

2015

Supplement to
Annual Reports and Resolutions
Volume 1

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Table of Contents Volume 1

Board Report 1/Credentials, Rules and Order

1000	Report 1 of the Board of Trustees: Association Affairs and Resolutions
1023	Nominations to Councils, Commissions and the New Dentist Committee (Res. 55)
1025	Report of the Standing Committee on Credentials, Rules and Order
1033	Standing Committee on Credentials, Rules and Order: Approval of Minutes of the 2014 House of Delegates (Res. 56)
1034	Standing Committee on Credentials, Rules and Order: Adoption of Agenda and Order of Agenda Items (Res. 57)
1035	Standing Committee on Credentials, Rules and Order: Referrals of Reports and Resolutions (Res. 58)

Budget, Business and Administrative Matters

2000	Report 4 of the Board of Trustees: Compensation and Contract Relating to the Executive Director
2002	Report 2 of the Board of Trustees: 2016 Budget
2045	Report 2 of the Board of Trustees: Approval of 2016 Budget (Res. 7)
2046	Report 2 of the Board of Trustees: Establishment of Dues Effective January 1, 2016 (Res. 8)
2047	Report 13 of the Board of Trustees: Information Technology Initiatives, Expenditures and Estimated Costs, and Anticipated Future Projects
2057	Report 14 of the Board of Trustees: ADA Pension Plans

Dental Benefits, Practice and Related Matters

3000	Council on Dental Benefit Programs: Rescission of Policy, Dental Procedure Code Changes (Res. 9)
3002	Council on Dental Benefit Programs: Revision of Policy, Explanation of Benefits (EOB) Statement and Identification of Claims Reviewers (Res. 10)
3004	Council on Dental Benefit Programs: Revision of Policy, Bulk Benefit Payment Statements (Res. 11)
3007	Council on Dental Practice: Medical Loss Ratio (Res. 12)
3009	Council on Dental Practice Supplemental Report 1: Comprehensive ADA Policy Statement on Teledentistry (Res. 45)
3011a	Fifth Trustee District: Substitute Resolution (Res. 45S-1)
3016	Fourteenth Trustee District: Interference in the Doctor/Patient Relationship By Third Party Carriers Through The Practice Of "Disallowing" Claims (Res. 79)
3017	Council on Dental Practice Supplemental Report 2: Response to Resolution 28H—Chairside Medical Screening
3034	Seventh Trustee District: Investigate Enhancements to Tripartite's Product and Service Offerings to Meet the Needs of Member Dentists (Res. 94)
3035	Seventeenth Trustee District: Increasing Member Value Proposition Through the Center for Professional Success (Res. 95)

TABLE OF CONTENTS

Dental Education, Science and Related Matters

4000	Council on Dental Education and Licensure: Amendment of the Policy, Dentistry (Res. 13)
4001	Council on Dental Education and Licensure: Amendment of the Policy, Continued Recognition of Dental Public Health as a Dental Specialty (Res. 14)
4002	Council on Dental Education and Licensure: Amendment of the Policy, Certifying Board in Dental Public Health (Res. 15)
4003	Council on Dental Education and Licensure: Amendment of the Policy, Recognition of Endodontics as a Specialty and Rescission of the Policy, Continued Recognition of Endodontics as a Dental Specialty (Res. 16)
4005	Council on Dental Education and Licensure: Amendment of the Policy, Certifying Board in Endodontics (Res. 17)
4006	Council on Dental Education and Licensure: Rescission of the Policy, Requirements for Endodontists (Res. 18)
4008	Council on Dental Education and Licensure: Rescission of the Policy, Requirements for Endodontists (Res. 19)
4010	Council on Dental Education and Licensure: Amendment of the Policy, Continued Recognition of Oral Pathology as a Dental Specialty and Rescission of the Policy, Redesignation of the Specialty of "Oral Pathology" to "Oral and Maxillofacial Pathology" (Res. 20)
4012	Council on Dental Education and Licensure: Amendment of the Policy, Certifying Board In Oral and Maxillofacial Pathology (Res. 21)
4013	Council on Dental Education and Licensure: Amendment of the Policy, Recognition of Oral and Maxillofacial Radiology as a Dental Specialty (Res. 22)
4014	Council on Dental Education and Licensure: Certifying Board in Oral and Maxillofacial Radiology (Res. 23)
4015	Council on Dental Education and Licensure: Amendment of the Policy, Continued Recognition of Oral and Maxillofacial Surgery as a Dental Specialty and Rescission of the Policy, Continued Recognition of Oral Surgery as a Dental Specialty (Res. 24)
4017	Council on Dental Education and Licensure: Certifying Board in Oral and Maxillofacial Surgery (Res. 25)
4018	Council on Dental Education and Licensure: Amendment of the Policy, Continued Recognition of Orthodontics as a Dental Specialty and Rescission of the Policy, Redesignation of the Specialty of "Orthodontics" to "Orthodontics and Dentofacial Orthopedics" (Res. 26)
4020	Council on Dental Education and Licensure: Amendment of the Policy, Certifying Board in Orthodontics and Dentofacial Orthopedics (Res. 27)
4021	Council on Dental Education and Licensure: Amendment of the Policy, Continued Recognition of Pediatric Dentistry as a Dental Specialty and Rescission of the Policy, Redesignation of the Specialty of "Pedodontics" to "Pediatric Dentistry" (Res. 28)
4023	Council on Dental Education and Licensure: Certifying Board in Pediatric Dentistry (Res. 29)
4024	Council on Dental Education and Licensure: Amendment of the Policy, Continued Recognition of Periodontics as a Dental Specialty (Res. 30)
4025	Council on Dental Education and Licensure: Certifying Board in Periodontics (Res. 31)
4026	Council on Dental Education and Licensure: Amendment of the Policy, Continued Recognition of Prosthodontics as a Dental Specialty (Res. 32)
4027	Council on Dental Education and Licensure: Certifying Board in Prosthodontics (Res. 33)
4028	Council on Dental Education and Licensure: Rescission of the Policy, Statement of Statutory Regulation of Dental Specialty Practice and Dental Specialists (Res. 34)
4030	Joint Commission on National Dental Examinations: Revisions to Standing Rules of the Joint Commission on National Dental Examinations (Res. 39)

4040	Joint Commission on National Dental Examinations: Revisions to <i>Bylaws</i> of the Joint Commission on National Dental Examinations (Res. 40)
4050	Second Trustee District: ADA Sponsored Dental Licensure Meeting (Res. 60) (Withdrawn)
4053	Report 9 of the Board of Trustees: Annual Report of the ADA Library & Archives Advisory Board
4059	Commission on Dental Accreditation Supplemental Report 1: Request to Transfer the Joint Advisory Committee on International Accreditation from its current ADA-CODA Structure to a Standing Committee of the Commission on Dental Accreditation (Res. 53)
4060	Commission on Dental Accreditation Supplemental Report 2: Revision of the Rules of the Commission on Dental Accreditation (Res. 54)
4071	Council on Dental Education and Licensure Supplemental Report 1: Proposed Amendments to the Sedation and Anesthesia Guidelines (Res. 77)
4072	Commission on Dental Accreditation Supplemental Report 3: Amendment of the ADA Bylaws Regarding the Duties of the Commission on Dental Accreditation (Res. 78)
4074	First Trustee District: Evaluation of Current Reforms in Initial Licensure Examinations Formats (Res. 91)
4075	Fifteenth Trustee District: Development of ADA Policy on Dentistry's Role in Sleep Related Breathing Disorders (Res. 96)

Board Report 1/ Credentials, Rules and Order

Resolution No. 55 NewReport: Board Report 1 Date Submitted: August 2015Submitted By: Board of TrusteesReference Committee: N/ATotal Net Financial Implication: None Net Dues Impact: _____Amount One-time _____ Amount On-going _____ FTE 0

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

Background: This is the first in a series of reports to be presented by the Board of Trustees to the House of Delegates at the 156th Annual Meeting of the American Dental Association.

Appreciation to the Council on ADA Sessions and the 2015 Committee on Local Arrangements: The American Dental Association is pleased to have its 156th Annual Meeting in Washington, DC.

The Council on ADA Sessions has created a meeting that lives up to the ADA's reputation for delivering an extraordinary education and exhibition experience. The Board of Trustees wishes to express its sincere gratitude to the Council, and the exceptional leadership of Dr. Robert E. Roesch, 2015-2016 council chair and Dr. Barry I. Cohen, program chair. They have planned and produced not only an innovative continuing education program, but an exhibition that allows dental professionals to experience firsthand the latest in cutting edge dental materials, services and new technologies.

Council Members. Dr. Terry L. Buckenheimer (Board of Trustees liaison), Dr. Grace A. Curcuru, Dr. Henry F. (Bud) Evans, III, Dr. Charles B. Foy, Jr., Dr. David J. Fulton, Jr., Dr. Chris Hasty (2015 NDC liaison), Dr. Andrea K. Janik (2016 NDC liaison), Dr. Gregory LaMorte, Dr. T. Harold Lancaster, Dr. Howard I.A. Lieb, Dr. Calbert M.B. Lum, Dr. C. Roger Macias, Jr., Dr. Mary E. Martin (2015 CE consultant), Dr. Rhett L. Murray (general chair 2016 Denver Committee on Local Arrangements), Mr. Christian R. Ortiz (ASDA liaison), Dr. Steven E. Parker, Dr. Andrea Richman, Dr. Robert E. Roesch, Dr. Nipa R. Thakkar (2015 NDC consultant), Dr. Neil E. Torgerson, Dr. Sidney R. Tourial, Dr. James H. Van Sicklen, Jr., Dr. Douglas W. Wyckoff are all to be recognized for their commendable achievement.

The Board also extends its sincere thanks for those chairpersons who so capably assisted Dr. Sally J. Cram, general chair of the 2015 Washington, DC Committee on Local Arrangements: Dr. Eugene T. Giannini, vice chair; Dr. Michael M. Blicher, program co-chair; Dr. Christos C. Loukaitis, program co-chair; Dr. James M. Ryan, operations co-chair; and Dr. Paula L. Russo, operations co-chair

Finally, the Board expresses tremendous appreciation to all of the volunteers on the Committee on Local Arrangements for the assistance they provide to the Council in the operation of this annual meeting. The Board recognizes and thanks the District of Columbia Dental Society for their contributions to the success of the 2015 Washington, DC Annual Meeting.

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

Remembrance of Former Leaders: Since the last meeting of the House of Delegates, the following ADA officers have passed away: Dr. Robert L. Bartheld, former vice president, 1995-1996; Dr. Bert Y. Hayashi, former trustee, 1985-1991; Dr. Alex J. McKechnie, former trustee, 1983-1989; **Dr. Carlos Noya, former vice president, 1980-1981**; and Dr. Eugene Wells, former vice president, 1978-1979.

Election of Honorary Membership: In accordance with the *Bylaws* which empowers the Board of Trustees to elect members of the Association, the following individuals have been elected to Honorary Membership:

Randi V. Andresen
Prof. (Dr.) Mahesh Verma
John D.B. Featherstone, M.Sc., Ph.D

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

Distinguished Service Award: Established in 1970, the Distinguished Service Award is the highest honor conferred by the Association's Board of Trustees. This year the Board selected two recipients for the Award. The Board is pleased to announce that the recipients of the 2015 Distinguished Service Award are Dr. Jeanne Sinkford and Dr. Richard Vaughn Tucker.

Jeanne C. Sinkford, D.D.S., Ph.D.: Dr. Jeanne C. Sinkford is Professor and Dean Emeritus, Howard University College of Dentistry. She is currently serving as the Senior Scholar in Residence of the American Dental Education Association Office of the President and Chief Executive Officer. In her present position as Senior Scholar, Dr. Sinkford promotes the growth of underrepresented minority and women students and faculty in dental education. Dr. Sinkford's distinguished career in dental education includes serving as Dean of Howard University College of Dentistry from 1975–1991.

Dr. Sinkford is a nationally and internationally renowned dental educator, administrator, researcher, champion of the advancement of women in dental education, and clinician. Dr. Sinkford became the first woman dean of a dental school in the United States in 1975. She served in that capacity for 16 years.

She has served on numerous committees and advisory councils of national significance including: the National Advisory Dental Research Council; Directors' Advisory Council, National Institutes of Health; Governing Board of the American Society for Geriatric Dentistry; Advisory Board, Robert Wood Johnson Health Policy Program; Committee A, Council on Dental Education and Chair, Appeal Board Council of Dental Education, American Dental Association; Council on Dental Research, American Dental Association; Tuskegee Study Advisory Panel; Special Medical Advisory Group (SMAG), Veterans Administration; Council, Institute of Medicine, National Academy of Sciences and the NRC Governing Board, National Academy of Sciences. She serves on Advisory Boards: Boston University Goldman School of Dental Medicine, Temple University School of Dentistry, Indiana University School of Dentistry and the New York University Oral Cancer Research for Adolescent and Adult Health Promotion (RAAHP) Center.

Dr. Sinkford has more than 90 articles published in refereed journals and has written an instructional manual for Crown and Bridge Prosthodontics. She is co-author of *Women's Health in the Dental School Curriculum*, Report of a Survey and Recommendations.

Dr. Sinkford holds honorary degrees from Meharry Medical College, Georgetown University, the University of Medicine and Dentistry of New Jersey (now the Rutgers School of Dental Medicine), and Detroit-Mercy University. She has received Alumni Achievement Awards from Northwestern

University and Howard University and numerous other citations for exceptional professional achievement. Dr. Sinkford was selected as an Outstanding Leader in Dentistry by the International College of Dentists. She is the first woman to be so honored.

Richard Vaughn Tucker, D.D.S.: Dr. Richard Vaughn Tucker graduated in dentistry in 1946 from Washington University in St. Louis, Missouri, and is a Fellow of the American College of Dentists and the American Academy of Restorative Dentistry. He is past president of the Washington State Dental Association; the American Academy of Operative Dentistry; and the Academy of Gold Foil Operators. His dental practice included the U.S. Navy, private practice and mentor and the Richard Tucker Study Clubs, in which there are 50 Tucker Clinical Operating Study Clubs around the world.

Dr. Tucker is a recipient of the Biaggi Gold Medal from the Italian Congress for his contribution to dental education in Italy; Medal of Excellence presented by the Academy of Operative Dentistry; and Distinguished Service Award from the College of Dental Surgeons of British Columbia (B.C.C.D.S.). Dr. Tucker was awarded Honorary Membership in the B.C.C.D.S. for his outstanding contributions to the art and science of dentistry, provincially, nationally, and internationally. He was also chosen as a Distinguished Alumnus of Washington University and holds an Honorary Doctorate of Law from University of British Columbia.

Dr. Tucker had a small town practice, where he studied to perfect and innovate gold procedures, which are especially practical to use in general dentistry. Dr. Tucker has designed two margin trimmers for use in gold restoration procedures which are manufactured. In recognition of his exceptional contribution to dentistry, a gold alloy has been named after him. He has made two teaching videos at the University of Washington pertaining to inlay procedures.

Dr. Tucker has presented more than 250 lectures and graduate courses in dental schools, institutes and other professional organizations all over the world on his favorite subject "Cast Restorative Dentistry" and has contributed to dental science and scientific literature with numerous papers written on the subject

Retiring Officers and Trustees: The Board of Trustees wishes to express its gratitude to the following officers and trustees for services rendered to the Association during their tenure on the Board: Dr. Jonathan Shenkin, vice president; Dr. Jeffrey D. Dow, trustee, First District; Dr. Hilton Israelson, trustee, Fifteenth District; Dr. Gary Roberts, trustee, Twelfth District; and Dr. Gary S. Yonemoto, trustee, Fourteenth District.

Appreciation to Employees: The Board of Trustees is pleased to bring to the attention of the House of Delegates 33 members of the Association staff for their years of service.

Thirty-Five Years: Stephen Gruninger, Science Institute; Gwendolyn Harrison, Finance and Operations; Sharon Stanford, Practice Institute

Thirty Years: Sabrina Collins, Practice Institute; Karen Hart, Education; Peter Solarz, Business and Publishing

Twenty-Five Years: Carolyn Tatar, Business and Publishing

Twenty Years: Michael Graham, Government Affairs, Washington Office; Richard Green, Communications and Marketing; Mary Griffin, Legal Division; Daniel Meyer, Office of the Executive Director; Sheron Parkman, Education; Dessiree Paschal, Membership and Client Services; David Richardson, Information Technology; Lisa Schnick, Legal Division; Debra Willis, Education

Fifteen Years: Alan Bardauskis, Information Technology; Roger Connolly, Science Institute; Stephen Feichtl, Information Technology; Cassandra Giles, Human Resources; Barry Grau, Health Policy Institute; Robert Hartman, Finance and Operations; Sean Hatchett, Information Technology; Patricia Lewis, Business and Publishing; Kathy Medic, Practice Institute; Dennis McHugh, Practice Institute; Bradley Munson, Health Policy Institute; Paul O'Connor, Government and Public Affairs; Darshna Patel, Human Resources; Frank Pokorny, Practice Institute; Alex Spivak, Information Technology; Jaydev Thakkar, Information Technology; Leslee Williams, Communications and Marketing

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

The nominees and their qualifications for membership appear in the report entitled, "Nominations to Councils, Commissions and the Committee on the New Dentist." Following Board action, the names and Qualifications of the nominees and resolution will be added to this report and transmitted to the 2015 House of Delegates.

The qualifications of these nominees appear on page 1009.

ACCESS, PREVENTION AND INTERPROFESSIONAL RELATIONS

Richard P. Herman, New York
Mark Koday, Washington
Alicia Risner-Bauman, Pennsylvania
Michael Wasserman, Massachusetts

ADA SESSIONS

Paul Kirkegaard, Minnesota
Stephen T. Radack, III, Pennsylvania
Beatriz E. Terry, Florida
Nanette C. Tertel, Ohio

COMMUNICATIONS

William H. Karp, New York
David J. Kenyon, Wisconsin
Gigi Meinecke, Maryland
Philip L. Schefke, Illinois
Karl P. Woods, Maine, *ad interim*

CONTINUING EDUCATION PROVIDER RECOGNITION

Nancy R. Rosenthal, Pennsylvania

DENTAL ACCREDITATION

Joseph F. Hagenbruch, Illinois*

DENTAL BENEFIT PROGRAMS

Christopher M. Bulnes, Florida
Brett H. Kessler, Colorado
Martin J. Makowski, Michigan
Mark J. Mihalo, Indiana

DENTAL EDUCATION AND LICENSURE

Edmund A. Cassella, Hawaii
Jennifer Korzeb, Massachusetts

DENTAL PRACTICE

Christopher M. Connell, Ohio
Hal E. Hale, Kansas
Julia K. Mikell, South Carolina
Stacey K. Van Scoyoc, Illinois

ETHICS, BYLAWS AND JUDICIAL AFFAIRS

David A. Anderson, Pennsylvania
M. Elwood Rice, Missouri
Petra von Heimburg, Illinois
James A. Smith, Oregon

GOVERNMENT AFFAIRS

Craig S. Armstrong, Texas
Daniel K. Cheek, North Carolina
Lauro Medrano-Saldaña, New York
Ariane R. Terlet, California

MEMBERS INSURANCE AND RETIREMENT PROGRAMS

Naomi L. Ellison, California
Robert L. Jolly, Sr., Arkansas
Katherine L. Kilcollin, West Virginia
Peter J. Pirmann, Illinois

MEMBERSHIP

Karin Irani, California
Ted Sherwin, Virginia
Stephen P. Tigani, District of Columbia
Alexa M. Vitek, Michigan
Heather A. Willis, Alaska, *ad interim*

NATIONAL DENTAL EXAMINATIONS

Cheryl Haley, Missouri

NEW DENTIST

Lauren M. Czerniak, Ohio
Andrea C. Fallon, Massachusetts
Raymond A. Jarvis, Louisiana
Robin M. Nguyen, Florida
Michael Saba, New Jersey, *ad interim*
Lindsey J. Yates, Illinois, *ad interim*

SCIENTIFIC AFFAIRS

Thomas W. Braun, Pennsylvania
Steven R. Jefferies, Pennsylvania, *ad interim*
Angelo J. Mariotti, Ohio
William B. Parker, Florida
Norman Tinanoff, Maryland

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

Resolution

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

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

ACCESS, PREVENTION AND INTERPROFESSIONAL RELATIONS

John P. Fisher, Massachusetts
E. Jane Gillette, Montana
Bernadette A. Logan, Pennsylvania
David C. Schirmer, Florida

ADA SESSIONS

Barry I. Cohen, Pennsylvania
Steven E. Parker, Ohio
Robert E. Roesch, Nebraska
Neil E. Torgerson, Florida

COMMUNICATIONS

Alice G. Boghosian, Illinois
Michael G. Maihofer, Michigan
Minerva Patel, New York
George R. Shepley, Maryland

DENTAL ACCREDITATION

Perry K. Tuneberg, Illinois

DENTAL BENEFIT PROGRAMS

Mark H. Blaisdell, Utah
Charles W. Hoffman, Florida
John G. Masak, Wisconsin
Robert L. Mazzola, Ohio

DENTAL EDUCATION AND LICENSURE

James M. Boyle, III, Pennsylvania
Roger B. Simonian, California

DENTAL PRACTICE

Miranda M. Childs, Arkansas
Charles B. Maxwell, South Carolina
J. Mark Thomas, Indiana
Joseph G. Unger, Illinois

ETHICS, BYLAWS AND JUDICIAL AFFAIRS

Darryll L. Beard, Illinois
Barry D. Curry, Kentucky
Linda K. Himmelberger, Pennsylvania
Laura Williams, Washington

GOVERNMENT AFFAIRS

Richard C. Black, Texas
Michael R. Breault, New York
Irving S. Lebovics, California
Gus C. Vlahos, Virginia

MEMBERS INSURANCE AND RETIREMENT PROGRAMS

Mark S. Chaney, Louisiana
Timothy J. Schwartz, Illinois

MEMBERSHIP

Edwin A. del Valle-Sepulveda, Puerto Rico
Natasha A. Lee, California
Shelley Barker Olson, North Carolina
Gene Shoemaker, Wisconsin

NATIONAL DENTAL EXAMINATIONS

Robert A. Hersh, New Jersey

NEW DENTIST

Michael A. LeBlanc, Kansas
Irene Marron-Tarrazzi, Florida
Heather A. Maupin, Indiana
Timothy W. Oh, Maine

SCIENTIFIC AFFAIRS

Thomas C. Hart, Illinois
*Peter Milgrom, Washington
Edward H. Segal, Illinois
Thomas P. Sollecito, Pennsylvania

*Presidential appointee to fulfill the 2012 Gold Medal Award for Excellence in Dental Research position.

ADA Institute for Diversity in Leadership

Program Aims: The 2002 ADA House of Delegates approved the ADA Board's proposal for an ADA leadership institute designed for:

- Building lifetime relationships with minority dentists;
- Mentoring promising leaders with potential to impact diverse communities; and
- Strengthening alliances with stakeholder institutions, including dental leaders, industry, public and governmental communities of interest.

Leadership Development: During their year-long program, Institute participants have faculty seminars at ADA Headquarters, conference calls with faculty and advisors, and guided experience with individual leadership projects for their dental societies or other community organizations. Faculty are from Northwestern University's Kellogg School of Management and Duke University's Fuqua School of Business. (The Kellogg School is not connected with the W.K. Kellogg Foundation.) ADA Leadership Institute videos on ADA CE Online are also a resource. An ADA Connect forum also serves the Institute community.

Enrollment: Since 2003, the program has admitted 161 dentists (including one dentist sponsored by the Asociación Dental Mexicana). In 2015, the ADA Board of Trustees admitted the following new class as recommended by the Board's Diversity and Inclusion Committee from a competitive field of applicants:

Dr. Courtney P. Barrett, Oklahoma City, OK
Dr. Drew A. Colantino, San Diego, CA
Dr. Sharon Colvin-Johnson, Waldorf, MD
Dr. Hadi Ghazzouli, Collegeville, PA
Dr. Yana Kushner, Austin, TX
Dr. Abrey Lopez, Van Nuys, CA
Dr. David James Manzanares, Albuquerque, NM
Dr. Liliam Ortiz Galarza, Humacao, PR
Dr. Joeseeph Potter, Los Angeles, CA
Dr. Tricia Quartey, Brooklyn, NY
Dr. Vinni K. Singh, Mountain View, CA

1 Dr. Susana Elena Torres, Chicago, IL
2 Dr. Radip Uprety, Bucksport, ME
3 Dr. Melissa Uriegas, Brownsville, TX
4 Dr. Christine Wankiiri-Hale, Pittsburgh, PA
5 Dr. Richard L. Williams, Fort Sam Houston, TX

6 **Sponsorship:** The ADA Institute for Diversity in Leadership is made possible through the generous
7 support of Henry Schein, Inc. and Procter & Gamble.

8 **Alumni Paths:** Institute alumni have gone on to serve as volunteer leaders at the local, state and
9 national levels.

- 10 • Service has included the ADA Strategic Planning Committee, Council on Membership, New
11 Dentist Committee, Board of Trustees Standing Committee on Diversity and Inclusion and House
12 of Delegates.
- 13 • Alumni have also served as volunteers and officers at the local and state levels of ADA and
14 community service organizations, as well as officers and leaders at the national levels of the
15 Society of American Indian Dentists, National Dental Association, Hispanic Dental Association,
16 and American Association of Women Dentists.
- 17 • Eleven alumni were among the state association representatives to this year's ADA Washington
18 Leadership Conference; and four members of the Institute community are attending the 2015
19 candidate school produced jointly by ADA and several other professional associations.
- 20 • Alumni led Veterans' Day access initiatives and championed a state dental society leadership
21 development program. Surveyed in 2015, alumni awarded the Institute an overall grade of 4.9 on
22 a 5-point scale.

23
24 **2014 Policy Review:** The publication, *Current Policies*, was updated in March 2015 to reflect the actions
25 of the 2014 House of Delegates. The following list identifies the new policies added to the policy book; the
26 policies that were rescinded and therefore deleted from the policy book; and the policies that were
27 amended. A copy of *Current Policies, 1954-2014*, is available in the Resources library on the House of
28 Delegates community of ADA Connect.

29 **New Policies added to *Current Policies***

30
31 Dental Schools to Provide Education to Dental Students on Drug and Alcohol Use and
32 Misuse—34H-2014
33 Advocacy for Dental Education Infrastructure—59H-2014
34 Advocacy for Graduate Student Loan Programs—60H-2014
35 Advocacy for Student Loan Forgiveness and Other Educational Debt Reduction Programs—61H-2014
36 Early Detection and Prevention of Oral Cancer—85H-2014
37 Child Identification Programs—86H-2014
38 Oral Health Education in Schools—87H-2014
39 Community-Based Topical Fluoride Programs—88H-2014
40 Educating Dental Professionals in Recognizing and Reporting Abuse—89H-2014
41 Prevention and Control of Early Childhood Caries—90H-2014
42 Dental Examinations for Pregnant Women and Women of Child-Bearing Age—94H-2014
43 Dental Treatment during Pregnancy—95H-2014
44 Designation of individuals with Intellectual Disabilities as a Medically Underserved Population—96H-2014
45 Definition of Oral Health—97H-2014
46 Dentist Rating by Third Parties—110H-2014
47 Titles and Descriptions of Continuing Education Courses—111H-2014

Rescinded Policies removed from *Current Policies*

Clarification of Support for Federal Legislation to Facilitate Formation of Association Health Plans --43H-2014
Medicaid Co-Payment—44H-2014
Dentists right to Opt Out of the Medicare Program—45H-2014
Guaranteed Dental Care for Medicaid Participants under Health System Reform—46H-2014
Improvements in Medicaid Program—47H-2014
Medicaid Block Grants—48H-2014
Safeguards for Medicare's Health Maintenance Organizations—49H-2014
Payment of Medicaid Benefits to Dental Schools—50H-2014
Deduction of Student Loan Interest—51H-2014
Federal Educational Loans—52H-2014
Federal Assistance for Dental Students—53H-2014
Federal Lobbying Efforts that Support Dental Education—54H-2014
Increased Support for Postgraduate Training Programs—55H-2014
Increased Federal Funding for General Practice Residencies and Advanced Education in General Dentistry Programs—56H-2014
Advocacy for Dental Education Funding—57H-2014
State Funding for Dental Education—58H-2014
Prevention and Early Oral Cancer Detection—85H-2014
Child Identification Program Partnerships—86H-2014
Topical Fluoride Programs; School Fluoride Mouthrinse Programs—88H-2014
ADA Efforts to Educate Dental Professionals in Recognizing and Reporting Abuse and Neglect; Child Abuse—89H-2014
Statement on Early Childhood Caries—90H-2014
Titles and Descriptions of Dental Hygiene Continuing Education Courses—111H-2014

Amended Policies

Closed Panel Dental Benefit Plans—4H-2014
Medically Necessary Care—5H-2014
Development of Alternate Pathways for Dental Hygiene Training—8H-2014
Certifying Board in Dental Assisting—9H-2014
Certifying Board in Dental Laboratory Technology—10H-2014
Criteria for Recognition of a Certification Board for Dental Assistants—11H-2014
Criteria for Recognition of a Certification Board for Dental Laboratory Technicians—12H-2014
Guidelines Governing the Conduct of Campaigns for All ADA Offices—15H-2014 and 27H-2014
The Dentist's Pledge—16H-2014
Tripartite Membership Application Procedures—19H-2014
Advocate for Adequate Funding Under Medicaid Block Grants—37H-2014
Medicaid and Indigent Care Funding—38H-2014
Federal Tax Credit/Voucher for Medicaid Dentist Providers—39H-2014
Support of Current Medicaid Law and Regulations Regarding Dental Service—40H-2014
Maldistribution of the Dental Workforce—41H-2014
Advocating for ERISA Reform—42H-2014
Manufacturer Sponsorship of Dental Programs and Promotional Activities—70H-2014
Health Planning Guidelines—71H-2014
Vision Statement on Access for the Underserved and Promotional Activities—72H-2014
Inclusion of Basic Oral Health Education in Nondental Health Care Training Programs—73H-2014
Women's Oral Health: Patient Education—74H-2014
Patient Safety—75H-2014
Tobacco and Harm Reduction—76H-2014

- 1 Tobacco Free Schools—77H-2014
- 2 Nondental Providers Notification of Preventive Dental Treatment—78H-2014
- 3 Nondental Providers Completing Educational Program on Oral Health—79H-2014
- 4 Definition of Dental Home—80H-2014
- 5 Definition of Primary Dental Care—81H-2014
- 6 Principles for Developing Children's Oral Health Programs—82H-2014
- 7
- 8
- 9
- 10

Resolution

(Resolution 55:Worksheet:1023)

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

Herman, Richard P., New York, 2019. Dr. Richard Herman is the dental director of the Greater Hudson Valley Family Health Center Newburgh, New York. The Center is Joint Commission Accredited and is MU 2 with two and soon to be three sites and treats a culturally diverse population. He has experience with Medicaid and SCHIP programs both through activities at the Center and working with New York State Dental Association (NYSDA) committees. In addition he is a past member of the ADA Council on Dental Benefit Programs. The Center is actively involved in expanding access to care and interprofessional relations via the Delivery System Reform Incentive Payment programs in New York with an eye to bringing care to underserved areas and reducing emergency room visits.

Koday, Mark, Washington, 2019. Dr. Mark Koday has an extensive work experience in the Indian Health Service and National Health Service Corps. Additionally, Dr. Koday has been involved as a director in an AEGD program since 2005, so his experience in educational settings gives him an appreciation for training and educating dentists. This is important background in interprofessional relations. Dr. Koday has been instrumental in his state working to improve health center outcomes by serving on the Health Centers User's Guide Committee, as well as serving on the Performance Improvement Collaborative. These leadership positions have helped him participate on improving access to care in his state. In regards to organized dentistry, Dr. Koday has been a member of the Washington State Dental Association Task Force on Public Policy Development since 2013. He is a past dental board member for the state licensing board, including chairing the Dental Quality Assurance Commission Board. He is a past chair of the Washington State Oral Health Coalition. He has been on the Yakima Oral Health Coalition as well as the Migrant Clinicians Network as a board member. He has experience teaching in dental schools both in Oregon and Washington.

Dr. Koday has authored articles in journals and has given multiple presentations on topics ranging from Coalitions, Caries Management, Mobile Dental Access and much more. With Dr. Koday's experience in Public Health and participation in state, local and national levels, he will bring a large body of experience and coalition building skills to CAPIR.

Risner-Bauman, Alicia, Pennsylvania, 2019. Dr. Alicia Risner-Bauman has shown her dedication and commitment to the underserved population of central Pennsylvania as the dental clinic director of the Tioga Dental Services Clinic for the past six years. She has overseen the provision of general dental services to patients of all ages, provided grant proposals in support of the free-service clinic along with the provision of new and innovative practice policies. She continues to have a special interest in the provision of dental care for those with special needs and has been instrumental in legislative efforts to assist this patient population as the chair of the Advisory Group on Access to Oral Health for the Pennsylvania Dental Association. She continues her commitment to our underserved population as a member of the Special Care Dentistry Association and the co-chair of the Workforce Committee of the Pennsylvania Coalition on Oral Health. Dr. Risner-Bauman continues her efforts toward access to oral health services for the underserved through her numerous lectures, research and appointments to workgroups on fluoridation and special needs dentistry.

Wasserman, Michael, Massachusetts, 2019. Dr. Michael Wasserman is a past president of the Massachusetts Dental Society. He is a past member of the MassHealth Dental Advisory Committee. He is a director of Eastern Dental Insurance Agency and served on the Massachusetts Special Commission on Dental Insurance.

