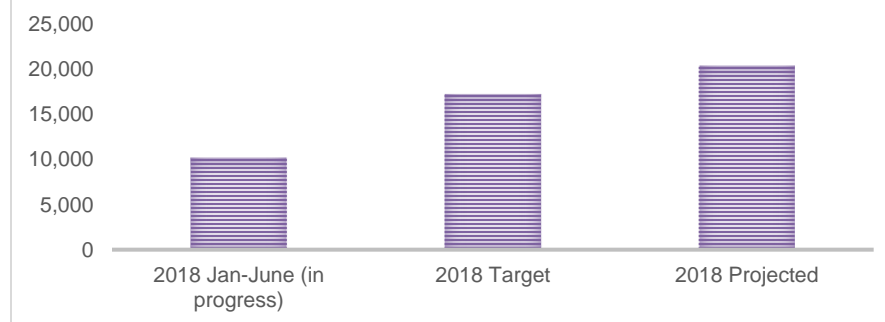
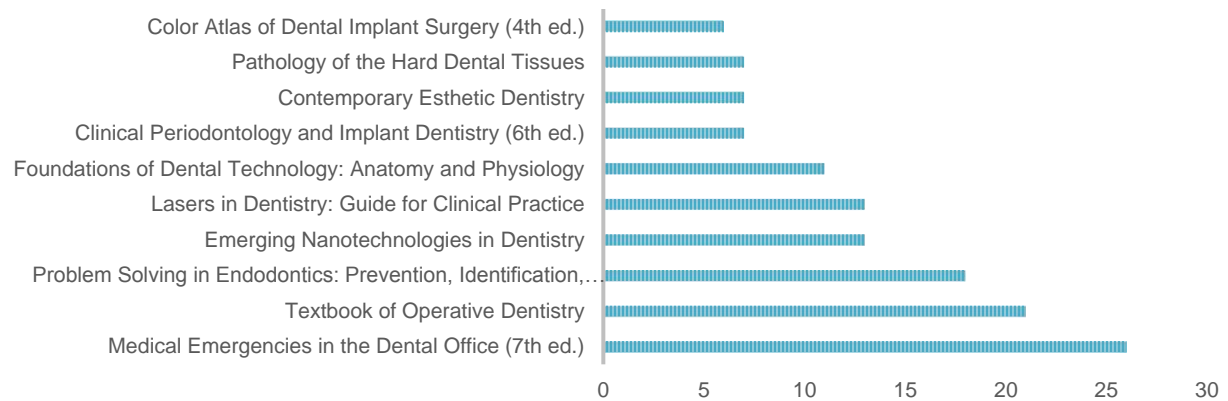
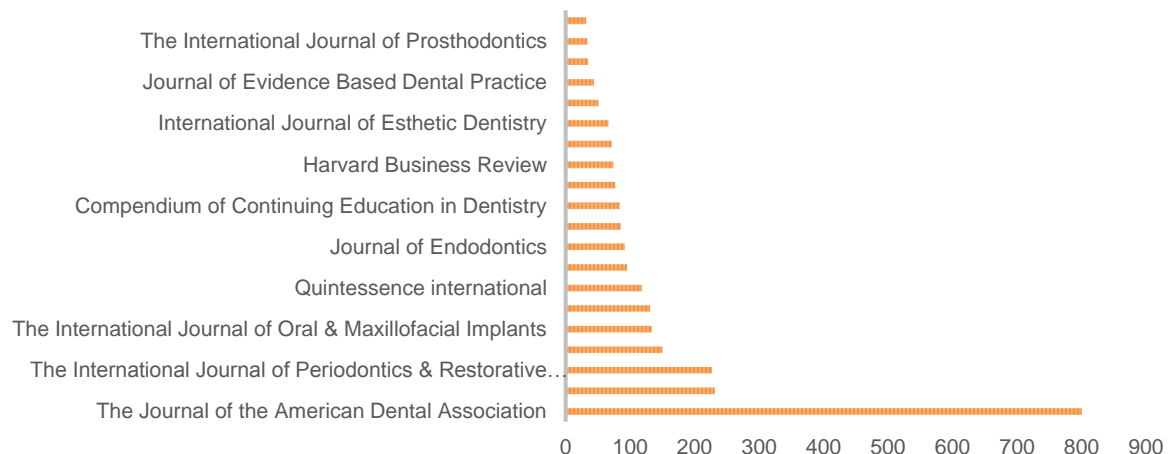
Success Measure: Increase in the number of full-text downloads from electronic resources by 10% over 15,664 full-text downloads in 2017.

Target: 17,230

Range: 17,000—18,000

Outcome: On Target; likely to exceed.

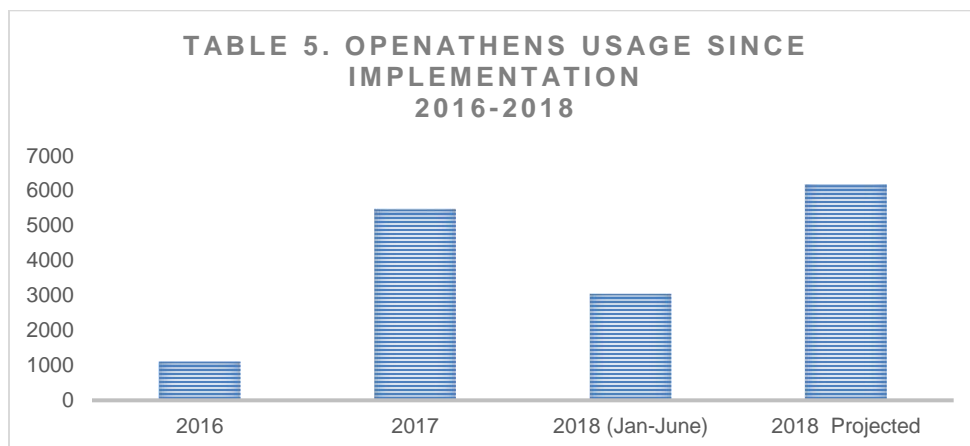
Downloads are more difficult to predict because ADA staff and members tend to search for known items (resulting in one download per search) and ask for staff assistance when conducting more open research (to answer a clinical question, for instance). As a result, ADA Library & Archives staff search more broadly, thus increasing the total search numbers but selecting fewer full-text downloads than the typical user might (Table 2). ADA Library & Archives service goals influence sending only the most relevant full-text downloads combined with abstracts and citations to prompt user evaluation.

TABLE 2. 2018 FULL-TEXT DOWNLOADS**TABLE 3. TOP E-BOOK TITLE USAGE
JAN-JUNE 2018****TABLE 4. TOP E-JOURNAL TITLE USAGE
JAN-JUNE 2018**

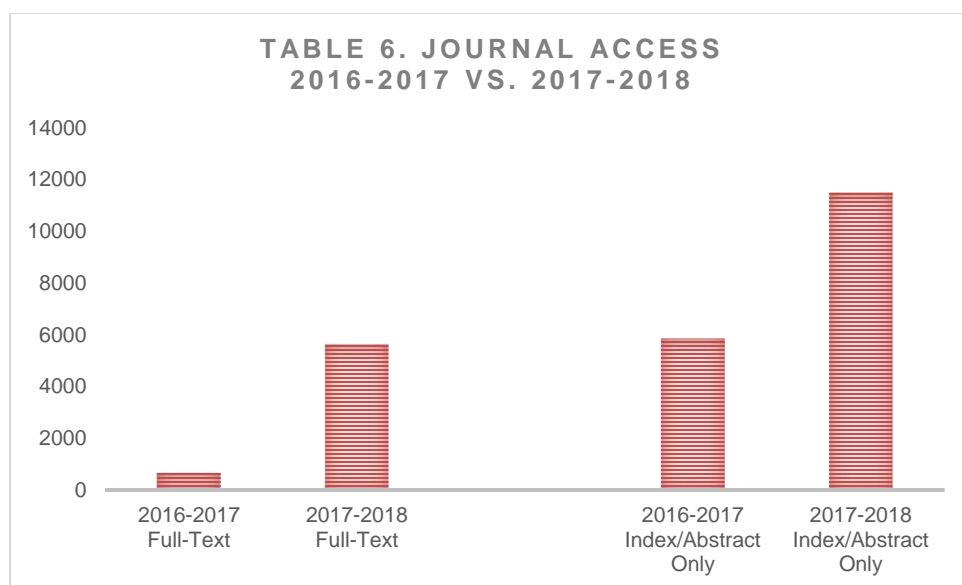
Emerging Issues and Trends

Libraries continue to maximize resources through the expanded use of digital and electronic means to convey information to their patrons. The ADA Library & Archives continually reviews these rapid changes in order to 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 24/7 knowledge center. This is partially accomplished by the implementation of DISCOVERY and OpenAthens, an identity access management tool that allows members to access subscribed electronic content 24/7.



- Maintaining and developing a comprehensive collection of evidence-based and clinical information sources for ADA members in appropriate formats. The current staff roles allow for faster, more robust reference assistance and user education, expert searching, and new means of engaging with members.



- Continuous support of various information needs of the Division of Science. The ADA Library & Archives staff actively engages in expert searching for EBD clinical guideline development and

1 systematic reviews, provides education and access to evidence-based clinical tools and drug
2 information, and provides expert support for initiatives such as 86H-2016, a HOD-directed
3 initiative to provide information on dental clearance for specific conditions and procedures.
4

- 5 • Archives expert support for ADA administration and operations provides information on
6 organizational and dental history for policy and product development, legal review, marketing,
7 communications, and public relations.
8
- 9 • Developing new success measures that emphasize impact on policy outcomes, impact on clinical
10 practice, and the research productivity of ADA members and staff.
11
- 12 • Developing online tutorials, instructional videos, and CE courses for members to assist in their
13 acquisition of evidence-based clinical research materials and search skill enhancement, as well
14 as database navigation and use.
15
- 16 • National Library of Medicine (NLM) Associate Fellow Nicole Strayhorn will spend her second
17 fellowship year at the ADA Library & Archives, helping develop the library's research impact
18 evaluation and assessment services and providing expertise in data management and data
19 visualization to librarians, health economists, statisticians, data analysts, and health services
20 researchers throughout the ADA and beyond.
21
- 22 • DynaMed Plus, an evidence-based resource of drug information and clinical summaries intended
23 to reduce time-to-answer, is available through the ADA Library & Archives website. Future
24 enhancements include CE via DynaMed Plus.
25
- 26 • Enabling online ADA Archives exhibits currently only displayed in-house. Current online exhibit
27 possibilities include "Golf & Dentistry" and "Heroes and Scandals: The Portrayal of Dentists in
28 Popular Entertainment Before the 20th Century".

29 **ADA Library & Archives Policy Review**

30 The ADA Library & Archives Archival and Historical Collections Outgoing Loan Policy was adopted in
31 2018. This policy was developed to better maintain the integrity and security of the ADA Library &
32 Archives archival and historical collections.

Resolution No. 83 New

Report: None Date Submitted: October 2018

Submitted By: Third Trustee District

Reference Committee: C (Dental Education, Science and Related Matters)

Total Net Financial Implication: \$44,200 Net Dues Impact: \$0.41

Amount One-time \$44,200 Amount On-going 0 FTE .25

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

How does this resolution increase member value: See Background

- 1 **GERIATRIC DENTISTRY**
- 2 The following resolution was adopted by the Third Trustee District and submitted on September 25, 2018,
- 3 by Rebecca Von Nieda, director of meetings and administration, Pennsylvania Dental Association.
- 4 **Background:** As various non-affiliated ADA advocacy groups involved in senior living and senior health
- 5 issues grapple with how best to provide dental care for America's citizens over age 60, the ADA has a
- 6 unique and small window of opportunity to **act** in advance of any legislation or mandates to begin
- 7 addressing this concern and help shape the conversation that benefits our members and those they
- 8 serve.
- 9 Currently, 20% of the country's population is 60 years or older (and growing and as stated in a recent
- 10 *ADA News* article the number of Americans over 60 years old will surpass those 18 and younger by
- 11 2030). This segment also faces similar challenges related to the aging process except that they are on
- 12 the other end of the chronologic spectrum. Therefore be it

13 **Resolution**

- 14 **83. Resolved**, that the Council on Dental Education and Licensure (CDEL) explore, with other
- 15 appropriate communities of interest, the feasibility of requesting the development of an
- 16 accreditation process and accreditation standards for advanced education programs in geriatric
- 17 dentistry by the Commission on Dental Accreditation. The feasibility study is to be provided to the
- 18 2019 House of Delegates.

- 19 **BOARD RECOMMENDATION: Received too late for Board comment.**

Legislative, Health, Governance and Related Matters

Resolution No. 24 New

Report: N/A Date Submitted: August 2018

Submitted By: ADA Election Commission

Reference Committee: D (Legislative, Health, Governance and Related Matters)

Total Net Financial Implication: None Net Dues Impact: _____

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

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

How does this resolution increase member value: Not Applicable

**REPORT OF THE ADA ELECTION COMMISSION TO THE HOUSE OF DELEGATES:
AMENDMENT OF THE ELECTION COMMISSION AND CAMPAIGN RULES**

Background: In February 2018, the Election Commission (the Commission) convened a Campaign Rules Workgroup (the Workgroup) for the purpose of reviewing and proposing revisions to the rules and procedures governing the conduct of campaigns for elective ADA office. The Commission appointed Dr. Robert A. Faiella, Dr. Michael H. Halasz (chair), Dr. Hilton Israelson, Dr. Andrew J. Kwasny and Dr. James E. Mercer to the Workgroup; these five volunteers have experience in all facets of the ADA campaign process – former candidates, a former President, a former campaign manager and a former chair of the Election Commission to the Workgroup. Dr. Glen D. Hall, the Speaker of the House of Delegates agreed to serve as a consultant to the Workgroup.

The Commission convened the Workgroup because it believes that the current Campaign Rules and Procedures are in need of significant revision in several respects. It communicated these areas of concern to the Workgroup and requested that the Workgroup provide the Commission with its recommendations by July 1, 2018.

The Workgroup provided the Commission with its recommended revisions to the Election Commission and Campaign Rules in late June, together with a comprehensive report supporting each of the revisions it recommended. The revised Election Commission and Campaign Rules recommended by the Workgroup and the Election Commission are appended as **Appendix 1**, while the Workgroup's report is submitted as **Appendix 2**.

The Workgroup report and its recommended revisions to the Campaign Rules were thoroughly reviewed and discussed by the Commission following which the Commission unanimously approved the amendments proposed by the Workgroup. In addition to the amendments proposed by the Workgroup, the Commission proposed one additional revision – that all violations of the campaign rules that occur during a campaign be reported to the House of Delegates. This addition appears as paragraph 33 of the Campaign Rules (**Appendix 1**). The current Election Commission and Campaign Rules marked to show the proposed revisions (additions underscored, deletions ~~stricken through~~) is provided as **Appendix 3** of the Workgroup report.

In light of the above and for the reasons provided in the Workgroup's report (**Appendix 2**), the Election Commission presents the following resolution to the 2018 House of Delegates with the recommendation that it be adopted.

Resolution

24. Resolved, that the Election Commission and Campaign Rules as they appear in the Manual of the House of Delegates be amended as set forth in Appendix 1, and be it further

Resolved, that provisions of the revised Election Commission and Campaign Rules become effective at the adjournment sine die of the 2018 House of Delegates with the exception of revisions to Paragraph 5 thereof, which shall become effective at the opening of the 2019 House of Delegates.

BOARD RECOMMENDATION: Vote Yes.

Vote: Resolution 24

ASAI	Yes	FISCH	Yes	KLEMMEDSON	Yes	ROBINSON	Yes
BITTER	No	GEHANI	Yes	KYGER	Yes	RODRIGUEZ	No
BLACK	Yes	HARRINGTON	Yes	MCDUGALL	Yes	SABATES	No
COHLMIA	Yes	HIMMELBERGER	No	MITCHELL	Yes	SHEPLEY	No
COLE	Abstain	HUOT	Yes	NORBO	Yes	THOMPSON	No

1

APPENDIX 1 – ELECTION COMMISSION AND CAMPAIGN RULES

2 The Election Commission is composed of three members: the immediate past President, and the chair
3 and vice chair of the Council on Ethics, Bylaws and Judicial Affairs (CEBJA). The chair of CEBJA serves as
4 the Election Commission chair. The Speaker and the President-elect's campaign manager or appointee
5 will serve as consultants to the Election Commission, each without the right to vote. Except as provided
6 below, in the event that one of the members is unavailable, a replacement member will be selected by
7 the chair of the Election Commission in consultation with the Election Commission. In the event that the
8 chair is unavailable due to a conflict with a candidate, the vice chair of CEBJA shall serve as chair and
9 shall appoint a replacement member in consultation with the Election Commission. In the event that
10 both the chair and vice chair of CEBJA are unavailable due to conflicts with a candidate, the senior class
11 of CEBJA shall select replacement members and the senior-most CEBJA member shall serve as chair.

12 The Election Commission is charged with (1) overseeing and adjudicating contested issues arising under
13 the Election Commission Rules Governing the Conduct of Campaigns for all ADA Elective Officers (the
14 Campaign Rules); (2) informing anyone identified as being under a disciplinary sentence of suspension or
15 probation for violating his or her duties to the constituent society within whose jurisdiction the member
16 practices or to this Association that they are ineligible to seek elective or appointive office while under
17 that disciplinary sentence; (3) referring any dispute of eligibility to CEBJA; (4) informing the House of any
18 violation of the Campaign Rules; (5) reviewing and proposing revisions to the Campaign Rules as
19 required; and (6) receiving summaries of campaign revenues and expenses from candidates for all ADA
20 elective offices.
21

APPENDIX 1 – ELECTION COMMISSION AND CAMPAIGN RULES**Election Commission Rules Governing the Conduct of Campaigns for All ADA Elective Officers**

The following Campaign Rules govern the announcement and conduct of campaigns for ADA elective officers. These Campaign Rules will be distributed annually to all candidates, delegates, alternate delegates and other parties of interest. Candidates for elective officers are expected to abide by the Campaign Rules.

Procedures Concerning Interpretation and Distribution of the Campaign Rules

1. To the extent one or more candidates has a question concerning the interpretation of the Campaign Rules or whether a particular activity is prohibited or permitted under the Campaign Rules, the following procedures shall be followed:
 - a. Prior to contacting the Election Commission concerning the question or interpretation, candidates and/or their campaign managers shall communicate and attempt in good faith to reach a consensus on the question.
 - b. If a consensus cannot be reached:
 - i. The campaign that raised the issue shall contact the Election Commission (copying the other candidates and their campaign managers) via a brief and succinct email, state the question or interpretation that has arisen and that the campaigns were unable to reach a consensus on the issue and provide the campaign's position on the issue presented.
 - ii. Within three business days of the receipt of the email referenced in Paragraph b.i, above, any other campaign desiring to do so shall send the Election Commission a brief and succinct email setting forth that campaign's position on the question or interpretation presented to the Election Commission.
2. Any communications from a candidate to the Election Commission regarding these Campaign Rules shall be submitted to the chair of the Election Commission via email addressed to electioncommission@ada.org or by such other means as the Election Commission may from time-to-time specify.
3. It is the responsibility of each candidate to inform their campaign committee members, the constituent Executive Directors within their trustee districts and other constituent staff within their trustee districts who are assisting the campaign of these Campaign Rules within fourteen (14) days of the candidate's announcement of candidacy.

Agreements between Candidates

4. Candidates can negotiate and enter into any agreement concerning the conduct of a campaign for elective officer that does not contravene and is not in conflict with any of the Campaign Rules contained herein; agreements between candidates that narrow any of the provisions of these Campaign Rules or agreements by which the candidates forego any campaign activities permitted under these Campaign Rules are permissible. The negotiation and enforcement of any such agreement will be the responsibility of the candidates. The Election Commission will neither facilitate nor enforce any such agreement.

Announcing Candidacy

5. Candidates for President-elect and Second Vice President shall formally announce their intent to run for office on the final day of the annual session immediately preceding their candidacy. A formal announcement shall include, at a minimum, the name of the candidate and an identification of the

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office being sought. Prior to this formal announcement, candidates may freely campaign within their own trustee districts. Campaign activities outside a candidate's own trustee district shall begin only after the official announcement at the annual session. Candidates for President-elect and Second Vice President not formally announcing their candidacies on the last day of the annual session immediately preceding their candidacy shall not be permitted to campaign outside their own trustee districts but shall be permitted to be nominated for elective office at the annual session of the House of Delegates pursuant to Chapter VI., Section B.1. of the *Governance Manual of the American Dental Association (Governance Manual)*.

6. Announcements of candidacies for the offices of Treasurer and Speaker of the House of Delegates shall be as stated in Chapter VI. Section B.2. and B.3., respectively, of the *Governance Manual*.

Travel and Meeting Attendance

7. Candidates for the office of President-elect shall limit their campaign travel to attending state and/or district annual meetings and/or leadership conferences and annual session district caucus meetings to which all candidates have been invited. The procedures for attendance at such events shall be as follows:
- a. Candidates for the office of President-elect may accept and attend any such event in a manner mutually agreed upon but only if all candidates have been invited.
 - b. Candidates for the office of Second Vice President, Speaker of the House of Delegates and Treasurer shall limit campaign travel to attending the district caucus meetings held during the ADA annual session.
 - c. District caucuses and state constituent societies shall issue timely invitations to the President-elect candidates through the Office of the Executive Director.
 - d. President-elect candidates shall negotiate a mutually agreeable travel schedule. It is the responsibility of the candidate and/or the campaign managers, through coordination among the campaigns, to determine the candidates' availability and respond directly to the inviting organizations. Except for conflicts due to a religious holiday observed by one or more of the candidates, candidates shall vote on whether to accept an invitation, with a majority needed to accept; a tie vote will result in accepting the invitation. A religious holiday conflict with a single candidate shall result in all the candidates declining the invitation.
 - e. Candidates who have scheduling conflicts prohibiting personal attendance at a district or caucus event may, at their option, participate in the event via electronic audio or audiovisual means available to both the candidate and the event's sponsor.
 - f. After a meeting has been accepted, if an emergency arises and a candidate must cancel their attendance, the remaining candidates may attend as planned. Candidates who cancel their attendance at an event due to an emergency may, at their option, participate in the event via electronic audio or audiovisual means available to both the candidate and the event's sponsor.
8. Caucuses and state meetings are requested to provide an appropriate opportunity for the candidates to meet with their members. It is recommended that such forums be structured to allow:
- a. All candidates to make presentations;
 - b. Caucuses freedom to assess candidates; and

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c. Each candidate to respond to questions.

9. Notwithstanding any of these Campaign Rules, nothing in these Rules shall prevent a candidate from traveling on a personal basis or attending a meeting, conference or other event as an official ADA representative. Campaigning while personally traveling or attending events as an ADA representative is strictly prohibited. When traveling personally or as an ADA representative, candidates shall notify other candidates of such travel as soon as possible once the travel has been scheduled.

10. Candidates shall not use campaign-sponsored social functions or hospitality suite/meeting rooms on behalf of their candidacy at any regional, national or annual meeting. (This is not intended, however, to limit candidates from holding campaign meetings for the purpose of strategizing.) Campaign receptions are not to be held at the ADA Annual Session. Additionally, a district that hosts a reception during the ADA annual session and is sponsoring a candidate in a contested election shall not host the reception prior to the officer elections; a reception may be held after the election. Prior to the election, candidates shall not attend events in or visit district hospitality suites. This prohibition shall not apply to a candidate visiting his or her own district's hospitality suite or attending events hosted by their own district exclusively for the district's members.

Publications and Media

11. News articles on and interviews of a candidate are permissible if published by a state dental journal. Online state dental journal news articles on and interviews of a candidate are permissible. Articles about a candidate's intention to run for office are permissible. Articles about why one person would make a better candidate are not permissible.

12. When announcing their candidacy for elective officer, except for the candidate's constituent and component, candidates shall notify all organizations and groups to which they belong of their candidacy and shall request that during the campaign such organizations and groups refrain from distributing or publishing any information or material referencing the campaign or the candidate's candidacy.

13. Candidates shall not participate in interviews on their leadership capacity with leadership or national journals that will be published within the timeframe of their campaign. Candidates shall not knowingly seek to have their name, photo, appearance, and writings published in national trade or non-peer reviewed publications or websites during the campaign, and shall avoid submitting articles in non-peer reviewed paper or electronic publications. Candidates who are participants in a speaker's bureau or earn revenue by speaking nationally or regionally shall avoid all unnecessary self-promotion during the campaign related to national speaking engagements.

Use of Social Media

14. In order to facilitate providing information to delegates and alternate delegates by candidates, any candidate may establish a closed-group Facebook page for purposes of disseminating information about the candidate's campaign and interacting with delegates and alternate delegates concerning campaign-related subjects and issues. Any such closed-group Facebook page instituted by a candidate shall comply with these Campaign Rules and shall also be governed by the ADA's Social Media Policy and the Social Media Posting Protocol for ADA Officers and Trustees. In the event of a conflict between these Campaign Rules, the Social Media Policy and the Social Media Posting Protocol for ADA Officers and Trustees, these Campaign Rules control.

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- a. The Election Commission will determine the appropriate administrative settings for the closed-group campaign Facebook page that candidates may use for campaign-related posts. Those settings will be communicated by the Election Commission to the candidates shortly after the candidates announce their intention to run for elective officer.
 - b. Only delegates, alternate delegates, campaign staff and Election Commission members and staff shall be invited to join a candidate's closed-group campaign Facebook page.
 - c. Shortly after a candidate's candidacy is announced, the ADA will provide the known email addresses of delegates and alternate delegates. Using that list, invitations to join the closed-group page may be issued via email by a candidate who wishes to initiate a closed-group campaign Facebook page. Invitations to join the closed-group page may also be sent to the candidate's campaign staff and shall be sent to members and staff of the Election Commission.
 - d. Following the compilation of the list of certified delegates and alternate delegates who will attend the House of Delegates session at which the election will occur, the ADA will send the candidate an updated list of certified delegates and alternate delegates that the candidate may use to send a second closed-group campaign Facebook page invitation so that newly listed delegates and alternate delegates may join the candidate's closed-group campaign Facebook page.
 - e. Only material that is relevant to the campaign shall be posted on a candidate's closed-group campaign Facebook page. No posts that are negative to any opposing candidate or that may be considered to be negative campaigning shall be permitted on the closed-group campaign page. Any candidate who develops a closed-group campaign Facebook page shall be responsible for the monitoring of posts to the page to ensure that posts comply with these Campaign Rules and that the posts are consistent with the ADA's Social Media Policy and the Social Media Posting Protocol for ADA Officers and Trustees.
 - f. No surveys or polls shall be used or conducted via a candidate's closed-group campaign Facebook page.
 - g. Interactions between a candidate and delegates and alternate delegates using the candidate's closed-group campaign Facebook page shall not count toward any limits on a candidate's contact with individual delegates and alternate delegates contained in these Campaign Rules.
15. Except for the closed-group campaign activity on Facebook specified in Paragraph 14, above, there shall be no campaigning using any social media platform or application.
16. Personal, non-campaign use of social media by candidates during the campaign for elective officer is permitted but candidates shall not post information or material relating to the campaign on personal social media sites. Candidates shall review their personal social media site settings to ensure that privacy and security settings are set to allow review and deletion of any third party post, and candidates shall frequently monitor their own personal Facebook pages and other personal social media sites and delete any posts that references the campaign or the candidate's campaign activities or posts that can be tagged for distribution to third party sites.

Campaign Literature and Communications to Delegates and Alternate Delegates

17. No printed campaign-related material may be distributed in the House of Delegates or to delegates and alternate delegates.