ADA SESSIONS

Kirkegaard, Paul, Minnesota, 2019. Dr. Paul Kirkegaard is a good match for the criteria listed under qualifications to be recommended for a seat on the Council on ADA Sessions. He has served in many leadership opportunities for the Minnesota Dental Association (MDA) including a seven-year term on the MDA Scientific Sessions Committee, the last year as the chair of this committee. The Scientific Sessions Committee is the committee that puts on the entire Minnesota Star of the North Annual Meeting, the

premier annual meeting in the upper Midwest, with 10,000 participants, a multitude of continuing education opportunities and 350 commercial vendors.

Dr. Kirkegaard definitely has the skills needed to plan a large dental meeting including developing relevant continuing education programs, scouting and selecting speakers, signing exhibitor vendors to commercial spaces, and an excitement that will go out to our membership with a spirit of participation. He is a general dentist in St. Paul, Minnesota and has the pulse of the average rank and file member of the ADA. He is very approachable, loves his profession and shares this excitement with everyone he meets. Dr. Kirkegaard is a worker bee, but also will have several unique and thoughtful ideas on how to make our meeting the best it can be.

When asked to consider this opportunity, Dr. Kirkegaard was excited and started to share many ideas he had on how to make this first class dental meeting even better, a must attend for our members, and a meeting that non-members will join the ADA to be able to attend America's Dental Meeting. Dr. Kirkegaard was quoted, saying, "One of the reasons I became involved in organized dentistry is to have the opportunity to be around like minded committed people who love their profession. The ADA has thousands of those individuals and I am eager to meet and work more with them."

Radack, Stephen T. III, Pennsylvania, 2019. Dr. Stephen Radack recently completed his term as president of the Pennsylvania Dental Association (PDA). One of his primary responsibilities was to oversee and implement a complete redirection of the educational content and administration of the annual meeting. The PDA Dental Meeting and Expo created a varied and inclusive opportunity for all members of his constituent dental society to receive continuing education, experience socialization with their colleagues, interact and develop relationships with exhibitors and directly discuss the issues affecting dentistry with state and national leadership. His experience as a past treasurer of the PDA, four-year member of its Strategic Planning Committee, director and treasurer of its for-profit subsidiary and commissioner of the JCNDE will provide the Council on ADA Sessions with a unique and talented representative. He was personally responsible for the creation and implementation of innovative communications techniques still utilized by PDA leadership.

Terry, Beatriz E., Florida, 2019. Dr. Beatriz Terry is an active member at all three levels of the Tripartite and in every affiliated dental organization she has joined. She has been president of her local dental society, her component dental association and currently serves on the Board of Trustees of the Florida Dental Association. At each level she has played an integral role in developing and leading educational meetings and programs that create value to the members of that organization. Dr. Terry served as program chair of the local Hispanic Dental Association Chapter (CEOLA/HELO) in 2002 and served for 11 years on the Florida Dental Association's Annual Meeting Committee and was program chair in 2008. She has the acute awareness of creating meetings that bring value to the attendees. She has the ability to draw in people of diverse backgrounds to make them feel welcome and play an important part of the success of the meetings. Dr. Terry is innovative in her thinking and is organized in her actions. She will bring a solid meeting experience background that will provide new ways to reach out to the diverse members within our organization.

Tertel, Nanette C., Ohio, 2019. Dr. Nanette Tertel has been in the leadership of the Ohio Dental Association Annual Sessions Committee for many years. She understands the importance of the non-dues revenue stream that comes from the Council on ADA Sessions.

COMMUNICATIONS

Karp, William H., New York, 2019. Dr. William Karp is a practicing dentist in Manlius, New York. Besides being a respected dentist in the community, he has been actively involved in organized dentistry at all levels. Some of his many qualifications for this council position include trustee of the New York State Dental Association (NYSDA) 2009 to present, member of the NYSDA's Executive Committee 2006-07, delegate to the American Dental Association 2003-08 and 2014 to present, governor of the NYSDA 2003-2008. He also served as president of Fifth District Dental Society (NYSDA component) 2001, and a member of NYSDA Council on Hospital Dentistry and Health Planning 1990-92. Dr. Karp is currently the

1 chair of the NYSDA's Strategic Planning Committee and also the chair of 2015 Annual Sessions. Dr.
2 Karp is a Fellow of the American College of Dentists, International College of Dentists and the Pierre
3 Fauchard Academy. Dr. Karp's ability to be a collaborative consensus builder will make him an asset for
4 the Council on Communications.

5 *Kenyon, David J., Wisconsin, 2019.* Dr. David Kenyon is a solo practitioner in general dentistry in
6 Altoona, Wisconsin, and he also serves as a clinical preceptor for one of Marquette University's
7 community clinics at Chippewa Valley Technical College. He was a Region 1 Trustee for the Wisconsin
8 Dental Association (WDA) from 2007 to 2014, and he served as an ADA delegate or alternate delegate
9 from 2004 to 2014. Dr. Kenyon has attended two previous ADA/WDA-sponsored spokesperson training
10 programs, and he has had the experience of providing telephone, in-person and on-camera interviews
11 with local and state media regarding significant dental issues. He has served on the WDA Strategic
12 Planning Committee and most recently participated in a Strategic Thinking Program with the WDA Board
13 of Trustees. He was a member of the WDA/BOT when a new logo and brand management philosophy
14 was adopted as part of a newly implemented marketing initiative. Dr. Kenyon had previously been
15 employed in a large group dental practice during a similar re-branding process along with a multi-faceted
16 marketing strategy. Throughout his tenure as a WDA Trustee, he worked closely with the Association's
17 Public Relations, Communications and Marketing Department as it became a well-known and respected
18 source for WDA members. The WDA, during that time, produced various media projects that have
19 received state and national recognition. Most recently Dr. Kenyon was instrumental in assisting the WDA
20 Board of Trustees when it was faced with a situation that required legal intervention to protect the
21 Association's brand and reputation. This matter was ultimately resolved with no harm to the WDA's
22 reputation. Dr. Kenyon's level of expertise is such that he is without a doubt the right person at the right
23 time to fulfill the duties and responsibilities of a member of the ADA Council on Communications.

24 *Meinecke, Gigi, Maryland, 2019.* Dr. Gigi Meinecke is a member of the Maryland State Dental Society
25 where she serves on the Legislative Council. She has served as a dental spokesperson for eight years.
26 For several years running, she has addressed the Maryland Legislature when they are in session, on
27 behalf of Maryland dentists, on various bills that have been introduced. Dr. Meinecke has participated in
28 several New York media tours, and has contributed to many national lay print publications such as:
29 *Men's Health, Women's Health, Marie Claire, Baltimore Sun, Fox News, Real Simple, Men's Fitness,*
30 *Working Mother, American Baby, Shape, Consumer Reports, Science Daily, and Readers Digest.*
31 Additionally, she had appeared on television on WJLA and radio on WTOP. She has served as a
32 member of the AGD Public Relations Council, and authored a blog for the web site "Know Your Teeth"
33 from 2008 to 2010. Dr. Meinecke's communication experience in various media outlets will make her an
34 asset to the Council on Communications.

35 *Schefke, Philip L., Illinois, 2019.* Dr. Philip Schefke is a graduate of the University of Illinois College of
36 Dentistry where he received his D.D.S. degree in 1987. He is currently a full-time assistant professor at
37 Midwestern University College of Dental Medicine. Prior to this, Dr. Schefke served as an adjunct faculty
38 member at Prairie State Dental Hygiene School (2012-14). He served as an alternate delegate to the
39 ADA House of Delegates. He currently serves as a trustee from the Chicago District to the Illinois State
40 Dental Society Board of Trustees; and has also served as the director from the South Suburban Branch
41 on the Board of Directors to the Chicago Dental Society. In addition, Dr. Schefke served on the
42 Communications Committee for both the Chicago Dental Society and the Illinois State Dental Society,
43 serving his final year as chair for both of these committees. He is a member of the ADA, the Illinois State
44 Dental Society, and the Chicago Dental Society; and is a Fellow of the International College of Dentists
45 and the American College of Dentists.

46 *Woods, Karl P., Maine, 2017.* In March 2015, Dr. Karl Woods was appointed to complete to unexpired
47 term of Dr. Carolyn Malon as a member of the Council on Communications. Dr. Woods is a general
48 dentist from Houlton, Maine.

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CONTINUING EDUCATION PROVIDER RECOGNITION

Rosenthal, Nancy R., Pennsylvania, 2019. Dr. Nancy Rosenthal is best known at the American Dental Association as a past chair of its Council on Membership. In this leadership position, she established her commitment to the future of our organization and to the development of innovative membership policies, including continuing education opportunities. This also establishes her dedication to the ADA, its policies and programs. Dr. Rosenthal has also assisted the Pennsylvania Dental Association on its Council on Dental Practice and a long-time member of its House of Delegates, including service on its various reference committees. She has also served as the volunteer chair for the Committee on Local Arrangements for the 2005 ADA Annual Session in Philadelphia. In this position, she assisted the committee in overseeing the organization and structure for the continuing educational opportunities experienced by the attendees.

Dr. Rosenthal recently completed her term as president of the Valley Forge Dental Society, Pennsylvania's largest component along with experience as the chair of both its Continuing Education and Constitution and Bylaws Committees. She currently shares an affiliation with Jeanes and Frankford Hospitals in Philadelphia and is an adjunct professor at the Kornberg School of Dentistry. Dr. Rosenthal also served as adjunct professor at the University of Pennsylvania from 1989 to 1989.

Dr. Rosenthal currently serves on the Internal Review Board of Salus University in Elkins Park, Pennsylvania, where she implemented a framework for developing and analyzing a range of health policy issues for healthcare professionals. The program provides broad strategies for rationally analyzing any public health policy issue. The core health policy course presents four analytic skills commonly used by policy makers to: analyze historical, political, ethical, and legal ramifications; assess need and demand; examine economic and financial considerations; and assess existing programs and policies. This program is designed to help the student apply these skills in the delivery of healthcare, injury prevention and trauma care, and emergency preparedness.

Dr. Rosenthal has been a member of the American Academy of Dental Practice Administration, the Academy of Stomatology and is a Fellow in the International College of Dentists, American College of Dentists and the Pierre Fauchard Society. She would be an asset to the Commission for Continuing Education Provider Recognition and work well toward furthering its mission.

DENTAL ACCREDITATION

Hagenbruch, Joseph F., Illinois, 2020. Dr. Joseph Hagenbruch has served the ADA on the Council on Dental Benefit Programs (chair of the council in 2009), the ADA Code Revision Committee, and as the ADA Eighth District Trustee from 2010 to 2014. In addition, he has served numerous times as a delegate or alternate delegate from the ADA Eighth District (Illinois) to the ADA House of Delegates. Dr. Hagenbruch has also served as president of the Illinois State Dental Society (ISDS), the McHenry County Dental Society, and the Illinois Academy of General Dentistry. Dr. Hagenbruch received the Distinguished Alumnus Award from the Washington University in St. Louis Dental Alumni Association in 2014, ADA Presidential Citations in 2009 and 2013, and the Healthy Smiles Hero Award from the State of Illinois Lieutenant Governor in 2007. While on the ADA Board of Trustees, Dr. Hagenbruch served as trustee liaison to the Commission on Dental Accreditation (CODA) in 2013-14, and the Dental Quality Alliance (DQA) Board from 2011 to 2014; and he served as chair of the ADA Board of Trustees Task Force on the ADA Library Transition Plan. Dr. Hagenbruch is a Fellow of the International College of Dentists and the American College of Dentists, where he serves as ACD Regency 5 Regent (2012-16). He is also a Fellow of the Academy of Dentistry Internationale and the Pierre Fauchard Academy.

DENTAL BENEFIT PROGRAMS

Bulnes, Christopher M., Florida, 2019. Dr. Christopher Bulnes is a dependable, hardworking individual with a strong willingness to serve our profession and our Association. He is educated in the CDT codes and is aware of the current trends facing dentistry and healthcare with respect to the ACA. Dr. Bulnes is

also aware of the significance of the IP (Intellectual Property) that the ADA has in place and its relationship to non-dues revenue and the overall budgetary process. Dr. Bulnes is active at all levels of the Tripartite having served as president of his local dental society, is currently the president of the West Coast District Dental Association (component) and is on the Board of Trustees of the Florida Dental Association (constituent). He also serves as a delegate to the FDA House of Delegates and an alternate delegate to the ADA House. Finally, he was named co clinical chair of the first Florida MOM event in 2014 and did an outstanding job coordinating the treatment of over 1,600 patients. He recently has given a three-year commitment to serve in the same capacity at the 2016 MOM in Jacksonville, 2017 MOM in Pensacola and the 2018 MOM event at a site to be determined. Dr. Bulnes will be a great asset to the Council.

Kessler, Brett H., Colorado, 2019. Dr. Brett Kessler is the immediate past president of the Colorado Dental Association. He has also served on the Chair Peer Review 2012-2013. He has helped to formulate and roll out Medicaid benefits for adults. Dr. Kessler has also testified multiple times before the State and United States Congress and Committees.

Makowski, Martin J., Michigan, 2019. Dr. Martin Makowski is currently completing his term as president of the Michigan Dental Association (MDA), having served previously as its president-elect, vice president and trustee representing his Macomb County component society. He has been an ADA delegate or alternate delegate each year since 2006. Dr. Makowski is a pediatric dentist practicing in a large group setting. He is a past president of the Michigan Academy of Pediatric Dentists and has served as a member of the Legislative Action Committee of the American Academy of Pediatric Dentists. Dr. Makowski served as a board member of the MDA Insurance & Financial Group, the for-profit subsidiary of the MDA, and/or the Michigan Dental Companies Inc. from 2008 to 2015. He has also served as liaison to the MDA Committee on Peer Review (Dental Care) and as a member of the MDA Employee Benefits Advisory Committee. Throughout his tenure as a member of the MDA Executive Committee, Dr. Makowski has been very involved in matters related to dental benefit plans, legislative advocacy initiatives related to dental benefit plans, Medicaid expansion, provider compensation, Michigan's Healthy Kids Program and other children's dental health programs, Delta Dental and BC/BS programs and other important related matters. He has experience in a wide variety of practice settings including private practice, hospital dentistry and as an educator in dental school and hospital residency programs. His office participates as a provider for Medicaid, Healthy Kids Dental, MI Child and multiple private insurance programs. Dr. Makowski brings a great deal of expertise to the ADA Council on Dental Benefit Programs, and he will serve the ADA well in this capacity.

Mihalo, Mark J., Indiana, 2019. Dr. Mark Mihalo has been in private practice in La Porte, Indiana since 1987 and a member of the ADA since 1985. He has been an active member of the Indiana Dental Association's Council on Dental Benefits since 2007.

DENTAL EDUCATION AND LICENSURE

Cassella, Edmund A., Hawaii, 2019. Dr. Edmund Cassella has been involved in education since 1969 and currently oversees Hawaii's flagship GPR Program at Queen's Medical Center where he is also chief of the dental division. He is an excellent nominee for this position.

Korzeb, Jennifer, Massachusetts, 2019. Dr. Jennifer Korzeb is a graduate of the Tufts University School of Dental Medicine and practices in Haverhill, Massachusetts. She is chair of the Massachusetts Dental Society Committee for Dental Education and a member of the Yankee Dental Congress Program Committee.

DENTAL PRACTICE

Connell, Christopher M., Ohio, 2019. Dr. Christopher Connell is a practicing dentist in Lyndhurst, Ohio.

Hale, Hal E., Kansas, 2019. Dr. Hal Hale has worked tirelessly to serve his profession since his graduation from the University of Missouri, Kansas City School of Dentistry. He has served as the Kansas Dental Association president and treasurer, as well as chair of their Budget and Finance Committee. He is a Congressional Action Team Leader. Dr. Hale is a member of ACD, ICD and a UMKC School of Dentistry Rinehart Medallion Recipient. His varied experiences and solid work ethic will make him an excellent member of the Council on Dental Practice.

Mikell, Julia K., South Carolina, 2019. Dr. Julia Mikell graduated with a B.S. degree in 1984 from Bryn Mawr College in Pennsylvania and from the University of North Carolina-Chapel Hill, School of Dentistry in 1989. She served in the United States Dental Corps from August 1989 until February 1995. Since that time she has been practicing general dentistry, starting her own solo practice in 1997 until the present time. She served part time on the faculty at Midlands Technical College in Columbia, South Carolina from 1995 to 1997. Her community volunteer experience is extensive and impressive having volunteered for three South Carolina DAD'S events (Dental Access Days); where in Charleston at the DAD'S event she served as the community volunteer coordinator and supervised over 200 non-dental volunteers. Dr. Mikell's service to South Carolina Dental Association (SCDA) cannot be overlooked either. She has been a member of the ADA since 1995. She served on the Executive Committee for the Central District of the SCDA from 2012 to 2014 and as president in 2014. During her year as president she was instrumental in getting the Central District bylaws on membership changed so that they would be in line with the ADA bylaws. Her leadership skills, willingness to take on any task, and her ability to get the job done make her an outstanding nominee for the Council on Dental Practice.

Van Scoyoc, Stacey K., Illinois, 2019. Dr. Stacey Van Scoyoc is a 1995 graduate of the University of Illinois Chicago, College of Dentistry. She and her husband practice together in Bloomington, Illinois. From 1995 to 2005, Dr. Van Scoyoc practiced at the McLean County Health Department in the Children's County Health Department Clinic. She is currently the Central District Trustee on the Illinois State Dental Society (ISDS) Board of Trustees. Dr. Van Scoyoc is also the DENT-IL-PAC Director representing the McLean County Dental Society, where she also served as president in 2009-10. She has also served the Eighth District as an alternate delegate to the 2012, 2013, 2014, and 2015 ADA House of Delegates. In dental school, she was the American Student Dental Association (ASDA) student representative on the ADA Council on Dental Practice.

ETHICS, BYLAWS AND JUDICIAL AFFAIRS

Anderson, David A., Pennsylvania, 2019. Dr. David Anderson has authored numerous articles concerning his special interests in dental ethics, clinical practice, dental education, dental research and diversity and inclusion in clinical care. Among his many accomplishments in dental education are a Master of Arts, Bioethics and Health Policy from Loyola University, a member of the Board of Editors of the Journal of the American College of Dentists, a member of the Academic Review Committee of the Journal of Healthcare, Science and Humanities and as the recipient of the Dr. Cecilia Dowes Fellowship Award from the American College of Dentists in support of graduate studies on Ethics. Dr. Anderson has also participated in numerous peer review processes with emphasis on medical mediation and conflict resolution.

Rice, M. Elwood, Missouri, 2019. Dr. M. Elwood Rice has been involved in organized dentistry for his entire career. He graduated dental school in 1982 and accepted his first position at his local dental society the next year. Dr. Rice continues to have a keen interest in ethics. Not only has he been involved in organized dentistry, he has served on his local school board for many years and is active in his local Elks club and the American College of Dentists, both organizations hold high ethical standards as paramount principals.

1 *Smith, James A., Oregon, 2019.* Dr. James Smith is a general dentist with a distinguished naval career,
2 and subsequently has been employed by Permanente Dental Associates. Dr. Smith has been very
3 committed to postgraduate education and training earning recognition with AGD as MAGD and Diplomate
4 in both the American Board of General Dentistry and the Federal Services Board of General Dentistry.
5 He has had leadership positions in the US Navy including director of Advanced Clinical Programs at the
6 Naval Dental Center Southwest as well as staffing Comprehensive Dentistry in the Naval Postgraduate
7 Dental School in Bethesda, Maryland. Dr. Smith has recently been working at the director level for a
8 large multisite group practice, Permanente Dental Associates. Dr. Smith has also been involved in
9 organized dentistry at the state level, serving as chair of the Leadership Development Committee for the
10 Oregon Dental Association, as well as serving on the Nominating Committee. Service on the Leadership
11 Development Committee included some extensive bylaws revisions. He has also served on the board of
12 the OHSU School of Dentistry Alumni Association including as president. He has many awards of
13 recognition, and some include the following: Oregon Academy of General Dentistry Oregon Dentist of the
14 Year, Stephen P. Peglow Memorial Fund Award, and Ernest A. Hurley Humanitarian Award. Dr. Smith is
15 a Fellow in ICD, PFA and ACD. Dr. Smith has made and continues to make a very generous volunteer
16 commitment to various charitable clinics locally like Give Kids a Smile, Creston Children's Dental Clinic
17 and multiple compassion clinics some of which he has helped chair. He has been the dental triage lead
18 for the Oregon MOM Clinics in Portland, Oregon. He has served on dental missions in Honduras and El
19 Salvador. Dr. Smith's broad background in various practice settings and locations along with his depth of
20 training and service in dentistry makes him a strong candidate to serve on CEBJA.

21 *von Heimbürg, Petra, Illinois, 2019.* Dr. Petra von Heimbürg is a graduate of Northwestern University
22 Dental School where she earned her D.D.S. degree. In 1995, Dr. von Heimbürg earned her Juris Doctor
23 from The John Marshall Law School in Chicago, Illinois. She has served as a director from the North-
24 west Suburban Branch to the Chicago Dental Society Board of Directors (2011-13). In addition to being a
25 member of the American Dental Association, the Illinois State Dental Society, and the Chicago Dental
26 Society, Dr. von Heimbürg is a member of the American Bar Association, the Illinois Bar Association, and
27 the Chicago Bar Association, as well as the Illinois Association of Healthcare Attorneys. She is also a
28 Fellow of the American College of Dentists. Her law firm concentrates on serving the dental profession in
29 particular. Dr. von Heimbürg has given numerous presentations and seminars on legal issues affecting
30 the dental profession; and she has written numerous articles published in the Chicago Dental Society's
31 CDS Review. Dr. von Heimbürg's background in both dentistry and the legal profession will make her an
32 excellent addition to the Council on Ethics, Bylaws and Judicial Affairs.

33 **GOVERNMENT AFFAIRS**

34 *Armstrong, Craig S., Texas, 2019.* Dr. Craig Armstrong currently serves as president of the Texas Dental
35 Association (TDA). In this capacity he is involved in the TDA's Council on Legislative and Regulatory
36 Affairs, which is responsible for advocating on behalf of the dentists in Texas at the state level. His
37 advocacy involvement also includes the national and component levels. He has served the ADA as a
38 member on the Council of Dental Practice. He is a delegate to the ADA's House of Delegates and
39 understands the inner workings of the ADA. He currently serves as one of the House members on the
40 ADA's Strategic Planning Committee. Dr. Armstrong will be a credit to the Council and to the ADA.

41 *Cheek, Daniel K., North Carolina, 2019.* Dr. Daniel Cheek graduated from the University of Michigan with
42 a B.S. in Microbiology in 1976 and in 1977 with a M.S. in Industrial Health. He graduated from the
43 University of Detroit with his D.D.S. in 1981. He is a member of the American College and the
44 International College of Dentists, as well as a member of the Pierre Fauchard Academy. He has served in
45 leadership positions at the local and state level, serving as president of the North Carolina Dental Society
46 (NCDS) in 2010. He served as an alternate delegate to the ADA House of Delegates and presently
47 serves as a delegate to the ADA House. Dr. Cheek has a particular interest in advocacy and has served
48 on the Academy of General Dentistry Council on Legislative and Governmental Affairs for several years.
49 He has also served on the NCDS Governmental Affairs Council and co-chaired the Council from 1998 to
50 2002. In addition to his work on governmental affairs he also chairs the NCDS Political Action Committee

1 which he has done since 2011. He most recently attended this year's ADA Washington Leadership
2 Conference and has a strong and knowledgeable voice that legislators listen to. These attributes and his
3 unparalleled experience make Dr. Cheek the perfect fit for the ADA Council on Government Affairs.

4 *Medrano-Saldaña, Lauro, New York, 2019.* Dr. Lauro Medrano-Saldaña meets all of the requirements for
5 member to the Council on Government Affairs due to his strong background in legislative processes. Dr.
6 Medrano is currently the chair of the New York State Dental Association Council on Governmental Affairs
7 and occupied the same position in 2010 through 2012. Also, he has served as Action Team Leader for
8 the past eight years. Dr. Medrano is a graduate of the Institute of Diversity in Leadership. He has worked
9 for many years with the Greater New York Dental Meeting and has been their director of International
10 Outreach. Dr. Medrano possesses the knowledge of association policies and the ability to apply such
11 policies to existing legislation desired in a nominee as he is involved with Empire Dental Political Action
12 Committee and with relation of elected officials in New York State and members of Congress at national
13 level. Dr. Medrano is a past president of the Second District Dental Society and of the Puerto Rico Dental
14 Association. He is very influential with many ethnic dental societies. Dr. Medrano is very active in
15 organized dentistry, but has always handled very well the ability to wear many hats in an appropriate
16 manner. He comes with the experience at the state and national level to perform excellently.

17 *Terlet, Ariane R., California, 2019.* Dr. Ariane Terlet served on the California Dental Board. She chaired
18 committees on legislation, continuing education and the ad hoc Committee on Foreign Schools. Dr.
19 Terlet has testified multiple times before the California Legislature on various bills and continues to be
20 involved in legislation that is moving forward. Dr. Terlet has served on the Government Affairs Council for
21 the CDS, work force committees, CVP (Committee on Volunteer Placement) and is an ADA and California
22 Dental Association (CDA) delegate. She is trustee for the CDA representing the Berkeley Dental Society.
23 She is also a past president of the Arthur A. Dugoni School of Dentistry Alumni Association. Dr. Terlet is
24 a member of the American College of Dentistry, the Pierre Fauchard Academy and the International
25 College of Dentists.

26 MEMBERS INSURANCE AND RETIREMENT PROGRAMS

27 *Ellison, Naomi L., California, 2019.* Dr. Ellison has had leadership positions at the local, state and
28 national level of organized dentistry. She also served on California Dental Association's (CDA)
29 TDIC/TDIC IS Board from 2003 to 2009. She chaired the Finance Committee and served as chair of the
30 Board in 2007 and 2008. She is familiar with liability insurance, property insurance, worker's
31 compensation, and health and life insurance. She also understands financial investment strategies,
32 running an insurance business and member/policyholder value and risk.

33 *Jolly, Robert L., Sr., Arkansas, 2019.* Dr. Robert Jolly is a past president of the Arkansas State Dental
34 Association who is well versed in all of the financial facets of the Association. He has immanent
35 knowledge of insurance and the financial aspects of retirement plans. His well-rounded experiences
36 working with his association, his dental school, and the examining community will make him a valuable
37 asset to the Council.

38 *Kilcollin, Katherine L., West Virginia, 2019.* Dr. Katie Kilcollin is a young dentist who in her short career
39 has already made significant contributions to organized dentistry. She graduated West Virginia University
40 School of Dentistry, Morgantown, West Virginia, with the degree of Doctor of Dental Surgery in June
41 2009. She is an adjunct faculty member of the West Virginia University School of Dentistry, teaching and
42 mentoring 4th year dental students in clinical and practice management procedures. In addition to being
43 an active member of the ADA at all three levels of the tripartite, she holds membership in the Academy of
44 General Dentistry, the American Association of Women Dentists, and the American Implant Dental
45 Association. Her enthusiasm and dedication will make her a valued member of this Council.

46 *Pirmann, Peter J., Illinois, 2019.* Dr. Peter Pirmann is a graduate of Washington University School of
47 Dental Medicine in St. Louis, Missouri where he received his D.M.D. degree in 1982. He is a member of
48 the ADA, the Illinois State Dental Society, and the local component Southern Illinois Dental Society. Dr.

Pirmann is a Fellow of the International College of Dentists and the American College of Dentists, and the Academy of General Dentistry. He is a past president of the Southern Illinois Dental Society (1987-88 and 2004-05), and served as a trustee from the Southern District to the Illinois State Dental Society Board of Trustees. Dr. Pirmann is retired from general practice, but continues to serve as an examiner for the Northeast Regional Dental Board/Commission on Dental Competency Assessments (2004-present). He has also served as an adjunct faculty member for the John A. Logan Community College Dental Hygiene Program and the Southern Illinois University, School of Dental Hygiene (since 1987).

MEMBERSHIP

Irani, Karin, California, 2019. Dr. Karin Irani has served in a variety of leadership positions, including her current service as chair of California Dental Association's (CDA) Leadership Development Committee and past service on CDA's Committee on the New Dentist and Council on Membership. From 2009 to 2013, she served as chair of San Fernando Valley Dental Society's New Dentist and Membership Committee. She has attended ADA's recruitment and retention conference every year since 2010 and is an alumni of ADA's Institute for Diversity in Leadership. In addition to her committee work, she works closely with students and new dentists at all levels of organized dentistry. She is active in recruiting and retention efforts and consistently works to address membership concerns on a local, state and national level.

Sherwin, Ted, Virginia, 2019. Dr. Ted Sherwin is a 1973 graduate of Florida State University and a 1984 graduate of the Medical College of Virginia Dental School. He has practiced general dentistry in Orange, Virginia since 1985. He is a Fellow in the American College and the International College of Dentists as well as a member of the Pierre Fauchard Academy. Dr. Sherwin has distinguished himself as a leader at all levels of the tripartite and was president of the Virginia Dental Association (VDA) 2013-2014. He was an alternate delegate to the ADA House of Delegates from 2004 to 2013 and a delegate from 2014 to present. In addition, he served on the ADA HOD Special Committee on Finance from 2009 to 2011. He has also served on the ADA Board of Trustees' Strategic Planning Committee as well as the Boards' Budget and Finance Committee as an appointed member representing the ADA HOD. He has intimate knowledge of ADA finances and how important growth in membership is to the overall financial stability of the ADA. He played an integral role in the VDA roll out of their new membership growth plan and his insight and out of the box thinking will be a tremendous asset to the Council on Membership.

Tigani, Stephen P., District of Columbia, 2019. Dr. Stephen Tigani is a past president of the District of Columbia Dental Society. He also served on the District of Columbia Dental Society Strategic Planning Task Force. This task force dealt with many complex issues involving dentistry as they related to the District of Columbia Dental Society and its future. Membership and member value issues were an integral part of the strategic planning process. Dr. Tigani's experience as president and his continuing work with the task force, gave him experience with many aspects of the issue of membership on a local level and how they relate to the national level.

Vitek, Alexa M., Michigan, 2019. Dr. Alexa Vitek, a 2004 graduate of the University of Detroit Mercy, School of Dentistry, is a sole practitioner and owner of Vitek Family Dentistry in Dewitt, Michigan. She is the immediate past president and editor of the Central District Dental Society and current chair of its Membership Committee. Dr. Vitek has been a member of the Michigan Dental Association's (MDA) Committee on Membership since 2006 and has been chair of the MDA Committee on Membership and Recruitment since 2010. She has played a vital role in the MDA's ability to maintain one of the highest membership performance records in the nation. She has attended and participated in the last five ADA Membership and Recruitment conferences. Dr. Vitek has been an ADA delegate or alternate delegate, first representing ASDA in 2003, and as a member of the Ninth District delegation since 2007. Dr. Vitek clearly understands the ADA's current membership crisis. She is an outspoken advocate for organized dentistry, a strategic thinker and a seasoned decision-maker. Dr. Vitek brings a wealth of experience in membership recruitment and retention to the Council. She will serve both the Council and the ADA with passion and distinction.

1 *Willis, Heather A., Alaska, 2018.* In May 2015, Dr. Heather Willis was appointed to complete the
2 unexpired term of Dr. Jonathan Woller as a member of the Council on Membership. Dr. Willis has
3 demonstrated leadership experience in her short professional career, recently serving as president of the
4 Alaska Dental Society as well as having served on multiple state committees such as Annual Meeting,
5 Bylaws, Legislative and Government Affairs. She has not shied away from additional leadership
6 responsibilities as she is co-chairing the AK-MOM in Fairbanks in 2015. Previously, she has served on a
7 committee for the state of Alaska that addressed Dental Work Force. Lastly, she has recently made the
8 transition from public health dentist to practice owner, and can very well relate to the challenges of all that
9 is entailed in the decision making of the younger dentist and how this relates to organized dentistry.

10 **NATIONAL DENTAL EXAMINATIONS**

11 *Haley, Cheryl, Missouri, 2019.* Dr. Cheryl Haley has a keen interest in organized dentistry; she has
12 attended, at her own expense, several ADA programs. She attends the ADA House of Delegates, even
13 in years that she is not a delegate or alternate. She has attended the ADA programs of Evidence Based
14 Dentistry and the Oral Health Colloquium. Her dedication to the ADA is evident! Dr. Haley has long been
15 interested in dental testing, beginning with her own experiences of sitting for examinations for both a
16 nursing license and a dental license. She will make a great addition to the Joint Commission on National
17 Dental Examinations.

18 **NEW DENTIST COMMITTEE**

19 *Czerniak, Lauren M., Ohio, 2019.* Dr. Lauren Czerniak is the current chair of the New Dentist Committee
20 of the Ohio Dental Association. She has been very active in organized dentistry since her student ASDA
21 involvement.

22 *Fallon, Andrea C., Massachusetts, 2019.* Dr. Andrea Fallon is a graduate of the University of Connecticut
23 School of Dental Medicine. She was the ASDA President there in 2008. She chairs the Massachusetts
24 New Dentist Committee. Dr. Fallon was a member of the Massachusetts Dental Society Women in
25 Dentistry Committee. She currently studies at the Pankey Institute.

26 *Jarvis, Raymond A., Louisiana, 2019.* Dr. Raymond Jarvis is an up and coming leader in his component
27 and constituent societies. He has served as secretary and president of his component society and on the
28 constituent New Dentist Committee. His willingness to serve and his leadership ability will make him a
29 valuable member of the New Dentist Committee.