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18. Candidates may prepare a piece of campaign literature to be electronically distributed to the delegates and alternate delegates following a candidate's announcement of candidacy for elective officer. Such campaign literature shall be sized so that if printed the literature is no larger than four single-sided sheets of 8½ x 11 inch paper. If desired, a second piece of campaign literature or similar length may be electronically distributed to the delegates and alternate delegates following the candidates' receipt from the ADA of the final list of certified delegates and alternate delegates.
19. Each candidate may prepare a video to be distributed as described below to delegates and alternate delegates and other members of the House of Delegates.
20. Each piece of literature and any video developed by any candidate shall be submitted to the ADA for review and approval prior to being distributed. Such literature review may take up to five (5) business days to complete. Video reviews will be completed as quickly as possible but are dependent on the length of the video. The candidates shall obtain permissions to use the likeness or image of any non-familial third party that appears in a piece of campaign literature or in any video. Candidates shall state that such permissions have been obtained when submitting the literature and any video for review. The permission should be retained by the candidates and submitted to the ADA only if requested.
21. Each candidate is permitted to individually communicate with each delegate and alternate delegate a single time via an electronic communication (i.e., email) for the purpose of campaigning, electioneering and soliciting votes following the receipt from the ADA of the list of certified delegate and alternate delegate contact information. A third party vendor may be used to send such electronic communications so long as the privacy of the email addresses and identities of the recipients are maintained and preserved and there is no ability to reply to all the recipients of the electronic communication. At each candidate's option, the candidate's electronic communication may contain the campaign literature and/or video referenced in these Campaign Rules, either by embedding or attaching the literature and/or the video to the electronic communication or by providing a hyperlink or hyperlinks that connect to the literature and/or the video that is stored in a remote location maintained by or on behalf of the candidate.
22. Each campaign is permitted to individually initiate a telephonic communication with each delegate and alternate delegate a single time for the purpose of campaigning, electioneering and soliciting votes following the receipt from the ADA of the list of certified delegate and alternate delegate contact information.
23. Nothing in these Campaign Rules shall prevent a candidate from communicating regarding matters within the specific duties of the candidate's position as an ADA officer, member of the Board of Trustees, task force or work group, as long as the communication is strictly related to such responsibilities and is not used for campaigning, electioneering or soliciting votes.
24. Candidates may each schedule up to three (3) telephone forums or town hall events during the campaign. A candidate desiring to hold up to three (3) telephone town hall events shall communicate to the ADA the date of each event and the times at which each such event shall commence and end, together with the instructions and contact information necessary for participants to email and/or call with the questions they would like asked during the telephonic town hall. The ADA will announce the telephone town hall information to delegates and alternate delegates via ADA Connect and provide the information to Election Commission members and staff. Candidates may also publicize the telephonic town halls they sponsor on any closed-group campaign Facebook page that they maintain.

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25. The agenda for a candidate's telephonic town hall meeting(s) shall be the prerogative of the candidate, with the candidates being permitted to provide opening and closing statements and whether follow-up questions are permitted. The length of the telephonic town hall event is also discretionary with the candidate.

26. No negative campaigning or negative comments concerning opposing candidates shall be permitted to be made by the candidate or any participant posing questions or making comments during the town hall event. Candidates shall be responsible for ensuring that a screening mechanism is employed during the town hall event so that broadcasting participant comments or questions that violate this provision is avoided.

Contributions

27. Contributions (including money and in kind services) are acceptable only from individual dentists, family members and ADA constituent and component dental societies, which includes component branches and study clubs recognized as part of the constituent society. Contributions from any other sources are not permissible. No candidate will knowingly accept campaign contributions which create the appearance of conflict of interest as reflected in the ADA *Bylaws*.

28. The sending of a brief note acknowledging a financial contribution or thanking a host of a campaign event to those contributors or hosts outside of the candidate's district is permitted, as long as no additional campaign message is included. Such thank you notes may be sent on campaign letterhead or a notecard containing the campaign logo; envelopes for the thank you note may contain an identification of the campaign or the campaign logo.

29. Any contribution source that could be interpreted to be a conflict of interest or creates the appearance of a conflict of interest must be reported to the Election Commission and the ADA Board of Trustees. In the event a contribution source is deemed to be a conflict of interest or creates the appearance of a conflict of interest, the candidates will be required to return the contribution.

30. Candidates for all ADA elective offices should submit a summary of campaign contributions and expenses to the Election Commission at the end of the campaign.

Violations

31. In the event a violation of the Campaign Rules is determined by the Election Commission to have occurred more than fourteen (14) days prior to the House of Delegates convening, then the Election Commission, if it cannot resolve the violation between the candidates, shall post a report of the violation in the House of Delegates section on ADA Connect. In addition, an email reporting on any such violations will be sent by the Election Commission to each certified delegates and alternate delegates with a working email address on file with the ADA on or about fourteen (14) days prior to the convening of the House of Delegates.

32. In the event a violation of the Campaign Rules is determined by the Election Commission to have occurred in the period from fourteen (14) days prior to the convening of the House of Delegates through the elections of elective officers, then the Election Commission, if it cannot resolve the violation between the candidates, shall report those violations to the House of Delegates. The report will be given orally by the Election Commission chair (or a designee of the Election Commission if the chair is absent from the House of Delegates session) at the first meeting of the House. If violations occur after that meeting, and before the election, then a report of such violations shall be read to each caucus by a designee of the Election Commission.

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2 33. In addition to the foregoing notifications of violations, all violations of the Campaign Rules that occur
3 shall be reported orally at the House of Delegates meeting by the Election Commission.

4 October 2018

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Background: In February 2018, the Election Commission (the Commission) adopted Resolution EC1-2018, authorizing the formation of a Campaign Rules Workgroup (the Workgroup) to review and propose revisions to the rules and procedures governing the conduct of campaigns for elective ADA office. The Commission appointed five volunteers to the workgroup as follows: Dr. Robert A. Faiella, Dr. Michael H. Halasz (chair), Dr. Hilton Israelson, Dr. Andrew J. Kwasny and Dr. James E. Mercer. The Commission named the Speaker of the House of Delegates, Dr. Glen D. Hall, as a consultant to the Workgroup.

The Commission also identified subjects that it believed merited the Workgroup's consideration as it reviewed and investigated revision to the campaign rules. The subjects identified by the Commission were:

- Revise campaign rules to allow candidates to fairly use social media and electronic communications tools in campaigns;
- Tighten up the campaign rules and make sure the rules are clearer / less ambiguous;
- Consider the use of “opt-out” electronic communications of campaign-related information vs. “opt-in” or the posting of campaign literature on ADA.org or other websites;
- Rules should be distilled to a set of guiding principles; and
- Consider simplifying rules.

The Commission also indicated it believed it would be helpful to have a historical perspective of how the campaign rules arose and the issues that were considered when the rules and amendments were adopted.

Finally, the Commission directed that the Workgroup submit a report to the Commission providing its recommendations by July 1, 2018. This Workgroup report is transmitted to the Commission to fulfill that directive.

The Work of the Workgroup: In March 2018, the Workgroup held an initial organizational telephone conference. During the call, the Workgroup reviewed and discussed its charge from the Commission (**Appendix 6**) that each Workgroup member had previously received. Workgroup members were strongly encouraged by Dr. Halasz to review records concerning campaign rules for elective office that had been reproduced from the ADA archives and forwarded to the Workgroup members prior to the March conference call. The Workgroup also discussed the most effective and efficient way to accomplish its charge by the date that the Commission set for the receipt of a report. The consensus of the Workgroup was to arrange for an in-person meeting, providing for sufficient time to allow the members to review Campaign Rules, the Candidates' Campaign Agreement and the historical material that had been provided. Subsequently, the dates of June 1-2, 2018 were selected for that meeting.

Very quickly after convening in person on June 1st, the Workgroup reached consensus on four issues:

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- Rules governing campaigns for elective office should be as clear and unambiguous as possible, with the rules delineating prohibited activities, with the interpretation that if the campaign rules do not affirmatively prohibit a campaign activity, that the activity is permitted.
- The Election Commission and Campaign Rules and the Candidates' Campaign Agreement annually negotiated by the candidates for President-elect ought to be merged into a single set of campaign rules adopted by the House of Delegates, thereby obviating the meeting of the President-elect candidates;
- To achieve of the benefit of economical and efficient distribution of information by the candidates to delegates and alternate delegates, candidates for elective office should, with appropriate limitations, be permitted to use social media for the distribution of campaign-related information; and
- For the same reasons that make social media use attractive, the Workgroup was in favor of allowing the candidates to schedule a limited number of internet-based "town halls" to introduce themselves to delegates and alternate delegates and to field questions posed by participants.

During the course of its meeting, the Workgroup reviewed the Election Commission and Campaign Rules and the current Candidates' Campaign Agreement (**Appendix 4** and **Appendix 5**, respectively) paragraph by paragraph, integrating those documents into a single proposed set of Campaign Rules. In fashioning the integrated revised set of Campaign Rules, the Workgroup also considered notes and comments from its consultant, Dr. Hall, who was unable to attend the meeting due to scheduling comments.

Following the meeting at which a consensus on the Campaign Rules were reached, the revised Campaign Rules were drafted by the Workgroup staff and forwarded to the Workgroup and Dr. Hall for review and comment. A telephone conference was also held on June 18 at which the draft Campaign Rules and this report were reviewed and discussed. Following that discussion, the Workgroup unanimously agreed to forward the report and revised Campaign Rules to the Election Commission with the Workgroup's recommendation that the revised Rules be forwarded to the House of Delegates with a recommendation to adopt.

Analysis. This report will now summarize some of the more notable revisions that the Workgroup approved and its rationale for adopting the amendments. Only major revisions will be highlighted in the report; other, less important revisions will be revealed by a review of the version of the Campaign Rules marked with the revisions (additions underlined and deletions ~~stricken~~) approved by the Workgroup (**Appendix 3**). An unmarked version of the Campaign Rules recommended by the Workgroup is submitted as **Appendix 1** for convenience.

Introductory Paragraphs. In reviewing the current Election Commission and Campaign Rules (**Appendix 4**), it was noted by the Workgroup that allowances should be made for the appointment of replacement members of the Election Commission when either the chair or the CEBJA vice chair are recused because of candidate conflict(s) as is the case this year. The Workgroup reasoned that the CEBJA vice chair should assume the Commission chair and select a replacement member when the CEBJA chair is recused. In the event of the recusal of both CEBJA members from their Commission roles, the Workgroup determined that the senior

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cadre of CEBJA members are in the best position to select replacement Commission members from the CEBJA volunteer ranks, with the senior-most replacement member serving as the chair of the Commission.

The second introductory paragraph is proposed to be modified to reflect the responsibilities of the Commission as set forth in the revised Campaign Rules.

The paragraph in the Workgroup's proposal (**Appendix 1**) that introduces the Campaign Rules themselves includes the statement that candidates are expected to abide by the Campaign Rules; the statement was moved from the first numbered paragraph of the Candidate's Campaign Agreement (**Appendix 5**).

Procedures Concerning Interpretation and Distribution of Campaign Rules. This section integrates material found in other areas of the current Rules (**Appendix 4**) and in the Candidates' Campaign Agreement (**Appendix 5**) with additional editing for the purposes of clarity. The material in numbered paragraph 1 of the proposed Campaign Rules was taken from paragraph 3 of the Candidates' Campaign Agreement (**Appendix 5**). The material in paragraphs 2 and 3 of the revised Campaign Rules were moved from other paragraphs 14 and 13, respectively, of the current Rules (**Appendix 4**).

Agreements between Candidates. Because the proposed revisions in the Campaign Rules contemplate merging the Campaign Rules and the Candidates' Campaign Agreement, there is no longer a need to hold an annual meeting of the candidates for the purposes of reaching agreement on the Candidates' Campaign Agreement. This will save time and money, both for the candidates and also for the ADA. However, the Workgroup considered that occasionally, the candidates may wish to reach understandings concerning aspects of the campaigns for elective officer that are not covered in the Campaign Rules that are proposed. The Workgroup proposed, therefore, that the Rules indicate that provisions not contravening or in conflict with the Campaign Rules may be negotiated between the candidates. However, Paragraph 4 of the proposed Rules makes clear that all aspects of any such agreements are the responsibility of the candidates, and that the Election Commission will not be involved in any with any privately negotiated agreements between the candidates.

Announcing Candidacy. The Workgroup believes it necessary to revamp the provisions of the current Campaign Rules (**Appendix 4**) regarding the announcement of candidacy for the offices of President-elect and Second Vice President. In reflecting on that issue, the Workgroup felt that it was possible for an individual desiring to run for office to delay their official announcement of candidacy until some point midway through the year. This has in fact occurred at least twice in recent memory in campaigns for Second Vice President. The Workgroup felt that there was nothing in the current Campaign Rules to prohibit a candidate from campaigning informally without an official announcement of candidacy and thus not being subject to the requirements of the Campaign Rules as are candidates who officially announce their candidacy. To "level the playing field" in this regard, paragraph 5 of the proposed Campaign Rules (**Appendix 1**) requires candidates for President-elect and Second Vice President to announce their candidacy on the last day of the House of Delegates session preceding their candidacy. Should candidates for President-elect and Second Vice President not announce on the last day of the House preceding their candidacy, they are foreclosed from campaigning outside their own trustee districts but are permitted to be nominated for office from the floor of the House of Delegates as stated in Chapter VI, Section B.1. of the *Governance and Organizational Manual*

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1 *of the American Dental Association (the Governance Manual)*. To allow adequate notice to candidates of this
2 change in the process of announcing candidacies, the Workgroup believes that the effective date of the
3 revisions to this paragraph of the Campaign Rules should be delayed until the close of commencement of the
4 2019 House of Delegates.

5 Paragraph 6 of the proposed Campaign Rules (**Appendix 1**) makes it clear that candidacy announcements
6 for the offices of Treasurer and Speaker of the House of Delegates are as stated in the *Governance Manual*.

7 The second, unnumbered paragraph of the “Announcing Candidacy” section of the current Campaign Rules
8 (**Appendix 4**) has been deleted in its entirety from the proposed Campaign Rules (see the third paragraph on
9 page 3 of **Appendix 3**) in light of the fact that Election Commission involvement in a candidate-negotiated
10 agreement is not contemplated under the proposed Campaign Rules, as discussed above.

11 Travel and Meeting Attendance. Generally speaking the provisions of paragraphs 7-10 of the proposed
12 campaign agreement are very similar to those that presently exist. Except for conflicts due to religious
13 holidays, when scheduling conflicts exist, candidates vote on whether to attend those events, with a majority
14 vote needed to allow attendance. The proposed Campaign Rules also allow for a candidate having a
15 scheduling conflict that prohibits personal attendance to attend the event via electronic means if that
16 capability is available to the event sponsor and the candidate.

17 One new provision in this section favored by the Workgroup is found in paragraph 9 of the proposed
18 Campaign Rules (**Appendix 1**). In light of difficulties that have occasionally arisen in past campaigns
19 respecting personal travel, the Workgroup inserted a provision that affirmatively states that personal (non-
20 campaign and non ADA business) travel or personal attendance at a meeting is permitted. Additionally, ADA
21 business-related travel and event attendance is, of course, permitted. However, under the proposed
22 Campaign Rules, all such travel by a candidate shall be disclosed to the other candidates as soon as possible
23 following the scheduling of the travel.

24 Publications and Media. Three significant differences from the current Rules are reflected in this section of
25 the recommended Campaign Rules. First, while the current Campaign Rules permit a candidate-related
26 article published in state dental journal to be distributed within the candidate’s trustee district, the Rules
27 prohibit distribution of the article beyond the district (see, **Appendix 4**, paragraph 6). The Workgroup
28 believes that this prohibition is unworkable and also unnecessary. The limitation on extra-territorial
29 distribution of articles concerning candidates plays havoc with state journals’ fulfillment of nationwide
30 subscriptions; also, some states do not put their journals behind web site firewalls, so those journals are freely
31 accessible to anyone outside the candidate’s trustee district. These issues combine to make the provision
32 extremely onerous on state associations. Moreover, the Workgroup is of the opinion that articles profiling
33 candidates contained in journals within the candidates’ home districts have very little, if any impact on those
34 individuals charged with electing ADA officers. Delegates are politically sophisticated and the Workgroup
35 feels that delegates expect articles appearing in the candidates’ home district journals to be favorable to the
36 candidate and would not allow such articles influencing election decisions.

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The second notable revision in this section of the proposed Campaign Rules is that paragraph 7 of the current Campaign Rules (**Appendix 4**) has been stricken in its entirety in favor of a new proposal allowing the use of social media by candidates. The social media aspects of the Workgroup's proposal is treated in detail below.

Finally, paragraph 12 of the proposed Campaign Rules (**Appendix 1**) adds a new provision that requires candidates to notify all organizations to which they belong (save the candidates' constituents and components) of their candidacy and request a moratorium on publishing or distributing material relating to the campaign or the candidate's candidacy. The Workgroup's consensus on this issue is that it may assist in decreasing, if not eliminating, campaign-related articles which reference the campaign for elective office or that the candidate is running for office. The Workgroup also believes that the provision makes a distinction between information related to a campaign and an article that is generally about a candidate unrelated to the campaign or an award that has been bestowed on a candidate. The latter two types of articles are permitted under the proposed Rules.

Use of Social Media. As indicated above, the Workgroup determined that candidates should be allowed to campaign using social media and the internet in order to efficiently and economically educate delegates and alternate delegates concerning candidate positions on issues relevant to dentistry and the ADA. The proposed Campaign Rules contemplate that information related to the campaign will not be made available on candidates' personal social media sites, and the proposed Rules require candidates to diligently review their personal social media sites so that any campaign-related content that is posted by third parties is quickly removed.

Paragraph 15 of the recommended Campaign Rules (**Appendix 1**) allows a candidate to establish a "closed-group" Facebook page for purposes of disseminating campaign-related information to individuals who are invited to join the closed Facebook group established by the candidate. The Rules provide that such invitations will be forwarded to delegates and alternate delegates via an email list furnished by the ADA. The Rules also contemplate that the candidate's campaign staff and the members of the Election Commission will also be able to view the candidate's Facebook campaign page.

The proposed Rules defines content that is appropriate to post on closed group Facebook campaign pages and states that negative campaigning is prohibited. The Rules also direct that candidates shall be responsible for ensuring that posts to their Facebook pages comply with the ADA's Social Media Policy and the Social Media Posting Protocol for ADA Officers and Trustees; the proposed Rules also require candidates to abide by that policy and the ADA social media protocol in any other social media activity that they undertake for their campaigns.

Campaign Literature and Communications to Delegates and Alternate Delegates. In its deliberations, the Workgroup also considered the candidates' use of campaign brochures and decided to extend the prohibition against printed brochures. The current Rules (**Appendix 4**) ban the distribution of printed brochures in the House of Delegates. The Workgroup felt that a total prohibition on printed campaign material would advance the desire for implementing further economies in the conduct of campaigns and would also be environmentally friendly. Further, with the adoption of the proposal of allowing candidates to distribute

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information relevant to campaigns via closed group Facebook pages, it was believed that the need for printed brochures to disseminate campaign information is largely obviated.

This section also collects other provisions relating to the distribution of campaign literature and communicating with delegates and alternate delegates in a single place in the proposed Campaign Rules:

- Campaign videos are still allowed, but the restrictions on length have been removed to allow the candidates themselves to determine the time parameters of their videos (paragraph 19);
- The proposed Campaign Rules still require any campaign literature (electronic) and campaign videos be reviewed by the ADA (paragraph 20);
- The parameters surrounding candidates communicating with delegates and alternate delegates via email (paragraph 21);
- The parameters surrounding candidates communicating with delegates and alternate delegates via telephone (paragraph 22); and
- A reminder that candidates are permitted to communicate regarding matters within the specific duties of the candidate's position as an ADA officer or as a member of the Board of Trustees, task force or work group, but that such communications must be only related to such responsibilities and are not to be used for campaigning, electioneering or soliciting votes.

Paragraphs 24-26 of the Campaign Rules proposed by the Workgroup also allow candidates to hold up to three telephone forums or town halls to allow campaign messages to be communicated to participants and questions to be posed to the candidates by the town hall participants. The proposed Rules contain guidelines so that the town halls are staged in a positive way that is helpful to delegates and alternate delegates.

Contributions. No revisions were deemed necessary to this section of the Campaign Rules with the exception of moving the provision on thank you notes from paragraph 5.g. of the Candidates' Campaign Agreement (**Appendix 5**).

Violations. The Commission spent considerable time considering and discussing the ramifications of violations of the Campaign Rules, especially relating to ways to ensure that delegates and alternate delegates receive information concerning unresolved violations and the timing of that notification. The Workgroup ultimately reached consensus on a two pronged notification process. First, for unresolved violations that occur more than two weeks prior to the start of the Annual Session, a report of those violations will be posted on ADA Connect. In addition, to bring information on violations to the delegates and alternates shortly before a House of Delegates session convenes, Paragraph 30 of the proposed Campaign Rules (**Appendix 1**) mandate that an email reporting such violations be sent on or about two weeks before the opening meeting of the House of Delegates.

The other prong of the notification procedure embodied in the proposed Campaign Rules is set forth in paragraph 31 of **Appendix 1**, and relates to notification of any unresolved violations occurring in the period

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WORKGROUP REPORT
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from fourteen (14) days before the convening of the House of Delegates through the holding of elections. An Election Commission report of any such violations will be given orally by the Election Commission chair (or a designee) at the first meeting of the House. If violations occur after that meeting, then the proposed Campaign Rules state that notification shall be provided to each caucus by a designee of the Election Commission personally delivering the report.

The Workgroup also discussed amending the Campaign Rules to provide the Election Commission with the power to terminate a candidate's candidacy for good cause, such as an egregious or multiple violations of the Campaign Rules, and believes providing the Election Commission with that power is appropriate. The Workgroup did not include any method by which the Election Commission is empowered to terminate the candidacy of an individual running for elective office in the proposed Campaign Rules (**Appendix 1**), however. It is believed that providing the Election Commission with that power will require an amendment to the *ADA Bylaws* and/or *Governance Manual* and should probably be considered by the House of Delegates by way of a separate resolution. It is suggested that the Election Commission consider this issue. If the Election Commission agrees that providing that power to the Election Commission is appropriate, the Workgroup will provide the Commission with a separate report covering that proposed further amendment to the Campaign Rules.

Conclusion. The Campaign Rules Workgroup wishes to thank the Election Commission for allowing it the opportunity to consider and discuss the current Campaign Rules. The Election Commission believes that the revised Campaign Rules it has submitted provide a significant and positive forward step over the current Rules in governing the campaigns for elective office. Thus, the Workgroup recommends that the Election Commission approve the Workgroup's proposal and forward the revised Rules to the House of Delegates with a recommendation that the House adopt the amended Rules. A proposed resolution to that effect follows:

Resolved, that the Election Commission approves the amendments to the Election Commission and Campaign Rules proposed by the Campaign Rules Workgroup;

and be it further

Resolved, the Election Commission recommends that the Election Commission and Campaign Rules be amended as set forth in **Appendix 3** attached to this report (additions underscored, deletions stricken through) (a clean version of the amended Campaign Rules is provided as **Appendix 1**);

and be it further

Resolved, that provisions of the revised Election Commission and Campaign Rules become effective at the adjournment *sine die* of the 2018 House of Delegates with the exception of revisions to Paragraph 5 thereof, which shall become effective at the opening of the 2019 House of Delegates.

APPENDIX 3 – ELECTION COMMISSION AND CAMPAIGN RULES**Election Commission and Campaign Rules**

The Election Commission is composed of three members: the immediate past President, and the chair and vice chair of the Council on Ethics, Bylaws and Judicial Affairs (CEBJA). The chair of CEBJA ~~the Council on Ethics, Bylaws and Judicial Affairs~~ serves as the Election Commission chair. The Speaker and the President-elect's campaign manager or appointee will serve as consultants to the Election Commission, each without the right to vote. Except as provided below, in the event that one of the members is unavailable, a replacement member will be selected by the chair of the Election Commission Council on Ethics, Bylaws and Judicial Affairs in consultation with the Election Commission. In the event that the chair is unavailable due to a conflict with a candidate, the vice chair of CEBJA shall serve as chair and shall appoint a replacement member in consultation with the Election Commission. In the event that both the chair and vice chair of CEBJA are unavailable due to conflicts with a candidate, the senior class of CEBJA shall select replacement members and the senior-most CEBJA member shall serve as chair.

The Election Commission is charged with (1) overseeing and adjudicating ~~all issues of contested elections for ADA offices~~ issues arising under the Election Commission Rules Governing the Conduct of Campaigns for all ADA Elective Officers (the Campaign Rules); (2) ~~meeting with all candidates to negotiate cost effective agreements on campaign issues such as promotional activities and gifts (which are limited to campaign pins, campaign literature, travel and electronic and other communication methods;~~ (3) informing anyone identified as being under a disciplinary sentence of suspension or probation for violating his or her duties to the constituent society within whose jurisdiction the member practices or to this Association that they are ineligible to seek elective or appointive office while under that disciplinary sentence; (3) referring any dispute of eligibility to ~~the Council on Ethics, Bylaws and Judicial Affairs-CEBJA;~~ (4) informing the House of any violation of the Campaign Rules; and (5) reviewing and proposing revisions to the Campaign Rules as required; and (6) receiving summaries of campaign revenues and expenses from candidates for all ADA elective offices.

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Resolution 24
Reference Committee D
Appendix 3

Election Commission Rules Governing the Conduct of Campaigns for All ADA Elective Officers

The following Campaign Rules govern the announcement and conduct of campaigns for ADA elective officers. These Campaign Rules will be distributed annually to all candidates, delegates, alternate delegates and other parties of interest. Candidates for elective officers are expected to abide by the Campaign Rules.

Procedures Concerning Interpretation and Distribution of the Campaign Rules

1. To the extent one or more candidates has a question concerning the interpretation of the Campaign Rules or whether a particular activity is prohibited or permitted under the Campaign Rules, the following procedures shall be followed:
 - a. Prior to contacting the Election Commission concerning the question or interpretation, candidates and/or their campaign managers shall communicate and attempt in good faith to reach a consensus on the question.
 - b. If a consensus cannot be reached:
 - i. The campaign that raised the issue shall contact the Election Commission (copying the other candidates and their campaign managers) via a brief and succinct email, state the question or interpretation that has arisen and that the campaigns were unable to reach a consensus on the issue and provide the campaign's position on the issue presented.
 - ii. Within three business days of the receipt of the email referenced in Paragraph b.i, above, any other campaign desiring to do so shall send the Election Commission a brief and succinct email setting forth that campaign's position on the question or interpretation presented to the Election Commission.
2. Any communications from a candidate to the Election Commission regarding these Campaign Rules shall be submitted to the chair of the Election Commission via email addressed to electioncommission@ada.org or by such other means as the Election Commission may from time-to-time specify.
3. It is the responsibility of each candidate to inform their campaign committee members, the constituent Executive Directors within their trustee districts and other constituent staff within their trustee districts who are assisting the campaign of these Campaign Rules within fourteen (14) days of the candidate's announcement of candidacy.

Agreements between Candidates

4. Candidates can negotiate and enter into any agreement concerning the conduct of a campaign for elective officer that does not contravene and is not in conflict with any of the Campaign Rules contained herein; agreements between candidates that narrow any of the provisions of these Campaign Rules or agreements by which the candidates forego any campaign activities permitted under these Campaign Rules are permissible. The negotiation and enforcement of any such agreement will be the responsibility of the candidates. The Election Commission will neither facilitate nor enforce any such agreement.