30 *Nguyen, Robin M., Florida, 2019.* Dr. Robin Nguyen is currently the new dentist representative from the
31 West Coast District Dental Association (WCDDA) to the Florida Dental Association where she serves as
32 the Council on the New Dentist's vice chair. She is actively involved with the local affiliate and is on the
33 ladder to be the affiliate president. She is also part of the WCDDA Program Committee that plans two
34 large continuing education programs throughout the year, and will be the Program Committee chair at
35 next year's term. Her history of involvement as a student with ASDA, student representative to the
36 California Dental Association, and ADEA have shown her commitment to organized dentistry and solidify
37 her experience. She is also currently a class member of the ADA's Institute for Diversity in Leadership
38 where her project, Divas in Dentistry, was aimed to increase more female non-members to join organized
39 dentistry and to engage current female members to play more active roles in the Association.

40 *Saba, Michael, New Jersey, 2018.* In August 2015, Dr. Michael Saba was appointed to complete the
41 unexpired term of Dr. Martin Smallidge as a member of the New Dentist Committee. Dr. Saba is currently
42 a practicing general dentist in Union and Westfield, New Jersey, and is advancing his education to
43 include a thorough understanding of Implantology at Vizstara Dental Education in Englewood Cliffs, New
44 Jersey. He also serves as restorative adjunct faculty at Temple University's Kornberg School of Dentistry.

45 Dr. Saba has an abundance of experience in leadership and development. As a recent graduate, he
46 serves as a member of the Union County Dental Society's Board and is a member of the New Jersey

Dental Association's New Dentist Committee. As a student leader, he has successfully managed and developed several organizations that received national attention. Dr. Saba worked diligently with the American Student Dental Association, locally and nationally. His efforts developed Temple University into a nationally recognize chapter. For this effort, he was awarded District 3 Delegate of the Year. Dr. Saba continued his endeavors with the Academy of General Dentistry, where he started AGD's first Temple University student chapter. His knowledge and professionalism with the AGD allowed for him to become among the first AGD House of Delegate student nominees in 2014.

Dr. Saba's qualifications go beyond work and organized dentistry. He has a multitude of hours of volunteer service, which have been both domestic and international. He is bilingual, fluent in English and Spanish. Michael is committed to his profession and organized dentistry, and will be an asset to the ADA New Dentist Committee.

Yates, Lindsey J., Illinois, 2017. In January 2015, Dr. Lindsey Yates was appointed to complete the unexpired term of Dr. Jill McMahon as a member of the New Dentist Committee. Dr. Yates is a 2008 graduate of Stony Brook University School of Dental Medicine. Dr. Yates is very active in the Illinois State Dental Society (ISDS), and serves in a leadership capacity on the ISDS New Dentist Committee. In addition, Dr. Yates is very active in her component society—the Chicago Dental Society (CDS)—and serves as recording secretary for the North Side Branch of the CDS. Dr. Yates is currently serving as acting dental director of the Sidney Hillman Health Centre in Chicago; and she serves as an attending in the Department of Dentistry at the Illinois Masonic Medical Center in Chicago.

Dr. Yates has been awarded the 2014 ISDA Foundation William J. Greek Memorial Leadership Award, an ADA 2014 Golden Apple Award, the New York Academy of Dentistry Award for Ethics (2008), the American College of Dentists Award for Outstanding Student Leadership (2008), and the Academy of Dentistry for Persons with Disabilities Award (2008).

SCIENTIFIC AFFAIRS

Braun, Thomas W., Pennsylvania, 2019. Dr. Thomas Braun is the current dean of the University of Pittsburgh School of Dental Medicine. At that institution, he has served on numerous committees to include Executive, Oral and Maxillofacial Surgery, Anatomy, Cleft Palate Institute and Graduate Education. His communication skills with the dental students and members of the ADA are exemplified through his work as the executive director of the Dental School Alumni Association and as an instructor in Anatomy and Oral and Maxillofacial Surgery.

Dr. Braun has also served as a member of the State Board of Dentistry in Pennsylvania and was an active participant in satisfying the needs of both organized dentistry and protecting the interests of the Commonwealth in determining the response to a legislative initiative concerning the administration of anesthesia in dental offices. This response was heralded by the dental community and the PA Department of State as enabling the dental practitioners in Pennsylvania to continue to administer both conscious and inhalation sedation in their offices.

Dr. Braun's term on the State Board of Dentistry has also provided him with an opportunity to oversee the discussions concerning teledentistry for the Community Dental Health Coordinator and the expansion of duties for the Expanded Function Dental Assistant (EFDA) program, which maintains direct oversight by a licensed dentist. He also served as a member of the ADA House of Delegates for thirteen years and understands the unique role of the Council on Scientific Affairs from the standpoint of a dental researcher, dental school administrator, consultant and member of the Council on Dental Accreditation, state board member and representative from Pennsylvania to the ADA.

Dr. Braun's appointment would also secure an ambassador for the ADA in a dental school which is on the list of target schools in the Dental School Outreach program within the Membership for Growth initiative. He also satisfies the criteria presented recently to the Board of Trustees to consider "strategic thinkers that have held academic leadership positions." Also, the recommendations of the CSA concerning future

1 appointments included, "the following fields of expertise: implementation science and science
2 communication, biomaterials, bioengineering and regenerative medicine, comparative effectiveness
3 research, oral medicine/pathology, geriatrics and cariology/prevention."

- 4 • Committee on Long-Term Planning (strategic planning)
- 5 • Current service on the Task Force on Practice-Based Research (research as it applies to dental
6 practice)
- 7 • Professional Ethics Committee, Dental Society of Western Pennsylvania
- 8 • Scientific Review Committee (comparative effectiveness research)
- 9 • Visiting professor in over ten countries
- 10 • Extensive research in practical approaches to surgical aspects of oral and maxillofacial surgery
11 (current dental practice application)
- 12 • Research on geriatric patients with emphasis on tissue management and surgical techniques
13 (geriatrics)
- 14 • Extensive research in alloplastic and augmentation procedures (bioengineering and regenerative
15 medicine)
- 16 • Publications in current topics such as obstructive sleep apnea, post-operative infections and
17 temporomandibular disorders

18 The nomination of Dean Thomas W. Braun presents the ADA Board of Trustees with a unique opportunity
19 to appoint a worldwide lecturer and participant in current dental research, an administrator and potential
20 ambassador to a targeted dental school within our membership outreach efforts and a potential council
21 member that understands current dental practice needs and regulatory oversight through service on a
22 state dental board and our own ADA House of Delegates.

23 *Jefferies, Steven R., Pennsylvania, 2016.* In June 2015, Dr. Steven Jefferies was appointed to complete
24 the unexpired term of Dr. John B. Ludlow as a member of the Council on Scientific Affairs. Dr. Jefferies
25 holds a Bachelor of Arts in Biology from Johns Hopkins University, a Master of Science in Chemical and
26 Biochemical Engineering from Rutgers University, a Doctor of Dental Surgery from the Baltimore College
27 of Dental Surgery and a Doctor of Philosophy in Dentistry from the School of Dentistry, University of
28 Limpopo, South Africa. He also completed a general practice residency at the United States Public
29 Health Service Hospital in New Orleans. He has held several adjunct and visiting faculty appointments,
30 an academic position as clinical associate professor in the Advanced General Dentistry Program at the
31 University of Maryland Dental School Baltimore and is currently professor of Restorative Dentistry at
32 Temple's Kornberg School of Dentistry.

33 Dr. Jefferies also serves as the director of Clinical Research and director of the Biomaterial Research
34 Laboratory at Kornberg. Over the years, he has been a consultant on biomaterials research to the Johns
35 Hopkins Department of Surgery, and an independent consultant for clinical/applied bioengineering and
36 biotechnology. At the Caulk Division of Dentsply International in Delaware, he has served as the director
37 of Clinical Research, vice president for Product Development and vice president for Advance Technology.

38 Dr. Jefferies holds 29 U.S. Patents relating to dental procedures and dental materials. He has published
39 43 scientific papers in peer-reviewed academic journals as well as 30 abstracts. He has presented
40 programs, lectures and seminars on dental and biomaterials on more than 100 occasions, both nationally
41 and internationally.

42 *Mariotti, Angelo J., Ohio, 2019.* Dr. Angelo Mariotti received his Ph.D. in pharmacology and toxicology
43 and his D.D.S. degree from West Virginia University and his certificate in periodontology from Virginia
44 Commonwealth University.

45 Dr. Mariotti is a professor and chair of the Division of Periodontology at The Ohio State University College
46 of Dentistry. He currently serves as a consultant for the ADA Council on Scientific Affairs, as a member of
47 the Ohio Dental Association's Finance Committee, as a member of the Advisory Board for the *Journal of*

1 *Periodontology and Clinical Advances in Periodontics*, as an examiner for the American Board of
2 Periodontology, and as an editor of the textbook, *Pharmacology and Therapeutics for Dentistry*. He is a
3 past president of the Columbus Dental Society and past member of the Ohio Dental Association's Council
4 of Access to Care and Public Service.

5 At The Ohio State University College of Dentistry, Dr. Mariotti spends 40% of his time teaching, 15% of his
6 time performing research, 10% of his time providing clinical care for patients, and the remainder of his
7 time is spent on service and administration responsibilities. He is aware of the time commitment needed
8 to serve as a member of the ADA Council on Scientific Affairs, including attending council meetings and
9 participating in council projects.

10 Dr. Mariotti has authored over 100 journal articles and book chapters related to dentistry and medicine
11 and has presented seminars to learned societies across the nation and the world.

12 With over 25 years of experience in academic medicine and clinical private practice, Dr. Mariotti is
13 prepared to critically evaluate the literature concerning safety, efficacy and appropriate use of
14 therapeutic agents that are used by the public or the dental profession.

15 *Parker, William B., Florida, 2019.* Dr. William Parker is an outstanding candidate for the Council on
16 Scientific Affairs. His distinguished career includes an extremely broad background and demonstrated
17 success in clinical dentistry (general dentistry and specialty practice), research, leadership, and
18 academics (predoctoral and postdoctoral). He is known as an extremely hard worker with excellent
19 interpersonal and problem solving skills.

20 Dr. Parker spent five years practicing as a general dentist before entering specialty training in
21 Periodontology. He subsequently obtained his board certification as a Diplomate of the American Board
22 of Periodontology and has practiced over 30 years as a periodontist. He later earned Diplomate status
23 with the International Congress of Oral Implantology. He also has excellent credentials in academia
24 having served almost 12 years as a full time faculty member between the Naval Postgraduate Dental
25 School and Nova Southeastern University College of Dental Medicine. He has served as a faculty
26 member, postdoctoral director, chair and now associate dean and he has earned the respect of students,
27 residents, faculty and higher administration for his dedication, demeanor and work ethic.

28 Dr. Parker has involved himself in clinical research and laboratory based research as both a principle
29 investigator and co-investigator with resulting publications in peer reviewed journals. He is well versed in
30 the scientific method, terminology, experimental design, and biostatistics. His clinical research has
31 involved dental implants, wound healing with amniotic membranes, guided bone regeneration, cone beam
32 computer tomography, and dental lasers. Dr. Parker has superior leadership and managerial credentials
33 having held positions beginning as a director of a five dentist clinic, to administering the dental operations
34 for the United States Pacific Fleet with over 86,000 patients. Other leadership positions included
35 executive officer and commanding officer of Naval Dental Commands where he demonstrated skills in
36 organization as well as financial and personnel management. Needless to say he also developed
37 excellent interpersonal skills and demonstrates the ability to work in stressful situations with a calm,
38 analytical approach.

39 Dr. Parker has a keen interest in the scientific, immunologic, and medical aspects of dental disease and
40 treatment which he imparts to the dental students and postdoctoral residents. He has instituted and
41 manages a moderate sedation curriculum for the postdoctoral residents in periodontology at the College
42 of Dental Medicine and is the course director for the didactic and clinical aspects of the training.

43 Dr. William Parker's extensive and varied experiences in clinical practice, research, academics,
44 leadership, and strong work ethic make him the ideal candidate to serve on the Council on Scientific
45 Affairs. With his proven record of success there is no doubt that he will serve with dedication and
46 distinction.

Tinanoff, Norman, Maryland, 2019. Dr. Norman Tinanoff received his dental degree from the University of Maryland in 1971. After receiving his certificate and Masters Degree in Pediatric Dentistry at the University of Iowa, he spent another year at the V.A. Hospital in Iowa City in a research fellowship. Dr. Tinanoff's two-year military service was at the Army Institute of Dental Research at Walter Reed Army Medical Center. For 23 years he was at the University of Connecticut Health Center where he was director of the Pediatric Dentistry graduate program for 16 years. In 1999, he became chairman of the Department of Pediatric Dentistry at the University of Maryland. Dr. Tinanoff has authored or co-authored over 175 publications, primarily on fluoride mechanisms, antimicrobials, caries risk factors, early childhood caries and prevention. Recent books/monographs include: "The Oral Cavity" in Nelson Textbook of Pediatrics, and "Use of Fluorides", in Early Childhood Oral Health. His current interests are concerned with early childhood caries, preventing dental caries and oral health access for underserved child populations.

Dr. Tinanoff's qualification specific for a position on the Council on Scientific Affairs include:

- NIH/NIDCR review panels (11 since 1995)
- ADA's Expert Panel for Professionally-Applied Topical Fluorides, 2005 and 2012
- Consultant to the ADA Council on Scientific Affairs, 2013 – present
- ADA Consultant to the Council on Access, Prevention and Interprofessional Relations, 2001 – present
- American Academy of Pediatric Dentistry, Council on Clinical Affairs, 2006 – present. Lead author on eight guidelines or policies
- Editorial Board of Pediatric Dentistry 1978 to present, including associate editor and section editor
- Manuscript referee for 21 Journals
- Funded research from federal agencies for 25 years
- Over 175 journal articles or book chapters published, with over 4,000 citations of these works.

Resolution No. 55 New

Report: Board Report 1 Date Submitted: August 2015

Submitted By: Board of Trustees

Reference Committee: N/A

Total Net Financial Implication: None Net Dues Impact: _____

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

NOMINATIONS TO COUNCILS, COMMISSIONS AND THE NEW DENTIST COMMITTEE

Background: (See Page 1009 for qualifications of nominees)

ACCESS, PREVENTION AND INTERPROFESSIONAL RELATIONS

Richard P. Herman, New York
Mark Koday, Washington
Alicia Risner-Bauman, Pennsylvania
Michael Wasserman, Massachusetts

ADA SESSIONS

Paul Kirkegaard, Minnesota
Stephen T. Radack, III, Pennsylvania
Beatriz E. Terry, Florida
Nanette C. Tertel, Ohio

COMMUNICATIONS

William H. Karp, New York
David J. Kenyon, Wisconsin
Gigi Meinecke, Maryland
Philip L. Schefke, Illinois
Karl P. Woods, Maine, *ad interim*

CONTINUING EDUCATION PROVIDER RECOGNITION

Nancy R. Rosenthal, Pennsylvania

DENTAL ACCREDITATION

Joseph F. Hagenbruch, Illinois*

DENTAL BENEFIT PROGRAMS

Christopher M. Bulnes, Florida
Brett H. Kessler, Colorado
Martin J. Makowski, Michigan
Mark J. Mihalo, Indiana

DENTAL EDUCATION AND LICENSURE

Edmund A. Cassella, Hawaii
Jennifer Korzeb, Massachusetts

DENTAL PRACTICE

Christopher M. Connell, Ohio
Hal E. Hale, Kansas
Julia K. Mikell, South Carolina
Stacey K. Van Scoyoc, Illinois

ETHICS, BYLAWS AND JUDICIAL AFFAIRS

David A. Anderson, Pennsylvania
M. Elwood Rice, Missouri
Petra von Heimbürg, Illinois
James A. Smith, Oregon

GOVERNMENT AFFAIRS

Craig S. Armstrong, Texas
Daniel K. Cheek, North Carolina
Lauro Medrano-Saldaña, New York
Ariane R. Terlet, California

MEMBERS INSURANCE AND RETIREMENT PROGRAMS

Naomi L. Ellison, California
Robert L. Jolly, Sr., Arkansas
Katherine L. Kilcollin, West Virginia
Peter J. Pirmann, Illinois

MEMBERSHIP

Karin Irani, California
Ted Sherwin, Virginia
Stephen P. Tigani, District of Columbia
Alexa M. Vitek, Michigan
Heather A. Willis, Alaska, *ad interim*

NATIONAL DENTAL EXAMINATIONS

Cheryl Haley, Missouri

NEW DENTIST

Lauren M. Czerniak, Ohio
Andrea C. Fallon, Massachusetts
Raymond A. Jarvis, Louisiana
Robin M. Nguyen, Florida
Michael Saba, New Jersey, *ad interim*
Lindsey J. Yates, Illinois, *ad interim*

SCIENTIFIC AFFAIRS

Thomas W. Braun, Pennsylvania
Steven R. Jefferies, Pennsylvania, *ad interim*
Angelo J. Mariotti, Ohio
William B. Parker, Florida
Norman Tinanoff, Maryland

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

Resolution

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

BOARD RECOMMENDATION: Vote Yes.

BOARD VOTE: UNANIMOUS

Resolution No. 56-58 NewReport: Credentials, Rules and Order Date Submitted: August 2015Submitted By: Standing Committee on Credentials, Rules and OrderReference Committee: N/ATotal Net Financial Implication: None Net Dues Impact: Amount One-time Amount On-going FTE **1 REPORT OF THE STANDING COMMITTEE ON CREDENTIALS, RULES AND ORDER**

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

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

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

12 **Minutes of the 2014 Session of the House of Delegates:** The minutes of the 2014 session of the
13 House of Delegates have been posted in the HOD Supplemental Information library on the House of
14 Delegates Community of ADA Connect.

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

18 **56. Resolved**, that the minutes of the 2014 session of the House of Delegate be approved.

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

24 **57. Resolved**, that the agenda as presented in the *2015 Manual of the House of Delegates and*
25 *Supplemental Information* be adopted as the official order of business for this session, and be it
26 further

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

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

This preliminary list of referrals (circulated in the form of an All Inclusive General Index to the resolution worksheets) will be provided with the second posting of resolution worksheets in early-October and updated and posted again on Thursday, November 5. The Speaker will announce additional referrals during the first meeting of the House of Delegates. A complete list of referrals by reference committee, in the form of an agenda, will be available in the reference committee hearing rooms on Saturday morning, November 7.

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

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

Annual Reports and Resolutions, Manual of the House of Delegates and Resolution Worksheets: The publication, *Annual Reports and Resolutions, 2015* was posted in July on ADA Connect and ADA.org and can be accessed through the following link: <http://www.ada.org/en/member-center/leadership-governance/historical-publications-policies>.

In addition, the first set of resolution worksheets will be posted on ADA Connect and ADA.org by the end of day, Friday, August 21. Per 74H-2012, effective in 2013, all materials of the House of Delegates are provided in an electronic format only, with the exception of reference committee reports and agendas; no paper copies of worksheets will be distributed.

The second set of resolution worksheets will become available shortly after the Board of Trustees' October 4-6 session. The second set of resolution worksheets will be posted on ADA Connect and ADA.org by end of day, Friday, October 9.

Note: In advance of the 2015 session, members of the House of Delegates are advised to download to their laptop or other electronic device copies of all pertinent meeting materials.

The *Manual of the House of Delegates and Supplemental Information* has been developed to complement the resolution worksheets. This document incorporates the "Rules of the House of Delegates" and all pertinent meeting information (*i.e.*, House agendas, members of the Standing and Reference Committees, reference committee hearing schedule, and schedule of the district caucuses). Any modifications to the *Manual* and specifically the Standing Rules of the House of Delegates reflect either actions of the previous House of Delegates, details regarding dates, times and locations of the 2015 meetings, or editorial corrections.

Supplement to Annual Reports and Resolutions is prepared primarily for historical purposes only since it is a compilation of all the reports and resolutions presented to the House of Delegates. This publication will be available online in the first quarter of 2016.

Reference Committees Hearings: The reference committees of the House of Delegates will hold hearings on Saturday, November 7, in various rooms of the Marriott Marquis. The list of reference committee hearing rooms appears in the *Manual of the House of Delegates and Supplemental Information*.

Saturday, November 7

7:00 a.m. to 9:00 a.m. Committee D (Legislative, Health, Governance and Related Matters)

8:00 a.m. to 10:00 a.m. Committee E (Membership and Related Matters)

- 1 9:00 a.m. to 11:00 a.m. Committee C (Dental Education, Science and Related Matters)
2 10:00 a.m. to 12 p.m. Committee B (Dental Benefits, Practice and Related Matters)
3 11:00 a.m. to 1:00 p.m. Committee A (Budget, Business and Administrative Matters)

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

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

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

17 **Reports of Reference Committees:** Printed copies of reference committee reports will be made
18 available to the chair of record of each delegation on Sunday, November 8. A sufficient number of copies
19 of each report will be provided for each delegation's delegates, alternate delegates, secretary, executive
20 director, trustee and editor. Reference committee reports will also be posted on ADA Connect and will be
21 available early morning on November 8.

22 Delegates must bring their copies of reference committee reports to the meetings of the House of
23 Delegates since additional printed copies will be limited. However, if using an electronic version of the
24 reference committee report during the meetings of the House, it is imperative that the documents be
25 downloaded prior to the Monday, November 9 meeting. The Speaker would like to remind everyone that
26 this is a "paperless" House of Delegates, not necessarily a wireless House. Wi-Fi is available in the
27 House of Delegates as a convenience, and advance preparation is extremely important.

28 **Nominations of Officers:** The nominations of officers (president-elect, second vice president, treasurer,
29 and speaker of the House of Delegates) will take place at the first meeting of the House on Friday
30 afternoon, November 6. Candidates for elective office will be nominated from the floor of the House by a
31 simple declaratory statement, which may be followed by an acceptance speech not to exceed four
32 minutes by the candidate. Seconding nominations is not permitted.

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

34 **Nomination of Trustees:** Nominations of members of the Board of Trustees from Districts 1, 12, 14 and
35 15 will take place at the first meeting of the House. Prior to such nominations, the delegates from each of
36 the districts concerned must caucus for the purpose of determining their nominee or nominees in
37 accordance with the provisions of Chapter VII, Section 40, of the *Bylaws*. A list of caucus meetings
38 appears in the *Manual of the House of Delegates and Supplemental Information*.

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

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

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

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

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

Election Procedures: Voting for the elective officers will be conducted in a separate room located in the vicinity of the House of Delegates, from 6:30 a.m. to 8:00 a.m. on Monday, November 9. Members should bring their number 6 meeting card and vote early in order to avoid a delay at the voting machines. To expedite the check-in and voting process on Monday, November 9, it is strongly recommended that any delegation changes be made no later than end of day on Sunday, November 8. Delegate registration hours for Sunday, November 8 are from 8 a.m. to Noon and delegate changes can be made at the Information and Resources Office up until 6 p.m. Sunday evening.

In the event a second balloting is necessary, the number 6 meeting card will be reused. The second balloting will be conducted on Monday, November 9, at a time announced by the Speaker.

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

Standing Order of Business—Installation of New Officers and Trustees: The installation ceremony for new officers and trustees will take place on Tuesday, November 10, as the first item of business with the time to be specified by the Speaker of the House of Delegates.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Replacement of Alternate Delegates for Delegates: Delegates wishing to substitute alternate delegates from their delegation for themselves during a meeting of the House of Delegates must complete the appropriate delegate-alternate substitution form. Delegates are required to sign the form and surrender their admission cards for the meeting or meetings not attended before admission cards will be issued to alternate delegates by the Committee on Credentials, Rules and Order. Substitution of alternate delegates may be made during all four meetings of the House of Delegates. In order for a complete and accurate attendance record for all meetings of the 2015 House of Delegates, submission of these completed substitution forms is essential.

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

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

1 is likely to include members and staff of the council(s) or commission(s) involved with the matter under
2 discussion and executive directors of constituent societies and the American Student Dental Association.
3 No official action may be taken nor business conducted during a closed session.

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

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

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

29 **Manual of the House of Delegates:** Each member of the House of Delegates has access to the *2015*
30 *Manual of the House of Delegates* through ADA Connect. The *Manual* contains the standing rules of the
31 House of Delegates and the pertinent provisions of the *Bylaws*.

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

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

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

43 **House of Delegates Information and Resource Office:** An Information and Resource Office will be
44 open Thursday, November 5 through Sunday, November 8, and will be located in the Marriott Marquis,
45 Level 4 Foyer. This office will be open to delegates, alternates, constituent society officers and staff. The
46 office will be equipped with computers with printing capability, a copy machine, and general information
47 about the meetings of the House of Delegates and related activities. Everyone is urged to use the
48 Information and Resources Office when drafting resolutions or testimony.

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

3 **Resolutions**

- 4 (Resolution 56:Worksheet:1033)
- 5 (Resolution 57:Worksheet:1034)
- 6 (Resolution 58:Worksheet:1035)

Resolution No. 56 New

Report: Credentials, Rules and Order Date Submitted: August 2015

Submitted By: Standing Committee on Credentials, Rules and Order

Reference Committee: N/A

Total Net Financial Implication: None Net Dues Impact: _____

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

MINUTES OF THE 2014 HOUSE OF DELEGATES

Background: The minutes of the 2014 session of the House of Delegates have been posted in the HOD Supplemental Information library on the House of Delegates Community of ADA Connect.

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

Resolution

56. Resolved, that the minutes of the 2014 session of the House of Delegate be approved.

Resolution No. 57 New

Report: Credentials, Rules and Order Date Submitted: August 2015

Submitted By: Standing Committee on Credentials, Rules and Order

Reference Committee: N/A

Total Net Financial Implication: None Net Dues Impact: _____

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

1 ADOPTION OF AGENDA AND ORDER OF AGENDA ITEMS

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

7 Resolution

8 **57. Resolved**, that the agenda as presented in the 2015 Manual of the House of Delegates and
9 Supplemental Information be adopted as the official order of business for this session, and be it
10 further

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

Resolution No. 58 NewReport: Credentials, Rules and Order Date Submitted: August 2015Submitted By: Standing Committee on Credentials, Rules and OrderReference Committee: N/ATotal Net Financial Implication: None Net Dues Impact: _____

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

1 **REFERRAL OF REPORTS AND RESOLUTIONS**

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

6
7 This preliminary list of referrals (circulated in the form of an All Inclusive General Index to the resolution
8 worksheets) will be provided with the second posting of resolution worksheets in early-October and
9 updated and posted again on Thursday, November 5. The Speaker will announce additional referrals
10 during the first meeting of the House of Delegates. A complete list of referrals by reference committee, in
11 the form of an agenda, will be available in the reference committee hearing rooms on Saturday morning,
12 November 7.

13 **Resolution**

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

Budget, Business and Administrative Matters

Resolution No. None N/AReport: Board Report 4 Date Submitted: August 2015Submitted By: Board of TrusteesReference Committee: A (Budget, Business and Administrative Matters)Total Net Financial Implication: None Net Dues Impact: _____Amount One-time _____ Amount On-going _____ FTE 0

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

How does this resolution increase member value: See Background

REPORT 4 OF THE BOARD OF TRUSTEES TO THE HOUSE OF DELEGATES: COMPENSATION AND CONTRACT RELATING TO THE EXECUTIVE DIRECTOR

Background: This report is provided for informational purposes and does not include any resolutions. In March 2015, the Board of Trustees executed a three-year employment agreement with the current Executive Director, which expires on March 15, 2018. The Executive Director is the only member of the ADA staff with a written employment contract.

Compensation and Benefits: The Executive Director's current annual base salary is \$526,442 and is paid in accordance with the Association's standard payroll schedule and policies. The contract provides that in March 2016 and March 2017, respectively, the Executive Director's annual salary shall increase 3% over the prior annual base salary. The current salary level was set in March 2015 based on external review by Arthur J. Gallagher & Co. in 2014 of comparable compensation for Executive Directors at national not-for-profit associations with median revenues around \$118 million and at post-doctoral institutions. The review covered approximately 200+ positions comparable to Executive Director; the weighted average median market base salary for these comparable positions was \$526,442.

The 2015 contract provides that the Executive Director is eligible to receive an annual bonus ranging from 0%-5% of her base salary, as determined by the Board, based upon criteria jointly approved by the Executive Director and the Board, and subject to the availability of funds. The Gallagher review identified that in the external market the typical bonus opportunity for Executive Directors in comparable positions was 20%-30% of base salary.

In March 2015, the Executive Director received a bonus in the amount of \$18,000 (4% of base), based on the assessment of 2014 performance.

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

The 2015 contract provided additional fringe benefits including a \$15,000 annual contribution to the Great-West Variable Annuity Plan; a parking space in the Association Headquarters building; the reimbursement of reasonable, substantiated expenses incurred to purchase and maintain a membership in one city or athletic club in the Chicago area; one cellular telephone, reasonable expenses for spousal

1 travel to the Association's annual session and any other required spousal travel consistent with the ADA
2 Board's spousal travel policy in effect at the time; and membership dues in professional associations up
3 to \$5,500 (except for the dues of the American Dental Association and its constituent and component
4 dental societies).

5 **Resolutions**

6 This report is informational and no resolutions are presented.

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

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

Board Rpt. 4

Resolution No. 7-8 New

Report: Board Report 2 Date Submitted: August 2015

Submitted By: Board of Trustees

Reference Committee: A (Budget, Business and Administrative Matters)

Total Net Financial Implication: \$(437) Net Dues Impact: No increase

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

ADA Strategic Plan Objective: 2016 Budget Supports All Strategic Plan Objectives

How does this resolution increase member value: Not Applicable

1 **REPORT 2 OF THE BOARD OF TRUSTEES: 2016 BUDGET**

2 **Introduction:** *All dollar figures are in thousands with unfavorable variances in parentheses.*

3 In accordance with its *Bylaws* duties, the Board of Trustees presents the proposed 2016 operating budget
4 for the Association. The Board of Trustees is recommending a 2016 operating budget of \$131,788 in
5 revenues and \$125,725 in expenses and income taxes, generating a surplus before transfers to the
6 insurance royalty reserve of \$6,063. After transferring \$6,500 in royalty revenue to the insurance royalty
7 reserve the operating budget is a net deficit of \$(437). The royalty reserve is dedicated to member value,
8 long term dues and financial stabilization as directed by the House of Delegates Resolution 84H-2013 and
9 Board action. Consistent with this resolution, the 2016 budget is also proposing to spend up to \$1M from
10 these "royalty" reserves for investment in innovation to drive member value.

11 In arriving at this proposed 2016 budget, the Board of Trustees analyzed budget requests relative to the
12 Association's strategic priorities, as directed by the 2011 House of Delegates in resolutions 44H-2011 and
13 52H-2011 (*Trans.*2011:444;445). Resources were allocated between programs and divisions in an effort to
14 maximize their effective use in executing the ADA's Strategic Plan for 2015-2020.

15
16 No national dues increase is included in the 2016 proposed budget.
17

1	Contents:	Page
2		
	Overview of Budget Approach and Philosophy.....	2003
	Mechanics of This Year's Program Prioritization Process.....	2013
	Budget Summary by Account.....	2019
	Changes in 2016 Budget versus 2015.....	2020
	Additional Information on Membership Trends.....	2024
	ADA Support for State and Local Dental Associations.....	2026
	ADA Employee Staffing.....	2028
	Detail on ADA Programs and Internal Activities.....	2029
	Capital Expenditures and Reserve Funds.....	2033
	2014 Variances from 2014 Budget.....	2038
	Headquarters Building Valuation.....	2039
	Appendices: Revenue and Expense Trends by Division.....	2041

Overview of Budget Approach and Philosophy

3
4 First, it is important to recognize that the budget presented in this report is the result of the cumulative
5 efforts of many volunteers and staff over many months and has built on process improvements made over
6 the past few years. The Board of Trustees greatly appreciates the involvement of the Councils in the
7 budget process, including each Council's participation in the Administrative Budget Review meeting, review
8 of the benefits and related costs of each of their programs, and the Council Budget Group, Budget &
9 Finance Committee and New Dentist Committee's ratings of every program against the Board's program
10 assessment criteria. A critical component of the House fulfillment of its fiduciary duty to review and approve
11 the budget is the engagement of its Councils in the budget development process. Many thanks are due to
12 everyone who contributed to both the content and process improvement suggestions during development of
13 the 2016 budget.

14 The 2016 budget represents the second year of the Members First 2020 five year Strategic Plan. This
15 strategic plan addresses declining ADA market share, due to rapidly changing economic conditions,
16 professional demographics, and changes in the health care delivery marketplace. At this point in time,
17 two of the six stated objectives in the Member First 2020 plan pose significant challenges under current
18 conditions. After many years of continued erosion in full active membership - the most important goals for
19 2016 are to decrease the non-renew rate in all age segments, increase recruitment in key segments of
20 new dentists, women, ethnically diverse, employee dentists and dental students; and to slow or stop the
21 decline in full active members. 2016 must be a year of focused innovation to try new initiatives to quickly
22 learn what has meaningful value and what doesn't in order to attract and retain dentists in the most critical
23 market segments and slow the rate of decline of market-share to stabilize membership.

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

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

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

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

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

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

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

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

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

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

Finance Goal: The ADA will be financially sustainable.

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

- 4.1 Budget for a surplus consistently year to year*

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

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

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

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

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

Recent Actual Results and Projected Future Trends

The construction of 2016 financial budgets started a few months later than in prior years, enabled by the House of Delegates' approval of a change to the notification date for member dues. This additional time enabled more study of the challenges and opportunities facing the ADA and of the programs needed to deliver results. So before starting the discussion on 2016 budget development process, it is helpful to review recent actual results and expected future trends to understand the "big picture" context of the proposed 2016 budget in relation to prioritization of resources in alignment with the strategic plan goals.

- A) The ADA has delivered 3 solid years of favorable surpluses compared to the 2012, 2013, and 2014 House-approved budgets which have contributed over \$20 million of annual surpluses to long term reserves. These results are shown in the following chart:

American Dental Association
Statement of Activities - Comparison to Budget
ADA Operations Total
As of December 31, 2014

2

	2012 December Actual	2012 December Budget	Variance Actual vs Budget	2013 December Actual	2013 December Budget	Variance Actual vs Budget	2014 December Actual	2014 December Budget	Variance Actual vs Budget
Revenues									
Membership Dues	54,552	54,812	(260)	56,935	57,550	(615)	56,433	58,146	(1,712)
Advertising	8,156	10,792	(2,636)	8,145	9,717	(1,572)	8,281	9,483	(1,202)
Rental Income	5,579	5,500	79	5,579	5,023	556	3,655	3,855	(200)
Publication & Product Sales	7,448	8,644	(1,196)	7,920	6,740	1,180	7,479	7,034	445
Testing Fees & Accreditation	18,855	17,427	1,427	19,805	18,020	1,786	21,705	20,130	1,575
Meeting & Seminar Income	11,315	11,634	(319)	9,342	10,225	(884)	8,586	9,429	(843)
Grants & Contributions	1,987	1,970	17	2,690	1,907	783	2,592	2,261	332
Royalties	6,609	4,960	1,649	13,054	5,293	7,761	13,506	7,127	6,380
Investment Income	2,362	2,063	299	2,271	2,085	187	2,365	1,476	889
Other Income	2,934	2,709	225	3,501	3,205	296	3,950	3,304	646
Total Revenues	119,797	120,512	(715)	129,241	119,764	9,477	128,553	122,244	6,309
Expenses									
Total Salaries/Temp Help	40,255	40,001	(254)	39,624	40,549	925	41,482	41,902	421
Total Fringe Benefits w/o Pension	6,286	6,843	557	5,875	6,528	653	5,031	6,626	1,595
Pension	6,561	7,902	1,341	4,909	7,195	2,285	1,186	7,591	6,404
Total Payroll Taxes	2,727	2,927	200	2,723	2,734	11	2,889	2,817	(72)
Staff Compensation	55,829	57,672	1,843	53,132	57,006	3,874	50,588	58,935	8,347
Total Travel Expenses	5,646	6,180	534	6,053	5,914	(139)	6,146	6,476	330
Printing, Publication & Marketing	9,668	12,118	2,450	9,214	11,027	1,813	10,292	11,341	1,049
Meeting Expenses	3,054	3,513	459	2,079	2,290	211	1,788	2,388	599
Consulting and Outside Services	7,602	7,204	(397)	6,485	6,534	49	8,166	8,146	(21)
Professional Services	8,672	8,707	34	8,931	9,396	464	9,681	9,468	(214)
Bank & Credit Card Fees	1,136	1,149	13	1,322	1,193	(128)	1,256	1,222	(34)
Office Expenses	4,781	5,422	641	4,576	5,252	676	4,655	5,280	625
Facility & Utility Costs	6,318	5,304	(1,014)	5,750	5,818	68	5,414	6,068	654
Grants and Awards	2,304	2,530	226	2,586	2,563	(23)	2,591	2,741	150
Endorsement Costs	660	647	(13)	718	695	(23)	854	803	(51)
Depreciation/Amortization	6,563	6,088	(475)	6,469	6,358	(111)	6,192	6,342	150
Other Expenses	1,352	2,216	865	1,287	1,484	197	1,677	1,548	(129)
ADA Health Foundation Grant	1,907	1,892	(15)	1,907	1,900	(7)	1,907	1,900	(7)
Total Expenses	115,491	120,642	5,152	110,508	117,430	6,922	111,207	122,657	11,450
Net Inc/(Loss) before Taxes	4,306	(130)	4,437	18,733	2,334	16,399	17,346	(413)	17,759
Income Taxes	1,109	1,250	141	1,817	1,300	(517)	1,435	1,300	(135)
Net Rev/(Exp) After Taxes	3,197	(1,380)	4,577	16,916	1,034	15,882	15,911	(1,713)	17,624
Capital Expenditures	(3,440)	(4,355)	916	(2,854)	(2,856)	2	(3,528)	(3,329)	(199)
Capital Reserve Fund	0	0	0	(3,500)	(3,500)	(0)	(3,013)	(3,013)	0
Depreciation (add back)	6,563	6,088	475	6,469	6,358	111	6,192	6,342	(150)
Transfer to Royalty Reserve	0	0	0	(6,270)	0	(6,270)	(6,229)	0	(6,229)
Net Cash/Capital Expenditures	3,123	1,733	1,390	(6,155)	3	(6,157)	(6,578)	(0)	(6,577)
Net ADA Operations	6,320	352	5,968	10,761	1,037	9,724	9,334	(1,713)	11,047

- B) Unfortunately, this chart also shows that favorable results came from mostly lower expense spending while actual revenue, except for royalties, for many sources lagged behind targets.
- C) The biggest problems remain the same: declining membership dues revenue and declining ADA member market share.
- D) Based on a review of recent membership projections, the biggest cause of the declining dues revenue is the retirement of long term full dues paying members who have reached the end of their careers. Given the demographics of the ADA's population of members, this trend will continue for several years and the ADA cannot stop it.
- E) The other factor contributing to the decline in revenue as well as the overall decline in ADA member market share is the fact that the ADA is not recruiting and retaining new dentists at a rate that will help to replace those dentists leaving the profession at the end of their careers.
- F) Today, the most valuable category of members for the ADA is its large group of full dues paying dentists who generate the largest share of ADA's current dues revenue. As a result, it's very important that the ADA deliver services and products to serve these "members of today."
- G) Looking at the same membership projections and adding some critical data, additional analyses reveal important information about the long term value of different member market segments and thereby help us to prioritize them. Adding "the estimated remaining number of career years" and "estimated future expected dues rate" (at current values) based on existing membership data enables us to see the "future potential value" of each market segment. This "potential value" analysis of existing dues categories clearly shows that the highest value segment is represented by student, graduate and new dentists. These are the ADA's potential "members of tomorrow."

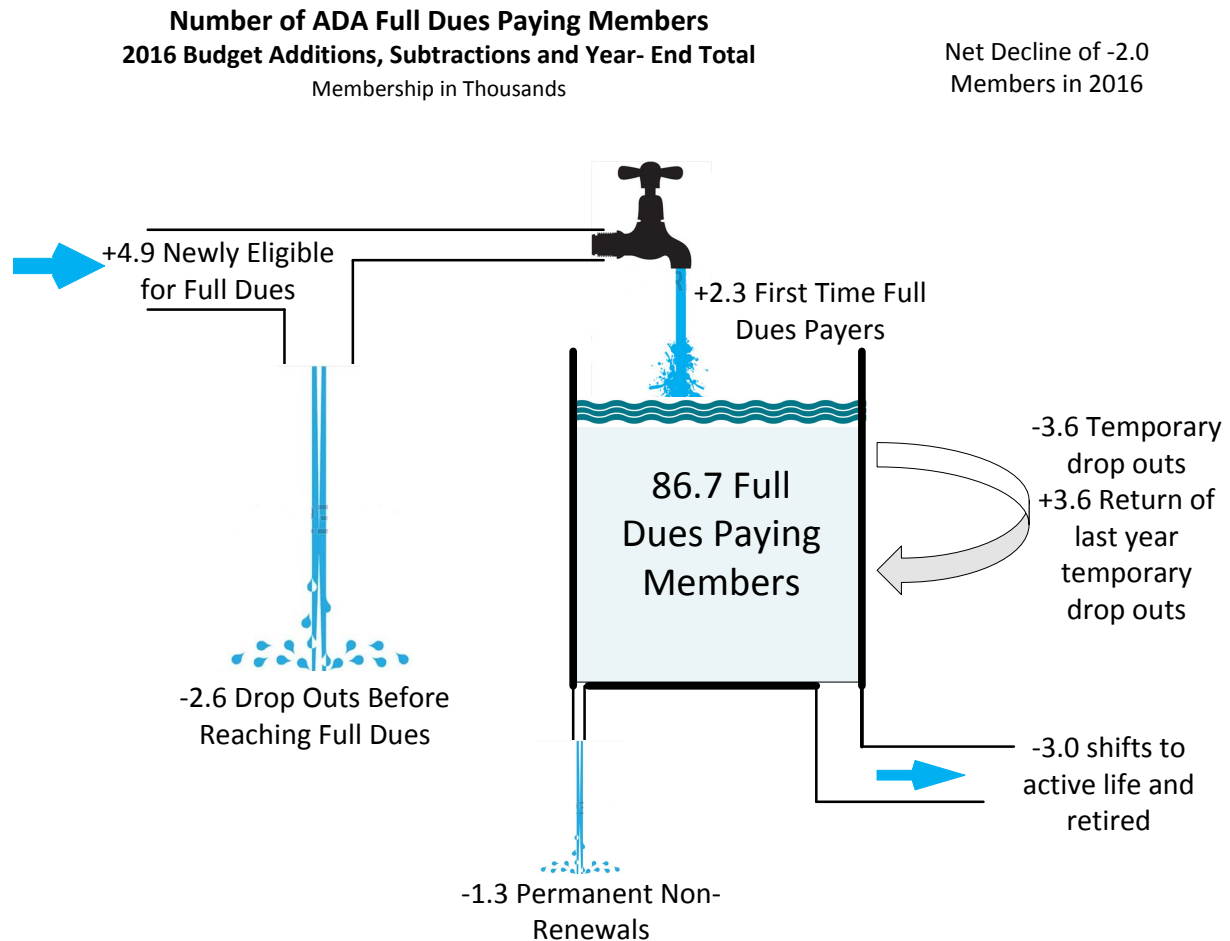
	Estimated # of Members 2016	% of Total # Members	Estimated Avg # Years Left in Career	Estimated Future Rate at 2016 level	Estimated Future Value \$	Estimated Future Value %
Active Full Dues	86,727	48.4%	14	\$522	\$633,800,916	43.7%
Student & New Dentists	39,608	22.1%	36	\$522	\$767,138,508	53.0%
Active Life	15,473	8.6%	6	\$392	\$36,392,496	2.5%
All Other Categories	37,480	20.9%	7	\$46	\$11,412,810	0.8%
Total Current Estimates	179,288	100.0%			\$1,448,744,730	100.0%

- H) ADA analyses of existing member characteristics has revealed that IF the ADA (national, state and local) can attract and retain a new dentist as a member from graduation from dental school all the way to full dues membership status, THEN it is likely that that dentist will continue as a member for their entire career. However, the same research revealed that if a new dentist never joins or is lost

1 in those early years before full dues status, they are likely lost forever and will never become ADA
2 members.

- 3
- 4 I) As a result, it is critical that the ADA focus considerable resources in two areas: attract, engage,
5 and thereby retain student and new dentists to improve the long term operational sustainability of
6 the Association. Focus on the needs of this important group will help to steer the agendas of many
7 ADA programs to deliver services and products to the dental profession. The second focus area is
8 to retain the mid and late career professionals, non-renewals in key segments has risen to an
9 alarming rate in several state and local societies.
- 10
- 11 J) Unfortunately, from a financial perspective, even with great success in the critical student/new
12 dentist market segments, the ADA will not see a significant improvement in dues revenue results
13 because student and new dentists pay much lower dues rates over a five year period. Focus on
14 reversing the non renew trend will have a far more immediate financial impact.
- 15
- 16 K) Therefore, it's important to recognize that the ADA will go through several years of challenging
17 financial conditions to invest in the long term turnaround in membership dues. Because members
18 are the ADA's reason for being, this is a worthy mission.
- 19
- 20 L) Although non-dues revenue has increased in certain categories such as testing, accreditation and
21 royalties, because the House urged the Board to transfer the member insurance plan royalties into
22 a separate reserve fund, that new revenue does not help the ADA's "budget basis" bottom line after
23 depreciation offset, capital spending and reserve contributions. This design for royalty reserves
24 was the intention of the House.
- 25

The following chart represents the flow of members in and out of full dues status on an annual basis.



Some have asked whether the recent years of ADA membership market share decline represent “the new normal” for the Association, and others have asked “at what level will ADA market share stop falling?” The answer to these questions obviously depends upon the success or failure to improve the “pipeline” of full dues paying members while actively managing the non-renews through the delivery of relevant and impactful programs that are valued enough to justify dues. If the ADA continues on the current path and the existing trends continue, it appears that many years from now the declines in membership market share will stop at around 48%, the current retention rate of dentists in their 4th year after graduation. Therefore, focus on understanding the needs and wants of new dentists and dentists at various points in their career trajectories, and engaging with them to improve the retention rates of each graduating class, is an organizational imperative.

ADA Programs and The Value Equation for ADA membership

In basic terms the value equation is: Benefits - Costs = Value. Perceived value is equal to member benefits minus the cost or price. Perceived value for each program should be measured by member awareness, satisfaction, and impact on likelihood to join or renew membership. The ADA has a portfolio of programs which, together with benefits delivered by state and local societies make up the total value proposition for

members. Given what ADA now understands about the members at various career stages as a result of intensive market research, we are certain that there has been a historic underinvestment in effective marketing and communications to key member segments related to key programs or key drivers of value. Building the data base of what programs and benefits drive value is underway and although the program descriptions may not possess all of the market data desired, the ADA is moving rapidly in a data driven decision making direction so that scarce resources are well allocated to those programs and activities that produce results in a defined period of time. Ideally, those programs and benefits that do not produce desired results within an agreed upon time frame will be sunset.

As summary descriptions were developed to support the evaluation of each program, new challenges related to measuring specific programs against the strategic plan goals reflected in the program assessment criteria surfaced. This year, the program briefing book provided much more consistent information about the ADA's work, but still lacked market data and lead indicators data on some programs. As a result, program evaluators needed to make judgments based on the information available as well as their own experience and personal knowledge of programs. The diversity of backgrounds among evaluators was an important factor in the rating process. This year's process has revealed that the perception of ADA programs may be different between leaders and end users. As a result, a goal of future surveys will be to focus survey samples on regular members to capture a more accurate picture of end user opinions.

The development of specific program outcome metrics or success measures is an organizational imperative for the next several years and this has become significant forward progress in the evolution of the ADA's strategic plan implementation, budget alignment, and performance monitoring process. As a result of these learnings during the 2016 budget process, we are planning for improved operational reporting with more relevant data to support decisions going forward, as we continue the evolution of our budget process. For budget purposes, the program scoring and prioritization process, although imperfect, still serves as one of several important inputs into the evaluation of the ADA's total portfolio of programs.

The delivery of value to members involves all divisions, not just membership. Like any business, the ADA must anticipate and understand the needs of its customers and then build and sell products and services that they want rather than what volunteer leaders and staff "think" they want. Every division has programs and functions which provide:

- member value through advocacy, products, benefits or services or influence the dentist's working environment through standards, or
- support state and/or local efforts in the above functions, or
- support infrastructure that enables the above.

The Need for Innovation

Another important result of this year's budget process was greater focus on the need for innovation. Early in the process, the New Dentist Committee ("NDC") was asked to go through a brainstorming process to generate new ideas for ADA programs. Although these program concepts were not fully reviewed by divisions except for those that were already included in other existing programs, these "new ideas" were reviewed and scored by the CBG so that new concepts could be evaluated alongside existing programs in the interests of innovation.

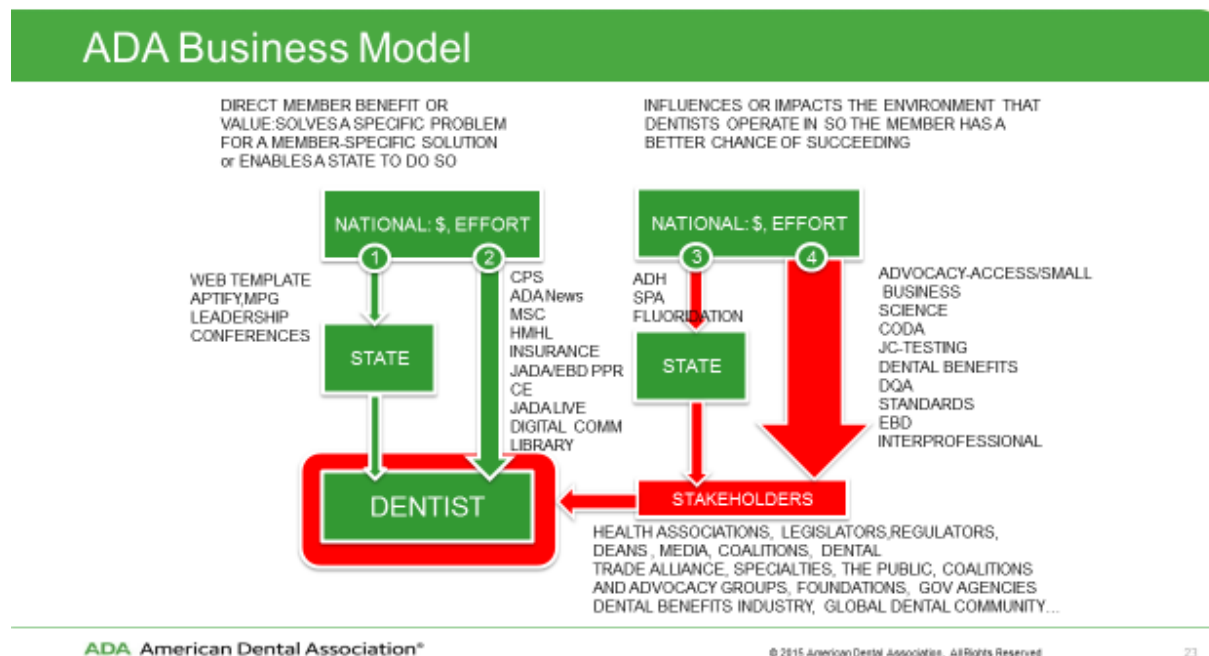
These internal budget discussions revealed a desire for a more structured innovation process that generates ideas to add value based on identification and analysis of member needs. An innovation process evaluates the feasibility of new products and/or services and decides if the new idea meets certain strategic criteria. These activities are overseen by the Senior Director, Product/Benefit Development within the

ADA's business development group that is charged with monitoring the entire ADA product/benefit portfolio. Each new idea is moved forward in concept to the Board of Trustees and then seeks funding out of contingent funds, which are set aside for other uses beside innovation. This budget proposes setting aside up to \$1 million from reserves, subject to the approval and oversight of the Board, to support an innovation center.

Because the future success of the ADA is strongly linked to the needs of new dentists who become full dues paying members, the ADA must overcome some of its traditional beliefs in what constitutes "value" and understand this important group of "future members". Another goal of future innovation efforts is the generation of additional non-dues revenue to support the 2020 strategic plan objective. The Board's plan to allocate up to \$1 million from reserves for innovative new products, benefits, services and non dues revenue generation is an important part of the Member First 2020 strategy.

The ADA Business Model

During this year's planning process, the ADA's business activities were modelled in the following chart to help understand how the Association delivers value to its members and the profession. This shows that while some programs deliver "direct to member" benefits either straight from the ADA or through the ADA's support of state and local components, the majority of ADA programs are focused on influencing the environment in which all dentists work.



It should also be noted that the ADA also has some programs that should be considered essential to maintaining the quality and integrity of the profession including education and testing, accreditation, standards and science. These programs are appropriate for the ADA to deliver at the national level and are critical to support of the ADA's mission to encourage the improvement of public health and to promote the art and science of dentistry. As a result, another highlight for the 2016 budget is the continued implementation of the reorganization of the Science division.

Member Engagement: a driver of value for many programs

Another finding from analysis of member data was a strong correlation between member engagement and market share. Active member engagement, in which a member actually interacts by attending a meeting, buying a product, or responding to a survey, is more valuable than passive engagement in which the ADA is simply pushing a publication or email out to a member. Most active member engagement is delivered by the state and local level components through meetings and events which the ADA National does not deliver. For example, it appears that existing members should be encouraged to form relationships with new dentists and other non-member dentists to increase local engagement and invest in the future. As a result, the 2016 budget includes the addition of membership outreach staff and more staff travel to support state client service initiatives.

In addition, "member engagement" is a critical measure of the value of many ADA programs. Therefore, this has identified the need for more specific member surveys on the perceived value of virtually every ADA program.

The Importance of Communications

The need for member survey metrics to gauge the value of ADA programs also highlights the importance of communications/marketing for every program. It's very likely that there are many dentists who are not aware of the benefits, products and services that the ADA delivers that the individual would find valuable. As a result, another goal for 2016 is the creation of specific communication/marketing plans for each program to ensure that members are made aware of their value through periodic communications to specific member segments through various channels such as, social media JADA, ADA News, email updates like the Morning Huddle or public press releases. This is especially critical for the majority of ADA programs focused on influencing the environment in which all dentists work. As a result, the 2016 budget reflects significant new investments in Communications capabilities including three new staff.

Designated Reserve Contributions, Surplus Budgeting, and Use of Reserves

In addition to the annual operating budget, this report also includes a projection of planned contributions to reserves and anticipated spending plans. The capital replacement reserve contribution represents a provision for the future repair and replacement of large and infrequent capital projects. Setting aside these funds in consistent amounts tied to depreciation less the total cost of smaller operating capital projects during each annual budget cycle enables the ADA to avoid special assessments which supports the goal of dues stabilization. Estimates for planned 2016 capital reserve spending projects subject to designated board review and approval are also included.

In addition, royalty revenue from ADA Members Insurance Plans is also planned for transfer to a designated reserve as part of the ADA operating budget. This royalty reserve is set aside to build member value, long term dues and financial stabilization as directed by the House of Delegates Resolution 84H-2013 and Board action. Consistent with this resolution, this budget is also proposing to allocate up to \$1 million from these reserves for innovation to drive member value.

While the strategic plan goal to plan for surplus budgets supports the accumulation of reserves, a long term perspective on the financial stability of the Association should also consider strategic investments – especially during periods of high investment values. Related to this, it should be noted that, in the ADA's budget basis income statement presentation, the ADA's annual contributions to reserves represent additional surplus. For example, if the insurance plan royalty now reported as a component of revenue was not transferred to the royalty reserves, then the ADA would report a surplus driven by the \$6.5 million of royalties expected in 2016. The House designed this royalty recognition and reserve process to avoid

1 automatically enabling increased spending in the ADA's annual operating budget and to ensure that
2 decisions on spending of royalty reserves would be kept separate from the determination of the annual
3 royalty coming from the insurance plans. In this way, the ADA would not become dependent on royalties
4 from the plan. However, to realize the intended purpose for the reserves, there must be a common
5 understanding and a will to spend from reserves when it's appropriate. In light of the predicted continued
6 decline in dues revenue at all levels, and the need to make new investments in member value and
7 engagement at all levels, to reverse this trend, the question of the "purpose of reserves" deserves
8 consideration as the budget is discussed.

9 In addition, good financial stewardship during periods of high investment values combined with multiple
10 years of actual surplus results that have built reserves enable strategic investments in member value,
11 such as the purchase of the D.C. townhouse. In fact, the original report which resulted in House
12 Resolution 84H-2013 stated that "the committee discussed potential guidelines for spending from this
13 royalty reserves and all agreed that they should be tied to the ADA's strategic 'big picture' of Association
14 success. For example, although building a \$100 million reserve may help the ADA's long term financial
15 stability, this would be a hollow victory if, while building that reserve, ADA membership market share falls
16 below 50%."

17
18 Regarding the use of reserves, it should also be noted that House Resolution 102H-1999 Resolved that "in
19 preparing the proposed Budget, the Board of Trustees be urged to add a new item in revenue 'surplus from
20 previous year' to the category of Operating Revenues reflecting the net surplus of the last completed year.
21 These funds can then be allocated between operating budget and reserves as appropriate." Although this
22 House resolution was later rescinded, it was replaced by another resolution 110H-2002 that urged the
23 Board "to use any reserve funds in excess of... [a specific] target level in developing the following year's
24 annual operating budget, capital expenditures budget, or funding of the building and technology funds, after
25 taking into account any known contingent use of reserves."

26 27 **Building Capabilities for Coordination of Tripartite Components**

28 Another area of significant investment in 2016 is the continued building of ADA capabilities to support a new
29 model for "client service" to state and local components. This includes the last year of the accelerated
30 Aptify implementation plan which rolled out the new Association Management software to most states in 3
31 years rather than the original 5 year plan. This accelerated schedule was recommended by the ADA Audit
32 Committee to manage the long term risk of all components not having access to consistent and reliable
33 information to serve members. After States have converted to Aptify and completed the learning of new
34 processes, it is expected that Aptify will enable more effective member relationship management, data
35 collection and analysis, and key segment marketing for state and local societies. Similarly, ADA providing
36 design support for state association websites using similar branding with an efficient architecture provides a
37 consistent customer experience that also enables easier online access to sign up new and renew existing
38 members. As Aptify implementation finishes in 2016, it is hoped that process improvements will make it
39 easier for members to interact with the ADA, state and local levels. For example, monthly dues installment
40 payments would be possible for all Aptify states, not just a few. These infrastructure improvements are
41 critical to the long term operational viability and interaction of the ADA as well as state and local
42 components.

43 Digital Content Management is another specific example of ADA building capabilities to serve the
44 tripartite. Member feedback on digital communications indicates that we overload our membership with
45 communications that are general in nature, lengthy, and repeated across multiple communication
46 channels. Digital Content Management is an effort that is under way to optimize the production of digital
47 content through business process changes and technology investments. The member benefits to making
48 these investments include targeted communications and content that is personalized and improves
49 member engagement and loyalty.

1 This project will be conducted in several phases. Two phases are included in the 2016 budget: Digital
2 Asset Management and Upgrades to Aptify eBusiness. Other phases will be included in 2017 and 2018.
3 This Digital Asset Management System enables storage, tracking, and utilizing digital images and videos
4 so they can be accessed quickly and used on a schedule to keep our content fresh and interesting.

5 Upgrades to Aptify eBusiness includes partnering with Aptify to include the ADA's eCommerce
6 requirements in the next version of the Aptify eBusiness product as well as configurations necessary to
7 meet the ADA's specific and unique needs. This enables the selling, distribution, and fulfillment of Digital
8 Content products. This project will be done by Aptify at no cost to the ADA for the items they are
9 including in their base product and with staff on hand for any ADA-specific configurations.

10 The definition and agreement of the ADA's role and responsibilities in relation to each element of the
11 tripartite continues to evolve as Aptify is implemented in more and more components and everyone is using
12 a common database of membership information rather than hundreds of separate databases. In fact, the
13 facilitation of sharing information, especially market analysis and best practices across states and local
14 components, is expected to drive value for all stakeholders. For example, successful recruitment and
15 member engagement strategies identified in one part of the country may be shared in others that seek
16 solutions. Specifically, some local dental societies have proven very successful in retaining new dentists
17 and could share best practices with local societies that have similar demographics but far higher non-
18 renewal rates on new dentists. Transfers of membership from student to active membership, from one state
19 to another, would be seamless. However, in its role as the national organization, the ADA recognizes that
20 while all relationships should be collaborative, the nature of roles and responsibilities with large states,
21 which may have their own infrastructure and capabilities, will necessarily be different than those with
22 smaller states that need more support to deliver value to members.

23 Currently the ADA is developing an approach to providing services to the state dental societies that allows
24 for an approach that best meets the needs of states that vary widely in capability and capacity.

25 The simplification and streamlining of processes to make it easier for members to find and access benefits
26 and solutions is an important priority to ensure that the member experience, whether it be digital or live, is
27 consistent across all states. A consistent look and feel is important to members. Websites (ADA, State and
28 Local) are a primary channel to interface with dentists looking for professional solutions and support. In an
29 ideal scenario, the member would be able to access the benefits, products and services that they desire in
30 real time, through a single interface, regardless of what city or state they live in. The ADA's collaboration
31 with the states is based on three focus areas: Focus the Message; Simplify, Rationalize, Standardize the
32 Member Experience, and Fill the Pipeline.

33 34 **Mechanics of this Year's Program Prioritization Process**

35
36 Because the critical goal of budget development is the prioritization of resources in alignment with the
37 strategic plan, the development of program assessment criteria tied to its goals was an important step in the
38 process. Program Assessment Criteria are intended to provide a framework for common understanding of
39 program prioritization as the Board of Trustees follows the direction of 2011 House resolutions. Specifically,
40 Resolution 44H-2011 asked that the Board develop a set of program assessment criteria and that each
41 Council use the criteria to evaluate its programs and report to the Administrative Review Committee.
42 Resolution 52H-2011 directed the Board to develop and follow a set of short and long-term financial
43 strategies that identify existing programs, services and products to be sunset so that existing finite human
44 and financial resources may be redeployed for new initiatives that align with the Strategic Plan of the ADA
45 and that deliver greater member value or public health impact.

46
47 The 2016 budget approach again started early to ensure that all Councils, as representatives of the House,
48 could be engaged in the budget process. A new collaborative software tool, Transparent Choice, was

chosen to replace Decision Lens to enable scoring of all ADA programs using one set of program assessment criteria with involvement by multiple stakeholders. Consistent with prior years, program scoring is still only one of many inputs to the overall budget process and the final decisions are still made by volunteer leaders. Councils of the House are uniquely positioned to aid the House in fulfillment of its fiduciary responsibilities and Council leaders compare all programs within the Association against one set of program assessment criteria. Councils are also best informed in their particular areas of bylaws authority.

Similar to last year, Council leaders formed a separate group of senior representatives ("CBG"), two from each Council, to rate all programs against the program assessment criteria. The New Dentist Committee ("NDC") and Budget & Finance Committee ("B&F") also scored each program against the program assessment criteria, as shown in the program summary below. These ratings were combined with Administrative Review Committee criteria weightings to generate the program scores which resulted in program rankings. Consistent with last year's process, the Administrative Review Committee meeting was dedicated to taking input from Council chairs and ADA staff to discuss their programs, including factors outside the program assessment criteria. ALL programs across the ADA were evaluated on a consistent basis by one group of representatives of the House and each Council also had a forum for additional input beyond the criteria-based program rankings.

Following the same method as last year, the 2016 budget prioritization of programs represents a process which is closer to an ideal "zero based" budget because all programs, new and old, were assessed together using one set of criteria. This is fundamentally different than older ADA presentations of base budgets, which included ongoing legacy programs, plus new programs. It should be noted that House resolutions passed after this budget process will not go through this same review and prioritization process, but it is hoped that the House of Delegates, at its annual session, will share this high level view of the ADA and that all resolutions introduced will also be reviewed and prioritized with consideration to the same criteria.

With this background, it should be noted that this 2016 budget represents the estimates of ADA revenue and expenses to deliver the listed programs and services based on the best information and assumptions available at the time these detail budgets were created and built into the ADA budget in mid 2015. As a result, it is very possible that some estimates or assumptions could change based on new information that becomes available closer to the start of the budget year. If that new information results in significant, quantifiable impacts to the 2016 budget, then those will be reported by the Treasurer to that House at the annual session as possible amendments to the budget subject to the discretion of the House. Unfortunately, potential changes are an inherent risk of the ADA's current budget process due to this long timeline. Some budget estimates made long before the start of the budget period may be less accurate than those that are built later.

From a higher level perspective, the ADA's 2016 budget is also a product driven by the ADA's program agenda which has been aligned as much as possible with the ADA's strategic plan goals as well as the core functions and services required to support a 400+ employee, \$120 million organization and all the supporting governance structures. This budget report is therefore focused more on programs and services being delivered and less on the accounting structures.

Budget Review and Approval Process Overview

The ADA *Bylaws* charge the Treasurer with design of the budgetary process in concert with the Board of Trustees and oversight of the Association finances and development of a budget for approval by the House of Delegates. Although the overall planning process still stretches over more than a year due to: multiple layers of volunteer involvement; the timing of council, committee and Board meetings; and the *Bylaws* requirement that the House be informed of the membership dues 30 days before the annual session, this

year's financial budgeting started later so that more time could be spent studying programs needed to drive the ADA toward the new strategic plan goals.

This year much greater focus has been placed on studying the benefits that justify the costs of programs. This has added value to the traditional budget framework. In compliance with House resolution 44H-2011, ADA expenditures are grouped by activity (aka "program") and scored against a set of Program Assessment Criteria.

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

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

Councils

In the first stage of this process, ADA staff worked with over 200 council members to determine which programs should be included in the 2016 budget. Each agency division defined a list of programs that represent their work products, i.e., what the division accomplishes that creates member value. This provided councils with better visibility at a summary level of the planned activities and resources required.

Management Internal Budget Reviews

In order to create realistic budgets the Executive Director and Chief Financial Officer provided each division with "starting point" 2016 financial goals and required that any proposed spending above the goal be identified separately with a written explanation. Next, staff input the initial draft budgets for their programs into the Hyperion budget system. Every hour of staff time and every dollar of non-staff expense were planned against the programs. The sum of the staff time in the programs equals the total staffing budget.

The Executive Director and Chief Financial Officer then held budget review meetings with division vice presidents to: evaluate the reasonableness of proposed budgets, identify synergies across the ADA, provide oversight on expenditure effectiveness, and discuss activities that do not fit solely into any single

council area. Budget adjustments from these discussions were then reflected in the Executive Director's budget proposal to the Administrative Review Committee.

Council Budget Group

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

1. **Program causes public to recognize the ADA or its members as leaders in oral health:** The percent of the American public that as a direct result of this program recognize the ADA or its members (but not other dentists) as being leaders in oral health.
2. **Program causes dentists to join the ADA:** Existing programs should be assessed based on actual results while any proposed completely new programs should be assessed based on expected potential to be a reason why members join or renew their ADA membership.
3. **Members with close knowledge of the program view it as is highly valuable:** based on knowledge of the program.
4. **States and Local organizations agree that the program is a responsibility of the national organization:** Of the ADA's 52 geographic constituents and 550 local societies, the percentage that would agree that this program is the responsibility of the National Organization would be high, moderate, limited or low.

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

The program scores and criteria weightings were collected in a web-based software which enabled independent voting by each participant. It should be noted that this software tool is not responsible for the program scores any more than a voting machine is responsible for the results of a public election.