Announcing Candidacy

5. Candidates for President-elect and Second Vice President shall ~~not~~ formally announce their intent to run for office ~~before~~ on the final day of the annual session immediately preceding their

APPENDIX 3 – ELECTION COMMISSION AND CAMPAIGN RULES

candidacy. A formal announcement shall include, at a minimum, the name of the candidate and an identification of the office being sought. Prior to this formal announcement, candidates may freely campaign within their own trustee districts. Campaign activities outside a candidate's own trustee district shall begin only after the official announcement at the annual session. Candidates for President-elect and Second Vice President not formally announcing their candidacies on the last day of the annual session immediately preceding their candidacy shall not be permitted to campaign outside their own trustee districts but shall be permitted to be nominated for elective office at the annual session of the House of Delegates pursuant to Chapter VI., Section B.1 of the *Governance Manual of the American Dental Association (Governance Manual)*.

6. Announcements of candidacies for the offices of Treasurer and Speaker of the House of Delegates shall be stated in Chapter VI. Section B.2 and B.3., respectively, of the *Governance Manual*.

~~The Election Commission shall meet with all candidates to negotiate cost-effective agreements on campaign issues such as promotional activities and gifts (which are limited to campaign pins), travel, and electronic communications.~~

Travel and Meeting Attendance

7. Candidates for the office of President-elect shall limit their campaign travel to attending state and/or district annual meetings and/or leadership conferences and annual session district caucus meetings to which all candidates have been invited. The procedures for attendance at such events shall be as follows:
- a. Candidates for the office of President-elect may accept and attend any such event in a manner mutually agreed upon but only if all candidates have been invited.
 - b. Candidates for the office of Second Vice President, Speaker of the House of Delegates and Treasurer shall limit campaign travel to attending the district caucus meetings held during the ADA annual session.
 - c. District caucuses and state constituent societies shall issue timely invitations to the President-elect candidates through the Office of the Executive Director.
 - d. President-elect candidates shall negotiate a mutually agreeable travel schedule. It is the responsibility of the candidate and/or the campaign managers, through coordination among the campaigns, to determine the candidates' availability and respond directly to the inviting organizations. Except for conflicts due to a religious holiday observed by one or more of the candidates, candidates shall vote on whether to accept an invitation, with a majority needed to accept; a tie vote will result in accepting the invitation. A religious holiday conflict with a single candidate shall result in all the candidates declining the invitation.
 - e. Candidates who have scheduling conflicts prohibiting personal attendance at a district or caucus event may, at their option, participate in the event via electronic audio or audiovisual means available to both the candidate and the event's sponsor.
 - f. After a meeting has been accepted, if an emergency arises and a candidate must cancel their attendance, the remaining candidates may attend as planned. Candidates who cancel their attendance at an event due to an emergency may, at their option, participate in the event via electronic audio or audiovisual means available to both the candidate and the event's sponsor.

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- 140 8. Caucuses and state meetings are requested to provide an appropriate opportunity for the
141 candidates to meet with their members. It is recommended that such forums be structured to
142 allow:

- 143 a. All candidates to make presentations;
144
145 b. Caucuses freedom to assess candidates; and
146
147 c. Each candidate to respond to questions.
148

149 ~~President-elect candidates shall negotiate a mutually agreeable travel schedule and when~~
150 ~~mutually agreeable, may utilize electronic communications (e.g., Skype) to accommodate~~
151 ~~conflicts with district schedules.~~
152

- 153
154 9. Notwithstanding any of these Campaign Rules, nothing in these Rules shall prevent a
155 candidate from traveling on a personal basis or attending a meeting, conference or other event
156 as an in his or her capacity as a trustee or other officer or official of the ADA representative.
157 Campaigning while personally traveling or attending at such events when attending in as an
158 ADA capacity representative is strictly prohibited. When traveling personally or as an ADA
159 representative, candidates shall notify other candidates of such travel as soon as possible once
160 the travel has been scheduled.
161

- 162 10. Candidates shall not use campaign-sponsored social functions or hospitality suite/meeting
163 rooms on behalf of their candidacy at any regional, national or annual meeting. (This is not
164 intended, however, to limit candidates from holding campaign meetings for the purpose of
165 strategizing.) Campaign receptions are not to be held at the ADA Annual Session.
166 Additionally, a district that hosts a reception during the ADA annual session and is sponsoring a
167 candidate in a contested election shall should not host the reception prior to the officer
168 elections; a reception may be held after the election. Prior to the election, candidates shall not
169 attend events in or visit district hospitality suites. This prohibition shall not apply to a candidate
170 visiting his or her own district's hospitality suite or attending events hosted by their own district
171 exclusively for the district's members.
172

173 Publications and Media

- 174
175 11. News articles on and interviews of a candidate are permissible if published by a state dental
176 journal, ~~within the candidate's district, providing that the distribution of the journal is kept within~~
177 ~~the district, with no intentional outside distribution.~~ Online state dental journal news articles on
178 and interviews of a candidate are permissible, ~~if posted in the members' only section of the~~
179 ~~state dental association website within the candidate's district.~~ Articles about a candidate's
180 intention to run for office are permissible. Articles about why one person would make a better
181 candidate are not permissible. ~~Candidates are discouraged from participating in interviews on~~
182 ~~their leadership capacity with leadership or national journals that will be published within the~~
183 ~~timeframe of their campaign.~~
184
185 12. When announcing their candidacy for elective officer, except for the candidate's constituent and
186 component, candidates shall notify all organizations and groups to which they belong of their
187 candidacy and shall request that during the campaign such organizations and groups refrain
188 from distributing or publishing any information or material referencing the campaign or the
189 candidate's candidacy. Candidates will not use a web page, either their own or their state
190 associations. All candidates' campaign statements and profiles which appear in the ADA News
191 will be posted on the Association's website, ADA.org, in an area dedicated to candidates for
192 ADA elective offices, and on ADA Connect. Candidates are allowed to use the ADA email
193 server and their ADA.org email addresses.
194

APPENDIX 3 – ELECTION COMMISSION AND CAMPAIGN RULES

13. Candidates shall not participate in interviews on their leadership capacity with leadership or national journals that will be published within the timeframe of their campaign. Candidates shall
should not knowingly seek to have their name, photo, appearance, and writings published in
national trade or non-peer reviewed publications or websites during the campaign; and shall
should avoid submitting articles in non-peer reviewed paper or electronic publications.
Candidates who are participants in a speaker's bureau or earn revenue by speaking nationally or regionally ~~must agree to~~ shall avoid all unnecessary self-promotion during the campaign related to national speaking engagements.

Use of Social Media

14. In order to facilitate providing information to delegates and alternate delegates by candidates, any candidate may establish a closed-group Facebook page for purposes of disseminating information about the candidate's campaign and interacting with delegates and alternate delegates concerning campaign-related subjects and issues. Any such closed-group Facebook page instituted by a candidate shall comply with these Campaign Rules and shall also be governed by the ADA's Social Media Policy and the Social Media Posting Protocol for ADA Officers and Trustees. In the event of a conflict between these Campaign Rules, the Social Media Policy and the Social Media Posting Protocol for ADA Officers and Trustees, these Campaign Rules control.
- a. The Election Commission will determine the appropriate administrative settings for the closed-group campaign Facebook page that candidates may use for campaign-related posts. Those settings will be communicated by the Election Commission to the candidates shortly after the candidates announce their intention to run for elective officer.
 - b. Only delegates, alternate delegates, campaign staff and Election Commission members and staff shall be invited to join a candidate's closed-group campaign Facebook page.
 - c. Shortly after a candidate's candidacy is announced, the ADA will provide the known email addresses of delegates and alternate delegates. Using that list, invitations to join the closed-group page may be issued via email by a candidate who wishes to initiate a closed-group campaign Facebook page. Invitations to join the closed-group page may also be sent to the candidate's campaign staff and shall be sent to members and staff of the Election Commission.
 - d. Following the compilation of the list of certified delegates and alternate delegates who will attend the House of Delegates session at which the election will occur, the ADA will send the candidate an updated list of certified delegates and alternate delegates that the candidate may use to send a second closed-group campaign Facebook page invitation so that the newly listed delegates and alternate delegates may join the candidate's closed-group campaign Facebook page.
 - e. Only material that is relevant to the campaign shall be posted on a candidate's closed-group campaign Facebook page. No posts that are negative to any opposing candidate or that may be considered to be negative campaigning shall be permitted on the closed-group campaign page. Any candidate who develops a closed-group campaign Facebook page shall be responsible for the monitoring of posts to the page to ensure that posts comply with these Campaign Rules and that the posts are consistent with the ADA's Social Media Policy and the Social Media Posting Protocol for ADA Officers and Trustees.

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- 248 f. No surveys or polls shall be used or conducted via a candidate's closed-group campaign
249 Facebook page.
- 250
- 251 g. Interactions between a candidate and delegates and alternate delegates using the
252 candidate's closed-group campaign Facebook page shall not count toward any limits on a
253 candidate's contact with individual delegates and alternate delegates contained in these
254 Campaign Rules.
- 255
- 256 15. Except for the closed-group campaign activity on Facebook specified in Paragraph 14 above,
257 there shall be no campaigning using any social media platform or application.
- 258
- 259 16. Personal, non-campaign use of social media by candidates during the campaign for elective
260 officer is permitted but candidates shall not post information or material relating to the campaign
261 on personal social media sites. Candidates shall review their personal social media site settings
262 to ensure that privacy and security settings are set to allow review and deletion of any third
263 party post, and candidates shall frequently monitor their own personal Facebook pages and
264 other personal social media sites and delete any posts that references the campaign or the
265 candidate's campaign activities or posts that can be tagged for distribution to third party sites.
- 266

Campaign Literature and Communications to Delegates and Alternate Delegates Literature

- 267
- 268 17. No printed campaign-related material may be distributed in the House of Delegates or to
269 delegates and alternate delegates. ~~Materials to be distributed to the House of Delegates on~~
270 ~~behalf of any member's candidacy for office shall be limited to electronic material posted in the~~
271 ~~Candidates' section on the ADA's website. The posting should consist of one electronic~~
272 ~~brochure per candidate. There is to be no mailing of campaign literature.~~
- 273
- 274
- 275 ~~Campaign literature will be limited to no more than one posting. The distribution of literature in the~~
276 ~~House of Delegates is prohibited.~~
- 277
- 278 18. Candidates may prepare a piece of campaign literature to be electronically distributed to the
279 delegates and alternate delegates following a candidate's announcement of candidacy for
280 elective officer. Such campaign literature shall be sized so that if printed the literature is no
281 larger than four single-sided sheets of 8-1/2 X 11 inch paper. If desired, a second piece of
282 campaign literature or similar length may be electronically distributed to the delegates and
283 alternate delegates following the candidates' receipt from the ADA of the final list of certified
284 delegates and alternate delegates.
- 285
- 286 19. Each candidate may prepare a video to be distributed as described below to delegates and
287 alternate delegates and other members of the House of Delegates.
- 288
- 289 20. Each piece of literature and any video developed by any candidate shall be submitted to the
290 ADA for review and approval prior to being distributed. Such literature review may take up to
291 five (5) business days to complete. Video reviews will be completed as quickly as possible but
292 are dependent on the length of the video. The candidates shall obtain permissions to use the
293 likeness or image of any non-familial third party that appears in a piece of campaign literature
294 or in any video. Candidates shall state that such permissions have been obtained when
295 submitting the literature and any video for review. The permission should be retained by the
296 candidates and submitted to the ADA only if requested.
- 297
- 298 21. Each candidate is permitted to individually communicate with each delegate and alternate
299 delegate a single time via an electronic communication (i.e., email) for the purpose of
300 campaigning, electioneering and soliciting votes following the receipt from the ADA of the list of
301 certified delegate and alternate delegate contact information. A third party vendor may be used
302 to send such electronic communications so long as the privacy of the email addresses and

APPENDIX 3 – ELECTION COMMISSION AND CAMPAIGN RULES

- identities of the recipients are maintained and preserved and there is no ability to reply to all the recipients of the electronic communication. At each candidate's option, the candidate's electronic communication may contain the campaign literature and/or video referenced in these Campaign Rules, either by embedding or attaching the literature and/or the video to the electronic communication or by providing a hyperlink or hyperlinks that connect to the literature and/or the video that is stored in a remote location maintained by or on behalf of the candidate.
22. Each campaign is permitted to individually initiate a telephonic communication with each delegate and alternate delegate a single time for the purpose of campaigning, electioneering and soliciting votes following the receipt from the ADA of the list of certified delegate and alternate delegate contact information.
23. Nothing in these Campaign Rules shall prevent a candidate from communicating regarding matters within the specific duties of the candidate's position as an ADA officer, member of the Board of Trustees, task force or work group, as long as the communication is strictly related to such responsibilities and is not used for campaigning, electioneering or soliciting votes.
24. Candidates may each schedule up to three (3) telephone forums or town hall events during the campaign. A candidate desiring to hold up to three (3) telephone town hall events shall communicate to the ADA the date of each event and the times at which each such event shall commence and end, together with the instructions and contact information necessary for participants to email and/or call with the questions they would like asked during the telephonic town hall. The ADA will announce the telephone town hall information to delegates and alternate delegates via ADA Connect and provide the information to the Election Commission members and staff. Candidates may also publicize the telephonic town halls they sponsor on any closed-group campaign Facebook page that they maintain.
25. The agenda for a candidate's telephonic town hall meeting(s) shall be the prerogative of the candidate, with the candidates being permitted to provide opening and closing statements and whether follow-up questions are permitted. The length of the telephonic town hall event if also discretionary with the candidate.
26. No negative campaigning or negative comments concerning opposing candidates shall be permitted to be made by the candidate or any participant posing questions or making comments during the town hall event. Candidates shall be responsible for ensuring that a screening mechanism is employed during the town hall event so that broadcasting participant comments or questions that violate this provision is avoided.

Contributions

27. Contributions (including money and in kind services) are acceptable only from individual dentists, family members and ADA constituent and component dental societies, which includes component branches and study clubs recognized as part of the constituent society. Contributions from any other sources are not permissible. No candidate will knowingly accept campaign contributions which create the appearance of conflict of interest as reflected in the ADA *Bylaws*.
28. The sending of a brief note acknowledging a financial contribution or thanking a host of a campaign event to those contributors or hosts outside of the candidate's district is permitted, as long as no additional campaign message is included. Such thank you notes may be sent on campaign letterhead or a notecard containing the campaign logo; envelopes for the thank you note may contain an identification of the campaign or the campaign logo.
29. Any contribution source that could be interpreted to be a conflict of interest or creates the appearance of a conflict of interest must be reported to the Election Commission and the ADA

APPENDIX 3 – ELECTION COMMISSION AND CAMPAIGN RULES

Board of Trustees. In the event a contribution source is deemed to be a conflict of interest or creates the appearance of a conflict of interest, the candidates will be required to return the contribution.

30. Candidates for all ADA elective offices ~~shall~~ should submit a summary of campaign contributions and expenses to the Election Commission at the end of the campaign.

Violations

31. ~~In the event of a violation of the House approved rules~~ Campaign Rules is determined by the Election Commission to have occurred more than fourteen (14) days prior to the House of Delegates convening, then the Election Commission, if it cannot resolve the violation between the candidates, shall post its a report of the violation in the House of Delegates section on ADA Connect. In addition ~~Additionally, an email reporting on any such violations will be sent by the Election Commission to all each certified delegate and alternate delegate with a working email address on file with the ADA on or about fourteen (14) days prior to the convening of the House of Delegates, alerting them that the report has been posted.~~
32. ~~In the event a If violations of the Campaign Agreement or Campaign Rules are is determined by the Election Commission to have occurred in the period from fourteen (14) days prior to the convening of the House of Delegates through the elections of elective officers, then the Election Commission, if it cannot resolve those the violations between the candidates, must shall report those violations to the House of Delegates. The report of the Election Commission will be given orally by the Chair of the Election Commission chair (or a designee of the Election Commission if the chair is absent from the House of Delegates session) at the first meeting of the House. If violations occur after that meeting and before the election, then a report of such violations shall be read to each caucus by a designee of the Election Commission; that information must be shared with the caucuses by direct contact of the constituent executive directors or the caucus chairs.~~
33. In addition to the foregoing notifications of violations, all violations of the Campaign Rules that occur shall be reported orally at the House of Delegates meeting by the Election Commission.

APPENDIX 4 – COMMISSION RULES GOVERNING THE CONDUCT OF CAMPAIGNS FOR ALL ADA ELECTIVE OFFICERS**Commission Rules Governing the Conduct of Campaigns
for All ADA Elective Officers**

The following rules govern the announcement and conduct of campaigns for ADA elective officers. These rules will be distributed annually to all candidates, delegates, alternate delegates and other parties of interest.

Announcing Candidacy

1. Candidates shall not formally announce their intent to run for office before the final day of the annual session immediately preceding their candidacy. A formal announcement shall include, at a minimum, the name of the candidate and an identification of the office being sought. Prior to this formal announcement, candidates may freely campaign within their own trustee districts. Campaign activities outside a candidate's own trustee district shall begin only after the official announcement at the annual session.

The Election Commission shall meet with all candidates to negotiate cost-effective agreements on campaign issues such as promotional activities and gifts (which are limited to campaign pins), travel, and electronic communications.

Travel and meeting attendance

2. Candidates for the office of President-elect shall limit their campaign travel to attending state and/or district annual meetings and/or leadership conferences and annual session district caucus meetings. Candidates for the office of President-elect may accept and attend any such event in a manner mutually agreed upon but only if all candidates have been invited.

Candidates for the office of Second Vice President, Speaker of the House of Delegates and Treasurer shall limit campaign travel to attending the district caucus meetings held during the ADA annual session.

3. District caucuses and state constituent societies shall issue timely invitations to the President-elect candidates through the Office of the Executive Director. Caucuses and state meetings are requested to provide an appropriate opportunity for the candidates to meet with their members. It is recommended that such forums be structured to allow:

- a) all candidates to make presentations;
- b) caucuses freedom to assess candidates; and
- c) each candidate to respond to questions.

President-elect candidates shall negotiate a mutually agreeable travel schedule and when mutually agreeable, may utilize electronic communications (e.g., Skype) to accommodate conflicts with district schedules.

4. Notwithstanding any of these campaign rules, nothing in these rules shall prevent a candidate from attending a meeting, conference or other event in his or her capacity as a trustee or other officer or official of the ADA. Campaigning at such events when attending in an ADA capacity is strictly prohibited.

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5. Candidates shall not use campaign-sponsored social functions or hospitality suite/meeting rooms on behalf of their candidacy at any regional, national or annual meeting. (This is not intended, however, to limit candidates from holding campaign meetings for the purpose of strategizing.) Campaign receptions are not to be held at the ADA Annual Session. Additionally, a district that hosts a reception during the ADA annual session and is sponsoring a candidate in a contested election should not host the reception prior to the officer elections; a reception may be held after the election. Prior to the election, candidates shall not attend events in or visit district hospitality suites. This prohibition shall not apply to a candidate visiting his or her own district's hospitality suite or attending events hosted by their own district exclusively for the district's members.

Publications and media

6. News articles on and interviews of a Candidate are permissible if published by a state dental journal within the candidate's district, providing that the distribution of the journal is kept within the district, with no intentional outside distribution. Online state dental journal news articles on and interviews of a Candidate are permissible if posted in the members' only section of the state dental association website within the candidate's district. Articles about a candidate's intention to run for office are permissible. Articles about why one person would make a better candidate are not permissible. Candidates are discouraged from participating in interviews on their leadership capacity with leadership or national journals that will be published within the timeframe of their campaign.
7. Candidates will not use a web page, either their own or their state associations. All candidates' campaign statements and profiles which appear in the ADA News will be posted on the Association's website, ADA.org, in an area dedicated to candidates for ADA elective offices, and on ADA Connect. Candidates are allowed to use the ADA email server and their ADA.org email addresses.
8. Candidates should not knowingly seek to have their name, photo, appearance, and writings in national trade or non-peer reviewed publications or websites during the campaign; and should avoid submitting articles in non-peer reviewed paper or electronic publications. Candidates who are participants in a speaker's bureau or earn revenue by speaking nationally or regionally must agree to avoid all unnecessary self-promotion during the campaign related to national speaking engagements.

Literature

9. No material may be distributed in the House of Delegates. Materials to be distributed to the House of Delegates on behalf of any member's candidacy for office shall be limited to electronic material posted in the Candidates' section on the ADA's website. The posting should consist of one electronic brochure per candidate. There is to be no mailing of campaign literature.
- Campaign literature will be limited to no more than one posting. The distribution of literature in the House of Delegates is prohibited.

Contributions

10. Contributions (including money and in kind services) are acceptable only from individual dentists, family members and ADA constituent and component dental societies, which includes component branches and study clubs recognized as part of the constituent society. Contributions from any other sources are not permissible. No candidate will knowingly accept campaign contributions which create the appearance of conflict of interest as reflected in the ADA Bylaws.

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ELECTIVE OFFICERS**

Any contribution source that could be interpreted to be a conflict of interest or creates the appearance of a conflict of interest must be reported to the Election Commission and the ADA Board of Trustees. In the event a contribution source is deemed to be a conflict of interest or creates the appearance of a conflict of interest, the candidates will be required to return the contribution.

11. Candidates for all ADA elective offices should submit a summary of campaign contributions and expenses to the Election Commission at the end of the campaign.

Violations

12. In the event of a violation of the House approved rules, the Election Commission shall post its report in the House of Delegates section on ADA Connect. Additionally, an email will be sent to all delegates and alternate delegates with a working email address on file, alerting them that the report has been posted.

If violations of the Campaign Agreement or Campaign Rules are determined to have occurred, then the Election Commission, if it cannot resolve those violations between the candidates, must report those violations to the House of Delegates. The Report of the Election Commission will be given orally by the Chair of the Election Commission at the first meeting of the House. If violations occur after that meeting and before the election, then that information must be shared with the caucuses by direct contact of the constituent executive directors or the caucus chairs.

Notification

13. It is the responsibility of each candidates' campaign staff to inform state Executive Directors within their districts of these election rules.
14. Any questions regarding these Campaign Rules should be directed to the chair of the Election Commission for clarification, in the manner that is approved by the Election Commission.

Amended October 2016

APPENDIX 5 – CAMPAIGN AGREEMENT FOR ADA ELECTIVE OFFICE (PRESIDENT-ELECT)**CAMPAIGN AGREEMENT FOR ADA ELECTIVE OFFICE (PRESIDENT-ELECT)**

The following campaign agreement (“Agreement”) has been developed and is agreed to by and between the undersigned 2018 candidates for the office of ADA President-elect as of the last date indicated below.

1. Campaign Rules Control. The provisions of this Agreement are supplementary to the "Election Commission Rules Governing the Conduct of Campaigns for All ADA Elective Officers" ("Campaign Rules") adopted by the House of Delegates. The candidates are expected to abide by the Campaign Rules and by the provisions of this Agreement. In the event of conflicts between the provisions of this Agreement and the Campaign Rules, the Campaign Rules control.
2. Permitted Campaign Activity. Unless prohibited by the Campaign Rules or this Agreement, all campaign activity is permitted.
3. Procedure Concerning Interpretation of Campaign Rules and this Agreement. To the extent one or more candidates should have a question concerning the interpretation of the Campaign Rules or this Agreement or whether a particular activity is prohibited under the Campaign Rules or this Agreement, the following procedures shall be followed:
 - a. Prior to contacting the Election Commission concerning the question or interpretation, candidates and/or their campaign managers shall communicate and attempt in good faith to reach a consensus on the question.
 - b. If a consensus is reached by the candidates or their representatives, an email shall be sent to the Election Commission informing it of the issue that was raised and the agreed upon outcome of the conference call. All candidates and their campaign managers shall be copied on that communication.
 - c. If a consensus cannot be reached:
 - i. The campaign that raised the issue should contact the Election Commission (copying the other candidates and their campaign managers) via a brief and succinct email, state the question or interpretation that has arisen and that the campaigns were unable to reach a consensus on the issue and provide the campaign’s position on the issue presented.
 - ii. Within three business days of the receipt of the email referenced in Paragraph 3.c.i., above, any other campaign desiring to do so should send the Election Commission a brief and succinct email setting forth that campaign’s position on the question or interpretation presented to the Election Commission.
4. Campaign Literature. As used herein, “literature” means any brochure, curriculum vitae or video meant to be distributed to ADA members for campaign purposes.

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- 1 a. Literature to be Distributed at Constituent and/or Trustee District Meetings. Candidates may
2 each prepare a piece of campaign literature in PDF format no larger than two 8.5x11 inch pages
3 in length (when printed) for distribution at constituent and trustee district campaign-related
4 events to which all candidates have been invited and agree to appear. The same piece of
5 campaign literature, approved pursuant to the provisions of this Paragraph, shall be used for all
6 pre-annual session constituent and trustee district meetings. Staff for the Election Commission
7 shall notify constituents and trustee districts that the candidates have elected to distribute only
8 electronic campaign literature and that the campaigns will be contacting organizers of
9 constituent and trustee district campaign events to coordinate the distribution of such
10 electronic campaign literature to attendees of the event. Campaigns shall be responsible for
11 providing a copy of their literature to the organizers of such events.*
- 12 b. Candidates may prepare a piece of campaign literature no larger than four pages (single sided)
13 or two pages (double sided) in length for distribution as described below and in the Campaign
14 Rules to delegates and alternate delegates to the 2018 Annual Session of the ADA House of
15 Delegates.
- 16 c. In addition to the literature specified in sub-paragraph 4(b) of this Agreement, the candidates
17 may prepare a video no longer than one (1) minute in length to be distributed as described
18 below to delegates and alternate delegates to the 2018 Annual Session of the House of
19 Delegates and other members of the House of Delegates.

20 Each piece of literature developed by any candidate shall be submitted to the ADA for review and approval
21 prior to being distributed. The candidates shall obtain permissions to use the likeness or image of any
22 non-familial third party that appears in a piece of campaign literature. Candidates shall state that such
23 permissions have been obtained when submitting the literature for review. The permission should be
24 retained by the candidates and submitted to the ADA only if requested.

25 5. Campaign Communications.

- 26 a. Electronic Communications. Each candidate is permitted to communicate with each Delegate
27 and Alternate Delegate to the 2018 Annual Session of the ADA House of Delegates a single
28 time via an electronic communication for campaigning, electioneering and vote solicitation
29 purposes following the receipt of delegate and alternate delegate contact information.
30 A third party vendor may be used to send such electronic communications so long as the
31 privacy of the email addresses and identities of the recipients are maintained and preserved
32 and there is no ability to reply to all the recipients of the email communication. At each

* Notwithstanding the provisions of Paragraph 4.a., due to the timing of the candidates' appearance at the 2018 Yankee Dental Congress ("the Yankee Congress") in January 2018, the candidates have agreed that, for that single event, PDF formatted versions of the candidates' respective campaign brochures announcing their candidacies may be provided to the organizers of the Yankee Congress for distribution to attendees.

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1 candidate's option, the candidate's electronic communication may contain the brochure or
2 curriculum vitae and/or the video referenced in paragraph 4, above, either by embedding or
3 attaching the brochure or curriculum vitae and/or the video to the electronic communication
4 or by providing a hyperlink or hyperlinks that connect to the brochure or curriculum vitae
5 and/or the video that is stored in a remote location maintained by or on behalf of the candidate.

6 b. Oral Communications. In addition to the communication referenced in paragraph 5(a), above,
7 each campaign is permitted to communicate with each Delegate and Alternate Delegate to the
8 2018 Annual Session of the ADA House of Delegates a single time via a campaign-initiated oral
9 communication for campaigning, electioneering and vote solicitation purposes. Unless counted
10 as the single permitted electronic or oral communication with each participating delegate and
11 alternate delegate, in person or internet-based town hall meetings or telephonic or video
12 conferences with multiple delegates and alternate delegates are prohibited.

13 c. In Person or Web-Based "Town Halls" or Webinars or Conference Calls with Multiple Delegates
14 and Alternate Delegates. Where all candidates have been invited by a constituent or trustee
15 district to appear at a campaign event, the candidates may agree (with the consent of the
16 organizers of the event) that all candidates shall appear by video conference in lieu of personal
17 appearances. In the event that candidates have agreed to personally appear at an invited
18 constituent or trustee district event but one (or more) candidates thereafter are unable to
19 personally appear, that candidate or those candidates may (with the consent of the event
20 organizers) appear by video conference and the candidates without conflicts may appear in
21 person as originally planned.

22 d. Responding to Requests. Responding to a request for a response received by a candidate or
23 campaign from a delegate or alternate delegate of the House of Delegates is not a candidate-
24 initiated oral communication and does not count toward the one electronic communication or
25 the one campaign-initiated oral communication referred to in the paragraph 5(b) of this
26 Agreement.

27 e. In District Communications. Notwithstanding anything to the contrary in this Agreement, a
28 candidate is not restricted in any way from communicating with delegates and alternate
29 delegates from the Trustee District of the candidate.

30 f. Communications as a Volunteer, Officer or Trustee. Communication between a candidate and
31 any individual regarding matters within the specific duties of the candidate's position as an
32 ADA officer, member of the Board of Trustees or other volunteer position, or any other
33 duties resulting from appointment to a position, task force or work group by the House of
34 Delegates, Board of Trustees or the ADA President is permitted as long as the communication
35 is strictly related to such responsibilities and is not used for campaigning, asking for
36 support or seeking a commitment to vote for the candidate.

37 g. Thank You Notes. The sending of a brief note acknowledging a financial contribution or

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1 thanking a host of a campaign event to those contributors or hosts outside of the candidate's
2 district is permitted, as long as no additional campaign message is included. Such thank you
3 notes may be sent on campaign letterhead or a notecard containing the campaign logo;
4 envelopes for the thank you note may contain an identification of the campaign or the
5 campaign logo.

6 6. Campaign Committee.

7 a. Identification of Campaign Committee Members. The candidates agree to provide the
8 Election Commission with the names of their campaign committee members. As used herein,
9 "campaign committee members" means the campaign chair or manager and the core group of
10 individuals working with or advising the candidate on his or her campaign.

11 b. Communications with Campaign Committee Members. Notwithstanding anything to the
12 contrary in this Agreement, candidates are not restricted in any way from communicating with
13 campaign committee members for the purpose of strategizing, planning or executing an
14 election campaign.

15 7. Indication of Candidacy on Communications. Except as indicated elsewhere in this Agreement or where a
16 communication is solely a fundraising communication within a candidate's own trustee district, candidates
17 shall not indicate their candidacy on email electronic signatures or letterhead.

18 8. Use of Contact Networks Prohibited. Contact networks cannot be used in an organized fashion or directed
19 to make delegate calls. (A contact network is a group of delegates and/or alternate delegates
20 organized by the campaign to contact other delegates or alternate delegates to solicit support for their
21 candidate.) General encouragement to individuals by a candidate to make contact with acquaintances
22 who are delegates or alternate delegates of the House of Delegates to discuss a candidate or solicit
23 support is permissible.

24 9. Limitations on Give Away Items (Pins and Stickers). "Give away" items shall be limited to campaign pins
25 and/or stickers. Mass distribution or mailing of campaign give away items is not permitted, but may be
26 distributed during the campaign year either by the candidate or campaign supporters or mailed in
27 response to an individual request.

28 10. Limitation on the Wearing of Campaign Pins. Candidates attending regional or specialty meetings as
29 individual members, or attending an ADA sponsored conference or meeting within the scope of the
30 candidate's responsibilities as a volunteer, officer or member of the Board of Trustees of the ADA
31 may not wear campaign pins or any other indication of being a candidate.

32 11. Promotional Apparel. Promotional apparel is not considered a "give away" item. Distribution of
33 promotional apparel is limited to members within the candidate's district and that promotional apparel
34 should at no time be worn in advance of the annual session meeting. Any intentional distribution of
35 promotional apparel outside of the candidate's district is prohibited.

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12. Invitations to Non-ADA Sponsored Events. Invitations to attend meetings of other dental or dental-related organizations (i.e., AADA, AGD, AADB, AGO, ADEA) for the purpose of campaigning for office shall not be accepted. However, candidates may accept invitations to events of dental-related organizations held during the ADA annual meeting (i.e., receptions, breakfasts, luncheons), and attend such events *as individuals and not as candidates*. No campaigning, solicitation of votes or electioneering shall occur at such events.

13. Delegates and Alternate Delegate Contact Information. The candidates will receive an Excel spreadsheet of the 2018 delegates and alternate delegates that will include the last known phone numbers and email addresses for use by the candidates when making delegate calls/emails. This list will be provided in late July or August.

14. Material Provided to All Candidates. Written information requested from the ADA by one candidate will be routinely provided to the other candidate(s).

15. Attendance at Constituent and Trustee District Events.

a. Pre-Annual Session Meetings. Invitations to the candidates to attend constituent society and pre-annual session caucus meetings will be collected through the Office of the Executive Director and distributed by Diane Ward (wardd@ada.org). It is the candidates' and/or campaign managers' responsibility, through coordination between campaigns, to determine candidates' availability and respond directly to the inviting organization. Except for conflicts due to a religious holiday observed by one or more of the candidates, candidates shall vote on whether to accept an invitation, with a majority needed to accept; a tie vote will result in declining the invitation. A religious holiday conflict with a single candidate shall result in all the candidates declining the invitation. Should the candidates that have scheduling conflicts prohibiting personal attendance at a campaign event but are able to participate via an audio or audio/visual conference pursuant to Paragraph 5(c), above, remaining candidates may attend the event personally, at their option. Coordination between campaigns to determine if an invitation can be accepted should occur as soon as possible, but must occur within two weeks following receipt of an invitation. During such coordination, campaigns should also discuss and agree upon the period of time that the candidates will be in attendance at the constituent's or trustee district's event. If an invitation has been accepted, the candidates will communicate their travel schedules and accommodation requests directly with the inviting organization. After a meeting has been accepted by all candidates and travel arrangements made, if an emergency arises and a candidate must cancel, the remaining candidates may attend as planned.

b. Caucus Meetings at Annual Session. For district caucus meetings held during the ADA annual session, the campaign managers should coordinate those invitations and manage the candidates' schedules directly with the district caucuses. A candidate who is a member of the ADA Board of Trustees or otherwise holds an elective position at the ADA during the campaign shall use his or her best efforts during the annual meeting to

APPENDIX 5 – CAMPAIGN AGREEMENT FOR ADA ELECTIVE OFFICE (PRESIDENT-ELECT)

combine any district caucus meetings for campaign purposes with any business-related topics that the candidate may need to discuss with the caucus so that a single appearance by the candidate is made.

- c. Except as allowed by the Campaign Rules and sub-paragraph 15.a. of this Agreement, each candidate shall refrain from attending meetings or events outside the candidates' trustee district except where such attendance is directly related to the specific duties of the candidate's position as an ADA officer, member of the Board of Trustees or other volunteer position, or any other duties resulting from appointment to a position, task force or work group by the House of Delegates, Board of Trustees or the ADA President.

16. Campaign Expense Accounting. Each candidate shall provide a final and complete campaign revenue/expense report to the ADA by December 31, 2018.

17. Sharing of Agreement and Campaign Rules with Campaign Committee Members. The candidates are responsible for sharing this Agreement and the Campaign Rules with appropriate individuals within their campaigns and with their state dental associations.

18. Limitation of Campaign Activities on Election Day. Candidates and their campaigns shall refrain from campaigning, electioneering or soliciting votes at the ADA annual meeting in or around the convention center on the day of the election. Election observers representing the campaigns shall not wear any campaign pins or apparel and shall observe the prohibition against campaigning, electioneering or soliciting votes.

19. Distribution of Agreement to Board of Trustees. A copy of the executed campaign agreement will be shared with the members of the Board of Trustees.

AGREED TO:

Rickland G. Asai, DMD
Dated: January __, 2018

Chad Gehani, DDS
Dated: January __, 2018

Ronald P. Lemmo, DDS
Dated: January __, 2018

Lindsey A. Robinson, DDS
Dated: January __, 2018

APPENDIX 6 – WORKGROUP CHARGE

Campaign Rules Workgroup Members,

On behalf of the Election Commission, I want to thank each of you for agreeing to serve on the workgroup. As it discussed the need for revision of the rules under which campaigns for elective office are run, members of the Election Commission identified several topics that it hopes will be considered as you conduct your review of the campaign rules. Those topics are:

- Revise campaign rules to allow candidates to fairly use social media and electronic communications tools in campaigns.
- Tighten up the campaign rules and make sure the rules are clearer / less ambiguous.
- Consider the use of “opt-out” electronic communications of campaign-related information vs. “opt-in” or the posting of campaign literature on ADA.org or other websites.
- Rules should be distilled to a set of guiding principles
- Consider simplifying rules

As you consider your charge of recommending revisions to the campaign rules, you should not feel constrained by the existing rules, the contents of the campaign agreement that is typically entered into by the candidates each year or the size and makeup of the Election Commission. The workgroup should utilize the diverse perspectives of candidates, campaign managers and Election Commission members that are represented on the workgroup. It is hoped that the recommendations arrived at by the workgroup will lead to a set of guidelines or rules that are clear and ensure that campaigns for ADA elective offices are fair, efficient and cost effective while not being overly prescriptive on the candidates. You should remember that the ultimate goal of every ADA campaign is to provide the voting members of the House of Delegates the opportunity to evaluate the candidates and their positions on the issues that will be critical to the ADA not only during the period during which they hope to serve, but into the future as well.

To assist you in completing your charge, the following material has been assembled and is provided with this message:

- The current Election Commission and Campaign Rules; and
- The current version of the Campaign Agreement that has been agreed to by the four candidates for President-elect.

Additionally, historical material relating to the campaign rules and guidelines that have been adopted at various times by the House of Delegates have been assembled and will be forwarded to you in subsequent emails.

Finally, the Election Commission informs you that it has selected Dr. Michael H. Halasz of Ohio as chair of the workgroup. Dr. Halasz is the immediate past chair of the Election Commission and the immediate past chair of the Council on Ethics, Bylaws and Judicial Affairs. Dr. Halasz has also served as the speaker of the Ohio Dental Association (ODA) House of Delegates and will serve as the president of the ODA next year. Dr. Halasz will be in contact with you soon to schedule an initial workgroup telephone conference.

Thank you,

ADA Election Commission

Resolution No. 24S-1 AmendmentReport: ADA Election Commission Date Submitted: September 2018Submitted By: First Trustee DistrictReference Committee: D (Legislative, Health, Governance and Related Matters)Total Net Financial Implication: None Net Dues Impact: _____Amount One-time _____ Amount On-going _____ FTE 0

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

How does this resolution increase member value: Not Applicable

**AMENDMENT TO RESOLUTION 24: ADA ELECTION COMMISSION: AMENDMENT OF THE
ELECTION COMMISSION AND CAMPAIGN RULES**

The following amendment to Resolution 24 (Worksheet:5000), was adopted by the First Trustee District and transmitted on September 24, 2018, by Dr. Rich Rosato, First District Caucus Chair.

Background: The Election Commission Guidelines task force has done a tremendous job of updating the election guidelines. Their due diligence in bringing the guidelines into the digital age has been tremendous. There is one area that the First District believes could be improved in the guidelines. The time and expense of travel and visitations by candidates before the ADA Annual meeting is onerous and unnecessary in this digital age. There has been enough improvement via video, social media and digital communication that these mechanisms will suffice to make the candidates known before the face to face meetings at the ADA Annual meeting.

This amendment by deletion (Travel and Maintenance Attendance, 7 through 10), eliminates the burden on small states and individuals to finance the bulk of the current campaign costs. It also eliminates the potential ethical dilemma of using dues dollars for travel and entertainment for a relatively small group of individuals.

Resolution

24S-1. Resolved, that the Election Commission and Campaign Rules as they appear in the Manual of the House of Delegates be amended as set forth in Appendix 1 (deletions ~~stricken~~), and be it further

Resolved, that provisions of the revised Election Commission and Campaign Rules become effective at the adjournment sine die of the 2018 House of Delegates with the exception of revisions to Paragraph 5 thereof, which shall become effective at the opening of the 2019 House of Delegates.

BOARD RECOMMENDATION: Received too late for Board Comment.

Appendix 1

Election Commission and Campaign Rules

The Election Commission is composed of three members: the immediate past President, and the chair and vice chair of the Council on Ethics, Bylaws and Judicial Affairs (CEBJA). The chair of CEBJA serves as the Election Commission chair. The Speaker and the President-elect's campaign manager or appointee will serve as consultants to the Election Commission, each without the right to vote. Except as provided below, in the event that one of the members is unavailable, a replacement member will be selected by the chair of the Election Commission in consultation with the Election Commission. In the event that the chair is unavailable due to a conflict with a candidate, the vice chair of CEBJA shall serve as chair and shall appoint a replacement member in consultation with the Election Commission. In the event that both the chair and vice chair of CEBJA are unavailable due to conflicts with a candidate, the senior class of CEBJA shall select replacement members and the senior-most CEBJA member shall serve as chair.

The Election Commission is charged with (1) overseeing and adjudicating contested issues arising under the Election Commission Rules Governing the Conduct of Campaigns for all ADA Elective Officers (the Campaign Rules); (2) informing anyone identified as being under a disciplinary sentence of suspension or probation for violating his or her duties to the constituent society within whose jurisdiction the member practices or to this Association that they are ineligible to seek elective or appointive office while under that disciplinary sentence; (3) referring any dispute of eligibility to CEBJA; (4) informing the House of any violation of the Campaign Rules; (5) reviewing and proposing revisions to the Campaign Rules as required; and (6) receiving summaries of campaign revenues and expenses from candidates for all ADA elective offices.

Election Commission Rules Governing the Conduct of Campaigns for All ADA Elective Officers

The following Campaign Rules govern the announcement and conduct of campaigns for ADA elective officers. These Campaign Rules will be distributed annually to all candidates, delegates, alternate delegates and other parties of interest. Candidates for elective officers are expected to abide by the Campaign Rules.

Procedures Concerning Interpretation and Distribution of the Campaign Rules

1. To the extent one or more candidates has a question concerning the interpretation of the Campaign Rules or whether a particular activity is prohibited or permitted under the Campaign Rules, the following procedures shall be followed:
 - a. Prior to contacting the Election Commission concerning the question or interpretation, candidates and/or their campaign managers shall communicate and attempt in good faith to reach a consensus on the question.
 - b. If a consensus cannot be reached:
 - i. The campaign that raised the issue shall contact the Election Commission (copying the other candidates and their campaign managers) via a brief and succinct email, state the question or interpretation that has arisen and that the campaigns were unable to reach a consensus on the issue and provide the campaign's position on the issue presented.
 - ii. Within three business days of the receipt of the email referenced in Paragraph b.i, above, any other campaign desiring to do so shall send the Election Commission a brief and succinct email setting forth that campaign's position on the question or interpretation presented to the Election Commission.
2. Any communications from a candidate to the Election Commission regarding these Campaign Rules shall be submitted to the chair of the Election Commission via email addressed to electioncommission@ada.org or by such other means as the Election Commission may from time-to-time specify.
3. It is the responsibility of each candidate to inform their campaign committee members, the constituent Executive Directors within their trustee districts and other constituent staff within their trustee districts who are assisting the campaign of these Campaign Rules within fourteen (14) days of the candidate's announcement of candidacy.

Agreements between Candidates

4. Candidates can negotiate and enter into any agreement concerning the conduct of a campaign for elective officer that does not contravene and is not in conflict with any of the Campaign Rules contained herein; agreements between candidates that narrow any of the provisions of these Campaign Rules or agreements by which the candidates forego any campaign activities permitted under these Campaign Rules are permissible. The negotiation and enforcement of any such agreement will be the responsibility of the candidates. The Election Commission will neither facilitate nor enforce any such agreement.

Announcing Candidacy

5. Candidates for President-elect and Second Vice President shall formally announce their intent to run for office on the final day of the annual session immediately preceding their candidacy. A formal announcement shall include, at a minimum, the name of the candidate and an identification of the office being sought. Prior to this formal announcement, candidates may freely campaign within their own trustee districts. Campaign activities outside a candidate's own trustee district shall begin only after the official announcement at the annual session. Candidates for President-elect and Second Vice President not formally announcing their candidacies on the last day of the annual session immediately preceding their candidacy shall not be permitted to campaign outside their own trustee districts but shall be permitted to be nominated for elective office at the annual session of the House of Delegates pursuant to Chapter VI., Section B.1. of the *Governance Manual of the American Dental Association* (*Governance Manual*).
6. Announcements of candidacies for the offices of Treasurer and Speaker of the House of Delegates shall be as stated in Chapter VI. Section B.2. and B.3., respectively, of the *Governance Manual*.

Travel and Meeting Attendance

- ~~7.—Candidates for the office of President-elect shall limit their campaign travel to attending state and/or district annual meetings and/or leadership conferences and annual session district caucus meetings to which all candidates have been invited. The procedures for attendance at such events shall be as follows:~~
 - ~~a.—Candidates for the office of President-elect may accept and attend any such event in a manner mutually agreed upon but only if all candidates have been invited.~~
 - ~~b.—Candidates for the office of Second Vice President, Speaker of the House of Delegates and Treasurer shall limit campaign travel to attending the district caucus meetings held during the ADA annual session.~~
 - ~~c.—District caucuses and state constituent societies shall issue timely invitations to the President-elect candidates through the Office of the Executive Director.~~
 - ~~d.—President-elect candidates shall negotiate a mutually agreeable travel schedule. It is the responsibility of the candidate and/or the campaign managers, through coordination among the campaigns, to determine the candidates' availability and respond directly to the inviting organizations. Except for conflicts due to a religious holiday observed by one or more of the candidates, candidates shall vote on whether to accept an invitation, with a majority needed to accept; a tie vote will result in accepting the invitation. A religious holiday conflict with a single candidate shall result in all the candidates declining the invitation.~~
 - ~~e.—Candidates who have scheduling conflicts prohibiting personal attendance at a district or caucus event may, at their option, participate in the event via electronic audio or audiovisual means available to both the candidate and the event's sponsor.~~
 - ~~e.—After a meeting has been accepted, if an emergency arises and a candidate must cancel their attendance, the remaining candidates may attend as planned. Candidates who cancel their attendance at an event due to an emergency may, at their option, participate in the event via electronic audio or audiovisual means available to both the candidate and the event's sponsor.~~
- ~~8.—Caucuses and state meetings are requested to provide an appropriate opportunity for the candidates to meet with their members. It is recommended that such forums be structured to allow:~~

- a. ~~All candidates to make presentations;~~
- b. ~~Caucuses freedom to assess candidates; and~~
- c. ~~Each candidate to respond to questions.~~

9. ~~Notwithstanding any of these Campaign Rules, nothing in these Rules shall prevent a candidate from traveling on a personal basis or attending a meeting, conference or other event as an official ADA representative. Campaigning while personally traveling or attending events as an ADA representative is strictly prohibited. When traveling personally or as an ADA representative, candidates shall notify other candidates of such travel as soon as possible once the travel has been scheduled.~~

10. ~~Candidates shall not use campaign-sponsored social functions or hospitality suite/meeting rooms on behalf of their candidacy at any regional, national or annual meeting. (This is not intended, however, to limit candidates from holding campaign meetings for the purpose of strategizing.) Campaign receptions are not to be held at the ADA Annual Session. Additionally, a district that hosts a reception during the ADA annual session and is sponsoring a candidate in a contested election shall not host the reception prior to the officer elections; a reception may be held after the election. Prior to the election, candidates shall not attend events in or visit district hospitality suites. This prohibition shall not apply to a candidate visiting his or her own district's hospitality suite or attending events hosted by their own district exclusively for the district's members.~~

Publications and Media

11. News articles on and interviews of a candidate are permissible if published by a state dental journal. Online state dental journal news articles on and interviews of a candidate are permissible. Articles about a candidate's intention to run for office are permissible. Articles about why one person would make a better candidate are not permissible.

12. When announcing their candidacy for elective officer, except for the candidate's constituent and component, candidates shall notify all organizations and groups to which they belong of their candidacy and shall request that during the campaign such organizations and groups refrain from distributing or publishing any information or material referencing the campaign or the candidate's candidacy.

13. Candidates shall not participate in interviews on their leadership capacity with leadership or national journals that will be published within the timeframe of their campaign. Candidates shall not knowingly seek to have their name, photo, appearance, and writings published in national trade or non-peer reviewed publications or websites during the campaign, and shall avoid submitting articles in non-peer reviewed paper or electronic publications. Candidates who are participants in a speaker's bureau or earn revenue by speaking nationally or regionally shall avoid all unnecessary self-promotion during the campaign related to national speaking engagements.

Use of Social Media

14. In order to facilitate providing information to delegates and alternate delegates by candidates, any candidate may establish a closed-group Facebook page for purposes of disseminating information about the candidate's campaign and interacting with delegates and alternate delegates concerning campaign-related subjects and issues. Any such closed-group Facebook page instituted by a candidate shall comply with these Campaign Rules and shall also be governed by the ADA's Social

Media Policy and the Social Media Posting Protocol for ADA Officers and Trustees. In the event of a conflict between these Campaign Rules, the Social Media Policy and the Social Media Posting Protocol for ADA Officers and Trustees, these Campaign Rules control.

- a. The Election Commission will determine the appropriate administrative settings for the closed-group campaign Facebook page that candidates may use for campaign-related posts. Those settings will be communicated by the Election Commission to the candidates shortly after the candidates announce their intention to run for elective officer.
- b. Only delegates, alternate delegates, campaign staff and Election Commission members and staff shall be invited to join a candidate's closed-group campaign Facebook page.
- c. Shortly after a candidate's candidacy is announced, the ADA will provide the known email addresses of delegates and alternate delegates. Using that list, invitations to join the closed-group page may be issued via email by a candidate who wishes to initiate a closed-group campaign Facebook page. Invitations to join the closed-group page may also be sent to the candidate's campaign staff and shall be sent to members and staff of the Election Commission.
- d. Following the compilation of the list of certified delegates and alternate delegates who will attend the House of Delegates session at which the election will occur, the ADA will send the candidate an updated list of certified delegates and alternate delegates that the candidate may use to send a second closed-group campaign Facebook page invitation so that newly listed delegates and alternate delegates may join the candidate's closed-group campaign Facebook page.
- e. Only material that is relevant to the campaign shall be posted on a candidate's closed-group campaign Facebook page. No posts that are negative to any opposing candidate or that may be considered to be negative campaigning shall be permitted on the closed-group campaign page. Any candidate who develops a closed-group campaign Facebook page shall be responsible for the monitoring of posts to the page to ensure that posts comply with these Campaign Rules and that the posts are consistent with the ADA's Social Media Policy and the Social Media Posting Protocol for ADA Officers and Trustees.
- f. No surveys or polls shall be used or conducted via a candidate's closed-group campaign Facebook page.
- g. Interactions between a candidate and delegates and alternate delegates using the candidate's closed-group campaign Facebook page shall not count toward any limits on a candidate's contact with individual delegates and alternate delegates contained in these Campaign Rules.

15. Except for the closed-group campaign activity on Facebook specified in Paragraph 14, above, there shall be no campaigning using any social media platform or application.

16. Personal, non-campaign use of social media by candidates during the campaign for elective officer is permitted but candidates shall not post information or material relating to the campaign on personal social media sites. Candidates shall review their personal social media site settings to ensure that privacy and security settings are set to allow review and deletion of any third party post, and candidates shall frequently monitor their own personal Facebook pages and other personal social media sites and delete any posts that references the campaign or the candidate's campaign activities or posts that can be tagged for distribution to third party sites.

Campaign Literature and Communications to Delegates and Alternate Delegates

17. No printed campaign-related material may be distributed in the House of Delegates or to delegates and alternate delegates.
18. Candidates may prepare a piece of campaign literature to be electronically distributed to the delegates and alternate delegates following a candidate's announcement of candidacy for elective officer. Such campaign literature shall be sized so that if printed the literature is no larger than four single-sided sheets of 8½ x 11 inch paper. If desired, a second piece of campaign literature or similar length may be electronically distributed to the delegates and alternate delegates following the candidates' receipt from the ADA of the final list of certified delegates and alternate delegates.
19. Each candidate may prepare a video to be distributed as described below to delegates and alternate delegates and other members of the House of Delegates.
20. Each piece of literature and any video developed by any candidate shall be submitted to the ADA for review and approval prior to being distributed. Such literature review may take up to five (5) business days to complete. Video reviews will be completed as quickly as possible but are dependent on the length of the video. The candidates shall obtain permissions to use the likeness or image of any non-familial third party that appears in a piece of campaign literature or in any video. Candidates shall state that such permissions have been obtained when submitting the literature and any video for review. The permission should be retained by the candidates and submitted to the ADA only if requested.
21. Each candidate is permitted to individually communicate with each delegate and alternate delegate a single time via an electronic communication (i.e., email) for the purpose of campaigning, electioneering and soliciting votes following the receipt from the ADA of the list of certified delegate and alternate delegate contact information. A third party vendor may be used to send such electronic communications so long as the privacy of the email addresses and identities of the recipients are maintained and preserved and there is no ability to reply to all the recipients of the electronic communication. At each candidate's option, the candidate's electronic communication may contain the campaign literature and/or video referenced in these Campaign Rules, either by embedding or attaching the literature and/or the video to the electronic communication or by providing a hyperlink or hyperlinks that connect to the literature and/or the video that is stored in a remote location maintained by or on behalf of the candidate.
22. Each campaign is permitted to individually initiate a telephonic communication with each delegate and alternate delegate a single time for the purpose of campaigning, electioneering and soliciting votes following the receipt from the ADA of the list of certified delegate and alternate delegate contact information.
23. Nothing in these Campaign Rules shall prevent a candidate from communicating regarding matters within the specific duties of the candidate's position as an ADA officer, member of the Board of Trustees, task force or work group, as long as the communication is strictly related to such responsibilities and is not used for campaigning, electioneering or soliciting votes.
24. Candidates may each schedule up to three (3) telephone forums or town hall events during the campaign. A candidate desiring to hold up to three (3) telephone town hall events shall communicate to the ADA the date of each event and the times at which each such event shall commence and end, together with the instructions and contact information necessary for participants to email and/or call with the questions they would like asked during the telephonic town hall. The ADA will announce the telephone town hall information to delegates and alternate delegates via ADA Connect and provide

the information to Election Commission members and staff. Candidates may also publicize the telephonic town halls they sponsor on any closed-group campaign Facebook page that they maintain.

25. The agenda for a candidate's telephonic town hall meeting(s) shall be the prerogative of the candidate, with the candidates being permitted to provide opening and closing statements and whether follow-up questions are permitted. The length of the telephonic town hall event is also discretionary with the candidate.

26. No negative campaigning or negative comments concerning opposing candidates shall be permitted to be made by the candidate or any participant posing questions or making comments during the town hall event. Candidates shall be responsible for ensuring that a screening mechanism is employed during the town hall event so that broadcasting participant comments or questions that violate this provision is avoided.

Contributions

27. Contributions (including money and in kind services) are acceptable only from individual dentists, family members and ADA constituent and component dental societies, which includes component branches and study clubs recognized as part of the constituent society. Contributions from any other sources are not permissible. No candidate will knowingly accept campaign contributions which create the appearance of conflict of interest as reflected in the ADA *Bylaws*.

28. The sending of a brief note acknowledging a financial contribution or thanking a host of a campaign event to those contributors or hosts outside of the candidate's district is permitted, as long as no additional campaign message is included. Such thank you notes may be sent on campaign letterhead or a notecard containing the campaign logo; envelopes for the thank you note may contain an identification of the campaign or the campaign logo.