Administrative Review Committee

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

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

Board of Trustees

The Administrative Review Committee, led by the Treasurer, made its budget recommendations to the full Board of Trustees, at the August Board meeting. The Board reviewed the Committee's report recommendations and asked questions and requested additional information as needed. Budget

1 adjustments agreed upon by the Board were then reflected in the subsequent final budget report to be sent
2 to the House.
3

4

5 **House of Delegates Meeting**

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

1 Conclusions

2 The primary purpose of the ADA strategic plan, which is supported by the ADA division operating plans and
3 budgets is to drive positive change toward member growth. In the words of one change agent: "If you focus
4 on results, you'll never change. If you focus on change; you'll get results." For many years, the ADA has
5 continued to confront falling membership dues revenue and market share. Even though the ADA has
6 enjoyed very positive bottom line financial results in recent years, the start of a turnaround in membership
7 market share is the most critical need for the ADA. As a result, this 2016 budget includes several new
8 initiatives to attempt to turn the negative trends. Alignment of the entire organization to drive value to attract
9 and retain members in critical market segments and improve non-dues revenue is critical to the long term
10 operational sustainability and financial stability of the ADA.

11 The proposed 2016 budget is designed to position the ADA for longer term growth. The ADA must focus on
12 development and delivery of products and services which are relevant and impactful to its key largest
13 member market segments. The ADA must serve the members of today as well as the members of
14 tomorrow. Identifying and developing solutions to meet the needs of the "members of tomorrow" through
15 innovation may change the direction of the ADA. However, this change in direction is necessary to remain
16 relevant to the profession by striving to ensure ADA members always represent a majority of U.S. dentists.
17

American Dental Association Operations

2016 Budget Summary by Natural Account

\$ 000

	2013 Actual	2014 Actual	2015 Budget	2016 Budget	2016 v 2014 Variance		2016 v 2015B Variance	
					Fav / (Unfav)		Fav / (Unfav)	
					\$	%	\$	%
Membership Dues	56,935	56,433	57,858	55,204	(1,229)	-2.2%	(2,653)	-4.6%
Advertising	8,145	8,281	6,926	6,650	(1,632)	-19.7%	(276)	-4.0%
Rental Income	5,579	3,655	4,685	4,361	706	19.3%	(324)	-6.9%
Publication & Product Sales	7,920	7,479	6,840	6,955	(524)	-7.0%	115	1.7%
Testing Fees & Accreditation	19,805	21,705	24,852	25,471	3,766	17.3%	619	2.5%
Meeting & Seminar Income	9,342	8,586	10,811	9,409	823	9.6%	(1,402)	-13.0%
Grants & Contributions	2,690	2,592	2,606	1,737	(856)	-33.0%	(869)	-33.4%
Royalties	13,054	13,506	16,151	16,056	2,550	18.9%	(95)	-0.6%
Investment Income	2,271	2,365	1,591	2,450	85	3.6%	859	54.0%
Other Income	3,501	3,950	3,758	3,496	(454)	-11.5%	(262)	-7.0%
Total Revenues	129,241	128,553	136,077	131,788	3,235	2.5%	(4,289)	-3.2%
Total Salaries and Temporary Help	39,624	41,482	42,741	42,756	(1,274)	-3.1%	(15)	0.0%
Total Fringe Benefits	10,784	6,217	11,895	11,329	(5,112)	-82.2%	566	4.8%
Total Payroll Taxes	2,723	2,889	2,829	2,856	33	1.2%	(26)	-0.9%
Total Travel Expenses	6,053	6,146	7,566	7,485	(1,339)	-21.8%	81	1.1%
Printing, Publication & Marketing	9,214	10,292	9,691	9,734	558	5.4%	(42)	-0.4%
Meeting Expenses	2,079	1,788	2,653	3,014	(1,225)	-68.5%	(360)	-13.6%
Consulting and Outside Services	6,485	8,166	11,339	9,649	(1,483)	-18.2%	1,690	14.9%
Professional Services	8,931	9,681	10,065	9,960	(278)	-2.9%	105	1.0%
Bank & Credit Card Fees	1,322	1,256	1,214	1,308	(52)	-4.2%	(94)	-7.8%
Office Expenses	4,576	4,655	5,797	4,970	(316)	-6.8%	827	14.3%
Facility & Utility Costs	5,750	5,414	6,273	6,197	(783)	-14.5%	76	1.2%
Grants and Awards	2,586	2,591	2,756	2,409	182	7.0%	348	12.6%
Endorsement Costs	718	854	827	1,297	(443)	-51.8%	(469)	-56.7%
Depreciation/Amortization	6,469	6,192	6,424	6,613	(421)	-6.8%	(189)	-2.9%
Other Expenses	1,287	1,677	2,833	2,289	(612)	-36.5%	544	19.2%
ADA Health Foundation - Grant	1,907	1,907	2,067	2,361	(455)	-23.8%	(294)	-14.2%
Total Expenses	110,508	111,207	126,971	124,225	(13,018)	-11.7%	2,746	2.2%
Income Before Taxes	18,733	17,346	9,106	7,563	(9,783)	-56.4%	(1,543)	-16.9%
Income Taxes	1,817	1,435	1,300	1,500	(65)	-4.5%	(200)	-15.4%
Net Income Before Reserves	16,916	15,911	7,806	6,063	(9,848)	-61.9%	(1,743)	-22.3%
Add Back Depreciation	6,469	6,192	6,424	6,613				
Operating Capital Expenditures	(2,854)	(3,528)	(1,962)	(4,495)				
Transfers to Capital Reserve	(3,500)	(3,013)	(4,462)	(2,118)				
Transfers to Ins Royalty Reserve	(6,270)	(6,229)	(7,300)	(6,500)				
Non-Operating Items	(6,155)	(6,578)	(7,300)	(6,500)				
Operating Surplus / (Deficit)	10,761	9,334	506	(437)				

The above financial summary compares the proposed 2016 budget against prior actual results and budgets. The operating surplus / (deficit) as defined by the House of Delegates is shown at the bottom of the schedule. The House of Delegates created the capital replacement reserve fund beginning with the 2013 budget. The ADA's annual budgets have historically included capital spending in the "net depreciation and capital add back." Budgets from 2004 through 2012 included only "operating capital" spending and did not include contribution to a capital replacement reserve fund. For the 2014-2016 budgets, the amount of the contributions to the capital replacement reserve fund is determined by the excess of budget depreciation over the operating capital expenditures. This assumes that over a multi-year period depreciation is a rough indicator of the future capital expenditures that will be required to replace ageing assets.

Changes in 2016 Budget Versus 2015

Revenues

Total revenues in the 2016 budget are \$131,788. Highlights of various revenue categories are provided below.

Membership Dues: The Division of Member and Client Services (formerly the Division of Membership, Tripartite Relations and Marketing) estimates the future membership levels for each of 28 dues paying categories and multiplies by the 28 dues rates. The 2016 budget anticipates 178,463 members, of which 86,727 will pay full dues of \$522 per year. The average dues rate per member is \$310 per year including discounts such as Active Life and Recent Graduate. These figures do not reflect any dues increase or assessment, as no such dues increase for 2016 has been put forth by the Board of Trustees.

Advertising: This category primarily includes advertising sales in ADA publications, new initiatives in electronic media, and secondarily, exhibits at the ADA annual session. The 2016 revenue of \$6,650 is a (4) % decline from 2015 budget. The decline is largely driven by the continued slowdown in print ads in ADA News and elimination of all MouthHealthy.org advertising revenue, a \$(200) impact.

Rental Income: This revenue category primarily includes rental income from the Chicago Headquarters and Washington DC Buildings. Revenue of \$4,361 is a decrease of (6.9) % from 2015 budget. The occupancy level is budgeted to be lower in 2016 than what was budgeted for 2015 using more conservative assumptions.

Publication and Product Sales: The category is anticipating a minimal increase of \$115 or 1.7 %.

Testing Fees and Accreditation: This category continues to be the ADA's largest source of non-dues revenue. Revenues from testing and accreditation fees are expected to rise by \$619 or 2.5 % versus 2015 budget. 2016 budget includes a 4% fee increase in the Dental Admissions Test, a 10% fee increase in Optometry Admissions Test and a 4% increase in accreditation fees. National Board Dental Exam (NBDE) fees remained flat in 2016.

Meeting and Seminar Income: Most of the \$(1,402) or (13) % decline is related to the 2016 ADA Annual Meeting in Denver being a smaller meeting when compared to the 2015 meeting in Washington DC. This impacts registration income, exhibit rental income, ticket sales and housing rebates.

Grants, Contributions, and Sponsorships: Grants, contributions, and sponsorships are projected to decrease by \$(869) or (33.4) %. Most of the decline is related to transferring all Give Kids a Smile activities

from the ADA to the ADA Foundation. There is a corresponding expense decrease that offsets most of the revenue decline. Additionally, continuing education sponsorships will be less due to the location of the 2016 ADA Annual Meeting. Also, the inter-professional relations RWY 14 grant concludes in 2015. Finally, CPS is expecting sponsorships to drop off in 2016.

Royalties: Includes royalties received from the *ADA Business Resources* program, CDT licenses, domestic and international product licenses, selling of mailing lists and JADA royalties to be paid by Elsevier.

Investment Income: A projection for revenue of \$2,450 for 2016 includes both interest and dividends on reserve fund assets and investment earnings on cash in the operating account. The increase of \$859 is an attempt to bring 2016 revenue forecast in line with 2014 actuals.

Other Income: This category is composed of miscellaneous revenue, including such items as overhead reimbursement from subsidiaries and Seal Program revenues. The \$(262) decrease is mostly due to the ADA no longer budgeting for the Central Administration department to charge the Members Insurance Department for reimbursement from the Member's Insurance Program. Since these charges were from one ADA department to another, this impacts both revenue and expense but has a net zero impact on the ADA budget.

Expenses

Total operating expenses are budgeted at \$124,225, a decrease of \$2,746 or 2.2 % versus the 2015 budget. The reduction is driven by accounting changes in three areas:

Education R&D Fund	\$815
Give Kids a Smile Non-Staff Costs	\$320
Insurance Plan Charges Between ADA Departments	<u>\$481</u>
Total	\$1,616

In all of these cases the ADA had previously reported revenue with equal offsetting expenses. Elimination of both the revenue and expense gives a clearer financial picture. Excluding these three accounting changes, 2016 budget expenses would have decreased by \$1,130 or 0.9 %.

Expense increases, such as for four additional employees, are offset by cost reductions and more accurate alignment of budgets with actual rates of expenditures.

ADA Management and the Board of Trustees also propose creation of a new ADA Innovation Center dedicated to development of major new member benefits and products. The Innovation Center is proposed to be funded from reserves and is therefore not included in the annual operating budget. However, use of reserves to create member value is consistent with prior house resolutions.

Highlights of various expense categories are provided below.

Salaries (Base Compensation): Base salary expenses are budgeted at \$41,305 which is unfavorable by \$(5) or (0) % from the 2015 budget. As shown in the table below under "ADA Employee Staffing", the number of full time equivalent employees at year end is projected at 433.6, an increase of 4.3 compared to the 2015 budget. The 2016 budget includes a 3% merit pool as well as 1% for market adjustments. The budget also assumes salary savings due to anticipated open positions throughout the year.

1 **Agency Compensation (includes Severance):** This category includes expense associated with
2 severance pay and service awards and the 2016 budget is expected to be relatively flat when compared to
3 2015.

4
5 **Temporary Help:** The ADA hires temporary staff for annual session and to assist divisions when staff
6 positions are open during the year. This category is expecting a moderate increase of \$(25) when
7 compared to the 2015 budget.

8
9 **Pension Fund:** This category is to cover annual contributions to the scaled back new pension plan that
10 went into effect January 1, 2012 as well as the liability of the full employee pension plan that was offered to
11 employees prior to 2012. The cost reflected in this category represents estimated plan contributions
12 required by the IRS rules for current employees, based on actuarial assumptions. The minimal increase of
13 \$(60) over 2015 budget is due to adding 4.3 additional staff positions in 2016.

14
15 **401K Contribution:** No significant change is anticipated for 2016.

16
17 **All Other Benefit Costs:** Expenses in this category include group medical premiums, dental direct
18 reimbursement, life insurance and workers compensation. The expenses in this category are expected to
19 decrease by \$596 or 11.6 % from 2015, driven by reductions in life insurance and medical insurance costs.

20
21 **Payroll Taxes:** This category includes expense associated with employer related taxes such as FICA, SUI
22 and FUI. This category is expecting a minimal increase in 2016.

23
24 **Travel Expenses:** Travel expenses are usually comprised of about three quarters volunteer travel and one
25 quarter staff travel. Budget expenses for travel are projected to increase by (1) % versus the 2015 budget.

26
27 **Printing, Publications and Marketing:** No significant change is anticipated for 2016.

28
29 **Meeting Expenses:** The 2016 budget anticipates an unfavorable variance of \$(360), largely attributable to
30 expenses associated with the ADA's Annual Meeting site in 2016. The 2016 meeting includes budget for a
31 Welcome Reception which was added to the program for 2016. Additionally, labor costs in Denver are
32 higher than Washington DC.

33
34 **Consulting Fees and Outside Services:** 2016 expenses in this area decrease by \$1,690 or 14.9 % when
35 compared to the 2015 budget. The decline is attributable to several factors. The division of Education is no
36 longer budgeting for revenue or expense associated with their Research and Development fund. This
37 resulted in \$815 in expense reductions in this category. There is a corresponding decrease in revenue
38 related to the Research and Development fund. Additionally, the GKAS transfer to the ADA Foundation
39 reduced expenses in this category. Also, the ADA's Annual Meeting is expected to be a smaller meeting
40 which reduces expenses. Finally, an association-wide budget directive led many divisions to reduce
41 expense budgets in this category to mirror prior year actual spending.

42
43 **Professional Services:** No significant change is anticipated for 2016.

44
45 **Bank and Credit Card Fees:** This category represents transaction fees paid to financial institutions and
46 reimbursements to state and local societies for credit card fees related to ADA membership dues collection.

47
48 **Office Expenses:** The \$827 decrease versus 2015 budget in office expenses is primarily driven by an
49 association-wide budget directive which led many divisions to reduce expenses in this category to mirror
50 prior year actual spending. Additionally, the Ad Council expense in 2016 was moved to the Print,
51 Publication and Marketing category.

52

1 **Facility and Utility Costs:** These expenses represent costs for building management and operations,
2 maintenance, and real estate taxes for the ADA Headquarters and Washington DC buildings. The decline
3 of \$76 is the largely the result of reducing the budget for property taxes and cleaning services for the
4 headquarters building which were both very conservative in the 2015 budget. Partially offsetting the decline
5 is increases in property management and utility expenses.
6

7 **Grants and Awards:** The ADA distributes grants to support various organizations for specific functions.
8 The \$348 net savings is partially due to restructuring of the Membership Program for Growth (MPG) grants
9 to focus solely on student and new dentists activities. These grants are paid to selected state dental
10 societies. Also, the Research & Development Fund in the division of Education is no longer budgeted as
11 part of the ADA operating budget. Partially offsetting this decline is a \$(175) increase in SPA grants to state
12 societies.

13 **Endorsement Costs:** This category represents royalty payments to state dental societies that participate
14 in the *ADA Business Resources* program and to the AMA for use of medical codes in *CDT* related products.
15 The increase of \$ (469) or (56.7) % is due to increased co-endorsements by many state societies. The
16 additional endorsement cost causes ADABEI products to become less profitable at the National Level, as
17 cost growth outpaces growth in revenue. But since these costs are new payments to states societies,
18 increased profits at the state level offset the decline at the National level.
19

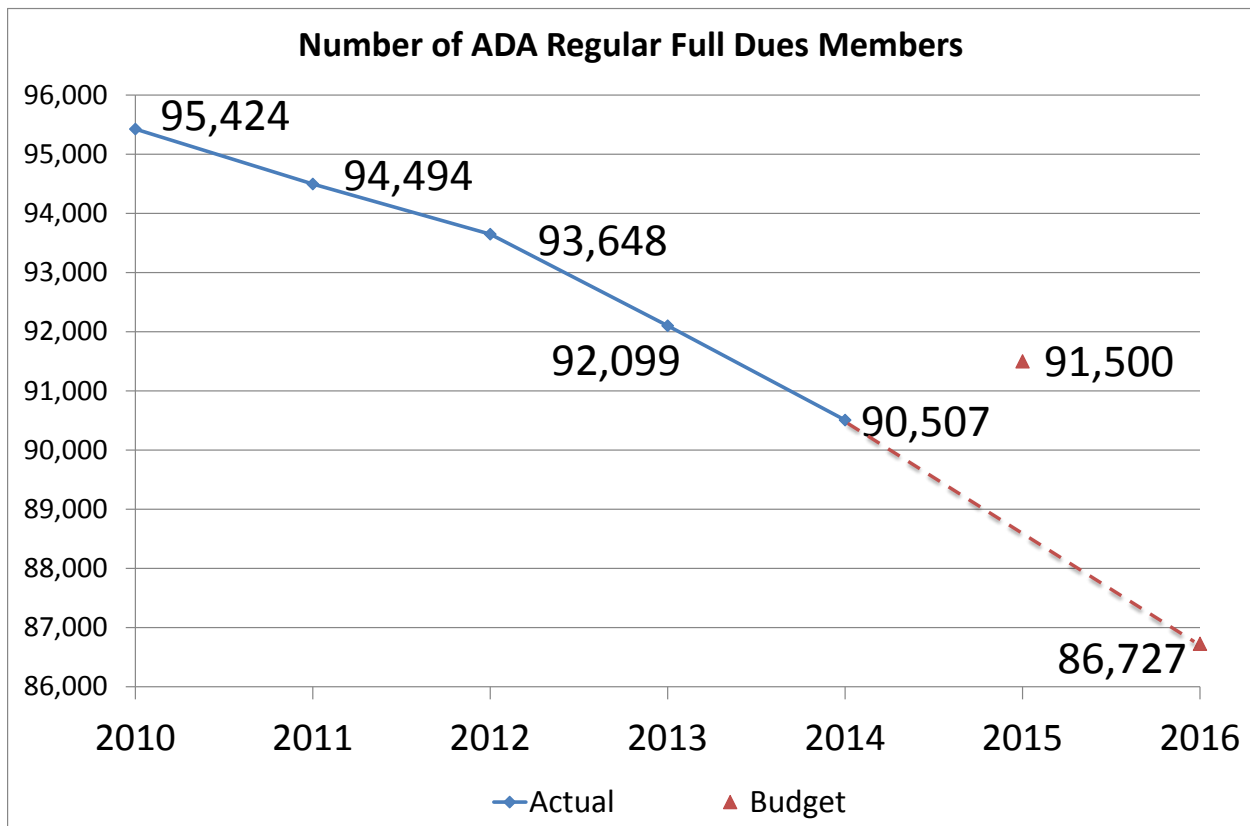
20 **Depreciation and Amortization:** Depreciation is calculated annually based on prior year and proposed
21 current year capital acquisitions. The increase of \$(189) in 2016 is due to the ADA focusing on upgrading
22 or implementing systems enhancing ADA's member experience via ADA.org/CPS website, continuation of
23 Aptify deployment and the implementation of a new financial system.
24

25 **Other Expenses:** Other expenses include general insurance, recruiting costs, staff development, and the
26 contingency fund. The ADA budgets \$1,000 per year in the contingency fund, against which spending
27 during the year is approved by the Board of Trustees. The reduction in "Other Expenses" is mostly due to
28 the ADA no longer budgeting for overhead recovery related to the Members' Insurance Program. This
29 impacts both revenue and expense and is a net zero impact on the ADA budget.
30

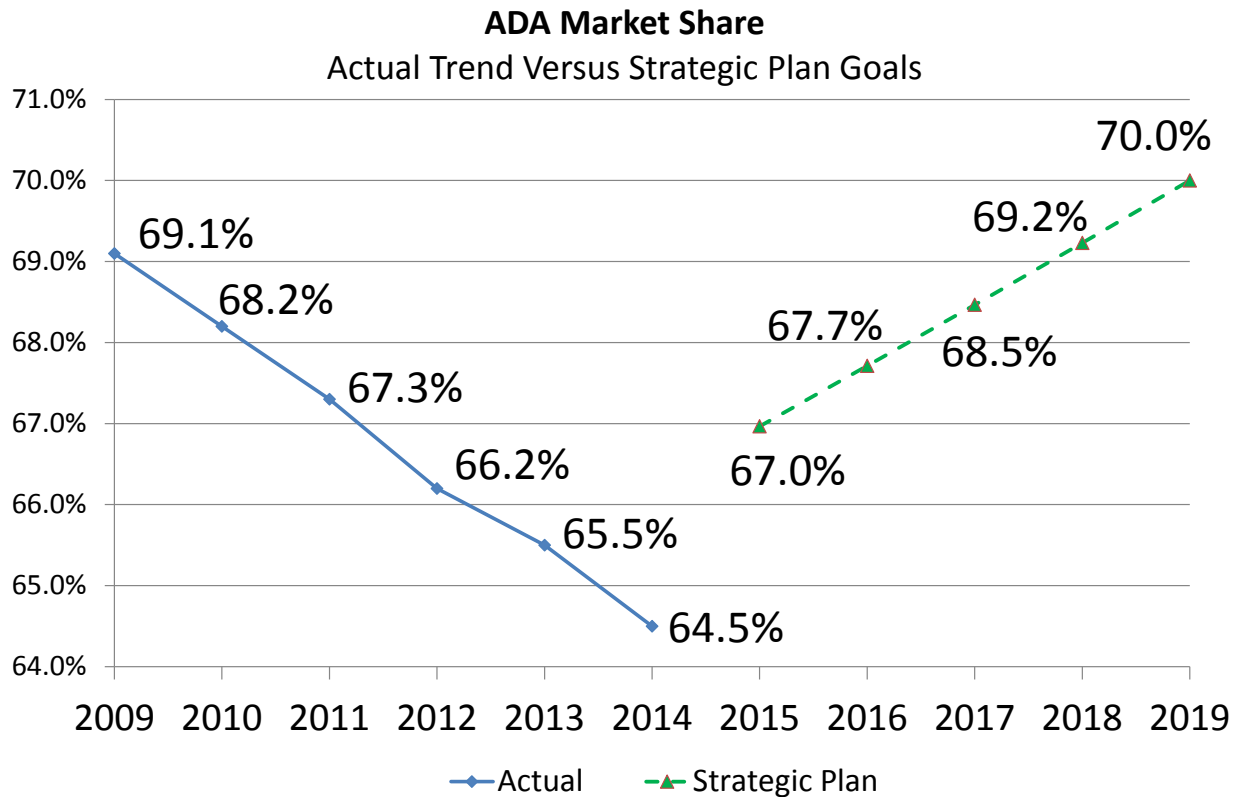
31 **ADA Foundation Grant:** The Association's annual grant to the Foundation is budgeted to increase by
32 \$(294) to \$2,361 based on funding of a transfer of the GKAS program from the ADA to the ADA Foundation
33 in 2015. This transfer is first reflected in the budget starting in 2016. This increase covers the cost of staff
34 who transferred with the program to the ADA Foundation as well as other GKAS administrative expenses.

Additional Information on Membership Trends

The chart below shows the actual and budget trend on the number of regular ADA members. Membership dues revenue is projected to continue to fall as the number of full dues paying members is projected to drop by 3.8 thousand members versus 2014, a compound annual growth rate of (2.1)%. For comparison, the average rate of decline from 2011 to 2014 was (1.4) %



Below is the trend in ADA market share versus the strategic plan goal. Currently, only 48 % of new dentists are projected to reach full dues paying status. Until that leading indicator changes, the ADA can expect a continuation of the downward trend in this chart.



ADA Support for State and Local Dental Associations**American Dental Association**

2016 Budget Programs That Directly Support States and Locals

Dollars in Thousands

Program	Division	Number of Employees	Operating Expense		
			Employees	Other	Total
Royalties	ADABEI	0.0	-	1,014	1,014
Mkting and Comm Suppt for ADA Natl State and Local	Communications	5.0	702	106	808
Public Digital Communications *	Communications	5.7	584	276	860
State Public Affairs Prog.	Government Affairs	4.8	678	2,847	3,524
Access Comm Oral Health Infra&Capacity	Government Affairs	1.7	268	215	482
Fluoridation and Prevention	Government Affairs	2.7	297	191	488
Infrastructure for States and Locals	Information Tech	2.5	333	7	339
Sharepoint and Reporting for States and Locals	Information Tech	1.6	243	33	277
Aptify for States and Locals	Information Tech	5.8	725	515	1,240
Websites for States and Locals	Information Tech	1.9	233	208	441
Outreach to ADA State and Local Societies	Member & CS	11.0	1,522	649	2,170
Total		42.7	5,585	6,061	11,643

* The Mouthhealthy.org website ultimately benefits the public, but is provided as a service to the State Dental Associations so that they can feature the Mouthhealthy link on their state websites.

The table above identifies some of the ADA's 2016 programs that include support of state and local dental associations. These costs have grown significantly in the past few years to build important capabilities. In some cases expenses previously borne by the states and locals have now been transferred to the ADA National Organization.

Not included in the table above are capital expenditures spent by the National Organization to support State and Local organizations. As shown in the Capital Expenditure section of this report, the Information Technology Division is planning for \$2,962 in capital expenditures in 2016, much of which is for technical infrastructure that will directly or indirectly provide benefits for state and local societies.

The 2016 costs shown above do not reflect investments in prior years. For example, the ADA's initial investments in Aptify in 2014 and 2015, including the accelerated implementation to state and local components, represents just over \$5 million of spending. In addition to the benefits of a more modern association management system, states that had previously supported their own "Non-TS" membership systems have also saved their total costs of those old software programs.

Once the initial implementation is complete, Aptify can and will enable more and better capabilities in the future. However, to see the return on these investments there is a big need for more standardization of state and local dues categories and membership policies and procedures to enable efficient services to all components rather than individual customized solutions for each one.

1 The ADA often has difficulty measuring the local results achieved by the above expenditures. Hopefully,
2 as more efficiencies through improved processes and systems are delivered by ADA, this will enable
3 states and locals to redeploy more of their resources toward local recruitment and retention efforts.
4 States vary widely in resources, capacities, capabilities and related costs per member.

5 In 2015 some state organizations appear to have encountered some type of difficulty that prevented
6 them from remitting the ADA dues that they have collected to the ADA in a timely manner. Currently,
7 ADA does not monitor which states might be headed towards financial or other types of difficulties, since
8 state and local societies are better positioned to manage their own local operations. However, ADA is
9 positioned to assist state societies when financial and other challenges appear and this has in fact been
10 the case for two or three states over the last five years.

ADA Employee Staffing

The table below shows staffing information for each ADA division.

American Dental Association Operations

Budget Year-End Full Time Equivalent Employees

	2015	2016	2016 v 2015	
			Inc / (Decr)	
			#	%
Administrative Services	16.0	17.0	1.0	6.3%
Human Resources	6.8	7.0	0.2	2.9%
Legal Affairs	15.6	16.6	1.0	6.4%
Finance and Operations, Buildings	33.0	32.0	(1.0)	-3.0%
Information Technology	52.0	55.0	3.0	5.8%
Education	63.0	65.0	2.0	3.2%
ADA Publishing	21.0	19.0	(2.0)	-9.5%
Business Relations	5.0	4.0	(1.0)	-20.0%
Conferences and Continuing Education	21.0	21.0	-	0.0%
Product Development and Sales	9.0	11.0	2.0	22.2%
Communications	28.0	30.0	2.0	7.1%
Government & Public Affairs	31.0	30.0	(1.0)	-3.2%
Member and Client Services	49.0	49.0	-	0.0%
Practice Institute	28.0	28.0	-	0.0%
Health Policy Institute	15.0	15.0	-	0.0%
Science	35.9	34.0	(1.9)	-5.3%
Total ADA	429.3	433.6	4.3	1.0%

In addition to a reallocation of resources across divisions to meet needs, the 2016 budget proposes FTE employees to add capabilities to Information Technology, Communications, and Membership.

The year-end budget headcounts shown above reflect the number of authorized employee positions. However, the ADA expects that at any given time some of these positions will be unfilled. Employees leave the ADA every month and the ADA normally takes a few months to hire their replacements. Also, in some cases the department is not ready to bring on new employees or needs several months to find the right candidate. Therefore, the budgeted employee salary expense reflects the following based on recent actual experience:

- All 2016 budget positions not filled as of March 2015 are assumed to be hired on July 1, 2016 and therefore carry no budgeted expense in the first half of 2016.
- 2016 total salary expense is further adjusted downward by \$1,200 to reflect expected open positions.

ADA Programs and Internal Activities

The table below shows financial and staffing information on each ADA member program and internal activity. Also shown for 75 member programs is the rank given by each volunteer group against the strategic plan. The sum of all the programs employees, revenue and costs equals the total ADA budget.