29. Any contribution source that could be interpreted to be a conflict of interest or creates the appearance of a conflict of interest must be reported to the Election Commission and the ADA Board of Trustees. In the event a contribution source is deemed to be a conflict of interest or creates the appearance of a conflict of interest, the candidates will be required to return the contribution.

30. Candidates for all ADA elective offices should submit a summary of campaign contributions and expenses to the Election Commission at the end of the campaign.

Violations

31. In the event a violation of the Campaign Rules is determined by the Election Commission to have occurred more than fourteen (14) days prior to the House of Delegates convening, then the Election Commission, if it cannot resolve the violation between the candidates, shall post a report of the violation in the House of Delegates section on ADA Connect. In addition, an email reporting on any such violations will be sent by the Election Commission to each certified delegates and alternate delegates with a working email address on file with the ADA on or about fourteen (14) days prior to the convening of the House of Delegates.

32. In the event a violation of the Campaign Rules is determined by the Election Commission to have occurred in the period from fourteen (14) days prior to the convening of the House of Delegates through the elections of elective officers, then the Election Commission, if it cannot resolve the

1 violation between the candidates, shall report those violations to the House of Delegates. The report
2 will be given orally by the Election Commission chair (or a designee of the Election Commission if the
3 chair is absent from the House of Delegates session) at the first meeting of the House. If violations
4 occur after that meeting, and before the election, then a report of such violations shall be read to
5 each caucus by a designee of the Election Commission.

6 33. In addition to the foregoing notifications of violations, all violations of the Campaign Rules that occur
7 shall be reported orally at the House of Delegates meeting by the Election Commission.

8
9 October 2018

Resolution No. 24S-2 AmendmentReport: ADA Election Commission Date Submitted: September 2018Submitted By: First Trustee DistrictReference Committee: D (Legislative, Health, Governance and Related Matters)Total Net Financial Implication: None Net Dues Impact: _____Amount One-time _____ Amount On-going _____ FTE 0

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

How does this resolution increase member value: Not Applicable

1 **AMENDMENT TO RESOLUTION 24: ADA ELECTION COMMISSION: AMENDMENT OF THE**
 2 **ELECTION COMMISSION AND CAMPAIGN RULES**

3 The following amendment to Resolution 24 (Worksheet:5000), was adopted by the First Trustee District
 4 and transmitted on September 24, 2018, by Dr. Rich Rosato, First District Caucus Chair.

5 **Background:** As the Association continues on our strategic plan, to increase membership and minimize
 6 the burden of dues on our newer dentists, with committed year by year reductions by our dues
 7 categories.

8 Piling on of the cost of ambitious individual political campaigns (subsidized by component dues
 9 contributing to those campaigns and assisted by salaried component employees) that require campaign
 10 "teams" (often comprised of family members and very close personal friends) to travel/fly around the
 11 country, hotel stays and meals for the "team, and many other affiliated costs, the Association should
 12 responsibly prohibit the use of the precious and dwindling dues revenues on non-essential and frivolous
 13 personal expenditures.

14 If deemed important, individuals and friends, should bear the burden to finance this personal political
 15 ambition for a new highly compensated position, not membership dues revenue.

16 Campaigns can still be vital and communicated by electronic and digital media, very effectively and
 17 conveniently accessed, on demand by delegates. Print material and the important speeches and verbal
 18 communication by candidates prior to the House will still be more than adequate to express a campaign.

19 Campaigns by individuals that involve commitments of Association dues to allow salaries that could later
 20 be paid directly to those individuals upon achievement of office, seems intrinsically double unfair to
 21 members. And abuse of Association finances.

22 Effectively, members pay for the individual to campaign for an office that will pay the individual a
 23 substantial personal salary, additionally paid for by the members.

24 The office seekers essentially have no personal financial stake in the attempt to increase their own salary
 25 and reach a new job. The members carry the entire burden.

26 This is borne out by the observation over the years that every member of the senior class of ADA
 27 trustees, suddenly, decides to enter the contest for the ADA president.

1 They encounter a year of travel to all parts of the country, with all flights, meals, and hotels, for their entire
2 "team" of friends and families, all borne by membership dues!

3 Use of membership dues, to finance this charade, needs to cease immediately!

4 **Resolution**

5
6 **24S-2. Resolved**, that the Election Commission and Campaign Rules as they appear in the Manual
7 of the House of Delegates be amended as set forth in Appendix 1 (additions underscored; deletions
8 ~~stricken~~), and be it further

9
10 **Resolved**, that provisions of the revised Election Commission and Campaign Rules become effective
11 at the adjournment sine die of the 2018 House of Delegates with the exception of revisions to
12 Paragraph 5 thereof, which shall become effective at the opening of the 2019 House of Delegates.

13
14 **BOARD RECOMMENDATION: Received too late for Board Comment.**
15

Appendix 1

Election Commission and Campaign Rules

The Election Commission is composed of three members: the immediate past President, and the chair and vice chair of the Council on Ethics, Bylaws and Judicial Affairs (CEBJA). The chair of CEBJA serves as the Election Commission chair. The Speaker and the President-elect's campaign manager or appointee will serve as consultants to the Election Commission, each without the right to vote. Except as provided below, in the event that one of the members is unavailable, a replacement member will be selected by the chair of the Election Commission in consultation with the Election Commission. In the event that the chair is unavailable due to a conflict with a candidate, the vice chair of CEBJA shall serve as chair and shall appoint a replacement member in consultation with the Election Commission. In the event that both the chair and vice chair of CEBJA are unavailable due to conflicts with a candidate, the senior class of CEBJA shall select replacement members and the senior-most CEBJA member shall serve as chair.

The Election Commission is charged with (1) overseeing and adjudicating contested issues arising under the Election Commission Rules Governing the Conduct of Campaigns for all ADA Elective Officers (the Campaign Rules); (2) informing anyone identified as being under a disciplinary sentence of suspension or probation for violating his or her duties to the constituent society within whose jurisdiction the member practices or to this Association that they are ineligible to seek elective or appointive office while under that disciplinary sentence; (3) referring any dispute of eligibility to CEBJA; (4) informing the House of any violation of the Campaign Rules; (5) reviewing and proposing revisions to the Campaign Rules as required; and (6) receiving summaries of campaign revenues and expenses from candidates for all ADA elective offices.

Election Commission Rules Governing the Conduct of Campaigns for All ADA Elective Officers

The following Campaign Rules govern the announcement and conduct of campaigns for ADA elective officers. These Campaign Rules will be distributed annually to all candidates, delegates, alternate delegates and other parties of interest. Candidates for elective officers are expected to abide by the Campaign Rules.

Procedures Concerning Interpretation and Distribution of the Campaign Rules

1. To the extent one or more candidates has a question concerning the interpretation of the Campaign Rules or whether a particular activity is prohibited or permitted under the Campaign Rules, the following procedures shall be followed:
 - a. Prior to contacting the Election Commission concerning the question or interpretation, candidates and/or their campaign managers shall communicate and attempt in good faith to reach a consensus on the question.
 - b. If a consensus cannot be reached:
 - i. The campaign that raised the issue shall contact the Election Commission (copying the other candidates and their campaign managers) via a brief and succinct email, state the question or interpretation that has arisen and that the campaigns were unable to reach a consensus on the issue and provide the campaign's position on the issue presented.
 - ii. Within three business days of the receipt of the email referenced in Paragraph b.i, above, any other campaign desiring to do so shall send the Election Commission a brief and succinct email setting forth that campaign's position on the question or interpretation presented to the Election Commission.
2. Any communications from a candidate to the Election Commission regarding these Campaign Rules shall be submitted to the chair of the Election Commission via email addressed to electioncommission@ada.org or by such other means as the Election Commission may from time-to-time specify.
3. It is the responsibility of each candidate to inform their campaign committee members, the constituent Executive Directors within their trustee districts and other constituent staff within their trustee districts who are assisting the campaign of these Campaign Rules within fourteen (14) days of the candidate's announcement of candidacy.

Agreements between Candidates

4. Candidates can negotiate and enter into any agreement concerning the conduct of a campaign for elective officer that does not contravene and is not in conflict with any of the Campaign Rules contained herein; agreements between candidates that narrow any of the provisions of these Campaign Rules or agreements by which the candidates forego any campaign activities permitted under these Campaign Rules are permissible. The negotiation and enforcement of any such agreement will be the responsibility of the candidates. The Election Commission will neither facilitate nor enforce any such agreement.

Announcing Candidacy

5. Candidates for President-elect and Second Vice President shall formally announce their intent to run for office on the final day of the annual session immediately preceding their candidacy. A formal announcement shall include, at a minimum, the name of the candidate and an identification of the office being sought. Prior to this formal announcement, candidates may freely campaign within their own trustee districts. Campaign activities outside a candidate's own trustee district shall begin only after the official announcement at the annual session. Candidates for President-elect and Second Vice President not formally announcing their candidacies on the last day of the annual session immediately preceding their candidacy shall not be permitted to campaign outside their own trustee districts but shall be permitted to be nominated for elective office at the annual session of the House of Delegates pursuant to Chapter VI., Section B.1. of the *Governance Manual of the American Dental Association* (*Governance Manual*).
6. Announcements of candidacies for the offices of Treasurer and Speaker of the House of Delegates shall be as stated in Chapter VI. Section B.2. and B.3., respectively, of the *Governance Manual*.

Travel and Meeting Attendance

7. Candidates for the office of President-elect shall limit their campaign travel to attending state and/or district annual meetings and/or leadership conferences and annual session district caucus meetings to which all candidates have been invited. The procedures for attendance at such events shall be as follows:
 - a. Candidates for the office of President-elect may accept and attend any such event in a manner mutually agreed upon but only if all candidates have been invited.
 - b. Candidates for the office of Second Vice President, Speaker of the House of Delegates and Treasurer shall limit campaign travel to attending the district caucus meetings held during the ADA annual session.
 - c. District caucuses and state constituent societies shall issue timely invitations to the President-elect candidates through the Office of the Executive Director.
 - d. President-elect candidates shall negotiate a mutually agreeable travel schedule. It is the responsibility of the candidate and/or the campaign managers, through coordination among the campaigns, to determine the candidates' availability and respond directly to the inviting organizations. Except for conflicts due to a religious holiday observed by one or more of the candidates, candidates shall vote on whether to accept an invitation, with a majority needed to accept; a tie vote will result in accepting the invitation. A religious holiday conflict with a single candidate shall result in all the candidates declining the invitation.
 - e. Candidates who have scheduling conflicts prohibiting personal attendance at a district or caucus event may, at their option, participate in the event via electronic audio or audiovisual means available to both the candidate and the event's sponsor.
 - e. After a meeting has been accepted, if an emergency arises and a candidate must cancel their attendance, the remaining candidates may attend as planned. Candidates who cancel their attendance at an event due to an emergency may, at their option, participate in the event via electronic audio or audiovisual means available to both the candidate and the event's sponsor.
8. Caucuses and state meetings are requested to provide an appropriate opportunity for the candidates to meet with their members. It is recommended that such forums be structured to allow:

- a. All candidates to make presentations;
 - b. Caucuses freedom to assess candidates; and
 - c. Each candidate to respond to questions.
9. Notwithstanding any of these Campaign Rules, nothing in these Rules shall prevent a candidate from traveling on a personal basis or attending a meeting, conference or other event as an official ADA representative. Campaigning while personally traveling or attending events as an ADA representative is strictly prohibited. When traveling personally or as an ADA representative, candidates shall notify other candidates of such travel as soon as possible once the travel has been scheduled.
10. Candidates shall not use campaign-sponsored social functions or hospitality suite/meeting rooms on behalf of their candidacy at any regional, national or annual meeting. (This is not intended, however, to limit candidates from holding campaign meetings for the purpose of strategizing.) Campaign receptions are not to be held at the ADA Annual Session. Additionally, a district that hosts a reception during the ADA annual session and is sponsoring a candidate in a contested election shall not host the reception prior to the officer elections; a reception may be held after the election. Prior to the election, candidates shall not attend events in or visit district hospitality suites. This prohibition shall not apply to a candidate visiting his or her own district's hospitality suite or attending events hosted by their own district exclusively for the district's members.

Publications and Media

11. News articles on and interviews of a candidate are permissible if published by a state dental journal. Online state dental journal news articles on and interviews of a candidate are permissible. Articles about a candidate's intention to run for office are permissible. Articles about why one person would make a better candidate are not permissible.
12. When announcing their candidacy for elective officer, except for the candidate's constituent and component, candidates shall notify all organizations and groups to which they belong of their candidacy and shall request that during the campaign such organizations and groups refrain from distributing or publishing any information or material referencing the campaign or the candidate's candidacy.
13. Candidates shall not participate in interviews on their leadership capacity with leadership or national journals that will be published within the timeframe of their campaign. Candidates shall not knowingly seek to have their name, photo, appearance, and writings published in national trade or non-peer reviewed publications or websites during the campaign, and shall avoid submitting articles in non-peer reviewed paper or electronic publications. Candidates who are participants in a speaker's bureau or earn revenue by speaking nationally or regionally shall avoid all unnecessary self-promotion during the campaign related to national speaking engagements.

Use of Social Media

14. In order to facilitate providing information to delegates and alternate delegates by candidates, any candidate may establish a closed-group Facebook page for purposes of disseminating information about the candidate's campaign and interacting with delegates and alternate delegates concerning campaign-related subjects and issues. Any such closed-group Facebook page instituted by a candidate shall comply with these Campaign Rules and shall also be governed by the ADA's Social

Media Policy and the Social Media Posting Protocol for ADA Officers and Trustees. In the event of a conflict between these Campaign Rules, the Social Media Policy and the Social Media Posting Protocol for ADA Officers and Trustees, these Campaign Rules control.

- a. The Election Commission will determine the appropriate administrative settings for the closed-group campaign Facebook page that candidates may use for campaign-related posts. Those settings will be communicated by the Election Commission to the candidates shortly after the candidates announce their intention to run for elective officer.
- b. Only delegates, alternate delegates, campaign staff and Election Commission members and staff shall be invited to join a candidate's closed-group campaign Facebook page.
- c. Shortly after a candidate's candidacy is announced, the ADA will provide the known email addresses of delegates and alternate delegates. Using that list, invitations to join the closed-group page may be issued via email by a candidate who wishes to initiate a closed-group campaign Facebook page. Invitations to join the closed-group page may also be sent to the candidate's campaign staff and shall be sent to members and staff of the Election Commission.
- d. Following the compilation of the list of certified delegates and alternate delegates who will attend the House of Delegates session at which the election will occur, the ADA will send the candidate an updated list of certified delegates and alternate delegates that the candidate may use to send a second closed-group campaign Facebook page invitation so that newly listed delegates and alternate delegates may join the candidate's closed-group campaign Facebook page.
- e. Only material that is relevant to the campaign shall be posted on a candidate's closed-group campaign Facebook page. No posts that are negative to any opposing candidate or that may be considered to be negative campaigning shall be permitted on the closed-group campaign page. Any candidate who develops a closed-group campaign Facebook page shall be responsible for the monitoring of posts to the page to ensure that posts comply with these Campaign Rules and that the posts are consistent with the ADA's Social Media Policy and the Social Media Posting Protocol for ADA Officers and Trustees.
- f. No surveys or polls shall be used or conducted via a candidate's closed-group campaign Facebook page.
- g. Interactions between a candidate and delegates and alternate delegates using the candidate's closed-group campaign Facebook page shall not count toward any limits on a candidate's contact with individual delegates and alternate delegates contained in these Campaign Rules.

15. Except for the closed-group campaign activity on Facebook specified in Paragraph 14, above, there shall be no campaigning using any social media platform or application.

16. Personal, non-campaign use of social media by candidates during the campaign for elective officer is permitted but candidates shall not post information or material relating to the campaign on personal social media sites. Candidates shall review their personal social media site settings to ensure that privacy and security settings are set to allow review and deletion of any third party post, and candidates shall frequently monitor their own personal Facebook pages and other personal social media sites and delete any posts that references the campaign or the candidate's campaign activities or posts that can be tagged for distribution to third party sites.

Campaign Literature and Communications to Delegates and Alternate Delegates

17. No printed campaign-related material may be distributed in the House of Delegates or to delegates and alternate delegates.
18. Candidates may prepare a piece of campaign literature to be electronically distributed to the delegates and alternate delegates following a candidate's announcement of candidacy for elective officer. Such campaign literature shall be sized so that if printed the literature is no larger than four single-sided sheets of 8½ x 11 inch paper. If desired, a second piece of campaign literature or similar length may be electronically distributed to the delegates and alternate delegates following the candidates' receipt from the ADA of the final list of certified delegates and alternate delegates.
19. Each candidate may prepare a video to be distributed as described below to delegates and alternate delegates and other members of the House of Delegates.
20. Each piece of literature and any video developed by any candidate shall be submitted to the ADA for review and approval prior to being distributed. Such literature review may take up to five (5) business days to complete. Video reviews will be completed as quickly as possible but are dependent on the length of the video. The candidates shall obtain permissions to use the likeness or image of any non-familial third party that appears in a piece of campaign literature or in any video. Candidates shall state that such permissions have been obtained when submitting the literature and any video for review. The permission should be retained by the candidates and submitted to the ADA only if requested.
21. Each candidate is permitted to individually communicate with each delegate and alternate delegate a single time via an electronic communication (i.e., email) for the purpose of campaigning, electioneering and soliciting votes following the receipt from the ADA of the list of certified delegate and alternate delegate contact information. A third party vendor may be used to send such electronic communications so long as the privacy of the email addresses and identities of the recipients are maintained and preserved and there is no ability to reply to all the recipients of the electronic communication. At each candidate's option, the candidate's electronic communication may contain the campaign literature and/or video referenced in these Campaign Rules, either by embedding or attaching the literature and/or the video to the electronic communication or by providing a hyperlink or hyperlinks that connect to the literature and/or the video that is stored in a remote location maintained by or on behalf of the candidate.
22. Each campaign is permitted to individually initiate a telephonic communication with each delegate and alternate delegate a single time for the purpose of campaigning, electioneering and soliciting votes following the receipt from the ADA of the list of certified delegate and alternate delegate contact information.
23. Nothing in these Campaign Rules shall prevent a candidate from communicating regarding matters within the specific duties of the candidate's position as an ADA officer, member of the Board of Trustees, task force or work group, as long as the communication is strictly related to such responsibilities and is not used for campaigning, electioneering or soliciting votes.
24. Candidates may each schedule up to three (3) telephone forums or town hall events during the campaign. A candidate desiring to hold up to three (3) telephone town hall events shall communicate to the ADA the date of each event and the times at which each such event shall commence and end, together with the instructions and contact information necessary for participants to email and/or call with the questions they would like asked during the telephonic town hall. The ADA will announce the telephone town hall information to delegates and alternate delegates via ADA Connect and provide

the information to Election Commission members and staff. Candidates may also publicize the telephonic town halls they sponsor on any closed-group campaign Facebook page that they maintain.

25. The agenda for a candidate's telephonic town hall meeting(s) shall be the prerogative of the candidate, with the candidates being permitted to provide opening and closing statements and whether follow-up questions are permitted. The length of the telephonic town hall event is also discretionary with the candidate.

26. No negative campaigning or negative comments concerning opposing candidates shall be permitted to be made by the candidate or any participant posing questions or making comments during the town hall event. Candidates shall be responsible for ensuring that a screening mechanism is employed during the town hall event so that broadcasting participant comments or questions that violate this provision is avoided.

Contributions

~~Contributions (including money and in-kind services) are acceptable only from individual dentists and family members and ADA constituent and component dental societies, which includes component branches and study clubs recognized as part of the constituent society.~~ Contributions (including money and in-kind services) are acceptable only from individual dentists and family members. Contributions from any other sources are not permissible. No candidate will knowingly accept campaign contributions which create the appearance of conflict of interest as reflected in the ADA *Bylaws*.

28. The sending of a brief note acknowledging a financial contribution or thanking a host of a campaign event to those contributors or hosts outside of the candidate's district is permitted, as long as no additional campaign message is included. Such thank you notes may be sent on campaign letterhead or a notecard containing the campaign logo; envelopes for the thank you note may contain an identification of the campaign or the campaign logo.

29. Any contribution source that could be interpreted to be a conflict of interest or creates the appearance of a conflict of interest must be reported to the Election Commission and the ADA Board of Trustees. In the event a contribution source is deemed to be a conflict of interest or creates the appearance of a conflict of interest, the candidates will be required to return the contribution.

30. Candidates for all ADA elective offices should submit a summary of campaign contributions and expenses to the Election Commission at the end of the campaign.

Violations

31. In the event a violation of the Campaign Rules is determined by the Election Commission to have occurred more than fourteen (14) days prior to the House of Delegates convening, then the Election Commission, if it cannot resolve the violation between the candidates, shall post a report of the violation in the House of Delegates section on ADA Connect. In addition, an email reporting on any such violations will be sent by the Election Commission to each certified delegates and alternate delegates with a working email address on file with the ADA on or about fourteen (14) days prior to the convening of the House of Delegates.

32. In the event a violation of the Campaign Rules is determined by the Election Commission to have occurred in the period from fourteen (14) days prior to the convening of the House of Delegates

1 through the elections of elective officers, then the Election Commission, if it cannot resolve the
2 violation between the candidates, shall report those violations to the House of Delegates. The report
3 will be given orally by the Election Commission chair (or a designee of the Election Commission if the
4 chair is absent from the House of Delegates session) at the first meeting of the House. If violations
5 occur after that meeting, and before the election, then a report of such violations shall be read to
6 each caucus by a designee of the Election Commission.

7 33. In addition to the foregoing notifications of violations, all violations of the Campaign Rules that occur
8 shall be reported orally at the House of Delegates meeting by the Election Commission.

9
10 October 2018

Resolution No. 32 New

Report: N/A Date Submitted: July 2018

Submitted By: Washington State Dental Association

Reference Committee: D (Legislative, Health, Governance and Related Matters)

Total Net Financial Implication: \$2,500,000 Net Dues Impact: \$25

Amount One-time Amount On-going \$2,500,000 FTE 1.5

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

How does this resolution increase member value: See Background

1 **EXPANDING DENTAL BENEFITS ADVOCACY IN THE STATE PUBLIC AFFAIRS (SPA) PROGRAM**

2 The following resolution was submitted by the Washington State Dental Association Board of Directors
3 and transmitted on July 30, 2018, by Ms. Brenda Berlin, director of operations.

4 **Background:** For the past 12 years, the State Public Affairs (SPA) program has been one of the most
5 valuable programs offered by the ADA. The program has fortified the efforts of state dental associations
6 to reduce barriers to care and oppose workforce models that allow non-dentists to perform irreversible
7 procedures. It has also helped state dental associations better showcase the good works of dentists and
8 provided extremely useful research and messaging on several important access issues. The SPA
9 program is a shining example of the power of coordinated work between the ADA and state dental
10 associations. Historically, the vast majority of SPA funds have been spent on dental access-to-care
11 issues.

12 Routinely, members of organized dentistry identify issues with dental benefits carriers as one of the
13 highest priorities (if not the highest priority) for which the tripartite should be focused. Investing in robust
14 dental benefits advocacy is an investment that will strongly resonate with all members of organized
15 dentistry.

16 Within the dental benefits arena, the ADA, state dental associations, and individual dentists must be fully
17 aware of antitrust law and the consequences of violating the law. We must not engage in any activities or
18 facilitate any agreements that are anticompetitive or seek to fix prices or drive individual practice
19 decisions to support or boycott specific benefit plans. However, Associations can engage in several
20 activities that do not violate antitrust law, including legislative advocacy, litigation in the courts, matters
21 before administrative bodies, and exercising governance rights with dental benefit provider organizations,
22 if applicable. Organized dentistry can also lead a public education campaign focused on informing
23 consumers that dental "insurance" is not actually insurance at all and explain the pitfalls with dental
24 benefits plans. The ADA can also showcase solutions that will benefit those who have and pay for dental
25 benefit coverage.

26 The American Dental Association should replicate the success it has achieved with access-to-care issues
27 in the SPA program with increased funding specifically focused on dental benefits advocacy. In addition
28 to providing states with financial public affairs and/or legal assistance, this increased investment should
29 help share best practices and coordinate activities between states, appropriate ADA committees and
30 boards, and external public affairs and legal experts. Isolated state-by-state efforts can grow into larger
31 campaigns with national momentum. The investment would focus on important dental benefit topics
32 including, but not limited to: loss ratio transparency, estimation and coordination of benefits, actions by

1 carriers to inappropriately interfere in the doctor-patient relationship, attempts by dental benefits carriers
2 to arbitrarily rate or tier enrolled providers, and supporting enrolled providers in enforcing provisions of
3 provider agreements. Additionally, the new program can help monitor trends in dental benefits across the
4 country and identify issues to be addressed on behalf of members.
5

6 **Resolution**

7 **32. Resolved**, that for the 2019 ADA Budget Year, funding for the State Public Affairs program be
8 increased by \$2,500,000 for dental benefits advocacy with \$1,500,000 allocated for in-state public
9 affairs and legal support and \$1,000,000 allocated for national coordination and the retention of
10 national public affairs and legal support.
11

12 **BOARD COMMENT:** The Board thanks the Washington State Dental Association for emphasizing the
13 need to expand dental benefits advocacy within the State Public Affairs (SPA) program.
14

15 The Board, after consultation with the members of the SPA Oversight Workgroup, supports making
16 \$125,000 available for competitive grant requests from all state associations in 2018-2019. These
17 existing SPA funds would be used in order to pilot test the value of this notion. In 2019, the Oversight
18 Workgroup will report to the Board on the level of interest by state associations in pursuing dental benefits
19 advocacy grants and any initial results of their efforts.
20

21 Therefore, based on the untested nature of the program as described, the Board proposes a no vote on
22 Resolution 32.

23 **BOARD RECOMMENDATION: Vote No.**

24 **BOARD VOTE: UNANIMOUS.**

Resolution No. 44 New

Report: N/A Date Submitted: September 2018

Submitted By: Council on Ethics, Bylaws and Judicial Affairs

Reference Committee: D (Legislative, Health, Governance and Related Matters)

Total Net Financial Implication: None Net Dues Impact: _____

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

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

How does this resolution increase member value: See Background

AMENDMENT OF THE POLICY ENTITLED "STATEMENT REGARDING EMPLOYMENT OF A DENTIST"

Background: In accord with Resolution 170H-2012, Regular Comprehensive Policy Review, the Council on Ethics Bylaws and Judicial Affairs recommends that the policy Statement Regarding Employment of a Dentist (*Trans.2013:353*) be amended. The Council believes that the proposed amendment makes the policy clearer and easier to read.

The Council therefore recommends adoption of the following resolution:

Resolution

44. Resolved, that policy entitled "Statement Regarding Employment of a Dentist" (*Trans.2013:353*) be amended as indicated (additions underscored, deletions ~~stricken through~~):

Statement Regarding Employment of a Dentist

Statement Regarding Employment of a Dentist^{*}

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

- I. As described in the *ADA Principles of Ethics and Code of Professional Conduct*, dentists' paramount responsibility is to their patients. An employee dentist should not be disciplined or retaliated against for exercising independent professional judgment in patient assessment, diagnosis, treatment and comprehensive management, including with respect to but not limited to:
 - a. The use of any materials, or the delivery of a prosthetic device, that represents an acceptable standard of care or the refusal to use materials or deliver a prosthetic

device that does not represent an acceptable standard of care;

- b. The use of techniques that are reasonably believed to be within the standard of care and are in the patient's best interest or the refusal to use techniques that are not within the standard of care and are not in the patient's best interests (recognizing the patient's right to select among treatment options);
- c. The mandated provision of treatment that the employee dentist feels unqualified to deliver; and
- d. The provision of treatment that is not justified by the employee dentist's personal diagnosis for the specific patient.

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

- a. Appropriate business practices, including but not limited to billing practices, are followed;
- b. Facilities and equipment are maintained to accepted standards; and
- c. Employment contractual obligations are adhered to.

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

- a. Guard against lay interference in the exercise of a dentist's independent professional judgment in patient assessment, diagnosis, treatment and comprehensive management;
- b. To the extent permitted by law, promptly provide the dentist access to all relevant patient records in the event of peer review, board complaint or lawsuit, both during and subsequent to the dentist's employment; and
- c. Recognize and honor the dentist's commitment, as an ADA member, to comply with *the ADA Principles of Ethics and Code of Professional Conduct*.

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

and be it further

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

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

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

Resolution No. 45 New

Report: N/A Date Submitted: September 2018

Submitted By: Council on Ethics, Bylaws and Judicial Affairs

Reference Committee: D (Legislative, Health, Governance and Related Matters)

Total Net Financial Implication: None Net Dues Impact: _____

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

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

How does this resolution increase member value: See Background

AMENDMENT OF CHAPTER VIII, SECTION F. OF THE GOVERNANCE AND ORGANIZATIONAL MANUAL OF THE AMERICAN DENTAL ASSOCIATION

Background: Chapter VIII, Section F of the *Governance and Organizational Manual of the American Dental Association* (the *Governance Manual*) states as follows:

F. Vacancy. In the event of a vacancy in the membership of any council, the President shall appoint a member of the Association possessing the same qualifications as established by the *Bylaws* or this *Governance Manual* for the previous member, to fill such vacancy until a successor is elected by the next House of Delegates for the remainder of the unexpired term. In the event such vacancy involves the chair of the council, the President shall have the power to appoint an ad interim chair. In the event it is the current recipient of the Gold Medal Award for Excellence in Dental Research who cannot serve on the Council on Scientific Affairs, the President, in consultation with the Board of Trustees, shall have the power to appoint a prominent research scientist who shall serve until the award is bestowed on the next honoree.

If the term of the vacated council position has less than fifty percent (50%) of a full term remaining at the time the successor member is appointed or elected, the successor member shall be eligible for election to a new term. If fifty percent (50%) or more of the vacated term remains to be served at the time of the appointment or election, the successor member shall not be eligible for another term.

As currently stated, an individual filling a council vacancy is eligible to complete only the remaining term of the vacated position if two (2) or more years of the position's term exists when the new member is either appointed by the President or thereafter elected by the House of Delegates. If less than two (2) years exist in the vacated position's term at the time the replacement member is appointed or elected, then the new member is eligible for election to a full four year term on the council following the completion of the remainder of the term of the vacated position.

Analysis: In early 2018, the Council received a request to examine the procedures for filling a vacancy. Further to that study, the Council received information that it may be difficult to attract the best candidate to fill a vacated position when if the timing of the vacancy is such that the candidate will have less than a full term of service and will be ineligible to serve an additional full term. Indeed, the Council became aware of instances where it appeared that a vacant council position went unfilled until such time as the volunteer filling the vacant position would have the opportunity to serve an additional full term at the

1 completion of the volunteer's tenure in the vacated position's partial term, which may result in denying the
2 House of Delegates being informed and allowed to approve of the successor appointment in a timely
3 fashion. Either of those occurrences is problematic. To succeed as an organization, the ADA needs to
4 be able to attract the best and most knowledgeable individuals available to fill council positions. And
5 where positions on councils remain vacant for an extended period of time, trustee districts are being
6 deprived from the representation on those councils that are guaranteed to them by the ADA *Bylaws*.
7

8 The Council appreciates and agrees with the principle of limiting the length of service of elected
9 individuals that underlies the council vacancy provisions. However, that principle must be balanced
10 against the deleterious effects of the council vacancy provisions presently included in the ADA *Bylaws*.
11 As a result of the review of the vacancy provisions of the ADA *Bylaws*, the Council concluded that the ill
12 effects of the council vacancy provision would be reduced if the provisions were amended to allow for
13 reappointment to a full four year term if the volunteer involved served two years or less in a vacated
14 position after being elected to the position by the House of Delegates. The change proposed would,
15 however, still preserve the principle of term limits for council positions.
16

17 The Council therefore recommends adoption of the following resolution:
18

19 Resolution

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21 **45. Resolved**, that Chapter VIII., Section F. of the *Governance and Organizational Manual of the*
22 *American Dental Association* be amended as follows (additions underscored, deletions ~~stricken~~
23 ~~through~~):
24

25 F. Vacancy. In the event of a vacancy in the membership of any council, the President shall
26 appoint a member of the Association possessing the same qualifications as established by
27 the *Bylaws* or this *Governance Manual* for the previous member, to fill such vacancy until a
28 successor is elected by the next House of Delegates for the remainder of the unexpired term.
29 In the event such vacancy involves the chair of the council, the President shall have the
30 power to appoint an ad interim chair. In the event it is the current recipient of the Gold Medal
31 Award for Excellence in Dental Research who cannot serve on the Council on Scientific
32 Affairs, the President, in consultation with the Board of Trustees, shall have the power to
33 appoint a prominent research scientist who shall serve until the award is bestowed on the
34 next honoree.
35

36 If the term of the vacated council position has ~~less than~~ fifty percent (50%) or less of a full
37 term remaining at the time the successor member is ~~appointed or~~ elected to the position by
38 the House of Delegates, the successor member shall be eligible for election to a new term. If
39 more than fifty percent (50%) ~~or more~~ of the vacated term remains to be served at the time of
40 ~~the appointment or~~ the appointment or successor member's election by the House of Delegates, the successor
41 member shall not be eligible for another term.

42 **BOARD RECOMMENDATION: Vote Yes.**

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

Resolution No. 46 New

Report: N/A Date Submitted: September 2018

Submitted By: Council on Ethics, Bylaws and Judicial Affairs

Reference Committee: D (Legislative, Health, Governance and Related Matters)

Total Net Financial Implication: None Net Dues Impact: _____

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

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

How does this resolution increase member value: See Background

AMENDMENT TO CHAPTER I OF THE GOVERNANCE AND ORGANIZATIONAL MANUAL OF THE AMERICAN DENTAL ASSOCIATION RELATING TO CAMPAIGN RULES ADOPTED BY THE HOUSE OF DELEGATES

Background: The parliamentary authority of the American Dental Association, the American Institute of Parliamentarians Standard Code of Parliamentary Procedure (*The Standard Code*), speaks of the right of a member of an organization to run for office and to nominate and elect officers and directors of the organization as “fundamental,” subject only to limitations expressed in the organization’s bylaws. Chapter I of the *Governance and Organizational Manual of the American Dental Association (Governance Manual)* lists the benefits and privileges of membership in the ADA. Among the privileges enjoyed by active, retired, life and provisional members is the right to run for elective office in the Association (see, Chapter I, Sections A.1.e. (first paragraph), A.2.e. (first paragraph), A.3.e. (first paragraph) and A.5.e. (first paragraph). Illustrative is the first paragraph of Section A.1.e., relating to active members:

e. Active members in good standing are eligible for election as a delegate or alternate delegate to the ADA House of Delegates and are also eligible for election or appointment to any office or agency of the ADA, except as may be otherwise provided in the ADA *Bylaws* or this *Governance Manual*.

The *Governance Manual* also expresses limitations on the right to be eligible to hold elective office. Again, when addressing active members, the second paragraph of Chapter I, Section A.1.e. states:

Active members under a disciplinary sentence of suspension or probation are not entitled to hold elective or appointive office, including delegate and alternate delegate, in the ADA or the members’ constituents or components. Also, such suspended or probated active members may not vote or otherwise participate in the selection or election of officers or other officials of the ADA or the members’ components and constituents.

Similar limitations as they relate to retired, life and provisional members are found at Chapter I, Sections A.2.e. (second paragraph), A.3.e. (second paragraph) and A.5.e. (second paragraph).

Discussion: For quite some time, candidates running for elective office have been subject to abiding by the Campaign Rules enacted by the House of Delegates and administered by the Election Commission. The current Election Commission and Campaign Rules can be found at https://www.ada.org/~media/ADA/Member%20Center/Files/EC_Rules_Governing_Conduct_of_Campaigns.pdf?la=en. Recently, the Speaker of the House of Delegates raised a concern that no mention of the Campaign Rules is made in either the ADA *Bylaws* or in the *Governance Manual*. If the Campaign Rules are

1 construed to be limitations on the right of active, retired, life and provisional members to run for office or on
2 the rights of members to nominate and vote for the candidates of their choice, then, under the ADA's
3 parliamentary authority, *The Standard Code*, that limitation should be codified in the governance documents
4 of the ADA.

5
6 Consequently, the House of Delegates is requested to amend Chapter I of the *Governance Manual* as set
7 forth in the following resolution:

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9 **Resolution**

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11 **46. Resolved**, that Chapter I of the *Governance and Organizational Manual of the American Dental*
12 *Association* be amended as follows (additions underscored, deletions ~~stricken through~~):

13
14 Chapter I, Section A.1.e. (first paragraph):

15 e. Active members in good standing are eligible for election as a delegate or alternate delegate
16 to the ADA House of Delegates and, subject to any limitation adopted by the House of
17 Delegates in the Election Commission and Campaign Rules, are also eligible for election or
18 appointment to any office or agency of the ADA, except as may be otherwise provided in the
19 ADA *Bylaws* or this *Governance Manual*.

20
21 Chapter I, Section A.2.e. (first paragraph):

22 e. Retired members in good standing are eligible for election as a delegate or alternate
23 delegate to the ADA House of Delegates and, subject to any limitation adopted by the House of
24 Delegates in the Election Commission and Campaign Rules, are also eligible for election or
25 appointment to any office or agency of the ADA, except as may be otherwise provided in the
26 ADA *Bylaws* or this *Governance Manual*.

27
28 Chapter I, Section A.3.e. (first paragraph):

29 e. Life members in good standing are eligible for election as a delegate or alternate delegate to
30 the ADA House of Delegates and, subject to any limitation adopted by the House of Delegates
31 in the Election Commission and Campaign Rules, are also eligible for election or appointment
32 to any office or agency of the ADA, except as may be otherwise provided in the ADA *Bylaws* or
33 this *Governance Manual*.

34
35 Chapter I, Section A.5.e. (first paragraph):

36 e. Provisional members in good standing are eligible for election as a delegate or alternate
37 delegate to the ADA House of Delegates and, subject to any limitation adopted by the House of
38 Delegates in the Election Commission and Campaign Rules, for election or appointment to any
39 office or agency of the ADA, except as may be otherwise provided in the ADA *Bylaws* or this
40 *Governance Manual*.

41 **BOARD RECOMMENDATION: Vote Yes.**

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

Resolution No. 47 New

Report: N/A Date Submitted: September 2018

Submitted By: Council on Ethics, Bylaws and Judicial Affairs

Reference Committee: D (Legislative, Health, Governance and Related Matters)

Total Net Financial Implication: None Net Dues Impact: _____

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

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

How does this resolution increase member value: See Background

AMENDMENT OF CHAPTER VIII, SECTION K.6.B. OF THE GOVERNANCE AND ORGANIZATIONAL MANUAL OF THE AMERICAN DENTAL ASSOCIATION

Background: In 2017, the Council on Ethics, Bylaws and Judicial Affairs proposed, and the House of Delegates adopted, a major revision to the ADA *Constitution and Bylaws*. Among the revisions adopted was the moving of operational and procedural details contained in the *Bylaws* to a new manual, the *Governance and Organizational Manual of the American Dental Association* (the *Governance Manual*).

Under the scheme of the previous edition of the ADA *Bylaws*, the Council was charged with the responsibility for the ADA *Constitution and Bylaws*. That responsibility continues in the revised documents adopted in 2017, and specifically Chapter VIII, Section K.6.b. of the *Governance Manual*:

6. Council on Ethics, Bylaws and Judicial Affairs. The areas of subject matter responsibility of the Council shall be:

* * *

- b. The *Constitution and Bylaws* of this Association, including:

- Review of the constitutions and bylaws of constituents and components to ensure consistency with the Association's *Bylaws*; and
- Correct punctuation, grammar, spelling and syntax, change names and gender references and delete moot material where such revisions do not alter the material's context or meaning in the *Bylaws* and the *Governance Manual* upon the unanimous vote of the Council members present and voting; and

* * *

Following the passage of the revisions to the ADA *Constitution and Bylaws* and the adoption of the *Governance Manual* by the House of Delegates in 2017, it was noticed that the reference to the *Governance Manual* in the second subparagraph of Section K.6.b. lacked an antecedent basis. To correct this oversight, the Council proposes to insert a reference to the *Governance Manual* in subsection b., so that it is clear that the Council has the responsibility not only for the *Constitution and Bylaws*, but also for the *Governance Manual*.

The Council therefore recommends adoption of the following resolution:

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Resolution

47. Resolved, that Chapter VIII., Section K.6.b. of the *Governance and Organizational Manual of the American Dental Association (Governance Manual)* be amended as follows (additions double underscored):

6. Council on Ethics, Bylaws and Judicial Affairs. The areas of subject matter responsibility of the Council shall be:

* * *

- b. The ADA Constitution and Bylaws and the Governance Manual of this Association, including:

- Review of the constitutions and bylaws of constituents and components to ensure consistency with the Association's *Bylaws*; and
- Correct punctuation, grammar, spelling and syntax, change names and gender references and delete moot material where such revisions do not alter the material's context or meaning in the *Bylaws* and the *Governance Manual* upon the unanimous vote of the Council members present and voting; and

* * *

23 **BOARD RECOMMENDATION: Vote Yes.**

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

Resolution No. 48 New

Report: N/A Date Submitted: September 2018

Submitted By: Council on Ethics, Bylaws and Judicial Affairs

Reference Committee: D (Legislative, Health, Governance and Related Matters)

Total Net Financial Implication: None Net Dues Impact: _____

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

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

How does this resolution increase member value: See Background

AMENDMENT OF THE POLICY ENTITLED "DEFINITION OF COMMITTEES"

Background: In accord with Resolution 170H-2012, Regular Comprehensive Policy Review, the Council on Ethics Bylaws and Judicial Affairs recommends that the policy Definitions of Committees (*Trans.*2001:421; 2013:340) be amended. The Council believes that the proposed amendments make the policy clearer and easier to read. The Council therefore recommends adoption of the following resolution:

Resolution

48. Resolved, that policy entitled "Definition of Committees" (*Trans.*2001:421; 2013:340) be amended as indicated (additions underscored, deletions ~~stricken through~~):

Definitions of Committees

Resolved, that the American Dental Association accepts the following definitions for the terms standing committee, special committee and subcommittee:

Standing committee—A standing committee is a group of members whose work, assignments, or tasks are ongoing, ~~and that A standing committee~~ performs any work within its particular field either assigned to it by the *Bylaws* or referred to it by the House of Delegates or Board of Trustees.

Special committee (also known as a Task Force)—A special committee or task force is a group of members created by the House of Delegates or, when the House is not in session, by the Board of Trustees, ~~to~~ It will perform specific tasks not otherwise assigned by the *Bylaws*, ~~and which ceases~~ A special committee will cease to exist either when its assigned task is completed or with the adjournment *sine die* of the annual session of the House of Delegates following its creation.

Subcommittee—A subcommittee is a subgroup of a body ~~which is~~ created for a specific purpose within the jurisdiction of that body, It may have authority delegated to it by the body, and which reports and is responsible to only the delegating body, ~~which A delegating body~~ may be a council, committee or commission.

BOARD RECOMMENDATION: Vote Yes.

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

Resolution No. 49 New

Report: N/A Date Submitted: September 2018

Submitted By: Council on Ethics, Bylaws and Judicial Affairs

Reference Committee: D (Legislative, Health, Governance and Related Matters)

Total Net Financial Implication: None Net Dues Impact: _____

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

ADA Strategic Plan Objective: Membership-Obj. 2: Net increase of 4,000 active licensed members by end of 2019

How does this resolution increase member value: See Background

AMENDMENT OF THE POLICY ENTITLED "THE DENTIST'S PRAYER"

Background: In accord with Resolution 170H-2012, Regular Comprehensive Policy Review, the Council on Ethics Bylaws and Judicial Affairs recommends that the policy The Dentist's Prayer (*Trans.*1991:643) be amended. The Council is concerned that, as presently worded, the policy may be viewed at least as unwelcoming and, at worst, a barrier, to member and non-member dentists not of Christian faiths. If that is the case, the policy would be in conflict with another ADA policy, Diversity in Association Membership Marketing and Consumer-Related Materials (*Trans.*1995:606) which states in part:

Resolved, that the American Dental Association is committed to promoting an inclusive environment that values and embraces the diversity of its membership ...

Indeed, there is some indication that the Association is sensitive to the fact that prayer may be objectionable to some, in that ADA policy also contains a policy recognizing religious diversity, Recognition of Religious Diversity (*Trans.*1995:607):

Resolved, that in recognition of the religious diversity of the membership, all meetings of this Association that begin with a prayer or invocation also include a moment of reflection.

Finally, to the extent that the policy in question is perceived to be unwelcoming to non-Christian dentists or a membership barrier to those dentists, the policy appears not to be aligned with the membership goal of the ADA's current strategic plan, Members First 2020. In particular, the policy may work against the second objective of the membership goal of the strategic plan, attaining an increase of 4,000 active licensed dentists by the conclusion of 2019.

The Council believes that the Association's policy of diversity and inclusion could be strengthened and the concern that The Dentist's Prayer may be seen as unwelcoming and a barrier to membership by deleting the words "O Lord" from the first line and revising "your" to "an" in the second line of the prayer. The proposed revisions would, the Council believes, transform The Dentist's Prayer from a Christian prayer to a policy that can be embraced by all members of the religiously diverse Association.

The Council therefore recommends adoption of the following resolution:

Proposed Resolution

49. Resolved, that The Dentist's Prayer (*Trans.*1991:643) be amended as indicated (additions underscored, deletions ~~stricken through~~):

The Dentist's Prayer

Resolved, that the American Dental Association express its belief on quality assurance by accepting the first general Parameter of Care:

Please take a moment if you wish, in your own faith or tradition, as we say The Dentist's Prayer:

The Dentist's Prayer

Thank you, ~~O Lord~~, for the privilege of being a dentist,

For letting me serve ~~as your instrument~~ in ministering to the sick and afflicted,

May I always treat with reverence the human life which ~~you have~~ has been brought into being and which I serve,

Deepen my love for people so that I will always give myself gladly and generously to those stricken with illness and pain,

Help me to listen patiently, diagnose carefully, prescribe conscientiously, and treat gently,

Teach me to blend gentleness with skill,

To be a dentist with a heart as well as a mind.

Joseph G. Kalil, D.D.S.
Modified October 2018

BOARD COMMENT: The Board appreciates the Council's sensitivity to and support of the Association's efforts to become a more diverse and inclusive organization in its consideration of this policy. During the Board's discussion of the resolution proposed by the Council, there was concern expressed that amending "The Dentist's Prayer" might itself be offensive to members. Ultimately, the Board's discussion evolved into a broader discussion of the role that religion and faith should play in the Association, a question that underlies the divergent opinions on this resolution. The Board believes that this underlying question needs to be addressed in order to reach a satisfactory conclusion on whether ADA policy should include "The Dentist's Prayer" and, if so, whether revisions to "The Dentist's Prayer" should be adopted. Consequently, the Board of Trustees recommends that the House refer the question of the proper role of faith and religion in the Association to the appropriate agency and to consider "The Dentist's Prayer" in light of the conclusions reached, following which a report on the referral be made to the 2019 House of Delegates.

BOARD RECOMMENDATION: Vote Yes on Referral.

BOARD VOTE: UNANIMOUS.

Resolution No. 50 New

Report: N/A Date Submitted: September 2018

Submitted By: Council on Ethics, Bylaws and Judicial Affairs

Reference Committee: D (Legislative, Health, Governance and Related Matters)

Total Net Financial Implication: None Net Dues Impact: _____

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

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

How does this resolution increase member value: Not Applicable

AMENDMENT OF SECTION 4.A. OF THE ADA PRINCIPLES OF ETHICS AND CODE OF PROFESSIONAL CONDUCT

Background: The National Council on Disability (“NCD”), an independent federal agency, contacted the ADA early in 2018 and requested that the ADA revise Section 4.A. of the ADA *Principles of Ethics and Code of Professional Conduct* (“the ADA Code”). The request was accompanied by the NCD’s “issue brief” entitled “Neglected for Too Long: Dental Care for People with Intellectual and Developmental Disabilities.” By its request, NCD requested that the ADA consider the amendment of the ADA Code “to better reflect the rights of people with disabilities.”

Discussion: Initially, the Council declined to make the substantial modifications to Section 4.A. of the ADA Code requested by NCD (see Appendix 1, Worksheet:5056), reasoning that Section 4.A. in its present form is far broader than NCD’s reading of the provision. The Council did, however, indicate to NCD that it was amenable to modifying Advisory Opinion 4.A.1. to explicitly state that it is unethical to refuse treatment solely because of the intellectual or developmental disability of the patient and to emphasize that if so, consultation or referral pursuant to Section 2.B. of the ADA Code is called for if an individual practitioner is ill equipped to treat a disabled patient.

In reply to the Council’s response, NCD presented a much abbreviated amendment to Section 4.A. of the Code which when considered, was approved by the Council. The renewed request comprises the addition of the word “disability” to the existing list of attributes listed in Section 4.A. Consequently, the Council proposes that the House of Delegates revise Section 4.A. of the ADA Code as shown in the following resolution:

Resolution

50. Resolved, that Section 4.A. of the ADA *Principles of Ethics and Code of Professional Conduct* be amended as indicated (additions underscoring, deletions ~~stricken through~~):

4.A. PATIENT SELECTION

While dentists, in serving the public, may exercise reasonable discretion in selecting patients for their practices, dentists shall not refuse to accept patients into their practice or deny dental service to patients because of the patient’s race, creed, color, gender, sexual orientation, or gender identity, ~~or~~ national origin or disability

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

National Council on Disability

Issue Brief



Highlights

- Though it does prohibit other forms of discrimination, the American Dental Association's *Principles of Ethics and Code of Professional Conduct* does not currently prohibit a practitioner from refusing to accept a patient based on their disability, generally.
- The American Academy of Developmental Medicine notes that people with I/DD regularly face an uphill battle in finding clinicians properly trained to treat them because most dentists lack proper training and exposure regarding the health and psychological needs of the I/DD population.
- Requirements of the Commission on Dental Accreditation do not require that dental school graduates be proficient in treating patients with I/DD, they only require graduates be competent in "assessing" treatment needs.
- Absent more generous Medicaid coverage, solutions must be sought to help encourage dental care providers to serve this underserved population despite the financial predicaments of those providers.

Neglected for Too Long: Dental Care for People with Intellectual and Developmental Disabilities

Fall 2017

This policy brief is designed to provide insight concerning the lack of dental care many people with intellectual and developmental disabilities (I/DD)* continue to experience due to a shortage of properly trained dental care providers and, consequently, a lack of dental care providers willing to provide that care.

The brief will provide recommendations regarding how to begin to rectify the problem, including modifying dental school accreditation and professional ethics requirements. It will also recommend that Congress amend the Public Health Service Act,¹ thereby providing more public funding and student loan debt forgiveness to improve dental care.

Introduction

Unfortunately, interactions with patients who have disabilities may become uncomfortable when the care providers themselves are unfamiliar with their disabilities. This may lead to a lack of care and, accordingly, a lack of preventive care. Adults with disabilities are four times more likely to report their health to be only fair or poor than people without disabilities.² More specifically, studies have shown that adults with developmental disabilities are at risk for multiple health problems including poor oral health.³ Further, in 2002, the U.S. Surgeon General reported that, compared with other populations, "adults, adolescents, and children with [intellectual disability (*sic*)] experience poorer health and more difficulty in finding, getting to, and paying for appropriate health care."⁴

There are multiple factors to consider as to why people with I/DD face challenges in finding proper care, including, among others, guardianship complications and compensation.⁵ Often times providers are concerned about the length of time it might take to treat just one patient with I/DD.⁶ As noted in NCD's 2005 publication *The Right to Health: Fundamental Concepts and The American Disability Experience*, dental care is a frequently forgotten area within the overall health care equation; and dental offices are often inaccessible and their equipment may not accommodate many disabilities. As was also noted, even when the physical environment has been adapted, a lack of understanding of disability issues among health professionals can minimize the effectiveness of the services provided, thus

* NCD recognizes that not all people with I/DD require particular accommodations when receiving dental care.

Discuss with NCD

NCD is available to provide you with advice and assistance pertaining to these and other issues of importance to people with disabilities and welcomes any inquiries from you. NCD would be happy to provide information and analysis in person or via email to Members of Congress and staff. Please contact NCD's Legislative Affairs Specialist, Phoebe Ball, at pball@ncd.gov, or by phone at (202) 272-0104.

creating another roadblock for those claiming their health care rights. Insufficient dental school training in this space is part and parcel of these phenomena.

While laws such as the Rehabilitation Act⁷ and, more broadly, the Americans with Disabilities Act⁸ are useful tools for claiming one's right to accessible health care, including dental care, the cost to litigate such cases is not inexpensive. It is prudent to look for solutions to a problem before the need for litigation arises. To begin with, **NCD recommends the American Dental Association review its current *Principles of Ethics and Code of Professional Responsibility* and make certain modifications to better reflect the rights of people with disabilities.**

Finding financial incentives through government programs for care providers to train for and treat people with I/DD is also worth considering.

The lack of proper training among dental students is among the most rooted problems. These future care providers are not adequately exposed to the I/DD population during their education to begin with.⁹ While there are some dental programs across the United States that do train their students in the care of patients with I/DD, a sample of which are examined here as potential models for the creation of other such programs, **NCD recommends all dental students have more robust training in the care of I/DD patients.** As such, a modification by the Commission on Dental Accreditation is also worth examining.

Principles of Ethics and Code of Professional Conduct

The American Dental Association's *Principles of Ethics and Code of Professional Conduct* does not prohibit a practitioner from refusing to accept a patient based on their disability, generally. It does, however, prohibit other forms of discrimination at Section 4.A., as provided, where it states that "while dentists, in serving the public, may exercise reasonable discretion in selecting patients for their practices, dentists shall not refuse to accept patients into their practice or deny dental service to patients because of the patient's race, creed, color, sex or national origin."¹⁰ This point is relevant because the established principles of ethics in a given profession is typically the guide a professional is taught to use in determining how to conduct themselves as they push forward in their career. Those principles of ethical obligations (as might be adopted by each respective state's law), also subjects practitioners to a legal liability concerning the proper execution of their professional conduct. Interestingly, the American Dental Association's principles do, though, mention one disability at Section 4.A.1. with respect to patients with bloodborne pathogens, as an advisory opinion, wherein it states that:

A dentist has the general obligation to provide care to those in need.

A decision not to provide treatment to an individual because the individual is infected with Human Immunodeficiency Virus [(HIV)], Hepatitis B Virus, Hepatitis C Virus or another bloodborne pathogen, based solely on that fact, is unethical. Decisions with regard to the type of dental treatment provided or referrals made or suggested should be made on the same basis as they are made with other patients. As is the case with all patients, the individual dentist should determine if he or she has the need of another's skills, knowledge, equipment or experience . . ."¹¹

Related NCD Work

The Current State of Health Care for People with Disabilities (2009)

<https://go.usa.gov/xnC9K>

The insertion of this “advisory opinion” would appear to be in response to *Bragdon v. Abbott*, 524 U.S. 624 (1998) wherein the U.S. Supreme Court held that an individual’s positive HIV status is a “disability” under the Americans with Disabilities Act.¹² The Court further stated that an HIV positive individual’s dentist, providing services as a public accommodation, would be in violation of that Act unless it be shown that the provider was faced with a risk to the health or safety of others. Reasonably then, and more broadly, **NCD recommends section 4.A. of these principles be modified to reflect that other disabilities covered under the Act should also be protected.** The relevant section should state that:

While dentists, in serving the public, may exercise reasonable discretion in selecting patients for their practices, dentists shall not refuse to accept patients into their practice or deny dental service to patients because of the patient’s race, creed, color, sex, national origin *or disability, unless it is medically necessary due to the patient’s disability or medical condition, in which case the dentist shall refer the patient to another care provider with the specialized skill and training required to meet the patient’s needs.* [Emphasis added].