American Dental Association

2016 Budget Programs

Dollars in Thousands

Ref #	Program	Strategic Plan Rank			Number of Employees	Revenue	Operating Expense			Net Income Before Reserves
		NDC	CBG	B&F			Employees	Other	Total	
1	FDI and International Relations	71	74	71	1.0	12	99	639	738	(726)
2	Board of Trustees				6.3	-	1,283	2,488	3,771	(3,771)
3	House of Delegates				3.3	-	522	748	1,270	(1,270)
4	Strategy				0.8	-	133	52	186	(186)
5	Operational Management				5.8	-	1,117	118	1,235	(1,235)
6	Total Administrative Services				17.0	12	3,155	4,045	7,201	(7,189)
7	Product/Benefit Management	46	51	49	1.1	-	193	68	261	(261)
8	International Business Activities	73	75	75	0.0	-	-	73	73	(73)
9	Corporate Relations	64	64	69	0.9	-	133	56	189	(189)
10	Innovation Center				2.1	-	298	6	304	(304)
11	Payer Benchmarking	5	22	40						-
12	ADA Mobile App	27	26	44						-
13	National Website for Local Information	21	39	36						-
14	National New-Dentist On-Line Meetings	15	31	58						-
15	Virtual Study Groups	29	40	64						-
16	Group Purchasing Discounts	2	32	22						-
17	Licensure Information and Policy	34	36	25						-
18	Total Business Relations				4.0	-	624	203	826	(826)
19	Grant to ADA Foundation & Other	66	59	73	0.0	-	-	2,434	2,434	(2,434)
20	Royalties				0.0	4,104	-	1,014	1,014	3,091
21	Retirees				0.0	-	-	-	-	-
22	Benefits not allocated to divisions				0.0	-	-	4	4	(4)
23	Expense Offsets				0.0	-	(2)	-	(2)	2
24	Association-wide expenses				0.0	25	1,596	503	2,099	(2,074)
25	Overhead billing				0.0	110	-	-	-	110
26	Depreciation							3,417	3,417	(3,417)
27	Total Central Administration				0.0	4,239	1,593	7,372	8,966	(4,727)
28	Council on Communications Admin				1.2	-	172	25	197	(197)
29	Public Relations outreach to National Media and P	32	43	24	1.8	-	247	546	794	(794)
30	Advocacy Comm on Legislative and Reg Issues	38	44	23	3.3	-	560	700	1,260	(1,260)
31	Graphic Design and Print Production				2.7	-	289	33	322	(322)
32	Marketing Research and Strategy				2.5	-	424	224	648	(648)
33	Public Digital Communications	31	41	37	5.7	-	584	276	860	(860)
34	Mktng and Comm Suppt for ADA Natl State and Lo	62	57	54	5.0	4	702	106	808	(804)
35	Member Digital Communications	39	33	40	8.0	-	821	589	1,410	(1,410)
36	Depreciation							1	1	(1)
37	Total Communications & Marketing				30.0	4	3,801	2,500	6,301	(6,297)

American Dental Association

2016 Budget Programs

Dollars in Thousands

Ref #	Program	Strategic Plan Rank			Number of Employees	Revenue	Operating Expense			Net Income Before Reserves
		NDC	CBG	B&F			Employees	Other	Total	
38	Council on AS Admin				1.9	-	240	261	500	(500)
39	Annual Meeting	4	4	16	11.1	9,767	1,247	6,468	7,715	2,053
40	Department of Continuing Education	11	10	32	1.3	340	152	111	263	77
41	Meeting Management				5.6	290	630	220	850	(560)
42	Video Studio	17	47	39	1.3	82	191	278	468	(387)
43	Depreciation							117	117	(117)
44	Total Conference Services and Continuing Education				21.0	10,478	2,460	7,454	9,914	564
45	Contingency Programs				0.0	-	-	1,000	1,000	(1,000)
46	Commission on CE Provider Recognition	58	53	33	1.7	289	199	63	262	28
47	JC-National Board Dental Exams	67	61	60	17.5	12,600	1,821	4,907	6,728	5,873
48	CODA(Accreditation)	57	62	59	10.1	3,453	1,021	964	1,985	1,468
49	Commission on DA Admin				5.0	-	539	403	942	(942)
50	JCNDE Admin				3.1	-	365	80	445	(445)
51	CCERP Admin				0.8	-	124	5	129	(129)
52	CDEL Admin				3.5	-	392	79	471	(471)
53	Library and ADA Archive Services	49	37	38	5.8	3	655	132	787	(785)
54	Dental Education and Licensure	56	54	35	1.3	2	156	29	185	(183)
55	Credential Verification Services	53	66	52	0.5	-	78	20	97	(97)
56	Dental Testing Services - Admission Testing	69	67	56	11.7	7,244	1,100	1,932	3,032	4,213
57	Dental Testing Services for Outside Clients	70	71	62	3.5	2,158	348	734	1,081	1,076
58	Intern'l Consulting for Dental Educ Programs	75	73	70	0.7	126	88	53	141	(15)
59	Total Education				65.0	25,875	6,884	9,400	16,284	9,591
60	Budget and Forecasting				3.6	-	593	54	647	(647)
61	Financial Reporting, Compliance, Treasury				5.4	-	705	39	744	(744)
62	Transaction Accounting				11.2	-	1,062	19	1,081	(1,081)
63	Association-Wide Governance and Volunteer Support				1.8	2,450	338	49	388	2,062
64	Purchasing/Mail/Shipping				6.1	35	528	75	603	(568)
65	Printing/Duplicating				3.5	-	309	-	309	(309)
66	HQ Building				0.4	2,648	70	5,390	5,460	(2,811)
67	Washington Building				0.1	1,683	20	1,145	1,165	518
68	Depreciation							854	854	(854)
69	Total Finance, Operations, and Buildings				32.0	6,816	3,625	7,625	11,250	(4,434)
70	Council CAPIR Admin				3.0	-	433	92	524	(524)
71	Council on Govt Affairs Admin				0.2	-	33	72	105	(105)
72	Washington Leadership Conference_	48	29	45	1.8	-	212	184	396	(396)
73	Advocacy Science, Educ, Approp, Well Issues	18	19	15	3.0	-	486	188	674	(674)
74	Advocacy for Dent Pract, Fed Dental Servcs	22	23	8	4.9	-	729	339	1,068	(1,068)
75	Advocacy Access, Dental Coverage	13	14	6	2.1	-	322	335	658	(658)
76	ADPAC Administration	30	25	55	3.3	10	404	262	666	(656)
77	Interprofessional Relations_	44	50	34	1.3	7	181	0	181	(174)
78	Lobbyist Conference	60	56	61	0.8	33	118	64	181	(149)
79	State Public Affairs Prog.	40	8	10	4.8	-	678	2,847	3,524	(3,524)
80	Access Comm Oral Health Infra&Capacity	26	21	13	1.7	-	268	215	482	(482)
81	Geriatrics and Special Needs	61	52	47	0.6	-	82	76	158	(158)
82	Fluoridation and Prevention	6	3	2	2.7	-	297	191	488	(488)
83	Total Government Affairs				30.0	50	4,242	4,864	9,106	(9,056)

American Dental Association

2016 Budget Programs

Dollars in Thousands

Ref #	Program	Strategic Plan Rank			Number of Employees	Revenue	Operating Expense			Net Income Before Reserves
		NDC	CBG	B&F			Employees	Other	Total	
84	Services to External Clients	72	68	68	1.5	206	188	-	188	18
85	Policy Research	43	49	14	8.9	-	1,167	894	2,061	(2,061)
86	Services to CODA	63	60	48	3.1	-	333	-	333	(333)
87	Services to ADA Divisions				1.5	-	195	-	195	(195)
88	Total Health Policy Institute				15.0	206	1,884	894	2,778	(2,572)
89	Benefits-HRIS				1.7	-	277	1	278	(278)
90	Employee Relations				1.6	-	299	110	409	(409)
91	Recruiting				1.5	-	221	299	520	(520)
92	Employee Development				1.1	-	276	388	663	(663)
93	Talent Management, Pay and Organizational Dev				1.2	-	175	67	241	(241)
94	Total Human Resources				7.0	-	1,248	864	2,112	(2,112)
95	Websites for National	51	58	26	4.3	-	602	407	1,009	(1,009)
96	Finance & Enterprise IT Support				10.7	-	1,447	538	1,986	(1,986)
97	Aptify for National				8.6	-	1,157	442	1,599	(1,599)
98	Infrastructure for National				14.9	-	1,826	1,034	2,860	(2,860)
99	Sharepoint and Reporting for National				4.9	-	623	386	1,009	(1,009)
100	Infrastructure for States and Locals	65	70	66	2.5	-	333	7	339	(339)
101	Sharepoint and Reporting for States and Locals	74	72	74	1.6	-	243	33	277	(277)
102	Aptify for States and Locals	59	63	72	5.8	-	725	515	1,240	(1,240)
103	Websites for States and Locals	68	69	67	1.9	-	233	208	441	(441)
104	Depreciation							2,121	2,121	(2,121)
105	Total Information Technology				55.0	-	7,189	5,690	12,879	(12,879)
106	Governance				3.8	-	681	705	1,386	(1,386)
107	Contracts				5.7	-	808	4	811	(811)
108	Litigation Management and Support				1.0	-	183	96	279	(279)
109	Legal Advice and Counsel-Int of Assoc.				4.0	48	763	209	972	(924)
110	Review and identif potential risk to Assoc				2.1	-	386	65	451	(451)
111	Total Legal Affairs				16.6	48	2,820	1,079	3,899	(3,851)
112	Council on MIRP Admin				1.5	-	241	58	299	(299)
113	Council on Membership Admin				2.2	-	264	82	346	(346)
114	Members Ins. & Retirement Programs	1	2	1	1.1	8,265	154	325	479	7,786
115	Diversity and Inclusion	55	55	46	0.5	50	68	140	208	(158)
116	Success Dental Student Program	25	24	50	0.5	150	59	107	166	(16)
117	New Dent Committee&New Dentist Prog	10	16	27	1.2	63	189	166	355	(291)
118	Member Service Cntr	33	38	21	12.1	-	1,042	7	1,049	(1,049)
119	Direct Member Outreach	36	45	43	0.0	-	-	30	30	(30)
120	Dental School Outreach	24	28	28	1.5	-	105	194	299	(299)
121	Outreach to non-ADA Associations	54	65	65	0.0	-	-	-	-	-
122	Membership Operations				13.2	55,284	1,640	560	2,200	53,085
123	Outreach to ADA State and Local Societies	22	27	42	11.0	103	1,522	649	2,170	(2,068)
124	Member Recrmt and Retention Mkt and Res	47	18	29	4.2	-	445	332	777	(777)
125	Total Member & Client Services				49.0	63,915	5,728	2,649	8,378	55,537

American Dental Association

2016 Budget Programs

Dollars in Thousands

Ref #	Program	Strategic Plan Rank			Number of Employees	Revenue	Operating Expense			Net Income Before Reserves
		NDC	CBG	B&F			Employees	Other	Total	
126	Quality Assessment & Improvement	42	46	57	2.8	-	384	41	426	(426)
127	Council on Dental Practice Admin				1.5	-	214	83	297	(297)
128	Council on Dental Benefits Admin				0.8	-	140	73	213	(213)
129	Dental Benefits & Third Party Issues	14	11	7	2.8	-	380	28	408	(408)
130	Practice Management Guidelines	16	20	20	2.6	15	369	120	489	(474)
131	Dental Informatics_	52	35	53	3.3	-	501	255	756	(756)
132	CDT Codes	20	17	4	2.8	-	385	47	432	(432)
133	ANSI and Standards Development	37	42	51	4.3	63	543	492	1,035	(972)
134	Center Profess Success (CPS)	45	12	31	4.3	85	535	334	869	(784)
135	Dental Practice Support	35	30	19	2.9	83	410	100	510	(428)
136	Depreciation							43	43	(43)
137	Total Practice Institute				28.0	246	3,863	1,616	5,479	(5,233)
138	Product Development & Sales	19	7	17	11.0	9,605	1,261	3,184	4,445	5,160
139	ADA News_	28	5	5	8.9	4,249	1,141	3,039	4,180	69
140	Digital Advertising_	50	48	63	7.0	2,293	906	436	1,342	951
141	JADA_	6	1	3	3.2	2,863	485	2,060	2,545	318
142	Total ADA Publishing				19.0	9,404	2,532	5,535	8,067	1,337
143	Council on SA Admin				2.3	-	275	89	364	(364)
144	Testing and Standards	41	34	30	4.7	-	549	183	732	(732)
145	Scientific Information	3	6	11	7.9	12	895	47	942	(930)
146	ADA Seal	12	15	12	3.7	732	445	259	705	27
147	Center Evidence Based Dentistry	8	13	18	5.9	146	764	462	1,226	(1,080)
148	Product Evaluation	9	8	9	9.8	-	1,104	210	1,314	(1,314)
149	Depreciation							59	59	(59)
150	Total Science Institute				34.0	890	4,033	1,309	5,342	(4,452)
151	Income Taxes									(1,500)
152	Transfer of Royalty to Reserves									(6,500)
153	Net Operating Surplus / (Deficit) after transfers				433.6	131,788	56,941	67,284	124,225	(437)

1 **Capital Expenditures and Reserve Funds**

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

- 2 1. **Operating Capital** spending to add, upgrade, or replace more common and short-lived fixed
3 assets. This category should include all items replaced within 5 years. A good example of this
4 would be the ongoing annual replacement of computer equipment which is done on a continuing
5 annual basis with 1/3 of all PC equipment turned over each year such that every computer at the
6 ADA is retired and replaced every 3 years. Operating Capital Spending is included as a line item
7 with detail support in the annual operating budget in Board Report 2.
8
- 9 2. **Reserve Capital** spending is a separate category of larger and much less frequent building repairs,
10 replacements, and renovations to ADA buildings. Such renovations will include the cost of tenant
11 improvements (TI) and related one-time costs to secure long term leases. Because this type of
12 major capital spending comes from a dedicated capital replacement reserve account, each actual
13 project must be reviewed and approved by the Finance Committee and Board. Costs of tenant
14 leasehold improvements must be justified as part of a complete capital authorization request (CAR)
15 in a Board report with appropriate economic analysis.

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

22 **Royalty Reserve Fund (Established in 2013):** House Resolution 84H-2013 and Board action created a
23 designated reserve funded by royalty revenue from the ADA Member Insurance Plans. Although these
24 funds were segregated from annual ADA operating budgets, House Resolution 84H-2013 also provided that
25 reserve funds would be available to build member value, long term dues and financial stabilization. As a
26 result, this budget also proposes spending up to \$1M for Board approved innovation products to drive
27 member value.

28 Innovation is a new idea leading to more effective products or benefits that better meet the existing or
29 emerging needs of ADA member dentists and potential member dentists. The current ADA development
30 cycle of new products or benefits must be accelerated to keep pace with a fast moving professional
31 dental market. In business, innovation is considered a necessary catalyst for growth. The most
32 significant long term threat to the ADA is the lack of member growth and innovation is an approach to
33 addressing that risk.

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American Dental Association		
Budget Depreciation and Capital Expenditures		
\$ 000		
	2015 Budget	2016 Budget
Depreciation/Amortization	\$6,424	\$6,613
Operating Capital Expenditures		
Division of Conferences and Continuing Education	(70)	(355)
Finance & Operations, Buildings	(507)	(1,178)
Information Technology	(1,385)	(2,962)
Total	(1,962)	(4,495)
Net-Contribution to Replacement Fund	(4,462)	(2,118)
Total Operating Capital + Contribution to Replacement Fund	(6,424)	(6,613)
Capital Replacement Fund		
Contributions	(4,462)	(2,118)
Replacement Fund Capital Expenditures		
Finance and Operations, Buildings	(4,067)	(4,362)
Replacement Fund Net Contributions Less Expenditures	\$ 395	\$ (2,244)
Total Capital Expenditures	\$ (6,029)	\$ (8,857)

2015 and 2016 are expected to be years of heavy investment in long term assets funded from the Capital Replacement Reserve Fund, largely due to spending required for new tenant leases in the ADA Headquarters Building and spending related to technology. In 2016, the withdrawals are in excess of the contributions largely because 2016 contributions are limited by operating capital expenditures on technology related projects. Although this avoids the need for special member dues assessments, the fund balance is not expected to grow much until the future years.

List of Capital Expenditures (Page 1 of 3)

List of 2016 Capital Expenditures by Division					
Thousands of Dollars					
Division Name: Conferences and Continuing Education					
	<u>Q1</u>	<u>Q2</u>	<u>Q3</u>	<u>Q4</u>	<u>2016</u>
Café, Dining Room Catering & China replacement		15			15
2nd Floor Conference Center upkeep furniture & soft goods		40			40
Auditorium Rennovation / Modernization			300		300
Total Division	0	55	300	0	355
Division Name: Information Technology					
	<u>Q1</u>	<u>Q2</u>	<u>Q3</u>	<u>Q4</u>	<u>2016</u>
Desktop Replacements (110)		132			132
Computer Monitors (150)				75	75
Network Printer Replacements				45	45
Network Servers				250	250
Network Upgrades				95	95
BOT Laptop Replacements (15)		29			29
Laptop Replacements (115)				219	219
ARCServe Backup Software Licenses				10	10
AV Upgrades (Lobby & 2nd Floor)			50		50
Telephone System Upgrade - Chicago			50		50
ADA Connect Upgrade to MS SharePoint 2013			225		225
ADA Publishing Aptify Upgrades			35		35
Aptify CODA/CERP Deployment			213		213
Aptify Continuing Education (CE)			25		25
Aptify DTS Upgrades			40		40
Aptify eCatalog for States & Local Societies			75		75
Aptify Mobile for Members Upgrade			40		40
ADABEI Buyers List Migration			25		25
Broadcast Email Solutions Deployments to States & Local Societies			76		76
CDA Aptify Integration Design			25		25
CPS Responsive Website Redesign			65		65
Digital Asset Management			225		225
MouthHealthy & MouthHealthy for Kids Responsive Website Redesign			65		65
National Credentialing System Upgrades			25		25
New Financial & HCM Systems - Phase I			525		525
Oral Pathologist Mobile Application Enhancements			41		41
Sitefinity Branded Templates Enhancements			282		282
Total Division	-	161	2,107	694	2,962

List of Capital Expenditures (Page 2 of 3)

List of 2016 Capital Expenditures by Division					
Thousands of Dollars					
Division Name: Finance & Operations					
	<u>Q1</u>	<u>Q2</u>	<u>Q3</u>	<u>Q4</u>	<u>2016</u>
Headquarters Building - Operating					
Emergency Lighting Rewiring in Stairwells	16				16
Fire Pump Replacement		61			61
2nd Floor DCMS Lighting Retrofit				32	32
Replace Lobby 65W Bulbs with LED Bulbs				16	16
Painting of Mechanical Rooms			47		47
Condensate Transfer Receiver Tanks 3rd & 23rd floors		63			63
3rd Floor Waterproofing				95	95
Recaulk Cooling Towers- Budgetary		50			50
Repair of Loading Dock & South Wall of Garage		38			38
Replace Hot Water Expansion Tank			40		40
Intall Light Weight Refractory on Rear Boiler Doors			35		35
Paint Canopy Metal on North side of building			30		30
DC Building - Operating					
HVAC-Penthouse Controls and Compressor/Air Balance	4	30	5		39
Fire Life Safety-Garage Supply Fans/Sprinkler Line	4	2	4		10
Plumbing-Buck Pumps, Sump Pumps, Main Control Valve, Air					
Comperssor, Cooling Tower Valve and controls	2	34	6	38	80
Common Area Stairwell & Machine Room	10		10		20
Central Serivces					
Furniture Replacement			100		100
Carpet, Science 4FL				28	28
Legal Private Office Remodel			250		250
Science VP New Private Office		25			25
Color Copier/Scanner	70				70
DC Building Equipment		33			33
Total Division	106	336	527	209	1,178

List of Capital Expenditures (Page 3 of 3)

List of 2016 Capital Expenditures by Division					
Thousands of Dollars					
	<u>Q1</u>	<u>Q2</u>	<u>Q3</u>	<u>Q4</u>	<u>2016</u>
Headquarters Building - From Capital Replacement Fund					
Switchgear Replacement		1,500			1,500
Upgrade 10th Floor Common Corridor & Restrooms	250				250
White Box Demo (14th Floor or other)		175			175
Common Corridors & Restrooms (on one floor)		250			250
Alliance of the ADA (Comm to be paid in 2015)	10				10
AADAE Boards			23		23
American Dental Society Anesthesiology			23		23
ADABEI (TI Only)				31	31
Tenant I			273		273
TenantJ		197			197
Tenant L			1,123		1,123
DC Building - From Capital Replacement Fund					
New Lease	117				117
New Lease		117			117
New Lease			117		117
Leasing Fees-New	28				28
Leasing Fees-New		28			28
Leasing Fees-New			28		28
Architectural & Construction Mgmt Fees	24	24	24		72
					-
Total Division	429	2,291	1,611	31	4,362
	<u>Q1</u>	<u>Q2</u>	<u>Q3</u>	<u>Q4</u>	<u>2016</u>
Total ADA Operating Capital	106	552	2,934	903	4,495
Total ADA Capital Replacement Fund	429	2,291	1,611	31	4,362
Grand Total - 2016 Capital Requests	535	2,843	4,545	934	8,857

2014 Results: Variances from 2014 Budget

ADA Operations				
2014 Variances from 2014 Budget				
\$ 000				
Revenue variances - Central Admin and FinOps/Buildings				
Membership dues	Unfavorable	Declining market share plus budgeted increase	(1,712)	
Royalty revenue	Favorable	ADABEI - better than expected	419	
Short-term investment earnings	Favorable	Better than expected - higher reserve balance	889	
Remainder of variances			(36)	(440)
Expense variances - Compensation, Travel, Depreciation, and Income Taxes				
Open positions	Favorable	Open positions	1,849	
Temporary help	Unfavorable	Fill open positions	(1,043)	
Pension expense	Favorable	Excess funding + high level investment returns within pension plan	6,404	
Group medical insurance	Favorable	Renegotiated contract	645	
401k employer expense	Favorable	Adjustment for overaccrual in prior years	797	
Remainder of variances			40	8,692
Division variances (without salaries/travel/depreciation - includes revenues)				
Contingency General	Favorable	Did not need all of the \$1 million budgeted	453	
Member and Client Services	Favorable	\$6.2 CMIRP royalties & increase to CMIRP expense reimbursement	6,738	
Product Development and Sales	Favorable	Stronger than budget product sales and CDT royalties	1,070	
ADA Publishing	Unfavorable	Advertising revenues and JADA supplements did not meet budget expectations	(893)	
Finance and Operations, Buildings	Favorable	Decrease in property tax estimates and lower costs due to fewer tenants	668	
Education	Favorable	Testing and accreditation revenues exceeded budget	1,492	
Remainder of variances			(155)	9,373

- 1 Note on pension expense variance: 2014 actual expense represents accrual basis costs including the impact of year end non cash
2 actuarial liability valuation net of 2014 actual pension investment returns which are not reliably predictable. 2016 budget pension cost
3 reflects actual cash funding of the pension plan.

Headquarters Building Valuation

The House adopted Resolution 69H-2002 (*Trans.*2002:372), directing that the estimated market value of the ADA headquarters building be included in Board Report 2. The two most likely uses of the ADA building by a purchaser would be as an office building or a conversion to a residential property. These are two very different uses and very different markets which yield different estimated valuations. Per discussion with real estate transaction professionals in Chicago, a rough estimate would be \$46.8 million. Related to this, the ADA's Washington DC Building at 1111 14th street NW has an estimated value of \$13.3 million.

These valuation estimates take current vacancies into consideration. These amounts represent gross selling price before any related sale and closing costs. Further, these valuations reflect current conditions in the local real estate market.

Ownership of the Chicago Headquarters building saves the ADA approximately \$4.5M in annual rent expense. The ADA currently occupies 151 thousand square feet in Chicago, for which local market rental rates are approximately \$30 per square foot.

1 **APPENDICIES:**

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Summaries by Division: Revenue, Expense, and Net Revenue/Expense

Appendices

American Dental Association Operations

Revenue Summary by Division

\$ 000

	2013 Actual	2014 Actual	2015 Budget	2016 Budget	2016 v 2014		2016 v 2015B	
					Fav / (Unfav)		Fav / (Unfav)	
					\$	%	\$	%
Contingency General	100	-	-	-	-	NA	-	NA
Administrative Services	14	13	-	12	(1)	-4.2%	12	NA
Human_Resources	-	-	-	-	-	NA	-	NA
Legal Affairs	60	51	70	48	(3)	-6.2%	(22)	-31.8%
Finance and Operations, Buildings	6,804	6,103	6,269	6,816	713	11.7%	548	8.7%
Central Administration	62,103	61,006	4,302	4,239	(56,766)	-93.1%	(63)	-1.5%
Information Technology	-	-	-	-	-	NA	-	NA
Education	20,155	22,112	25,247	25,875	3,763	17.0%	627	2.5%
ADA Publishing	9,574	9,088	9,064	9,404	316	3.5%	341	3.8%
Business Relations	351	523	383	-	(523)	-100.0%	(383)	-100.0%
Conferences and Continuing Education	10,078	9,436	11,752	10,478	1,042	11.0%	(1,274)	-10.8%
Product Development and Sales	9,618	9,610	9,366	9,605	(4)	0.0%	239	2.5%
Communications	144	228	354	4	(224)	-98.2%	(350)	-98.9%
Government & Public Affairs	256	115	126	50	(66)	-56.9%	(76)	-60.4%
Member and Client Services	8,906	8,945	67,709	63,915	54,970	614.5%	(3,793)	-5.6%
Practice Institute	349	454	353	246	(208)	-45.9%	(108)	-30.5%
Health Policy Institute	45	114	200	206	92	80.8%	6	3.0%
Science	684	756	882	890	134	17.8%	8	0.9%
Total ADA	129,241	128,553	136,077	131,788	3,235	2.5%	(4,289)	-3.2%

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American Dental Association Operations

Expense Summary by Division

\$ 000

	2013 Actual	2014 Actual	2015 Budget	2016 Budget	2016 v 2014		2016 v 2015B	
					Fav / (Unfav)		Fav / (Unfav)	
					\$	%	\$	%
Contingency General	893	466	1,000	1,000	(534)	-114.6%	-	0.0%
Administrative Services	6,614	6,967	7,024	7,201	(234)	-3.4%	(176)	-2.5%
Human Resources	1,854	2,196	2,021	2,112	85	3.8%	(91)	-4.5%
Legal Affairs	3,559	3,794	4,144	3,899	(105)	-2.8%	245	5.9%
Finance and Operations, Buildings	10,058	9,837	11,381	11,250	(1,414)	-14.4%	131	1.1%
Central Administration	9,557	2,294	7,683	8,966	(6,672)	-290.8%	(1,283)	-16.7%
Information Technology	9,387	11,645	12,851	12,879	(1,234)	-10.6%	(28)	-0.2%
Education	13,413	14,926	17,090	16,284	(1,358)	-9.1%	806	4.7%
ADA Publishing	8,713	9,170	8,182	8,095	1,075	11.7%	86	1.1%
Business Relations	1,313	1,402	1,483	826	576	41.1%	656	44.3%
Conferences and Continuing Education	8,009	8,071	10,412	9,914	(1,843)	-22.8%	498	4.8%
Product Development and Sales	4,033	4,418	4,222	4,417	1	0.0%	(195)	-4.6%
Communications	4,900	5,675	6,406	6,301	(626)	-11.0%	105	1.6%
Government & Public Affairs	8,469	8,898	9,145	9,106	(207)	-2.3%	39	0.4%
Member and Client Services	8,705	8,686	9,547	8,378	308	3.5%	1,170	12.3%
Practice Institute	3,849	4,929	5,611	5,479	(549)	-11.1%	133	2.4%
Health Policy Institute	2,329	2,763	3,272	2,778	(15)	-0.5%	495	15.1%
Science	4,852	5,069	5,498	5,342	(273)	-5.4%	156	2.8%
Total ADA	110,508	111,207	126,971	124,225	(13,018)	-11.7%	2,746	2.2%

American Dental Association Operations

Net Income

\$ 000

	2013	2014	2015	2016	2016 v 2014		2016 v 2015B	
	Actual	Actual	Budget	Budget	Fav / (Unfav)		Fav / (Unfav)	
					\$	%	\$	%
Contingency General	(793)	(466)	(1,000)	(1,000)	(534)	114.6%	-	0.0%
Administrative Services	(6,601)	(6,954)	(7,024)	(7,189)	(234)	3.4%	(164)	2.3%
Human Resources	(1,854)	(2,196)	(2,021)	(2,112)	85	-3.8%	(91)	4.5%
Legal Affairs	(3,500)	(3,743)	(4,074)	(3,851)	(108)	2.9%	223	-5.5%
Finance and Operations, Buildings	(3,254)	(3,733)	(5,112)	(4,434)	(701)	18.8%	678	-13.3%
Central Administration	52,546	58,712	(3,380)	(4,727)	(63,438)	-108.1%	(1,346)	39.8%
Information Technology	(9,387)	(11,645)	(12,851)	(12,879)	(1,234)	10.6%	(28)	0.2%
Education	6,742	7,185	8,157	9,591	2,405	33.5%	1,434	17.6%
ADA Publishing	861	(82)	882	1,309	1,391	-1699.2%	427	48.5%
Business Relations	(962)	(879)	(1,100)	(826)	53	-6.0%	273	-24.9%
Conferences and Continuing Education	2,069	1,365	1,340	564	(801)	-58.7%	(776)	-57.9%
Product Development and Sales	5,585	5,191	5,144	5,188	(3)	-0.1%	44	0.9%
Communications	(4,756)	(5,447)	(6,052)	(6,297)	(850)	15.6%	(245)	4.0%
Government & Public Affairs	(8,212)	(8,783)	(9,019)	(9,056)	(273)	3.1%	(37)	0.4%
Member and Client Services	201	260	58,161	55,537	55,278	21274.4%	(2,624)	-4.5%
Practice Institute	(3,499)	(4,476)	(5,258)	(5,233)	(758)	16.9%	25	-0.5%
Health Policy Institute	(2,284)	(2,649)	(3,072)	(2,572)	77	-2.9%	501	-16.3%
Science	(4,169)	(4,313)	(4,615)	(4,452)	(139)	3.2%	164	-3.5%
Total ADA	18,733	17,346	9,106	7,563	(9,783)	-56.4%	(1,543)	-16.9%
Income Taxes	1,817	1,435	1,300	1,500	(65)	-4.5%	(200)	-15.4%
Net Income Before Reserves	16,916	15,911	7,806	6,063	(9,848)	-61.9%	(1,743)	-22.3%
Add Back Depreciation	6,469	6,192	6,424	6,613				
Operating Capital Expenditures	(2,854)	(3,528)	(1,962)	(4,495)				
Transfers to Capital Reserve	(3,500)	(3,013)	(4,462)	(2,118)				
Transfers to Ins Royalty Reserve	(6,270)	(6,229)	(7,300)	(6,500)				
Non-Operating Items	(6,155)	(6,578)	(7,300)	(6,500)				
Operating Surplus / (Deficit)	10,761	9,334	506	(437)				

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Resolutions

(See Resolution 7; Worksheet:2045)
(See Resolution 8; Worksheet:2046)

Resolution No. 7 NewReport: Board Report 2 Date Submitted: August 2015Submitted By: Board of TrusteesReference Committee: A (Budget, Business and Administrative Matters)Total Net Financial Implication: \$131,788 (Revenue) Net Dues Impact: \$0
\$125,725 (Ongoing Expense)

Amount One-time Amount On-going FTE

ADA Strategic Plan Objective: Supports All Strategic Plan Objectives

How does this resolution increase member value: See Background

1 **APPROVAL OF 2016 BUDGET**

2 **Background:** (See Report 2 of the Board of Trustees to the House of Delegates: 2016 Budget,
3 Worksheet: 2002). The Board of Trustees is recommending a 2016 operating budget of \$131,788 in
4 revenues and \$125,725 in expenses and income taxes, generating a surplus before transfers to the
5 insurance royalty reserve of \$6,063. After transferring \$6,500 in royalty revenue to the insurance royalty
6 reserve the operating budget is a net deficit of \$(437). The royalty reserve is dedicated to member value,
7 long term dues and financial stabilization as directed by the House of Delegates Resolution 84H-2013
8 and Board action.

9

10 **Resolution**

11

12 **7. Resolved,** that the 2016 Annual Budget of revenues and expenses, including net capital
13 requirements be approved.

14 **BOARD RECOMMENDATION: Vote Yes.**15 **Vote: Resolution**

ASAI	Yes	DOW	Yes	JEFFERS	Yes	STEVENS	Yes
BITTER	Yes	FAIR	Yes	KWASNY	Yes	SUMMERHAYS	Yes
BUCKENHEIMER	Yes	GAMBA	No	ROBERTS	No	YONEMOTO	Yes
COLE	Yes	GEHANI	Yes	ROBINSON	Yes	ZENK	Yes
CROWLEY	Yes	ISRAELSON	Yes	SHENKIN	No	ZUST	Yes

Resolution No. 8 NewReport: Board Report 2 Date Submitted: August 2015Submitted By: Board of TrusteesReference Committee: A (Budget, Business and Administrative Matters)Total Net Financial Implication: None Net Dues Impact: _____Amount One-time _____ Amount On-going _____ FTE 0

ADA Strategic Plan Objective: Supports All Strategic Plan Objectives

How does this resolution increase member value: See Background

1 **ESTABLISHMENT OF DUES EFFECTIVE JANUARY 1, 2016**

2 **Background:** The Board of Trustees at its August 2015 meeting approved a preliminary budget with net
3 income before reserves of \$6,063 based on the current full dues rate of five hundred and twenty-two
4 dollars \$(522). After planned transfer of \$6,500 in Member Insurance royalties into a designated reserve
5 fund, the preliminary budget is at a net operating deficit of \$(437). A dues increase is not being sought.
6 Notification of the proposed dues level will be circulated electronically to all constituent dental societies
7 and announced in an official Association publication. The following resolution is submitted by the Board
8 of Trustees.

9 **Resolution**

10 **8. Resolved,** that the dues of ADA active members shall be five hundred twenty-two dollars
11 \$(522.00), effective January 1, 2016.

12 **BOARD RECOMMENDATION: Vote Yes.**

BOARD VOTE: UNANIMOUS.

Res. 8 (Bd. Rpt. 2)

Resolution No. None NewReport: Board Report 13 Date Submitted: October 2015Submitted By: Board of TrusteesReference Committee: A (Budget, Business and Administrative Matters)Total Net Financial Implication: None Net Dues Impact: Amount One-time Amount On-going FTE 0

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

How does this resolution increase member value: See Background

REPORT 13 OF THE BOARD OF TRUSTEES TO THE HOUSE OF DELEGATES: INFORMATION TECHNOLOGY INITIATIVES, EXPENDITURES AND ESTIMATED COSTS, AND ANTICIPATED FUTURE PROJECTS

Background: This report to the House of Delegates on the ADA's Information Technology initiatives, expenditures and future projects is submitted as required by Resolution 30H-2003 (*Trans.*2003:334), which urged the Board to provide an annual report summarizing technology initiatives, expenditures, estimated costs, anticipated projects and their sources of funding. This report is informational only; there are no resolutions.

Year 2015 Projects and Expenditures: As of this report, the following projects are completed and others are currently in the working stages with a completion goal by the end of the year.

- *Document Management (ADA Knowledge Center).* The Association implemented Open Text Livelink as its document management system in 2002. This system, which was branded "ADA FileWeb", allowed ADA staff to store and share documents. In 2013, an outside IT consulting firm was retained to assist staff with completing a planning effort, which included a project scope and budget to migrate away from Open Text Livelink to a Microsoft (MS) SharePoint solution. The project officially kicked-off in July 2014. The project was completed in March 2015, with all ADA divisions along with ADABEI and ADAF converted to the new ADA Knowledge Center. In 2016, work will begin on replacing the ADA Employee Intranet with a solution that integrates with the ADA Knowledge Center. The actual site creations and deployments will be completed by existing IT staff, which will help staff access information for members faster.
- *Data Warehouse.* In 2014, vendor demonstrations were conducted to select a replacement for the existing front-end software tool. Information Builders was the selected solution and was purchased for implementation in 2015. The software has been installed and work is underway to convert all existing reports to the new software. Business Objects, the existing back-end software tool is being upgraded in 2015. Any requests in 2015 and 2016 for new data marts or enhancements to existing data marts will be completed using existing IT staff. This product set will provide advanced analytics capabilities to our staff to analyze market trends and make more proactive decisions.
- *Websites.* In April 2014, a website reorganization project was completed to move ADA.org and all related microsites from OpenText RedDot to SiteCore, the ADA's new content management software solution. This website reorganization improves overall site navigation and content. The Evidence-Based Dentistry (EBD) website was also rewritten and updated as part of this project to address some underlying performance issues. In addition new mapping software was purchased

and implemented onto ADA.org to support the "Action for Dental Health" program by displaying maps overlaid with eight (8) data layers showing where Action for Dental Health initiatives have occurred. A redesign of the MouthHealthy.org homepage provides more opportunities for new and dynamic content to increase search engine optimization (SEO) and web traffic. A conversion was completed to move online JADA access from the previous hosted vendor, HighWire Press to Elsevier, the new hosted vendor. This conversion included moving all existing publications at HighWire Press to Elsevier as well as converting hard copies of JADA dating back to 1913 into electronic format so they could be made accessible to members via Elsevier. In 2015, a project is underway to implement a new search software called Coveo, which integrates with SiteCore and provides search functionality improvements for all ADA websites. In 2016, a project is scheduled to move the MouthHealthy.org and MouthHealthy for Kids.org websites to a responsive web design so that visitors can easily view these websites from any device, whether it be a phone, tablet or a full-sized computer. This redesign also helps future-proof the sites and brings them up to the same code base as all other ADA websites.

As part of the Power of 3 initiative, the ADA developed branded website templates to deploy to the states and local societies who were also converting from the Tripartite System (TS) to Aptify. These branded website templates integrate with Aptify. This integration allows member data entered into a web form to be captured into Aptify. The branded templates offer the states and locals a similar "look and feel" web presence, which gives visitors a similar web experience at the state, local and national level. 35 states and locals are scheduled to rollout in 2015 with another 152 state and locals in 2016. Enhancements to the branded website templates that were identified by state and local societies will be implemented in 2016.