This suggested language is inclusive while also recognizing that not every practitioner, at present, will be properly trained in providing specialized care if needed.

Dental Training

The American Academy of Developmental Medicine and Dentistry (AADMD) Consensus Statement on Health Disparities for Persons with Neurodevelopmental Disorders and Intellectual Disabilities notes that people with I/DD regularly face an uphill battle in finding clinicians properly trained to treat them.¹³ This is because most physicians and dentists lack the proper training and exposure with respect to the health and psychosocial needs of this population.¹⁴ According to one study, more than 50 percent of dental and medical school deans have stated that their graduates are not competent to treat patients with I/DD.¹⁵ As a result, people with I/DD are more likely to have poor oral hygiene, periodontal disease, and untreated dental caries than are members of the general population.¹⁶ Additionally, people with I/DD have been more likely to not have had their teeth cleaned in the past five years, or never to have had their teeth cleaned, than those who are not disabled.¹⁷

It has been reported that due to the lack of proper skills among dentists, dental care is often more difficult to find than any other type of service for people with I/DD.¹⁸ Again, society’s ability to provide proper dental care to people with I/DD rests on whether dentists are properly trained to provide such services at the outset, and said training has been all too scarce. A series of studies of dental and dental hygiene educational programs through the 1990s and early 21st century found that more than 50 percent of dental students reported no clinical training in the care of patients with such specific care requirements, and 75 percent reported little to no preparation in providing care to these patients.¹⁹ Only

75%

According to a series of studies, 75% of dental students reported little to no preparation in providing care to people with I/DD.

10 percent of general dentists responding in a study indicated that they treated children with cerebral palsy, intellectual disability, or medically compromising conditions often or very often.²⁰ Further, a national study of dental hygiene programs reported similar findings for treatment of people with disabilities in that 48 percent of 170 programs offered 10 hours or less of didactic training (including 14 percent with 5 hours or less); and 57 percent of programs reported no clinical experience.²¹

Dental School Curricula Requirements

New language for dental and dental hygiene education programs were adopted by the Commission on Dental Accreditation (CODA) in 2004.²² However, there is still only one accreditation requirement for dental schools with respect to treating patients characterized as requiring specialized dental care, which states, in only quite general terms, that:

Graduates must be competent in assessing the treatment needs of patients with special needs. Intent: An appropriate patient pool should be available to provide experiences that may include patients whose medical, physical, psychological, or social situations make it necessary to consider a wide range of assessment and care options. The assessment should emphasize the importance of non-dental considerations. These individuals include, but are not limited to, people with developmental disabilities, cognitive impairment, complex medical problems, significant physical limitations, and the vulnerable elderly. Clinical instruction and experience with patients with special needs should include instruction in proper communication techniques and assessing the treatment needs compatible with the special need.²³

This standard clearly does not require that graduates be proficient in the techniques necessary to provide treatment, merely that they “be competent in assessing the treatment needs” of patients with disabilities. Gaining expertise in these areas requires added education and training beyond what is standard dental school curricula. There are, however, some dental schools that go beyond what is required in order to train dentists that are truly knowledgeable and practiced in providing quality specialized dental care to patients, including patients with I/DD.

Sample of Programs that Train Dental Students in Providing Care for Patients with I/DD

Though they are few and far between, the dental school programs throughout the United States that have built clinics in this space have shown themselves to be leaders in providing education and experience in the treatment of people with I/DD, including programs at Tufts, West Virginia University, the University of Pittsburgh, the State University of New York (SUNY) at Stony Brook, and Rutgers University (among others). As previously noted, the Commission on Dental Accreditation has set a standard that dental school graduates “must be competent in assessing the treatment needs of patients with special needs.”²⁴

While it is certainly vital that dentists can “assess” patients’ treatment needs, it is also imperative that dental programs attempt to prepare students for the actual treatment of patients with I/DD. Through its discourse with the American Academy of Developmental Medicine and Dentistry in examining this issue, NCD was pointed to two dental programs that serve as good specific examples of schools that go beyond the “assessment” requirement in the training of their students: Rutgers and SUNY-Stony Brook.

Within the Rutgers program,²⁵ training of predoctoral students includes both didactic and clinical components. Rutgers’ Special Care Treatment Center (SCTC) facility contains nine fully equipped dental operatories, one of which is dedicated to dental hygiene and two of which are specially configured to accommodate large wheelchairs and stretchers. The operatories, unlike standard dental school student treatment bays, are all enclosed to permit privacy and are equipped with individual x-ray and nitrous oxide delivery units.

Lectures to the predoctoral students by SCTC faculty regarding care for patients with I/DD are provided in several courses spread throughout the four-year curriculum, including among others: 1) pediatric dentistry: two lecture hours focusing on medical and dental issues in the most commonly encountered I/DD populations; 2) clinical communications: two lecture hours addressing specialized communication challenges and techniques for people with I/DD; 3) third-year problem-based learning seminar: three small-group seminar hours covering case-based assessment of people with I/DD primarily, including medical history, consultations and diagnostics, triage and treatment planning essentials; and 4) a fourth-year elective in specialized care dentistry: 20 lecture hours of advanced topics in specialized care, focusing on interdisciplinary issues. SCTC faculty also provide didactic education to pediatric dentistry and prosthodontic postgraduate programs as well as dental assisting and dental hygiene programs, and a lecture series for oral medicine and general practice residency residents and fellows. SCTC faculty have also provided continuing dental education for community dentists through the school’s program.

All fourth-year dental students at Rutgers are required to complete a one-week rotation through the SCTC. During this week, they serve as direct care providers to patients with I/DD primarily, as well as the complex geriatric population. The students provide any needed diagnostic, preventative, restorative or surgical services under the supervision of SCTC faculty. There is a strong focus on reinforcing the individuality of people with disabilities, identifying opportunities for interdisciplinary care, developing communication skills, integrating medical and dental knowledge as well as principles of basic sciences in treatment planning and care, and introducing specialized techniques optimized for people with disabilities, if needed. By the completion of the week-long rotation, students demonstrate competency in patient assessment by taking and passing a patient-based competency exercise.

Similarly, in the SUNY-Stony Brook School of Dental Medicine, a program was created to prepare students for the treatment of patients with disabilities whereby those students receive the didactic portion beginning in their second year as an integrated component of the Children’s Dentistry curriculum. The course includes

Supported Decision Making

Supported decision-making (SDM) is an alternative to guardianship that allows an individual with a disability to work with a support network of people they have chosen to help them make decisions including regarding medical care. Dentists and other medical practitioners who are required to obtain informed consent should be aware of this and other alternatives to guardianship so that they can accommodate the individual.

Supported decision-making is discussed in depth in NCD's report on guardianship, which will be posted to NCD's website in 2018.

a seven-hour series addressing the needs of patients with varied disabilities, including risk of disease identification, appropriate scope of care, informed consent, management of behavioral issues, and conventional versus alternative treatment approaches. In their third-year, students are presented with medical, developmental, and social topics specific to care of patients with disabilities. As the students progress during that year, they provide treatment to patients with increasingly complex needs and management challenges. Finally, in their senior year, all students participate in a 13-week comprehensive care clinic that is specific to adults with disabilities. A postgraduate program is also available and includes a 12-month fellowship.²⁶

Clearly, the more experience and practice dental students receive with I/DD patients the more comfortable they will be to provide services to that population upon entering private practice. In consideration of this, **NCD recommends a modification to the relevant dental school accreditation requirement.** As opposed to simply requiring that students be "competent in assessing the treatment needs of patients with special needs," **NCD recommends students also "demonstrate clinical practice skills to perform the designated treatment; and to demonstrate a sensitivity to their ancillary needs (including respectful nomenclature, supported decision making, knowledge of living arrangements that might impact compliance, communication avenues, and systems of support)."**

Per Dr. Evan Spivack, Professor of Pediatric Dentistry at the SCTC, the thinking behind the mere "assessment" requirement of the CODA standard is that not every school has an equitable amount of resources to build such a specific clinic. These programs also require hiring qualified professors who are content with the salary a university can provide in comparison to how much compensation is available in private practice. The creation of such a clinic has often come by way of educators with a personal dedication to the cause of proper treatment for those in the I/DD community.

Dr. Steven Perlman, Clinical Professor of Pediatric Dentistry at the Boston University School of Dental Medicine, added that patients with I/DD often have no choice but to travel several hours away to clinics such as those found at Rutgers and SUNY-Stony Brook because of the difficulty in finding private practitioners who are properly trained, willing, and able to provide the care they need. Perlman, who provided care for the late Rosemary Kennedy, at the request of her sister, the late Eunice Kennedy Shriver, has noted that many patients with I/DD may need some form of sedation or general anesthesia to complete the medically necessary dental care. In speaking with other practitioners, it was also noted that in the rare instance that the treatment provider *did* have the proper training, this process clearly requires more time than other patients are likely to need, thus private practitioners, many of whom have student loan debt they must pay, obviously find it more financially feasible to treat three patients in the time it would take to care for one patient with I/DD (a patient also unlikely to have private insurance).

Medicaid

Approximately 60 percent of people in the United States with I/DD rely on Medicaid for their health insurance coverage;²⁷ and Medicaid's reimbursement doesn't always suffice. While comprehensive dental coverage is mandatory for children enrolled in Medicaid, dental benefits for adults eligible for Medicaid varies depending on the state.²⁸ States determine the scope of the dental services covered. While some states provide extensive coverage with more generous expenditure caps annually, others provide limited coverage with shorter caps, and some states only provide coverage for emergency relief alone.²⁹ Obviously, there is an ongoing debate concerning the proper allocation of public funds with respect to health care, and more specifically dental care, both nationally and within each respective state; however, the effect proper dental care has on preventing larger health concerns and costs cannot be underestimated.³⁰ **NCD recommends states that have limited their Medicaid coverage of adult dental benefit identify and implement mechanisms to pay for and provide more extensive coverage, including a per-person annual expenditure cap of at least \$1,000.** Ultimately, absent more generous Medicaid coverage funding, solutions must be sought to not only produce better trained dental care providers in this space, but also to help encourage health care providers to serve the underserved despite their financial predicaments.

Underserved Population

Many federal programs designed to improve access to health care services are offered through designations made by the Health Resources and Services Administration (HRSA), in accordance with the Public Health Service Act as amended.³¹ As noted above, some people with I/DD experience significant health disparities, poorer health, and a lack of access to care. Also, as previously noted, not enough providers and specialists are trained or make themselves available to provide proper dental care to people of the I/DD population, thus creating a situation of medical underservice whereby patients must travel exceptionally long distances to find the clinics that do provide specialized care.

Currently, government programs that may help resolve these issues require population groupings based upon geography, which is problematic for people with I/DD. Historically, many people with I/DD were institutionalized and received what medical and dental care they may have received in the facility in which they resided, far removed from the rest of society and, for many decades, outside of meaningful oversight in terms of their care. The conditions at institutions such as Willowbrook, the largest facility of its kind and the most notorious for having been described by Robert Kennedy as a "snakepit," were extremely poor, with one former resident blaming her 19 years at Willowbrook for her mouth full of cavities.³² (Because of this history and because institutionalization runs counter to the goals of the Americans with Disabilities Act, NCD has a longstanding position in favor of deinstitutionalization.)

Following the exposure of the deplorable conditions of many state-run institutions in the 1970s and following, the trend toward deinstitutionalization swept across the country and people with I/DD have no longer necessarily lived in congregate settings in the same geographic location, thus ineligible to access

many government programs that may otherwise help address their ongoing inadequate dental care.³³ Because deinstitutionalization was a significant civil rights achievement that advanced the equality of opportunity for people with disabilities to be full participants in society with respect to housing, employment, and community living, it should not result in a different step backward in equality of opportunity with respect to finding and availing oneself of accessible and appropriate dental care.³⁴

As a means of helping to rectify the lack of proper dental care for people with I/DD, **NCD recommends that Congress further amend the Public Health Services Act to authorize additional grants to public and nonprofit dental care providers to expand resources (including but not limited to proper and accessible equipment) and deliver, in specific, proper dental care to people with I/DD in scarcity areas (geographic areas that are not reasonably accessible to facilities equipped to provide such care), and to bolster loan repayment programs (not excluding the Student to Service Loan Repayment Program of the National Health Service Corps) for dentists training or already properly trained in the treatment of people with I/DD and are willing to provide that care in the aforementioned scarcity areas. NCD recommends that Congress form an advisory committee to determine and rectify any existing or potential conflicts of laws or programs, or other identifiable impediments, as a means of streamlining efforts for maximum efficiency in achieving the policy goals** outlined above.

Conclusion

Post-deinstitutionalization, many people of the I/DD population have become more reliant on local practitioners for their dental care and specialized clinics are often quite a distance away from many who could make use of them. It is imperative that members of the dental profession recognize their professional responsibility and dental students be provided with improved training in this area accordingly. It is also essential that Congress strengthen programs that provide dental practitioners additional incentives to provide that care once they enter practice.

Limited access to proper dental care is a significant problem for many people with I/DD. NCD's recommendations are intended to rectify this problem and secure professional dental care for people with I/DD in the same manner as others and in compliance with the Americans with Disabilities Act and the Rehabilitation Act.

Recommendations

Recommendation to Federal Policymakers

1. NCD recommends that Congress further amend the Public Health Service Act to authorize additional grants to public and nonprofit dental care providers to expand resources (including but not limited to proper and accessible equipment) and deliver, in specific, proper dental care to people with I/DD in scarcity areas (geographic areas that are not reasonably accessible to facilities equipped to provide such care), and to bolster loan repayment programs (not excluding the

Student to Service Loan Repayment Program of the National Health Service Corps) for dentists training or already properly trained in the treatment of people with I/DD and are willing to provide that specialized care in the aforementioned scarcity areas.

2. NCD recommends that Congress form an advisory committee to determine and rectify any existing or potential conflicts of laws or programs, or other identifiable impediments, as a means of streamlining efforts for maximum efficiency in achieving these policy goals.

Recommendation to State Policymakers

3. NCD recommends states that have limited their Medicaid coverage of adult dental benefits provide the more extensive coverage options, including a per-person annual expenditure cap of at least \$1,000.

Recommendation to the Commission on Dental Accreditation

4. NCD recommends a modification to the relevant dental school accreditation requirement. All dental students must have more robust training in the care of I/DD patients. As opposed to simply requiring that dental students be “competent in assessing the treatment needs of patients with special needs,” NCD recommends students be required to “demonstrate clinical practice skills to perform the designated treatment; and to demonstrate a sensitivity to their ancillary needs (including respectful nomenclature, supported decision making, knowledge of living arrangements that might impact compliance, communication avenues, and systems of support).”

Recommendation to the American Dental Association

5. NCD recommends that the American Dental Association review its current *Principles of Ethics and Code of Professional Responsibility* and make certain modifications to better reflect the rights of people with disabilities. It must modify its standard with respect to Patient Selection whereby it is established that “While dentists, in serving the public, may exercise reasonable discretion in selecting patients for their practices, dentists shall not refuse to accept patients into their practice or deny dental service to patients because of the patient’s race, creed, color, sex, national origin or disability, unless it is medically necessary due to the patient’s disability or medical condition, in which case the dentist shall refer the patient to another care provider with the specialized skill and training required to meet the patient’s needs.”

Endnotes

1. 42 U.S.C. § 201 *et seq.*
2. Krahn, et. al. 2015. “Persons with Disabilities as an Unrecognized Health Disparity.” *American Journal of Public Health* 105: 198.
3. National Council on Disability. 2009. “The Current State of Health Care for People with Disabilities.” 86.
4. Slashcheva, Lyubov, Rick Rader, MD, and Stephen B. Sulkes, MD. 2016. “Would People with Intellectual Disabilities Benefit from Being Designated ‘Underserved’?” *American Medical Association Journal of Ethics* 18(4): 424.
5. *Ibid.*, 425.

6. National Council on Disability. 2009. "The Current State of Health Care for People with Disabilities." 89.
7. 29 U.S.C. § 794.
8. 42 U.S.C. § 12101.
9. Slashcheva, Lyubov, Rick Rader, MD, and Stephen B. Sulkes, MD. 2016. "Would People with Intellectual Disabilities Benefit from Being Designated 'Underserved'?" *American Medical Association Journal of Ethics* 18(4): 425.
10. American Dental Association. *Principles of Ethics and Code of Professional Conduct*. 4.A. (Accessed October 20, 2017)
11. *Ibid.*, 4.A.1.
12. 42 U.S.C. § 12101.
13. American Academy of Developmental Medicine and Dentistry Consensus Statement on Health Disparities for Persons with Neurodevelopmental Disorders and Intellectual Disabilities. <http://aadmd.org/articles/health-disparities-consensus-statement>. (Accessed October 16, 2017)
14. *Ibid.*
15. Kornblau, Barbara L., JD, OTR, FAOTA. "The Case for Designating People with Intellectual and Developmental Disabilities as a Medically Underserved Population." *Autistic Self Advocacy Network*, 9.
16. Morgan, et al. 2012. "The Oral Health Status of 4,732 Adults with Intellectual and Developmental Disabilities." *Journal of the American Dental Association*: 839.
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19. Waldman, DDS, MPH, Ph.D., H. Barry; Sanford J. Fenton, DDS, MDS; Steven P. Perlman, DDS, MScD; Deborah A. Cinotti, DDS. 2005. "Preparing Dental Graduates to Provide Care to Individuals with Special Needs." *Journal of Dental Education*: 250.
20. *Ibid.*
21. *Ibid.*
22. *Ibid.*, 251.
23. Commission on Dental Accreditation. *Accreditation Standards for Dental Education Programs*. § 2-24.
24. *Ibid.*
25. Information regarding the Rutgers School of Dental Medicine curriculum was submitted to NCD by Evan Spivack, DDS, FAGD, Professor, Pediatric Dentistry, Special Care Treatment Center, Rutgers School of Dental Medicine, February 16, 2017.
26. Waldman, DDS, MPH, Ph.D., H. Barry; Sanford J. Fenton, DDS, MDS; Steven P. Perlman, DDS, MScD; Deborah A. Cinotti, DDS. 2005. "Preparing Dental Graduates to Provide Care to Individuals with Special Needs." *Journal of Dental Education*: 252.
27. The Arc. "Still in the Shadows with Their Future Uncertain." <http://www.thearc.org/document.doc?id=3672>. (Accessed October 16, 2017)
28. Center for Health Care Strategies, Inc. 2017. "Medicaid Adult Dental Benefits: An Overview." 1.
29. *Ibid.*
30. United States Department of Health and Human Services. "Oral Health in America: A Report of the Surgeons General." <https://www.nidcr.nih.gov/datastatistics/surgeongeneral/report/executivesummary.htm#message>.
31. 42 U.S.C. § 201 *et seq.*
32. National Public Radio, "Remembering an Infamous New York Institution." <http://www.npr.org/templates/story/story.php?storyId=87975196>. (Accessed October 17, 2017)
33. Section 330 of the Public Health Service Act. 42 USCS § 254b(b)(3)(B).
34. *Olmstead v. L.C.*, 527 U.S. 581 (1999).

NCD would like to acknowledge the following individuals and thank them for their input in relation to this policy brief: Dr. Evan Spivack, Professor of Pediatric Dentistry, Rutgers School of Dental Medicine; Dr. Steven Perlman, Clinical Professor of Pediatric Dentistry, Boston University School of Dental Medicine; and Dr. Rick Rader, Director, Morton J. Kent Habilitation Center, Orange Grove Center, Chattanooga, TN.

Resolution No. 51 New

Report: N/A Date Submitted: September 2018

Submitted By: Council on Ethics, Bylaws and Judicial Affairs

Reference Committee: D (Legislative, Health, Governance and Related Matters)

Total Net Financial Implication: None Net Dues Impact: _____

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

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

How does this resolution increase member value: Not Applicable

AMENDMENT OF THE MANUAL OF THE HOUSE OF DELEGATES RELATING TO THE STANDING COMMITTEE ON CONSTITUTION AND BYLAWS

Background: In 2017, the Council on Ethics, Bylaws and Judicial Affairs proposed, and the House of Delegates adopted, a major revision to the ADA *Constitution and Bylaws*. Among the revisions adopted was the moving of operational and procedural details contained in the *Bylaws* to a new manual, the *Governance and Organizational Manual of the American Dental Association* (the *Governance Manual*).

Under the scheme of the previous edition of the ADA *Bylaws*, the Standing Committee on Constitution and Bylaws was charged with the responsibility for reviewing all resolutions proposing amendments to the ADA *Constitution and Bylaws* and either approving the text of the amendment as written or redrafting the amendment to accomplish the intent of the maker of the resolution in the form currently used by the House of Delegates. That duty was codified in Chapter V., Section 140.A.b. of the ADA *Bylaws* (2017 edition). Recitation of the duties of the Standing Committee on Constitution and Bylaws was moved from the ADA *Bylaws* to the *Manual of the House of Delegates* when the *Bylaws* were revised by the 2017 House of Delegates.

However, when the *Governance Manual* was created as a part of the 2017 *Bylaws* revision, assigning the responsibility for reviewing proposed amendments to the *Governance Manual* was inadvertently overlooked. Given that the reviews of proposed *Governance Manual* amendments that need to be conducted are very similar to the reviews of proposed amendments to the *Constitution and Bylaws* that are already conducted by the Standing Committee on Constitution and Bylaws, it is believed that the Standing Committee on Constitution and Bylaws should also be charged with the responsibility for conducting reviews of proposed *Governance Manual* amendments.

Consequently, the Council on Ethics, Bylaws and Judicial Affairs proposes the following resolution:

Resolution

51. Resolved, that *Operations of the House of Delegates*, published in the *Manual of the House of Delegates* be amended as follows (additions underscored, deletions ~~stricken through~~):

Page 8:

Duties of the Speaker of the House of Delegates.

As recited in the ADA *Bylaws*, the Speaker of the House of Delegates shall (1) preside at all meetings of the House of Delegates; (2) with the assistance of the Secretary of the House of Delegates, determine the order of business for all meetings subject to the approval of the House of Delegates; (3) appoint tellers to assist in determining the result of any action taken by vote; and (4) perform such other duties as custom and parliamentary procedure require. The decision of the Speaker shall be final unless an appeal from such decision shall be made by a member of the House, in which case final decision shall be by majority vote. In addition, following adjournment of the Standing Committee on Constitution and Bylaws, the Speaker and the Chair of the Council on Ethics, Bylaws and Judicial Affairs shall be responsible for reviewing and either approving or redrafting any new resolutions or changes to resolutions that propose amendments to the *Constitution and Bylaws or to the Governance Manual*, in accordance with provisions in the Standing Committee section of the *Manual of the House of Delegates*.

and be it further

Resolved, that *Standing Committees of the House of Delegates* published in the *Manual of the House of Delegates*, be amended as follows:

Page 21:

Committee on Constitution and Bylaws. The Standing Committee on Constitution and Bylaws shall consist of not more than eight (8) nor less than six (6) members of the Council on Ethics, Bylaws and Judicial Affairs of this Association appointed by the President in consultation with the Speaker of the House of Delegates and the Council Chair. The Committee reviews the wording of all proposed amendments to the *Constitution, Bylaws and Governance Manual* that are submitted prior to the first meeting of each new session of the House of Delegates. The Standing Committee either approves the text of the amendment as written or redrafts the resolution to accomplish the intent of the maker in the form currently used by the House of Delegates. The Standing Committee files a report of its findings and actions at the first meeting of the House of Delegates and then adjourns. Thereafter, and until the House of Delegates adjourns *sine die*, the Speaker of the House and the Chair of the Council on Ethics, Bylaws and Judicial Affairs (CEBJA) are responsible for reviewing any new resolutions or changes to resolutions that propose amendments to the *Constitution, and Bylaws and Governance Manual*. Each reference committee is required to clear the wording of a proposed amendment either with the Standing Committee or, if the amendment is proposed after the Standing Committee adjourns, with the Speaker who, with the Chair of CEBJA, will determine whether the language of the amendment is in appropriate ~~Bylaws~~ form.

BOARD RECOMMENDATION: Vote Yes.

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

Resolution No. 54 New

Report: N/A Date Submitted: September 2018

Submitted By: Board of Trustees

Reference Committee: D (Legislative, Health, Governance and Related Matters)

Total Net Financial Implication: None Net Dues Impact: _____

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

ADA Strategic Plan Objective: None

How does this resolution increase member value: Not Applicable

AMENDMENT TO CHAPTER XIV, SECTION 30B OF THE ADA BYLAWS: PROCEDURAL MANUALS OF THE ASSOCIATION

Background: In 2017, the House of Delegates adopted Resolution 7H, submitted by the Council on Ethics, Bylaws and Judicial Affairs, which proposed significant revisions to the ADA *Constitution and Bylaws*. Among the revisions adopted was the moving of operational and procedural details contained in the *Bylaws* into the new *Governance and Organizational Manual (Governance Manual)* and the *Manual of the House of Delegates (House Manual)*. In its background statement to Resolution 7, the Council noted that the *Governance Manual*, like the ADA *Bylaws*, is amendable only by the House of Delegates and that this would also be true for the following sections of the *House Manual*: *Rules of the House of Delegates*, *Operations of the House of Delegates*, *Representation of Constituents and Periodic Reapportionment of Delegates and Alternate Delegates* and *Standing Committees of the House of Delegates*. Further, the background statement noted that, consequently, despite the fact that provisions have been removed from the *Bylaws* in the proposed revisions, the removed material is still under the control and authority of the House of Delegates.

Prior to the adoption of Resolution 7H-2017, all sections of the *House Manual*, with the exception of the *Rules of the House of Delegates*, did not require approval by the House of Delegates. This was because the House Manual serves as a general information resource. It helps prepare those who participate in the annual session to have a better understanding of House activities and operations. Any explanations and details about ADA governance functions and activities were recapitulations of relevant provisions from the ADA *Constitution and Bylaws*. Administrative staff, in consultation with the Speaker and the Executive Director, annually updated and revised the *House Manual* to make clarifying and logistical edits as well as the necessary conforming changes to applicable sections based on the actions of the previous House of Delegates.

Following the adoption on Resolution 7H-2017, it was noticed that the transfer of *Bylaws* material into the *Operations of the House of Delegates* section of the *House Manual* was not a transfer *per se*, but instead continued to be a recitation of existing language in the *Bylaws*. Examples include duties of the House of Delegates, Board of Trustees and Speaker of the House of Delegates. Incidentally, other topics covered within the *Operations* section of the *House Manual* also include reiterations of content currently contained in the *Bylaws* or the *Governance Manual*.

Based on the forgoing, the Board believes that the Speaker and staff should be provided with flexibility to continue to make any necessary technical edits and updates to the *Operations* section of the *House Manual* without first obtaining approval of the House of Delegates.

The Board of Trustees recommends adoption of the following resolution:

Resolution

54. Resolved, that Chapter XIV, PROCEDURAL MANUALS OF THE ASSOCIATION, Section 30. AMENDMENTS, Subsection B, of the ADA *Bylaws* be amended as follows (deletions ~~stricken~~):

B. The ~~Operation of the House of Delegates~~, *Rules of the House of Delegates, Representation of Constituents and Periodic Reapportionment of Delegates and Alternate Delegates, Standing Committees of the House of Delegates and Election Commission and Campaign Rules* published in the *Manual of the House of Delegates* are amendable by a majority vote of the members of the House present and voting unless the section of the *Manual of the House of Delegates* under consideration requires otherwise.

BOARD RECOMMENDATION: Vote Yes.

BOARD VOTE: UNANIMOUS.

Resolution No. 68 New

Report: N/A Date Submitted: September 2018

Submitted By: Board of Trustees

Reference Committee: D (Legislative, Health, Governance and Related Matters)

Total Net Financial Implication: None Net Dues Impact: _____

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

ADA Strategic Plan Objective: None

How does this resolution increase member value: Not Applicable

**AMENDMENT OF THE GOVERNANCE AND ORGANIZATIONAL MANUAL TO STREAMLINE
TECHNICAL AND CONFORMING AMENDMENTS TO GOVERNANCE DOCUMENTS**

Background: From time to time it is necessary to spend the limited and valuable time of the Board of Trustees and the House of Delegates presenting and adopting resolutions to amend the Association's governance documents when the amendments are, in reality, merely ministerial administrative revisions that could be considered editorial in nature for the purpose of bringing the Association's governance documents up to date and into alignment with one another. The Council on Ethics, Bylaws, and Judicial Affairs (CEBJA) is already authorized in the *Governance and Organizational Manual of the American Dental Association (Governance Manual)* to correct punctuation, grammar, spelling and syntax, change names and gender references and delete moot material where such revisions do not alter the material's context or meaning in the *Bylaws* and the *Governance Manual* upon the unanimous vote of the Council members present and voting (*Governance Manual*, Chapter VIII, Section K.6.b.ii.):

K. Areas of Responsibility.

* * *

6. Council on Ethics, Bylaws and Judicial Affairs. The areas of subject matter responsibility of the Council shall be:

* * *

- b. The *Constitution and Bylaws* of this Association, including:

* * *

- ii. Correct punctuation, grammar, spelling and syntax, change names and gender references and delete moot material where such revisions do not alter the material's context or meaning in the *Bylaws* and the *Governance Manual* upon the unanimous vote of the Council members present and voting; and

* * *

But the authority given to CEBJA to make technical and administrative revisions to the Association's governance documents does not encompass every instance where conforming amendments are necessary. For example, from time to time it is necessary to amend the *Bylaws*, *Governance Manual* or *Manual of the House of Delegates* because the location to a cited reference has changed. Because these instances are not within the scope of correcting punctuation, grammar, spelling or syntax, is not a change in name or gender reference and does not delete moot material, such amendments are not within CEBJA's autonomous revision authority under the provision set forth above. Thus, the Board of Trustees and House of Delegates must spend their time considering such ministerial amendments. The

time of both the Board of Trustees and the House of Delegates could be better spent considering substantive and important issues, rather than the type of clerical and ministerial details that are required to keep the governing documents aligned and consistent with one another. Consequently, the Board of Trustees proposes the following resolution:

Resolution

68. Resolved, that Chapter VIII, Section K.6.b.ii of the *Governance Manual* be amended as follows (additions underscored, deletions ~~stricken through~~):

K. Areas of Responsibility.

* * *

6. Council on Ethics, Bylaws and Judicial Affairs. The areas of subject matter responsibility of the Council shall be:

* * *

- b. The ~~Constitution and Bylaws~~ governing documents of this Association, including:

* * *

ii. ~~Correct~~ To correct punctuation, grammar, spelling and syntax, change names and gender references and delete moot material where such revisions do not alter the material's context or meaning in the Bylaws and the Governance Manual, and to correct article, chapter and section designations, punctuation, and cross-references and to make such other technical and conforming revisions as may be necessary to reflect the intent of the House in connection with amendments to the Association's Bylaws, Governance Manual, Manual of the House of Delegates, Principles of Ethics and Code of Professional Conduct and Current Policies where such revisions do not alter the material's context or meaning upon the unanimous vote of the Council members present and voting; and

* * *

BOARD RECOMMENDATION: Vote Yes.

BOARD VOTE: UNANIMOUS.

Resolution No. 69 New

Report: N/A Date Submitted: September 2018

Submitted By: Council on Advocacy for Access and Prevention

Reference Committee: D (Legislative, Health, Governance and Related Matters)

Total Net Financial Implication: None Net Dues Impact: _____

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

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

How does this resolution increase member value: See Background

STATE MEDICAID DENTAL PEER REVIEW COMMITTEE

Background: The goals of the ADA's *Action for Dental Health* Medicaid Initiative are to increase the number of dentists participating and to increase the number of dental services delivered to Medicaid-eligible individuals. Increasing reimbursement is the primary incentive, but one that is not always feasible within the current political and fiscal climate of individual states. There are other incentives that may prove similarly attractive, as well as disincentives that discourage participation in this program. To that end, the Council on Advocacy for Access and Prevention's (CAAP) Medicaid Provider Advisory Committee (MPAC) continues to seek ways in which to reduce the administrative burdens associated with Medicaid participation.

The 2015 House of Delegates passed Resolution 85H-2015, Chief State Medicaid Dental Officer and Medicaid Dental Advisory Committee (*Trans.2015:275*), which contained the following two actions that laid a solid foundation for state Medicaid agencies to support strong dental Medicaid programs.

- The American Dental Association encourages all state dental associations to work with their state Medicaid agency in hiring a Chief Medicaid Dental Officer, who is a member of organized dentistry; and
- The American Dental Association encourages all state dental associations to actively participate in the establishment or continuation of an existing Medicaid dental advisory committee that is recognized by the state Medicaid agency as the professional body to provide recommendations on Medicaid dental issues.

The 2017 House of Delegates passed a subsequent action that encouraged fairness and equity within audits conducted via the state Medicaid agency itself or through a contracted entity Peer to Peer State Dental Medicaid Audits 33H-2017 as follows.

- The American Dental Association encourages all state dental associations to work with their respective state Medicaid agency to ensure that Medicaid dental audits be conducted by dentists who have similar educational backgrounds and credentials as the dentists being audited, as well as being licensed within the state in which the audit is being conducted.

Though these three actions have helped many states improve the oral health of Medicaid-eligible individuals, there remains an ongoing challenge of recruiting sufficient dentists to provide the care that is

1 needed and retaining those currently participating. It would help for participating dentists to know that
2 when questions about their practice arise, their unique circumstances will be reviewed and evaluated in a
3 fair and equitable manner by their peers. A peer review committee made up of state licensed general
4 dentists, pediatric dentists and other specialists would answer that need.

5
6 To that end, the Council on Advocacy for Access and Prevention, upon the recommendation of its
7 Medicaid Provider Advisory Committee, recommends the following resolution to the 2018 House of
8 Delegates:

9 **Resolution**

10
11 **69. Resolved**, that the American Dental Association encourages all state dental associations to work
12 with their respective state Medicaid agency to create a dental peer review committee, made up of
13 licensed current Medicaid providers who provide expert consultation on issues brought to them by the
14 state Medicaid agency and/or third party payers.

15 **BOARD RECOMMENDATION: Vote Yes.**

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

Resolution No. 72 New

Report: N/A Date Submitted: September 2018

Submitted By: Ninth Trustee District

Reference Committee: D (Legislative, Health, Governance and Related Matters)

Total Net Financial Implication: None Net Dues Impact: _____

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

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

How does this resolution increase member value: Not Applicable

AMENDMENT TO ADA BYLAWS: CHAPTER III, HOUSE OF DELEGATES, SECTION 10. MEMBERS, D. ELECTION OR SELECTION

The following resolution was adopted by the Ninth Trustee District and transmitted on September 12, 2018, by Michelle Nichols-Cruz, governance manager, Michigan Dental Association.

Background: As members of the tripartite, constituent and component bylaws are not to be in conflict with the *bylaws* of the ADA. In reviewing the *bylaws* of the ADA, the Michigan Dental Association noted a conflict in Section 10. Election or Selection.

The Michigan Dental Association House of Delegates approved changes to its governance structure. While members of the ADA House of Delegates are elected by the members of the House of Delegates, the governing legislative body of the MDA is its Board of Trustees. Therefore, none of the provisions described correctly reflect this protocol.

Amending the *bylaws* in Section 10, would allow for flexibility with these governance changes, while not removing any of the provisions that have been adopted by other constituents.

Resolution

72. Resolved, that Section 10. D. of Chapter III of the ADA *Bylaws*, be amended as follows (additions underscored; deletions ~~stricken through~~):

D. ELECTION OR SELECTION. A constituent's delegates shall be elected or, in the case of a constituent's alternate delegates elected or selected by one or more of the following methods:

1. By the membership at large of that constituent;
2. By the constituent's governing legislative body, House of Delegates, or Board of Directors, or in the case of alternate delegates, ~~selected by the constituent's board of directors~~, at the discretion of the constituent; and or
3. By a component with respect to the delegates representing that component.

- 1 **BOARD RECOMMENDATION: Vote Yes.**
- 2 **BOARD VOTE: UNANIMOUS.**

Resolution No. 74 New

Report: N/A Date Submitted: September 2018

Submitted By: Fourteenth Trustee District

Reference Committee: D (Legislative, Health, Governance and Related Matters)

Total Net Financial Implication: \$18,000 Net Dues Impact: \$0.17

Amount One-time \$18,000 Amount On-going FTE .25

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

How does this resolution increase member value: See Background

CONTINUING EDUCATION TO IDENTIFY ABUSED AND NEGLECTED PATIENTS

The following resolution was adopted by the Fourteenth Trustee District and transmitted on September 12, 2018, by Dr. Patsy Fujimoto, Fourteenth District Caucus Chair.

Background: The ADA *Principles of Ethics and Code of Professional Conduct* confers an ethical obligation for dentists to “become familiar with the signs of abuse and neglect and report suspected cases to the proper authorities, consistent with state laws.”

An Advisory opinion on this topic follows, and includes the following statement:

“Dentists are ethically obligated to keep current their knowledge of both identifying abuse and neglect and reporting in the jurisdictions where they practice.”

In 2014, the House of Delegates adopted Resolution 89H-2014, stating that “the ADA supports educating dental professionals to recognize abuse and neglect across all age groups and reporting such incidences to the proper authorities as required by state law.”

Since the 1970’s all States have legislated Mandatory Reporting of abuse by Dental Providers. Nearly every state has misdemeanor or felony charges if a provider fails to report.

There are only a few states that require training in identifying and reporting abuse. Many providers have only had one course on the matter.

As a preeminent national association, the ADA can elevate the awareness among members of our professional responsibility to our most vulnerable citizens, children and the elderly.

Many states already offer free online training courses. The ADA may be able to adapt existing courses and inject dental specific materials to offer a free accredited CE via the ADA website.

Utilizing the Child Abuse Prevention and Treatment Act (CAPTA), this project likely could be funded by federal grant.

To fail to recognize the value and importance of this training would be a blatant disregard of properly and professionally performing our duty to protect our children and elderly in this country.

Proposed Resolution

74. Resolved, that the appropriate ADA agency be encouraged to draft model regulations for the use by each state regulatory board for the purpose of including continuing education for the identification and reporting of abuse of children, people with disabilities, intimate partners and elders in continuing education requirements for ethics, and be it further

Resolved, that each state be encouraged to pursue such regulations, and be it further

Resolved, the ADA provide CERP accredited courses about identification and reporting of abuse to ADA member dentists as a free member benefit.

BOARD COMMENT: The Board recommends removing “for ethics” in consideration of states without continuing education requirements specifically for ethics. The final resolving clause reflects the fact that CERP does not accredit courses, but course providers.

74B. Resolved, that the appropriate ADA agency be encouraged to draft model regulations for the use by each state regulatory board for the purpose of including continuing education for the identification and reporting of abuse of children, people with disabilities, intimate partners and elders in continuing education requirements ~~for ethics~~, and be it further

Resolved, that each state be encouraged to pursue such regulations, and be it further

Resolved, that the ADA provide ~~CERP accredited~~ courses about identification and reporting of abuse to ADA member dentists as a free member benefit.

BOARD RECOMMENDATION: Vote Yes on the Substitute.

BOARD VOTE: UNANIMOUS.

Resolution No. N/A N/AReport: CEBJA Report 1 Date Submitted: September 2018Submitted By: Council on Ethics, Bylaws and Judicial AffairsReference Committee: D (Legislative, Health, Governance and Related Matters)Total Net Financial Implication: None Net Dues Impact: _____Amount One-time _____ Amount On-going _____ FTE 0

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

How does this resolution increase member value: See Background

COUNCIL ON ETHICS, BYLAWS AND JUDICIAL AFFAIRS REPORT 1 TO THE HOUSE OF DELEGATES: RESPONSE TO RESOLUTION 62H-2017: STUDY OF THE EFFECTS OF STATES REQUIRING LICENSURE AS A PREREQUISITE FOR ACTIVE MEMBERSHIP

Background: In 2016, the House of Delegates adopted via the consent calendar a resolution for a wholesale amendment of Chapter I of the *Bylaws*, Membership. One of the provisions affected by the amendment was the requirement that members of the ADA hold a license to practice dentistry. Instead, the amended *Bylaws* stipulated that members in the Association must hold D.D.S., D.M.D. or an equivalent degree, with the *Bylaws* defining the term "equivalent degree" as a degree that the individual's jurisdiction deems sufficient to allow the degree holder to sit for a full and complete dental licensure examination without any additional training. The rationale for the deletion of the membership requirement of holding an active license was explained in the report to the House of Delegates (*Trans.2016:6010*):

The current *Bylaws* requirement that an applicant have an active license was identified as a potential barrier to membership. New dental school graduates or residents may want to join while completing the licensure process; mandating a license is clearly a barrier to entry for these dentists seeking to join. A licensure requirement also presents barriers in circumstances that are less common, such as a dental school dean who is not licensed to practice in the state of his or her dental school and is therefore ineligible to participate in tripartite activity, thereby presenting a barrier for this dean to promote the value of tripartite membership to dental students. In this draft of CHAPTER I a member must hold a D.D.S., D.M.D. or equivalent degree; licensure is not a requirement for membership.

While the amendment of Chapter I was adopted by the House of Delegates in 2016, the effective date of the amendment was delayed for one year, until the close of the 2017 House of Delegates. The necessity for that delay was explained as follows (*Trans.2016:6011*):

Because the bylaws of constituent and component dental societies cannot be in conflict with ADA *Bylaws*, the proposed resolution provides that the revisions take effect at the conclusion of the 2017 House of Delegates session in order to allow sufficient time for constituent and component dental societies to revise their bylaws, as necessary.

Consequently, it was contemplated that constituents and components would review the amendments to Chapter I and amend their respective bylaws to delete licensure as a requirement for membership so that constituent and component bylaws would be aligned with the amended membership provisions of the ADA *Bylaws* when the amendments took effect in October 2017.

At the hearing of the Reference Committee on Legislative, Health, Governance and Related Matters (“the Committee”) at the 2017 House of Delegates, the Committee received testimony requesting that the ADA *Bylaws* be amended to allow a constituent’s bylaws to include licensure as an eligibility requirement for membership even though the ADA’s *Bylaws* no longer require members to hold a dental license. The Committee was “concerned about proposing such an amendment without studying the potential effects of the amendment on other areas of the *Bylaws*” (Reference Committee D Report, page 5077). The Committee, therefore, proposed Resolution 62, commissioning the Council on Ethics, Bylaws and Judicial Affairs to study the effects that allowing the constituents to require licensure would have on other portions of the *Bylaws* and to propose amendments that would allow constituents the latitude of requiring licensure as a condition of constituent membership:

62H-2017. Resolved, that the Council on Ethics, Bylaws and Judicial Affairs is directed to study the proposal for allowing a constituent’s bylaws to require licensure as one prerequisite for active membership and the effects, if any, that such an amendment would have on other portions of the ADA *Bylaws*, and to report back to the 2018 House of Delegates with proposed amendments to the ADA *Bylaws* that would allow states to require licensure as a condition of membership in the constituent.

Analysis: As noted in the worksheet that introduced the amendments to Chapter I of the *Bylaws*, the requirement for licensure creates barriers to membership in the ADA. Requiring an applicant to hold a dental license before being admitted to membership serves as a roadblock to recent graduates from dental school who desire to join organized dentistry prior to the receipt of the graduates’ dental licenses. By reinstituting a license requirement for membership, it is to be expected that a percentage of recent graduates, upon encountering the barrier to membership, will abandon the thought of becoming an ADA member. Such a result would undercut one of the objectives of the ADA’s Member’s First 2020 Strategic Plan, namely, to achieve a net increase of 4,000 members by the close of 2019.

The imposition of a licensure requirement to join the tripartite will also impact recruiting dental school faculty and administrators, some of whom hold licenses in jurisdictions other than where they serve as educators. This may also have a detrimental effect on the ability of organized dentistry to recruit new members from dental school graduates.

Also, the current *Bylaws* contemplate that members have a choice in joining the constituent of the jurisdiction where the member either practices, lives or is employed. Allowing constituents to impose the additional requirement of holding a dental license issued by their jurisdiction has the potential for impacting the constituent choice of that the applicant may make. For example, if an applicant lives in State A and practices in (and, of course holds a license issued by) State B, State A’s requiring its members to hold a license issued by State A will extinguish the applicant’s freedom to choose between joining State A’s or State B’s state society. And, again, this scenario is likely to result in at least a percentage of affected dentists opting not to join the tripartite at all instead of being required to join a constituent that is not of their own choosing – all again at a time when the ADA’s objective is to add thousands of new members to its membership rolls.

So too will allowing constituents to optionally require members to hold a dental license increase the workload of membership staff at both the state and component level and also at the ADA level. In addition to the impacts that giving constituents the option of requiring licensure to become a tripartite member discussed above, the current ADA *Bylaws* require that the bylaws of constituents be aligned with the ADA *Bylaws* (ADA *Bylaws* Chapter II, Section 20):

Section 20. CONSTITUTION AND BYLAWS: Each constituent shall adopt and maintain a constitution and bylaws which shall not be in conflict with, or limit, the *Constitution and Bylaws* of this Association. Each constituent shall keep a current version of its constitution and bylaws on file with the Executive Director of this Association.

In order to provide constituent societies the option of requiring licensure to become a member, this would need to be amended so that constituents that adopted that option would not be in conflict with the ADA *Bylaws*.

It should be noted that such a change will add complexity to the governance of organized dentistry, a result that the rewriting of the ADA *Bylaws* adopted by the 2017 House of Delegates was designed to diminish. Adoption of the provision may cause confusion among members, especially those members whose circumstances find them moving between constituents when relocating, which is occurring more frequently in recent years with dentists that have employed partners or spouses. Also, an unlicensed dentist moving from a jurisdiction whose constituent does not require licensure to one that does will be unable to transfer membership and will be foreclosed from continuing membership.

It is the Council's opinion that the prospect of allowing unlicensed dentists trained outside of the United States to enjoy the privilege of membership – the predominant reason given to require licensure – is more than adequately protected by mandating that only those individuals holding non-DDS or DMD dental degrees deemed the equivalent of a DDS or DMD degree may be members of the ADA. As is explained in the first footnote in Chapter I of the ADA *Bylaws*, "the term "equivalent degree" means a degree that the jurisdiction involved deems sufficient to allow the degree holder to sit for a full and complete dentist's licensure examination in the jurisdiction without any additional training."

In light of the above analysis, the Council does not recommend any amendment to the ADA *Bylaws* that would allow for the imposition of a licensure requirement for membership on a constituent-by-constituent basis. However, even though the Council does not recommend such an amendment, in accord with the directive issued by the 2017 House of Delegates, the Council advises that it believes the following *Bylaws* amendments would be required to implement such a change (additions underscored, deletions ~~stricken through~~):

Resolved, that Chapter I and Chapter II of the ADA *Bylaws* be amended as follows (additions are underscored, deletions are ~~stricken through~~) to allow constituents to individually require licensure in order to attain membership in the tripartite:

CHAPTER I MEMBERSHIP

Section 20. MEMBERSHIP ELIGIBILITY

- A. ACTIVE MEMBER. Any person holding a D.D.S., D.M.D. or equivalent degree* shall be eligible to be an active member of this Association if he or she meets the following qualifications:
 - a. Maintains membership in good standing in this Association as that term is defined in these Bylaws; and
 - b. Maintains a license and/or registration to practice dentistry when:

*As used in these *Bylaws*, the term "equivalent degree" means a degree that the jurisdiction involved deems sufficient to allow the degree holder to sit for a full and complete dentist's licensure examination in the jurisdiction without any additional training

1. ~~Is licensed and/or registered to practice dentistry where the laws and/or regulations of a constituent's jurisdiction require licensure and/or registration in order to be a member of the constituent,**; and or~~

~~e.2. Where required by a constituent's bylaws or other governing documents, is licensed and/or registered to practice dentistry; and~~

c. Is a member in good standing of the constituent and component where the member either resides, or is employed or practices; or if not a member of such constituent and component is:

1. employed by or is serving on active duty in one of the federal dental services*** on a full time basis and is not otherwise employed or practicing dentistry within the jurisdiction of a constituent or component; or
2. employed or practicing dentistry in a country other than the United States and is a graduate of a dental school or a graduate of a training program accredited by the Commission on Dental Accreditation; or
3. otherwise ineligible for active membership in a constituent or component where the individual resides, is employed, or practices.

An individual qualifying pursuant to subsections b.1 through 3 shall be referred to as a "direct member."

* * *

CHAPTER II CONSTITUENTS AND COMPONENTS

Section 20. CONSTITUTION AND BYLAWS: With the exception of constituents requiring licensure under Chapter I, Section A.b.2., each Each constituent shall adopt and maintain a constitution and bylaws which shall not be in conflict with, or limit, the Constitution and Bylaws of this Association. Each constituent shall keep a current version of its constitution and bylaws on file with the Executive Director of this Association.

Resolution

This report is informational and no resolutions presented.

BOARD RECOMMENDATION: Vote Yes to Transmit.

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

** As used herein, the term "constituent" means a dental association organized in a state or territory of the United States or in Washington, D.C. that is chartered by the ADA House of Delegates. The term "component" means a local dental association that may be created within the boundaries of a constituent by the constituent.

*** The term "federal dental services" as used herein shall mean the dental departments of the Air Force, the Army, the Navy, the Public Health Service, the department of Veterans Affairs and other federal agencies.

Resolution No. 81 New

Report: N/A Date Submitted: October 2018

Submitted By: Fifteenth Trustee District

Reference Committee: D (Legislative, Health, Governance and Related Matters)

Total Net Financial Implication: None Net Dues Impact:

Amount One-time Amount On-going FTE 0

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

How does this resolution increase member value: See Background

1 DENTAL BENEFITS IN A CHILD SUPPORT ORDER

2 The following resolution was adopted by the Fifteenth Trustee District and transmitted on October 1,
3 2018, by Ms. Linda Bradley, executive director, Texas Dental Association.

4 **Background:** According to the 2000 report *Oral Health in America: A Report of the Surgeon General*,
5 "For every child under 18 years of age without medical insurance, there are at least two children without
6 dental insurance."¹ A national report about dental benefits notes that, "Just as access to medical care
7 results in better general health, access to dental care results in both improved oral and overall health."²

8
9 Children covered by dental benefits are more likely to make their first dental visit at an earlier age
10 compared to uninsured children.³ A 2005 national survey on children's oral health showed that the most
11 commonly reported reason for children not receiving needed dental care was that the child had no
12 insurance to cover the services.⁴

13
14 It is well known that the consequences of untreated early childhood caries may lead to more widespread
15 health issues. A healthy mouth is integral to maintaining an overall healthy body. Children with untreated
16 oral disease often have difficulty eating, speaking and sleeping.

17
18 Oral health is improved by regular visits to the dentist—and dental benefits play an important role
19 connecting patients to the dentist. Children subject to child support orders often receive medical support
20 but may not receive dental support unless it is ordered by a state court or specified by the parties
21 involved. This state-rights flexibility is mirrored in federal law. For example, the "Personal Responsibility
22 and Work Opportunity Reconciliation Act of 1996" includes a section governing "Enforcement of Orders
23 for Health Care Coverage" (Section 382) which requires medical support as part of required health
24 insurance in child support orders, but does not mandate dental support.

25
26 Requiring dental support for a child subject to a child support order is an important step in helping to
27 ensure that children have access to dental care. A healthy mouth and teeth are an integral part of a
28 child's wellness.

30 Resolution

31
32 **81. Resolved,** that the American Dental Association pursue federal legislative or regulatory efforts to
33 require dental support in child custody orders as a child support obligation, like medical support, and
34 be it further

1
2 **Resolved**, that constituent societies of the American Dental Association be urged to pursue individual
3 state legislative or regulatory efforts to require dental support in child custody orders as a child
4 support obligation.
5

6 **BOARD RECOMMENDATION: Received after the September 2018 Board of Trustees meeting.**
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24 REFERENCES

- 25
26 1. U.S. Department of Health and Human Services. Oral Health in America: A Report of the
27 Surgeon General. Rockville, MD: U.S. Department of Health and Human Services, National
28 Institute of Dental and Craniofacial Research, National Institutes of Health, 2000.
29 2. America's Oral Health: The Role of Dental Benefits. Delta Dental. Available at
30 <https://wstag.deltadental.com/AmericaOralHealthRoleDentalBenefits.pdf>.
31 3. Delta Dental Children's Oral Health Survey, 2009. News Release. September 14, 2009.
4. U.S. Department of Health and Human Services, Health Resources and Services Administration,
Maternal and Child Health Bureau. The National Survey of Children's Health 2003. Rockville,
Maryland: U.S. Department of Health and Human Services, 2005.

Resolution No. 32S-1 Citation for Original Resolution: Gray:5085
 Submitted By: Eleventh Trustee District Date Submitted: October 2018
 Reference Committee Report On: D (Legislative, Health, Governance and Related Matters)
 Financial Implications (if different from original resolution): \$12,000

**SUBSTITUTE FOR RESOLUTION 32: EXPANDING DENTAL BENEFITS ADVOCACY IN THE STATE
 PUBLIC AFFAIRS PROGRAM**

The following substitute for Resolution 32 (Worksheet:5085) was submitted by Dr. Ron Dahl, caucus chair.

Background: The Eleventh Trustee District appreciates learning that the Reference Committee and Board of Trustee's understand the importance of dental benefits advocacy to the Association's membership. We urge the House of Delegates to make a meaningful step towards showing our membership that the Association is taking action on dental benefits advocacy this year.

Based on the testimony and taking into consideration the scope of the State Public Affairs Program, the Eleventh Trustee District wishes to put forward the following substitute resolution:

Resolution

32S-1. Resolved, that a task force be convened to develop a broad-reaching strategy for state-based dental benefits advocacy to minimize interference of dental benefit carriers into the doctor-patient relationship. This strategy should include the development of policy actions that states can include in their respective advocacy agendas and what public affairs support would be needed to ensure successful outcomes and, be it further

Resolved, that the task force be comprised of equal representation from the Board of Trustees, Council on Dental Benefits, Council on Government Affairs, at-large Delegates or Alternate Delegates of the 2018 House of Delegates, and state dental association executive directors with dental benefits advocacy experience and, be it further

Resolved, that the task force shall report its strategy recommendations to the 2019 ADA House of Delegates.

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Res. 4	3010	Council on Dental Practice Amendment of Policy, ADA Statement on Alcoholism and Other Substance Use Disorders
Res. 5	4000	Council on Dental Education and Licensure Amendment to the ADA Policy on Promotion of Freedom of Movement for Dental Hygienists
Res. 6	4001	Council on Dental Education and Licensure Amendment of ADA Policy on Examinations for Allied Dental (Non-Dentist) Personnel
Res. 7	4002	Council on Dental Education and Licensure Amendment to the <i>Governance Manual</i> Regarding Council on Dental Education and Licensure Appointments and Vacancies
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