- *Center for Professional Success.* On-going content updates occurred for The Center for Professional Success (CPS) throughout 2014, which included an online financial analyzer tool, The Benefit Plan Analyzer that launched in October. In 2015, any programming changes will be completed using existing IT staff. In 2016, the CPS website will be moved to a responsive web design for optimal viewing across devices. In addition, enhancement to the Oral Pathologist mobile application will be developed and implemented to allow sharing of information with business partners.
- *Mobility.* The CDT mobile app was updated to provide new, revised and changed CDT codes. The Toothflix Videos mobile application was expanded to include Spanish versions of the videos. The ADA is developing an Aptify Member Mobile portal to allow ADA members to access their information stored in Aptify from their smart phones and/or tablets. The app includes such functionality as updating their profile, registering for a meeting and paying dues. This mobile application is a new free member benefit. The development and implementation of this application will be completed in 2015. In 2016, the member mobile application will be updated to include new features and functionality to access CE videos; careers and classifieds including alerts for posting and retrieving information; and advocacy alerts and updates.
- *ADA Connect.* System support and updates for the MS SharePoint environment, which is the platform for ADA Connect continue in 2015. MS SharePoint Plug-in software will be purchased that expands the functionality and adds features that will improve document and process management in ADA Connect. A MS SharePoint 2013 upgrade is scheduled to be completed in 2016. This upgrade will use a design to build a new ADA Connect that addresses site improvements, design and enhancements. The upgrade will integrate ADA Connect and ADA Knowledge Center to ensure each maintains a secure environment while allowing the proper level of collaboration as appropriate.
- *PeopleSoft.* A project began in 2014 to convert PeopleSoft financial integrations to the ADA's new bank, JP Morgan Chase. This integration work was completed in early 2015. In 2015, a project is underway to begin researching a replacement for PeopleSoft Finance and HRMS.

1 Oracle has informed the ADA that they are eliminating their mid-sized PeopleSoft market and
2 replacing it with a product called Fusion.

- 3 • *Tripartite System.* The Tripartite System (TS) is scheduled to be shut down in April 2017. At this
4 time, all current TS users will have been converted to Aptify and the 2016 dues billing process will
5 have been completed.
- 6 • *Infrastructure, Hardware and Software Licenses.* The expenditures reflected in 2014, 2015 and
7 2016 are primarily for hardware and software licenses to maintain the Association's network
8 infrastructure as well as provide end-user equipment such as desktops, laptops and printers. In
9 addition, funding is budgeted annually for a manufacturer-certified on-site technician. As part of
10 the network server maintenance agreement, this technician is available on-site to fix hardware
11 under warranty instead of depending on "depot warranty service." This on-site service minimizes
12 downtime for users. In 2014, Microsoft SQL licenses were purchased to upgrade database
13 servers and Microsoft (MS) Office 2013 was purchased to upgrade end-user software tools such
14 as Word, Excel, PowerPoint and Outlook. An Acrobat Adobe software upgrade was purchased
15 and deployed to support the MS Office 2013 rollout. A pair of redundant CISCO switches were
16 implemented to support the new HP SAN (Storage Area Network) in order to store ADA
17 Knowledge Center SharePoint data. In 2015, upgrades were completed to the Boardroom's
18 audio-visual equipment as well as the voting and microphone queuing systems. Additional
19 upgrades on the 22nd Floor will be completed in 2015 for the Executive Conference Room, Video
20 Conference Room, Board Reception Room and the Executive Dining Room. A telephone system
21 upgrade is planned for Chicago to maintain software compliance. In 2015 and 2016, PCI
22 compliance and network security will continue to be monitored with security improvements
23 implemented as needed.
- 24 • *Aptify.* State deployments of Aptify began in 2014 and following states were converted: New
25 Hampshire, Virginia, Minnesota, Nevada, Indiana, North Carolina, Florida, Washington State,
26 Connecticut, Louisiana, Arizona, Idaho, Mississippi, Vermont, Kentucky and Washington DC. In
27 addition to the Aptify deployments, a Legislative module and Peer Review module were
28 developed and deployed in 2014. An online membership application was developed and
29 deployed in 2014, which integrates with Aptify and is accessed through ADA.org. Additional
30 Education licenses were purchased in 2014 to support the two separate Education environments
31 within Aptify. Aptify rollouts to the states continue in 2015 with a goal of 26 deployments by year
32 end. As of this report, Oregon, New Mexico, South Carolina, Iowa, Maine, Arkansas, Georgia,
33 Alaska, Colorado, Maryland, Missouri, Oklahoma, Montana, Illinois and Michigan have been
34 converted to Aptify. South Dakota, Texas, Wisconsin, Nebraska, New Jersey, Kansas, Puerto
35 Rico, Alabama, Wyoming and Utah are on the scheduled to be converted by year end. In
36 addition to the 2015 deployments, the Aptify Fund Raising and Grants Management modules are
37 being configured to deploy to the ADA Foundation. An integration between Aptify and Sitefinity
38 allows for website users to update profile information and register and pay for meetings with the
39 data maintained in Aptify. Aptify is also providing additional support to states and local societies
40 that have recently converted to help them get more comfortable with the new system and to
41 assist with billing dues for the first time using Aptify. This support will be handled by ADA IT staff
42 once the Aptify deployments are completed. In 2016, six deployments are scheduled for
43 Delaware, Hawaii, North Dakota Tennessee, Ohio and New York bringing the total to 47 states,
44 Puerto Rico and Washington DC. In addition to the remaining Aptify deployments, several Aptify
45 projects are scheduled to be completed in 2016. New features and functionality will be added to
46 Aptify to allow for subscription-type products to be sold via the eCatalog. An integration will be
47 designed between the ADA and California Dental Association (CDA), which allows the ADA and
48 CDA to share some data in each direction; significantly reduces errors by automating manual
49 processes and allows the ADA to recognize CDA members in a more timely fashion. An
50 eCatalog solution will be built for the states and local societies using Aptify to sell products and
51 services and to solicit donations using the existing product setup functionality within Aptify. This
52 initiative allows states and local societies to collect online voluntary dues (PAC, Foundation, etc.)

and to sell products to generate non-dues revenue. A broadcast email solution will be built for the states and local societies to create and send bulk email messages and to easily create and send newsletters. The existing CODA Accreditation database, CODA Consulting Training website and the CERP Online Provider Application will be replaced with an Aptify solution.

- *Aptify/Learning Management System.* A new CE module is being deployed to the states converting to Aptify in 2015 and will be deployed to the remaining states converting in 2016. In 2016, any system enhancements and fixes will be prioritized and implemented using existing IT staff with outside IT consulting services being retained to assist when needed.
- *Aptify/DTS Conversion.* In 2014, a new process was developed and implemented to import paper application files into Aptify and a system enhancement developed to transmit these files to Prometric, the vendor used by DTS for test development and test delivery. In addition, work began on migrating outdated custom software applications that manage the online application and payment processes from ADA.org to Aptify's eBusiness module. This migration will eliminate custom application support, reduce credit card fees and remove custom integrations. In 2015, system enhancements and fixes will be prioritized and implemented using existing IT staff with outside IT consulting services being retained to assist when needed. In 2016, outside IT consulting will be retained to assist with developing and implementing system upgrades that bring more functionality onto Aptify so that DTS staff can process transactions more efficiently resulting in better user experience for dentists and students. These upgrades will continue to transition the DTS staff from using multiple older systems and onto one core ADA application.

The table below outlines actual expenditures in the core areas in 2014; projected spending in 2015 and planned spending in 2016. Also disclosed is spending related to infrastructure hardware and major projects.

IT Core Area	2014 Actual Spending	2015 Projected Spending	2016 Planned Spending
FileWeb	15,600	0	0
ADA Knowledge Center	591,693	262,479	40,000
Data Warehouse	152,408	59,497	0
Websites	463,879	498,439	486,500
Branded Templates Design & Development (ADA Reserves)	23,700	0	
New Search Tool Implementation (ADA Contingency)	0	261,800	0
Ctr. for Professional Success (CPS)	34,667	0	140,000
Mobile Applications	29,455	88,074	70,000
ADA Connect	5,115	25,000	260,000
PeopleSoft (PS)	27,250	88,441	600,000
PS Integration to New Bank (ADA Contingency)	83,544	0	0
Hyperion Budgeting Plan Tool	14,220	91,280	63,000
Tripartite System	0	0	0
Infrastructure, Hardware & Software Licenses	1,130,318	1,440,704	1,095,000
Aptify	279,728	925,588	778,200
Aptify Rollouts (ADA Reserves)	495,492	0	0
ADA Catalog Enhancements (ADA Contingency)	175,000	0	0
Total Project Spending	3,522,069	3,741,302	3,532,700
Balance of IT Operating Budget	11,037,290	11,444,957	12,008,808

Total IT Spending	\$14,559,359	15,186,259	15,541,508
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The tables below summarize the previous information based on the source of funding. The IT division continues to maintain and upgrade its current core areas while also providing ongoing support and completing various IT-related projects for ADA divisions.

2014 Actual Spending	Operating Budget	Capital Budget	Contingency Fund	Reserves Fund	Total
FileWeb (1)	15,600	0	0	0	15,600
ADA Knowledge Center (2)	147,286	444,407	0	0	591,693
Data Warehouse (3)	0	152,408	0	0	152,408
Websites (4)	143,205	320,674	0	23,700	487,579
Ctr. for Professional Success (5)	0	34,667	0	0	34,667
Mobile Applications (6)	29,455	0	0	0	29,455
ADA Connect (7)	5,115	0	0	0	5,115
PeopleSoft (8)	12,325	14,925	83,544	0	110,794
Hyperion Budgeting Plan Tool (9)	14,220	0	0	0	14,220
Tripartite System	0	0	0	0	0
Infrastructure, Hardware & Software Licenses (10)	136,178	994,140	0	0	1,130,318
Aptify (11)	104,728	175,000	175,000	495,492	950,220
Total Project Spending	608,112	2,136,221	258,544	519,192	3,522,069
Balance of IT Operating Budget	11,037,290	0	0	0	11,037,290
Total IT Spending	\$11,645,402	\$2,136,221	\$258,544	\$519,192	\$14,559,359

2014 Consulting Projects	Operating Budget	Capital Budget	Total Actual Spending
FileWeb Upgrade & Support	15,600	0	15,600
FileWeb Totals (1)	15,600	0	15,600
ADA Knowledge Center Implementation	147,286	444,407	591,693
ADA Knowledge Center Totals (2)	147,286	444,407	591,693
Front-End Reporting Software	0	152,408	152,408
Data Warehouse (DW) Totals (3)	0	152,408	152,408
ADA.org Re-Organization	54,167	138,434	192,601
Mapping Software Implementation	8,250	13,140	21,390
SiteCore Content Management Support	23,898	0	23,898
JADA Conversion to Elsevier	56,890	0	56,890
Web Analytics Software Upgrade	0	9,000	9,000
MouthHealthy Homepage Redesign	0	7,500	7,500
Sitefinity Content Management Software for Branded Templates	0	152,600	152,600
Branded Templates Design & Development (ADA Reserves)	0	23,700	23,700
Websites Totals (4)	143,205	344,374	487,579
Oral Pathologist Mobile Application	0	0	0
Financial Analyzer Tool Implementation	0	34,667	34,667
CPS Totals (5)	0	34,667	34,667

Annual NDC Mobile Application	3,000	0	3,000
Symptom Checker (English & Spanish)	1,875	0	1,875
Find-A-Dentist Updates	1,875	0	1,875
CDT Code Check Updates	10,480	0	10,480
ADA Member Mobile Portal	12,225	0	12,225
Mobile Application Totals (6)	29,455	0	29,455
MS SharePoint support	5,115	0	5,115
ADA Connect Totals (7)	5,115	0	5,115
PS Integration to New Bank (ADA Contingency)	6,903	76,641	83,544
Talent Mgmt. Implementation	6,325	14,925	21,250
Talent Mgmt Support Services	6,000	0	6,000
PeopleSoft Totals (8)	19,228	91,566	110,794
Hyperion Plan Tool Support	14,220	0	14,220
Hyperion PlanTool Totals (9)	14,220	0	14,220
Tripartite System (TS) Totals	0	0	0
Warranty Technician	72,745	0	72,745
CISCO Switch implementation	6,000	0	6,000
Operating Software	57,433	0	57,433
Capital Hardware	0	547,182	547,182
Capital Software	0	336,492	336,492
Network Infrastructure	0	110,466	110,466
Infrastructure Totals (10)	136,178	994,140	1,130,318
Aptify Support	89,335	0	89,335
Aptify LMS for ADA HR	11,565	0	11,565
Aptify Training (FDA & WDSA)	3,828	0	3,828
Aptify EDUC licenses (DTS)	0	99,000	99,000
Legislative & Peer Review Modules	0	50,000	50,000
Online Membership Application	0	26,000	26,000
Aptify Rollouts (ADA Reserves)	495,492	0	495,492
ADA Catalog Enhancements (ADA Contingency)	52,500	122,500	175,000
Aptify Totals (11)	652,720	297,500	950,220
2014 Grand Totals	1,163,007	2,359,062	3,522,069

1

IT Core Area

2015 Projected Spending	Operating Budget	Capital Budget	Contingency Fund	Reserves Fund	Total
FileWeb	0	0	0	0	0
ADA Knowledge Center (1)	161,707	100,772	0	0	262,479
Data Warehouse (2)	12,941	46,556	0	0	59,497
Websites (3)	128,340	370,099	261,800	0	760,239
Ctr. for Professional Success	0	0	0	0	0
Mobile Applications (4)	21,615	66,459	0	0	88,074
ADA Connect (5)	10,000	15,000	0	0	25,000
PeopleSoft (6)	25,000	63,441	0	0	88,441
Tripartite System	0	0	0	0	0
Hyperion Budgeting PlanTool (7)	57,160	34,120	0	0	91,280
Infrastructure, Hardware & Software Licenses (8)	147,200	1,293,504	0	0	1,440,704
Aptify (9)	841,768	83,820	0	0	925,588
Total Project Spending	1,405,731	2,073,771	261,800	0	3,741,302
Balance of IT Operating Budget	11,444,957	0	0	0	11,444,957
Total IT Spending	\$12,850,688	\$2,073,771	\$261,800	\$0	15,186,259

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2015 Consulting Projects	Operating Budget	Capital Budget	Total Projected Spending
FileWeb Support	0	0	0
FileWeb Totals	0	0	0
ADA Knowledge Center Implementation	161,707	100,772	262,479
ADA Knowledge Center Totals (1)	161,707	100,772	262,479
Business Objects Data Integrator Software	0	13,897	13,897
Business Objects Software Upgrade	12,941	32,659	45,600
Data Warehouse (DW) Totals (2)	12,941	46,556	59,497
SiteCore Content Management support	15,000	0	15,000
Search Tool Implementation (ADA Contingency)	55,575	206,225	261,800
ADA Branded Templates for States & Locals	68,000	272,000	340,000
Sitefinity CMS for States & Locals	0	98,099	98,099
Sitefinity CMS support for States & Locals	45,340	0	45,340
Websites Totals (3)	183,915	576,324	760,239
CPS Totals	0	0	0
Ongoing Mobile Application support	5,000	0	5,000
Member Mobile Portal	16,615	66,459	83,074
Mobile Application Totals (4)	21,615	66,459	88,074
MS SharePoint support	10,000	0	10,000

MS SharePoint Plug-Ins	0	15,000	15,000
ADA Connect Totals (5)	10,000	15,000	25,000
PS Integration to New Bank (Phase 2)	0	48,000	48,000
DR Integration to PeopleSoft		15,441	15,441
PS Replacement Planning	25,000	0	25,000
PeopleSoft Totals (6)	25,000	63,441	88,441
Tripartite System (TS) Totals	0	0	0
Hyperion Plan Tool Support	30,000	0	30,000
Hyperion System Upgrade	27,160	34,120	61,280
Hyperion PlanTool Totals (7)	57,160	34,120	91,280
Warranty Technician	75,000	0	75,000
Network Security	15,000	0	15,000
Operating Software	50,000	0	50,000
Capital Hardware	0	512,000	512,000
Capital Software	0	10,000	10,000
Network Infrastructure	7,200	175,000	182,200
AV Upgrades on 22 nd Floor	0	496,504	496,504
Chicago Telephone System Upgrades	0	100,000	100,000
Infrastructure Totals (8)	147,200	1,293,504	1,440,704
Aptify Support	458,048	0	458,048
Aptify Accounting Assistance for States	68,400	0	68,400
Aptify Support (additional)	240,000	0	240,000
Aptify Fund Raising for ADAF	25,000	46,516	71,516
Aptify Grants Management for ADAF	25,000	37,304	62,304
Aptify Integration Design	25,320	0	25,320
Aptify Totals (9)	841,768	83,820	925,588
2015 Grand Totals	1,461,306	2,279,996	3,741,302

1

IT Core Area

2016 Planned Spending	Operating Budget	Capital Budget	Total
ADA FileWeb	0	0	0
ADA Knowledge Center (1)	40,000	0	40,000
Data Warehouse	0	0	0
Websites (2)	139,125	347,375	486,500
Ctr. for Professional Success (3)	33,750	106,250	140,000
Mobile Applications (4)	30,000	40,000	70,000
ADA Connect (5)	35,000	225,000	260,000
PeopleSoft (6)	75,000	525,000	600,000
Tripartite System	0	0	0
Hyperion Budgeting PlanTool (7))	63,000	0	63,000
Infrastructure, Hardware & Software Licenses (8)	140,000	955,000	1,095,000
Aptify (9)	314,500	463,700	778,200
Total Project Spending	870,375	2,662,325	3,732,700
Balance of IT Operating Budget	12 008 808	0	12,008,808
Total IT Spending	12,879,183	2,662,325	15,541,508

2

2016 Planned Consulting Projects	Operating Budget	Capital Budget	Total Planned Spending
FileWeb Support	0	0	0
FileWeb Totals	0	0	0
ADA Knowledge Center Support	15,000	0	15,000
Intranet Conversion Design	25,000	0	25,000
ADA Knowledge Center Totals (1)	40,000	0	40,000
Data Warehouse Totals	0	0	0
SiteCore Content Management support	25,000	0	25,000
MouthHealthy/MouthHealthy Kids Responsive Web Design	20,000	65,000	85,000
Branded Web Templates Enhancements	94,125	282,375	376,500
Website Totals (2)	139,125	347,375	486,500
CPS Responsive Web Design	20,000	65,000	85,000
Oral Pathologist Mobile App Updates	13,750	41,250	55,000
CPS Totals (3)	33,750	106,250	140,000
Ongoing Mobile Application support	20,000	0	20,000
Members Mobile Portal App Updates	10,000	40,000	50,000
Mobile Application Totals (4)	30,000	40,000	70,000
MS SharePoint support	10,000	0	10,000
ADA Connect Upgrade to MS SP 2013	25,000	225,000	250,000
ADA Connect Totals (5)	35,000	225,000	260,000
PeopleSoft Replacement	75,000	525,000	600,000
PeopleSoft Totals (6)	75,000	525,000	600,000

Tripartite System (TS) Totals	0	0	0
Hyperion Plan Tool Support	63,000	0	63,000
Hyperion PlanTool Totals (7)	63,000	0	63,000
Warranty Technician	75,000	0	75,000
Network Security	15,000	0	15,000
Operating Software	50,000	0	50,000
Capital Hardware	0	500,000	500,000
Capital Software	0	10,000	10,000
Network Infrastructure	0	345,000	345,000
AV Upgrades (Lobby & 2 nd Floor)		50,000	50,000
Chicago Telephone System Upgrades	0	50,000	50,000
Infrastructure Totals (8)	140,000	955,000	1,095,000
Aptify Rollout Support	190,000	0	190,000
Aptify eCatalog for States & Locals	25,000	75,000	100,000
Broadcast Email for States & Locals	12,000	76,200	88,200
Aptify Continuing Education (CE)	0	25,000	25,000
Aptify Updates for PUB Division	0	35,000	35,000
Aptify Integration with CDA	25,000	0	25,000
Aptify DTS Updates	0	40,000	40,000
Aptify CODA/CERP Implementation	62,500	212,500	275,000
Aptify Totals (9))	314,500	463,700	778,200
2016 Grand Totals	870,375	2,662,325	3,532,700

Resolutions

This report is informational and no resolutions are presented.

BOARD RECOMMENDATION: Vote Yes to Transmit.

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

Resolution No. None N/AReport: Board Report 14 Date Submitted: October 2015Submitted By: Board of TrusteesReference Committee: A (Budget, Business and Administrative Matters)Total Net Financial Implication: None Net Dues Impact: Amount One-time Amount On-going FTE 0

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

How does this resolution increase member value: See Background

REPORT 14 OF THE BOARD OF TRUSTEES TO THE HOUSE OF DELEGATES: ADA PENSION PLANS**Background:** This report is in response to House of Delegates Resolution 77H-2011 (*Trans.*2011:444).

Resolution 77H-2011 reads as follows:

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

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

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

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

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

- a. the accrual basis liability included in the ADA's 12/31/14 balance sheet (based on ASC 715 accounting rules), and
- b. the "cash basis" liability, percent funded status and funding requirements included in the ADA's 1/1/15 Adjusted Funding Target Attainment Percentage ["AFTAP"] Range Certification Report (based on ERISA calculation rules).

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

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

Accrual Basis Pension Liability (included in the ADA's 12/31/14 audited balance sheet): The following roll-forward analysis of the ADA's 12/31/14 balance sheet liability shows all the changes in the net accrual basis liability since the beginning of the year compared to prior periods.

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

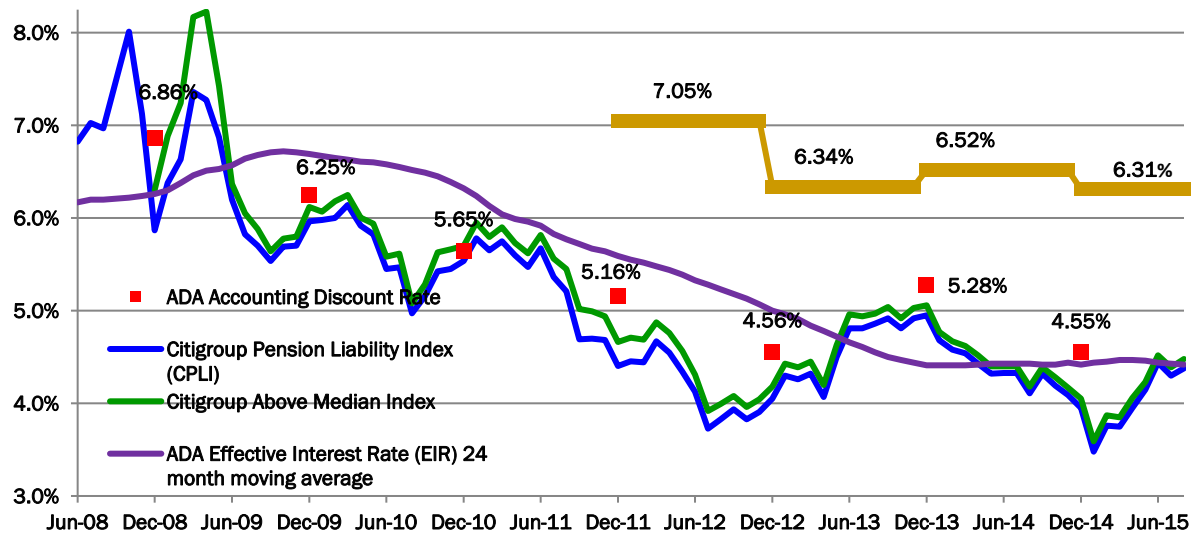
1. The ADA's contribution of cash to the plan assets which reduces the liability includes two parts:
 - a. The funding of "normal service" costs for current employees of the ADA who earn benefits during the plan year; and
 - b. The funding of supplemental payments to help get the plan to 100% funded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

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

The following historical roll-forward analysis chart shows a four year history of the pension plan. The results for fiscal year 2011 shows normal service costs under the old plan while years 2012 through 2014 present the actual results after plan changes. Beyond normal service costs and interest on the unfunded pension liability (i.e., Expected Obligation Increase), the biggest change to the accrual basis Net Pension Liability is the non-cash impact of the discount rate on the year-end valuation. For year-end 2012, discount rates dropped from 5.16% to 4.56%, which was offset by favorable investment performance. For year-end 2013, discount rates increased from 4.56% to 5.28% and the Plan experienced favorable investment performance. For year-end 2014, the liability increased due to a decrease in discount rates from 5.28% to 4.55%, updated mortality assumptions, and a one-time adjustment to reflect the impact of a change in IRS regulations. These increases were partially offset by favorable investment performance. So far in 2015, interest rates have been increasing while asset performance has been mixed. The impact of increasing "spot" interest rates has a big impact on the year-end valuations of future benefit liabilities but these are non-cash adjustments. For further reference, the rates used for accounting purposes, and approved by our auditors, are shown at the bottom of the chart for each year.

ADA Consolidated					
Pension Liability Analysis - Historical					
Millions of Dollars; Increase/(Decrease) in Liability					
	2011	2012	2013	2014	Notes
Beginning Balance, December 31 of prior year	48.8	51.1	56.8	29.0	Net liability, based on discount rate in effect at start of year less plan assets
Contributions (Cash):					Actual cash cost to ADA in each plan year
Normal Service Cost Funding	(5.2)	(1.7)	(1.8)	(2.0)	Based on Old Plan formula in 2011; New Plan formula for 2012 to 2014
Supplemental/Catch-up Funding of Prior Service	(7.6)	(4.6)	(4.4)	(5.1)	Required contributions of prior service costs on path to 100% status
Expected Obligation Increase	13.4	10.0	10.0	10.5	Service Cost (benefit accrual) and Interest Cost (interest on prior obligation).
Net Investment (Gains)/Losses	(2.0)	(16.7)	(15.5)	(13.0)	Actual plan investment results based on market values at each year end
Actuarial (Gain)/Loss	2.1	4.5	0.4	9.6	Impact of updated participant population, salaries and mortality assumptions
Reduction in Benefits	(8.9)	-	-	-	2011 reflects impact of change in Plan formula
Annual FAS 158 Actuarial Valuation Adjustment					
Discount Rate	10.0	14.1	(16.4)	18.2	Estimated non-cash impact of changing discount rate per accounting rules
Impact due to adjustment for application of IRS Regs				3.1	One-time adjustment to reflect the impact of a change in IRS regulations
Supplemental Benefit Trust	0.5	0.1	(0.1)	0.1	Net change in supplemental plan liability as reported
Ending Balance, December 31	51.1	56.8	29.0	50.4	Net Liability, based on discount rate in effect at end of year less plan assets
Discount Rate					
Beginning of Year	5.65%	5.16%	4.56%	5.28%	
End of Year	5.16%	4.56%	5.28%	4.55%	

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



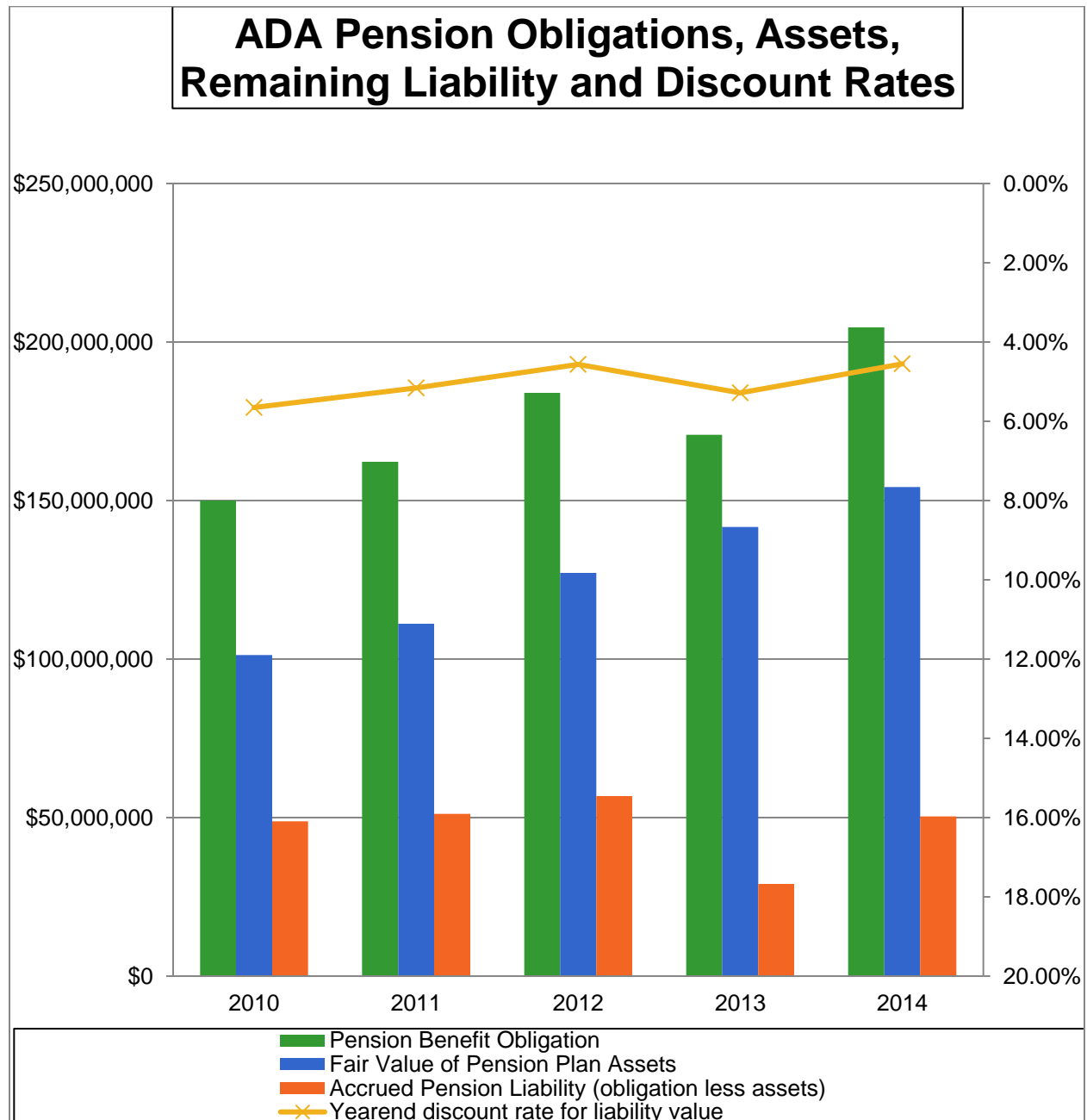
1

2 The "ADA Accounting Discount Rate" shown in this graph reflects the rates used for the year-end
 3 financial statements. The "ADA Effective Interest Rate (EIR)" is a 24 month moving average of rates
 4 published by the IRS which would typically apply to funding requirements. However, the "MAP-21 Rates",
 5 further modified by "HATFA", reflect higher rates based on a 25 year average to provide pension relief
 6 which reduced the Plan's funding requirements for 2012, 2013, 2014 and 2015.

7 The Citigroup Indexes are also included as an indicator of current interest rate trends. These rates were
 8 trending downward in 2014 resulting in a lower accounting rate at 12/31/14 than at 12/31/13. However,
 9 so far during 2015, these rates have been increasing.

10 The inverse relationship between interest rates and the valuation of the year-end pension liability can also
 11 be seen in the following multi-year graph that includes:

- 12 a) the gross pension obligation,
- 13 b) the pension plan asset balance,
- 14 c) the net ADA pension liability balance, and
- 15 d) the year-end discount rate used to value the pension liability.

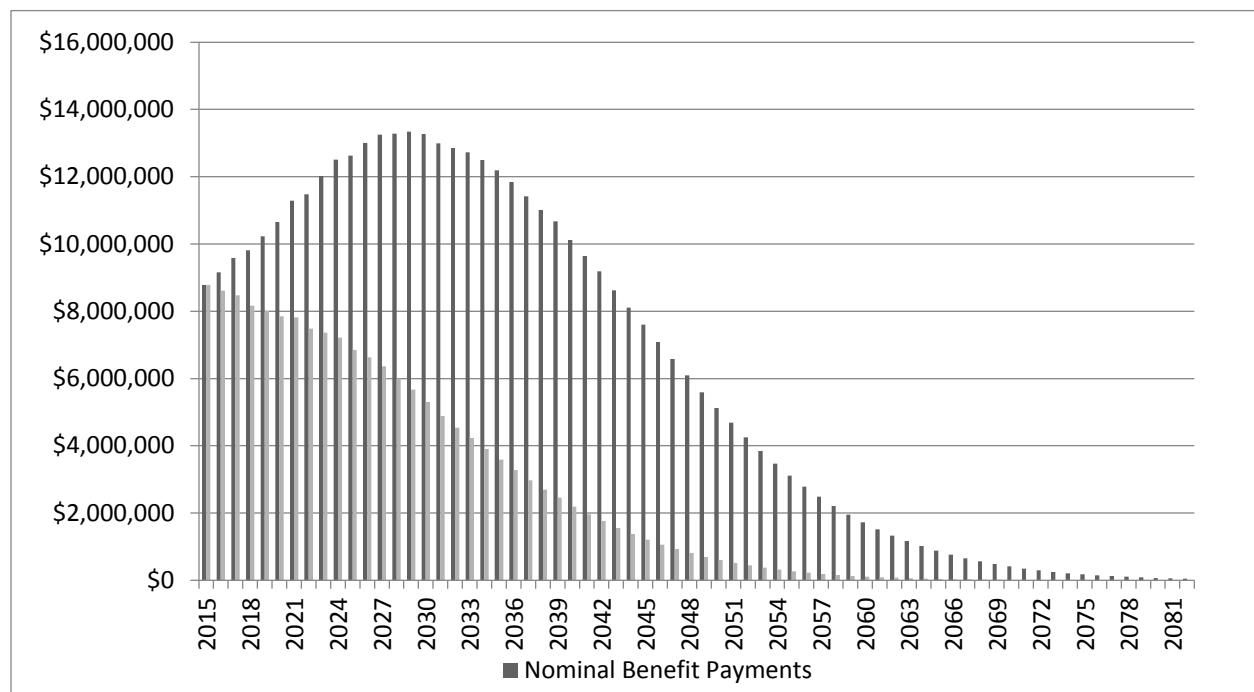


The line graph of the year-end discount rate is shown at the top of the chart with a separate vertical axis on the right side with "zero" at the top of the chart and higher rates extending downward. In this format, the chart shows the correlation between the changes in the discount rate and the liability balance. It should also be noted that this graph also shows the benefits of a consistent funding policy and investment results through the steady increase in plan assets.

Each year, the ADA's investment advisors review the pension benefit obligation in relation to the pension plan asset strategy to update investments. As part of this review, these advisors estimate the non-cash impact of interest rates on the "net" accrued pension liability. The latest estimates indicate that a 1% change in the year-end spot rates will result in an impact of \$23.8M on the liability with an offsetting

1 impact on the plan assets estimated at \$8.3M which combine to a total “net impact” of \$15.5M. Because
2 U.S. interest rates have remained at historical low values based on a Fed funds rate just above zero at
3 0.25%, this means that there is considerable potential for favorable valuation adjustments if and when
4 interest rates rise in the future.

5 It is important to note that although the use of year end “spot rates” determines the value of the liabilities
6 for accounting purposes at year end, and while lower rates can also drive higher contribution rates to plan
7 assets, it is the actual cash payout of the retirement benefits that will only happen over many decades
8 that represents the true economic cost of the plan. Cash contributed to the plan to fund future benefits
9 stays in the plan until those benefits are paid. And the actual payout of the 12/31/14 pension plan liability
10 through monthly benefits to retirees will only happen over the next 30 to 40 years with the final payment
11 expected in the year 2081. The following graph shows these expected annual payments to plan
12 participants from plan assets:



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

17 **Pension Relief:** Because so many actuaries for large pension plans questioned the use of “spot rates” to
18 value pension liabilities and lobbied legislators to use a longer 25 year average interest rate to calculate
19 the requirements for cash contributions to pension plans, “pension relief” was passed under MAP-21 in
20 2012 to reduce the short-term funding burden on pension plan sponsors caused by the current, low
21 interest rate environment. This “pension relief” was further modified by HATFA in 2014.

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

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

American Dental Association									
Employees' Retirement Trust									
Adjusted Funding Target Attainment Percentage ("AFTAP") Funding Status									
as of January 1, 2015 (valuation date)									
(\$000s)	Year End 2011		Year End 2012		Year End 2013 ¹		Year End 2014		
	amount	%	amount	%	amount	%	amount	%	
AFTAP Net Effective Interest Rate	7.05%		6.35%		6.52%		6.31%		
Cash Basis Target Liability (= 100% status)	\$ 131,580	100.0%	\$ 146,710	100.0%	\$ 147,812	100.0%	\$ 159,408	100.0%	
Less: Plan Assets	(112,255)	85.3%	(127,125)	86.7%	(148,591)	100.5%	(154,676)	97.0%	
Net AFTAP Report Unfunded Plan Liability	\$ 19,325	14.7%	\$ 19,585	13.3%	\$ (779)	-0.5%	\$ 4,732	3.0%	
¹ Revised from prior report reflect HATFA									

2
3

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

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

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

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

17 Board changes to retirement benefit plans helped reduce total pension liabilities by \$8.9 million at
18 12/31/11 (all plan changes actually account for \$21.8 million of direct reduction which was partially offset
19 by the impact of interest and investment).

20 In addition, the significant cut in pension plan benefits reduced "normal" pension costs, for 1 year of
21 service, from \$5.2 million in 2011 to \$1.7 million in 2012 to \$1.8 million in 2013 and to \$2.0 in 2014.

22 Although the historic low "point in time" interest rates at year end (in conjunction with mortality
23 improvements) have resulted in higher pension liability valuations, expected long term higher interest
24 rates will turn this liability into an asset in the future. Pension relief intended to reduce the funding
25 burdens on pension plan sponsors caused by the current, low interest rate environment was signed into
26 law in 2012 as part of the MAP-21 Act and further modified by HATFA in 2014 is expected to reduce ADA
27 contributions.

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

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

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

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

9 **Resolutions**

10 This report is informational and no resolutions are presented.

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

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

Dental Benefits, Practice and Related Matters

Resolution No. 9 NewReport: N/A Date Submitted: August 2015Submitted By: Council on Dental Benefit ProgramsReference Committee: B (Dental Benefits, Practice and Related Matters)Total Net Financial Implication: None Net Dues Impact: _____Amount One-time _____ Amount On-going _____ FTE 0

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

How does this resolution increase member value: See Background

1 RESCISSION OF POLICY, DENTAL PROCEDURE CODE CHANGES**2 Background:** (*Reports:* 34)

3 Rescission of Policy, Dental Procedure Code Changes: The Council reviewed all policies related to
4 identification of procedure codes on Explanation of Benefits (EOB) and found this policy to be duplicative
5 and redundant. The Council recommends rescission of this policy.

6 Resolution

7 9. Resolved, that the ADA policy, “Dental Procedure Code Changes” (*Trans.*2001:433) be
8 rescinded.
9

10 BOARD RECOMMENDATION: Vote Yes.**11 BOARD VOTE: UNANIMOUS. (BOARD OF TRUSTEES CONSENT CALENDAR—NO BOARD
12 DISCUSSION)****13** Resolution 9**14**

1 **WORKSHEET ADDENDUM**

2
3 **POLICY TO BE RESCINDED**

4 **Dental Procedure Code Changes** (*Trans.2001:433*)

5 **Resolved**, that when a third-party payer, or any other entity adjudicating a dental claim, changes the
6 submitted dental procedure code for internal processing purposes, all outgoing transactions, including
7 EOBs, should show the originally submitted dental procedure code to prevent the dentist and the
8 dental plan from having inconsistent records of the treatment rendered.

Resolution No. 10 NewReport: N/A Date Submitted: August 2015Submitted By: Council on Dental Benefit ProgramsReference Committee: B (Dental Benefits, Practice and Related Matters)Total Net Financial Implication: None Net Dues Impact: _____Amount One-time _____ Amount On-going _____ FTE 0

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

How does this resolution increase member value: See Background

REVISION OF POLICY, EXPLANATION OF BENEFITS (EOB) STATEMENT AND IDENTIFICATION OF CLAIMS REVIEWERS**Background:** (*Reports: 34*)**Revision of Policy, Explanation of Benefits (EOB) Statement and Identification of Claims**

Reviewers: Payers limit reimbursement for certain services using tactics such as bundling, downcoding and least expensive alternative treatment (LEAT) clauses. While the ADA opposes such practices, current ADA policies stipulate that the EOB statement include the CDT codes for the services rendered by the dentist, as well as the CDT code against which the benefit was determined.

Since claims data is used for utilization management and frequency limit determinations, some payers are placing frequency limits based on codes used to determine benefits rather than based on actual services rendered and reported. For example, if a dentist reported a combination of periapical and bitewing radiographs and the payer determined the benefit against CDT Code D0210 (intraoral--complete series of radiographic images), the patient is then limited from receiving a benefit for a full mouth series for the time period stipulated in the plan's policies. The proposed revisions to this policy address this issue by stating the ADA position requiring payers to include a statement on the EOB indicating how the submitted service was adjudicated rather than including an alternate procedure code (which the dentist did not provide) within the list of rendered services on the EOB.

Resolution

10. Resolved, that the ADA policy, Explanation of Benefits (EOB) Statement and Identification of Claims Reviewers (*Trans.1995:610*), be amended as follows (additions are underscored; deletions are ~~stricken~~):

Resolved, that in all communications from a third-party payer or other benefits administrator which attempt to explain the reason(s) for a benefit reduction or denial to beneficiaries of a dental benefits plan, the following statement be included:

Any difference between the fee charged and the benefit paid is due to limitations in your dental benefits contract. Please refer to (*insert pertinent provisions of summary plan description*) of your summary plan description for an explanation of the specific policy provisions which limit or exclude coverage for the claim submitted.

and be it further

1 **Resolved**, that in reporting the benefit determination to the beneficiary, the following information
2 be reported on the explanation of benefits statement:

- 3 1. the treatment reported on the submitted claim by CDT ADA procedure codes as
4 submitted by the dentist numbers and nomenclature; and
5 2. ~~the ADA procedure code numbers and nomenclature on which benefits were determined~~
6 a statement indicating how the submitted procedures were adjudicated.

7 and be it further

8 **Resolved**, that if EOB statements list CDT codes on which benefits were determined that are
9 different from what was submitted by the treating dentist then payers should not use the code
10 applied for adjudication to limit the frequency of that procedure, and be it further

11 **Resolved**, that in all correspondence between a third-party carrier and the patient regarding the
12 patient's dental claims, the carrier should provide the name, area code and telephone number of
13 the individual who is acting on behalf of the carrier, and be it further

14 **Resolved**, that the Council on Dental Benefit Programs work with third-party payers, plan
15 purchasers, benefits consultants, and government agencies to implement this policy.

16 **BOARD RECOMMENDATION: Vote Yes.**

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

Resolution No. 11 NewReport: N/A Date Submitted: August 2015Submitted By: Council on Dental Benefit ProgramsReference Committee: B (Dental Benefits, Practice and Related Matters)Total Net Financial Implication: None Net Dues Impact: _____Amount One-time _____ Amount On-going _____ FTE 0

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

How does this resolution increase member value: See Background

REVISION OF POLICY, BULK BENEFIT PAYMENT STATEMENTS**Background:** (*Report: 35*)

Revision of Policy, Bulk Benefit Payment Statements: In the interest of facilitating efficient settlement of patients' accounts, individual claim amounts should be adjusted for any secondary plan payment when the bulk payment is made for the coordinated amount. The proposed revisions address this issue.

Further, payers limit reimbursement for certain services using tactics such as bundling, downcoding and least expensive alternative treatment (LEAT) clauses. While the ADA opposes such practices, current ADA policies stipulate that the Explanation of Benefits (EOB) statement include the Code on Dental Nomenclature (CDT) for the services rendered by the dentist, as well as the CDT code against which the benefit was determined.

Since claims data is used for utilization management and frequency limit determinations, some payers are placing frequency limits based on codes used to determine benefits rather than based on actual services rendered and reported. For example, if a dentist reported a combination of periapical and bitewing radiographs and the payer determined the benefit against CDT Code D0210 (intraoral--complete series of radiographic images), the patient is then limited from receiving a benefit for a full mouth series for the time period stipulated in the plan's policies. The proposed revisions to this policy address this issue by stating the ADA position requiring payers to include a statement on the EOB indicating how the submitted service was adjudicated rather than including an alternate procedure code (which was not provided by the dentist) within the list of rendered services on the EOB.

Resolution

11. Resolved, that the ADA policy, Bulk Benefit Payment Statements (*Trans.*1990:536; 2013:308), be amended as follows (additions are underscored; deletions are ~~stricken~~):

Resolved, that ~~although~~ the ADA goes on record as being opposed to bulk payments by a third party payer, in the interest of facilitating prompt settlement of patients' accounts, bulk benefit payments may be made by a third-party but should include a statement containing, at a minimum, the following information for each claim payment represented in the bulk payment:

1. Subscriber (employee) name
2. Patient name
3. Dates of service
4. Specific service reported on the submitted claim, by *CDT Code* number and nomenclature

5. Total fee charged

6. Statement indicating how the submitted procedures were adjudicated ~~Specific CDT Code number and nomenclature on which benefits were determined~~

7. Total covered expense

8. Total benefits paid, ~~and~~

9. In instances where benefits are reduced or denied, an explanation of the reason(s) why the total covered expense differs from the total fee charged, consistent with Association policy on Explanation of Benefits Statements, ~~and~~

10. If the bulk payment amount on the EOB reflects the final amount paid to the dentist, taking into account any secondary plan payment, then the individual claim amounts should also be adjusted appropriately to avoid discrepancy between the individual claim amounts listed on the EOB and the bulk payment amount.

and be it further

Resolved, that ~~insurance companies'~~ third-party payers should not withhold funds from current bulk benefit payments as a means of settling disputes over prior claims experience with the dentist or another dental office and that ~~constituent state~~ dental societies be encouraged to seek legislation to resolve this problem, and be it further

Resolved, that bulk payments should be issued to dentists at intervals of not longer than every ten business days, and be it further

Resolved, that the Council on Dental Benefit Programs work with the insurance industry and ~~dental service plans~~ third-party payers to incorporate this policy into their administrative procedures.

BOARD RECOMMENDATION: Vote Yes.

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

Resolution No. 12 NewReport: N/A Date Submitted: August 2015Submitted By: Council on Dental Benefit ProgramsReference Committee: B (Dental Benefits, Practice and Related Matters)Total Net Financial Implication: None Net Dues Impact: Amount One-time Amount On-going FTE 0

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

How does this resolution increase member value: See Background

1 MEDICAL LOSS RATIO**2 Background: (Report: 36)**

3 Resolution on Medical Loss Ratio: The Affordable Care Act (ACA) requires health insurance issuers to
 4 submit data on the proportion of premium revenues spent on clinical services and quality improvement,
 5 also known as the Medical Loss Ratio (MLR). It also requires these plans to issue rebates to enrollees if
 6 this percentage does not meet minimum standards (i.e. at least 80% or 85% of premium dollars to be
 7 spent on medical care). Dental plans are generally exempt from MLR reporting stipulated in the ACA. In
 8 general, the medical threshold for loss ratio cannot be directly applied to dental plans and, at present, it is
 9 difficult to determine the threshold for any universal dental plan loss ratio.

10 California recently passed legislation that requires dental plans that issue, sell, renew, or offer specialized
 11 dental health care service plan contracts to file a report, to be known as the MLR annual report. Through
 12 this legislation, California lawmakers also declared their intent that the data reported pursuant to these
 13 provisions will be considered in adopting a specific medical loss ratio standard for dental plans. The state
 14 of Washington has passed similar legislation regarding the reporting of information.

15 Key aspects included within the legislation are as follows:

- 16 • A dental plan shall file an annual report which shall be known as the MLR annual report. It will be
 17 filed with the state insurance commissioner and will contain the same information required in the
 18 2013 federal MLR Annual Reporting Form (CMS-10418)¹.
- 19 • The MLR reporting year shall be for the calendar year during which dental coverage is provided
 20 by the plan. All terms used in the MLR annual report shall have the same meaning as used in the
 21 federal Public Health Service Act (42 U.S.C. Sec. 300gg-18), Part 158 (commencing with
 22 158.101) of Title 45 of the Code of Federal Regulations, and Section 1367.00.
- 23 • If the state decides to conduct a financial examination, as described in Section 1382, because the
 24 state finds it necessary to verify the dental plan's representations in the MLR annual report, the
 25 state shall provide the plan with a notification 30 days before the commencement of the financial
 26 examination.

¹ Note that California is working on adapting this form for stand-alone dental plans.

- 1 • The dental plan shall have 30 days from the date of notification to electronically submit to the
2 state all requested records, books and papers. The state may extend the time for the plan to
3 comply with this subdivision upon a finding of good cause.
- 4 • The state shall make available to the public all of the data provided to the state pursuant to this
5 Section.
- 6 • This section does not apply to a dental plan contract for coverage provided in the state's Medicaid
7 or other public programs to the extent consistent with the federal Patient Protection and
8 Affordable Care Act (Public Law 111-148).

9 These laws stipulate that dental plans should be held accountable for paying claims in a fair and
10 consistent manner. Appropriate premium dollars should be paid to beneficiaries for clinical services and
11 quality improvement and not used for excessive administrative services and company profits.

12 Resolution

13 **12. Resolved**, that the ADA supports the concept of a "Medical Loss Ratio" for dental plans
14 defined as the proportion of premium revenues spent on clinical services and quality
15 improvement versus administrative services and company profits, and be it further

16 **Resolved**, that the ADA support legislative efforts to require dental benefit plans to file a
17 comprehensive MLR report annually and to establish a specific loss ratio for dental plans in each
18 state.

19 **BOARD RECOMMENDATION: Vote Yes.**

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

22 Resolution 12

Resolution No. 45 NewReport: Council on Dental Practice Supplemental Report 1 Date Submitted: August 2015Submitted By: Council on Dental PracticeReference Committee: B (Dental Benefits, Practice and Related Matters)Total Net Financial Implication: None Net Dues Impact: _____Amount One-time _____ Amount On-going _____ FTE 0

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

How does this resolution increase member value: See Background

**COUNCIL ON DENTAL PRACTICE SUPPLEMENTAL REPORT 1 TO THE HOUSE OF DELEGATES:
COMPREHENSIVE ADA POLICY STATEMENT ON TELEDENTISTRY**

Background: The 2012 House of Delegates adopted policy, Teledentistry (*Trans.*2012:455), that defined teledentistry and encouraged the use of Digital Imaging and Communications in Medicine (DICOM) standards when selecting an imaging system. The ADA's current policy on teledentistry is as follows:

Resolved, that the following definition of teledentistry be adopted:

Teledentistry, a component of telehealth, is the electronic exchange of dental patient information from one geographic location to another for interpretation and/or consultation among authorized healthcare professionals. Teledentistry utilizes both information and communication technologies and includes the electronic exchange of diagnostic image files, including radiographs, photographs, video, optical impressions and photomicrographs of patients.

and be it further

Resolved, that dentists should be encouraged to consider conformance with the Digital Imaging and Communications in Medicine (DICOM) standards when selecting and using imaging systems, and be it further

Resolved, that the appropriate ADA agencies develop standards and implementation guidelines to assist dentists with all aspects of teledentistry.

Following the 2012 House, the Council on Dental Practice (CDP) requested that appropriate standards and implementation guidelines be developed by the Standards Committee on Dental Informatics (SCDI). Standards relevant to the use of teledentistry (Appendix 1) were identified.

Since the technical aspects of teledentistry were already in place, CDP then turned its focus to developing a comprehensive policy on teledentistry that would assist members and the profession in the delivery of teledental services. The Council discussed numerous related topics including: ways in which teledentistry was likely to impact the delivery of care; its possible effects on the patient/provider relationship; which members of the dental team should be authorized to provide or oversee teledental

services; which types of services could be provided; and how teledental services would be coded for reimbursement.

CDP focused its efforts on the issues of licensure, reimbursement and workforce and reviewed current literature and relevant policies of other healthcare associations. CDP members noted that there was no mechanism to address coding and third-party coverage of teledentistry activities and learned that the Council on Dental Benefit Program's Coding Subcommittee had not received any formal requests to develop teledentistry codes and that third-party payers did not support the use of modifiers to indicate treatment provided via teledentistry. There was discussion regarding the differences in state regulations and dental practice acts and the possibility that dentistry could be integrated into the federal telehealth systems through efforts to promote the national licensure of physicians. There is also the possibility that the Centers for Medicare and Medicaid Services' could seek to enroll health care providers as a requirement for receiving reimbursement for treatment provided.

CDP agreed that it was important to involve other councils whose activities and *Bylaws* responsibilities were relevant to the topic in order to ensure that the recommended policy would appropriately address issues of concern to other ADA councils. CDP worked with representatives of the Council on Access, Prevention and Interprofessional Relations, the Council on Dental Benefit Programs, the Council on Dental Education and Licensure, the Council on Dental Practice, the Council on Ethics, Bylaws and Judicial Affairs, and the Council on Government Affairs. After the draft policy was developed, council representatives shared the proposed policy with their councils and provided feedback to CDP. The proposed policy statement was revised to incorporate suggestions received from the councils.

As the use of teledental services becomes more widespread, policy on its use is essential for both individual dentists and policymakers. Therefore, the Council recommends adoption of the following resolution.

Resolution

45. Resolved, that the Comprehensive ADA Policy Statement on Teledentistry be adopted.
and be it further

Resolved, that ADA policy on Teledentistry (*Trans.*2012:455) be rescinded.

Comprehensive ADA Policy Statement on Teledentistry

Teledentistry refers to the use of telehealth systems and methodologies in dentistry. Telehealth refers to a broad variety of technologies and tactics to deliver virtual medical, health, and education services. Telehealth is not a specific service, but a collection of means to enhance care and education delivery.

Teledentistry can include patient care and education delivery using, but not limited to, the following modalities:

- Live video (synchronous): Live, two-way interaction between a person (patient, caregiver, or provider) and a provider using audiovisual telecommunications technology.
- Store-and-forward (asynchronous): Transmission of recorded health information (for example, radiographs, photographs, video, digital impressions and photomicrographs of patients) through a secure electronic communications system to a practitioner, who uses the information to evaluate a patient's condition or render a service outside of a real-time or live interaction.

- Remote patient monitoring (RPM): Personal health and medical data collection from an individual in one location via electronic communication technologies, which is transmitted to a provider (sometimes via a data processing service) in a different location for use in care and related support of care.
- Mobile health (mHealth): Health care and public health practice and education supported by mobile communication devices such as cell phones, tablet computers, and personal digital assistants (PDA):

General Considerations: The treatment of patients who receive services via teledentistry must be properly documented and should include providing the patient with a summary of services. Dentists who deliver services using teledentistry must establish protocols for appropriate referrals when necessary.

Patients' Rights: Dental patients whose care is rendered or coordinated using teledentistry modalities have the right to expect:

1. That any dentist delivering services using teledentistry technologies will be licensed in the state where the patient receives services, or be providing these services as otherwise authorized by that state's dental board.
2. Access to the licensure and board certification qualifications of the oral health care practitioner who is providing the care in advance of the visit.
3. That the delivery of services through teledentistry technologies will follow evidence-based practice guidelines, to the degree they are available, as a means of ensuring patient safety, quality of care and positive health outcomes.
4. That they will be informed about the identity of the providers collecting or evaluating their information or providing treatment, and of any costs they will be responsible for in advance of the delivery of services.
5. That relevant patient information will be collected prior to performing services using teledentistry technologies and methods including medical, dental, and social history, and other relevant demographic and personal information.
6. That the provision of services using teledentistry technologies will be properly documented and the records and documentation collected will be provided to the patient upon their request.
7. That services provided using teledentistry technologies and methods include care coordination as a part of a dental home and that the patient's records be made available to any entity that is serving as the patient's dental home.
8. That the patient will be actively involved in treatment decisions, will be able to choose how they receive a covered service, including considerations for urgency, convenience and satisfaction and without such penalties as higher deductibles, co-payments or coinsurance relative to that of in-person services.
9. That the delivery of services using teledentistry technologies are performed in accordance with applicable laws and regulations addressing the privacy and security of patients' private health information.

Quality of Care: The dentist is responsible for, and retains the authority for ensuring, the safety and quality of services provided to patients using teledentistry technologies and methods. Services delivered via teledentistry should be consistent with in-person services, and the delivery of services utilizing these modalities must abide by laws addressing privacy and security of a patient's dental/medical information.

Supervision of Allied Dental Personnel: The extent of the supervision of allied dental personnel should conform to the applicable dental practice act in the state where the patient receives services and where the dentist is licensed. The dentist should be knowledgeable

1 regarding the competence and qualifications of the allied personnel utilized, and should have the
2 capability of immediately contacting both the allied dental personnel providing service and the
3 patient receiving services.

4 **Licensure:** Dentists and allied dental personnel who deliver services through teledentistry
5 modalities must be licensed or credentialed in accordance with the laws of the state in which the
6 patient receives service. The delivery of services via teledentistry must comply with the state's
7 scope of practice laws, regulations or rules. The American Dental Association opposes a single
8 national federalized system of dental licensure for the purposes of teledentistry.

9 **Reimbursement:** Dental benefit plans and all other third-party payers, in both public (e.g.
10 Medicaid) and private programs, shall provide coverage for services using teledentistry
11 technologies and methods (synchronous or asynchronous) delivered to a covered person to the
12 same extent that the services would be covered if they were provided through in-person
13 encounters. Coverage for services delivered via teledentistry modalities will be at the same levels
14 as those provided for services provided through in-person encounters and not be limited or
15 restricted based on the technology used or the location of either the patient or the provider as
16 long as the health care provider is licensed in the state where the patient receives service.

17 **Technical Considerations:** Dentists are encouraged to consider conformance with applicable
18 data exchange standards to facilitate delivery of services via teledentistry modalities. These
19 include, but are not limited to, Digital Imaging and Communications in Medicine (DICOM)
20 standards when selecting and using imaging systems, X12/HL7 for the exchange of information
21 and ICD-9/10-CM/SNOMED/SNODENT for documentation consistency.

22 **BOARD RECOMMENDATION: Vote Yes.**

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

Resolution No. 45S-1 New

Report: N/A Date Submitted: October 2015

Submitted By: Fifth Trustee District

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

Total Net Financial Implication: None Net Dues Impact: _____

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

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

How does this resolution increase member value: See Background

**SUBSTITUTE FOR RESOLUTION 45: COMPREHENSIVE ADA POLICY STATEMENT ON
TELEDENTISTRY**

The following substitution for Resolution 45 (Worksheet:3009) was submitted by the Fifth Trustee District and transmitted on October 28, 2015 by Dr. Red Stevens, Fifth District trustee.

Resolution

45S-1. Resolved, that the following proposed Comprehensive ADA Policy Statement on Teledentistry be adopted (additions are underscored), and be it further

Resolved, that ADA policy on Teledentistry (*Trans.2012:455*) be rescinded.

Comprehensive ADA Policy Statement on Teledentistry

Teledentistry refers to the use of telehealth systems and methodologies in dentistry. Telehealth refers to a broad variety of technologies and tactics to deliver virtual medical, health, and education services. Telehealth is not a specific service, but a collection of means to enhance care and education delivery.

Teledentistry can include patient care and education delivery using, but not limited to, the following modalities:

- Live video (synchronous): Live, two-way interaction between a person (patient, caregiver, or provider) and a provider using audiovisual telecommunications technology.
- Store-and-forward (asynchronous): Transmission of recorded health information (for example, radiographs, photographs, video, digital impressions and photomicrographs of patients) through a secure electronic communications system to a practitioner, who uses the information to evaluate a patient's condition or render a service outside of a real-time or live interaction.
- Remote patient monitoring (RPM): Personal health and medical data collection from an individual in one location via electronic communication technologies, which is transmitted to a provider (sometimes via a data processing service) in a different location for use in care and related support of care.

- Mobile health (mHealth): Health care and public health practice and education supported by mobile communication devices such as cell phones, tablet computers, and personal digital assistants (PDA):

General Considerations: The treatment of patients who receive services via teledentistry must be properly documented and should include providing the patient with a summary of services. Dentists who deliver services using teledentistry must establish protocols for appropriate referrals when necessary.

Patients' Rights: Dental patients whose care is rendered or coordinated using teledentistry modalities have the right to expect:

1. That any dentist delivering services using teledentistry technologies will be licensed in the state where the patient receives services, or be providing these services as otherwise authorized by that state's dental board.
2. Access to the licensure and board certification qualifications of the oral health care practitioner who is providing the care in advance of the visit.
3. That the delivery of services through teledentistry technologies will follow evidence-based practice guidelines, to the degree they are available, as a means of ensuring patient safety, quality of care and positive health outcomes.
4. That they will be informed about the identity of the providers collecting or evaluating their information or providing treatment, and of any costs they will be responsible for in advance of the delivery of services.
5. That relevant patient information will be collected prior to performing services using teledentistry technologies and methods including medical, dental, and social history, and other relevant demographic and personal information.
6. That the provision of services using teledentistry technologies will be properly documented and the records and documentation collected will be provided to the patient upon their request.
7. That services provided using teledentistry technologies and methods include care coordination as a part of a dental home and that the patient's records be made available to any entity that is serving as the patient's dental home.
8. That the patient will be actively involved in treatment decisions, will be able to choose how they receive a covered service, including considerations for urgency, convenience and satisfaction and without such penalties as higher deductibles, co-payments or coinsurance relative to that of in-person services.
9. That the delivery of services using teledentistry technologies are performed in accordance with applicable laws and regulations addressing the privacy and security of patients' private health information.

Quality of Care: The dentist is responsible for, and retains the authority for ensuring, the safety and quality of services provided to patients using teledentistry technologies and methods. Services delivered via teledentistry should be consistent with in-person services, and the delivery of services utilizing these modalities must abide by laws addressing privacy and security of a patient's dental/medical information.

Supervision of Allied Dental Personnel: The extent of the supervision of allied dental personnel should conform to the applicable dental practice act in the state where the patient receives services and where the dentist is licensed. The dentist should be knowledgeable regarding the competence and qualifications of the allied personnel utilized, and should have the capability of immediately contacting both the allied dental personnel providing service and the patient receiving services. All services delivered by allied dental personnel should be non-

1 surgical/reversible and consistent with the ADA Comprehensive Statement on Allied Dental
2 Personnel.

3 **Licensure:** Dentists and allied dental personnel who deliver services through teledentistry
4 modalities must be licensed or credentialed in accordance with the laws of the state in which the
5 patient receives service. The delivery of services via teledentistry must comply with the state's
6 scope of practice laws, regulations or rules. The American Dental Association opposes a single
7 national federalized system of dental licensure for the purposes of teledentistry.

8 **Reimbursement:** Dental benefit plans and all other third-party payers, in both public (e.g.
9 Medicaid) and private programs, shall provide coverage for services using teledentistry
10 technologies and methods (synchronous or asynchronous) delivered to a covered person to the
11 same extent that the services would be covered if they were provided through in-person
12 encounters. Coverage for services delivered via teledentistry modalities will be at the same levels
13 as those provided for services provided through in-person encounters and not be limited or
14 restricted based on the technology used or the location of either the patient or the provider as
15 long as the health care provider is licensed in the state where the patient receives service.

16 **Technical Considerations:** Dentists are encouraged to consider conformance with applicable
17 data exchange standards to facilitate delivery of services via teledentistry modalities. These
18 include, but are not limited to, Digital Imaging and Communications in Medicine (DICOM)
19 standards when selecting and using imaging systems, X12/HL7 for the exchange of information
20 and ICD-9/10-CM/SNOMED/SNODENT for documentation consistency.

21 **BOARD RECOMMENDATION: Received after the October Board of Trustees meeting.**

Appendix 1

ADA Technical Report No. 1006—Infection Control for Dental Information Systems: 2013

This Technical Report is intended as a working document to assist in developing standards for infection control guidelines for dental informatics devices and equipment. Dental informatics equipment and devices consist of the computerized clinical information systems used in dentistry. Devices are those items intended for intraoral use and include digital radiographic equipment, intraoral camera and microscope systems, periodontal probing devices, occlusal force analysis systems, pulp testers, apex locators, and intraoral printers. Equipment is used to support these devices and includes foot controls, headsets, keyboards, pointing devices, and computers and other peripheral hardware such as printers, scanners, CD players, and monitors. This report addresses infection control issues related to the devices and equipment used in dental informatics and is based on the existing infection control protocols related to dental patient care. Devices and equipment used in patient treatment areas should be designed or be able to be adapted to allow appropriate infection control protocols which prevent patient cross-contamination as well as the introduction of environmental infectious agents into the operative site.

ADA Technical Report No. 1021—Data Integrity, Redundancy, Storage and Accessibility: 2005 (Reaffirmed 2013)

This report presents options available to prevent data loss and corruption, maintain data integrity and maintain and restore access to data. It also discusses appropriate contingency plans in emergency situations for recovery and authentication of the data as well as accessing the information.

ADA Technical Report No. 1023—Implementation Requirements for DICOM in Dentistry: 2005 (Reaffirmed 2013)

This report provides a technical standard based on the DICOM version 3 Standard as it applies to dentistry with the goal of increasing interoperability between digital radiographic systems. It lists the components required for intraoral and extra-oral digital radiography.

ADA Technical Report No. 1029—Digital Photography: 2004 (Reaffirmed 2013)

The focus of this Technical Report is to provide basic information on the use of digital photography in dentistry and to help facilitate: 1). The appropriate selection of the necessary equipment; 2). Consistent communication between concerned parties with and interoperability of digital images and the information the contained therein. The information provided will address the digital imaging needs of the various dental specialties, the general dental practitioner, other health care providers, the patient and any interested third parties such as insurance carriers, prosthetic and pathology laboratories. These discussions take into consideration the interoperability requirements to insure proper identification, exporting and importing of the image and database management of the image. To capture a quality digital image is not enough—the image has to have proper and standardized labeling of what it contains (the structures that are visible in the image) and the necessary DICOM descriptors of what, how and when it was captured.

ADA Technical Report No. 1031—Internet Security Issues for Dental Information Systems: 2004 (Reaffirmed 2013)

The Scope of this Technical Report is to create security awareness and education for the dental practitioner associated with a connection to the Internet. The Internet has proven to be an effective means of communication, yet its vulnerability to interception raises issues of privacy, authentication and

integrity of the communicated message. Therefore, data security is of utmost importance to users of dental information systems.

Because of the personal and private nature of health record, the dental practitioner needs to understand the security issues associated with "data at rest" and "data in transit." This paper is intended to explain security concepts and the risks associated with the maintenance of data in storage and transit, and over an Internet connection.

ADA Technical Report No. 1048—Attachment of DICOM Dataset Using Email: 2011

This report provides a technical standard based on the DICOM (Digital Imaging and Communications in Medicine) version 3 Standard as it applies to dentistry with the goal of increasing interoperability between practitioners. In particular, this report highlights the benefits of the ZIP File over Email Interchange Profiles of the DICOM Standard for dentists or specialists who don't share the same image data repository, but need to exchange patient data in a fast and secure manner.

ADA Technical Report No. 1051—Implementation Requirements for DICOM in Institutional Dentistry: 2009 (Reaffirmed 2012)

This report provides a technical standard based on the DICOM Standard as it applies to dentistry with the goal of increasing interoperability within and between institutional digital radiographic systems. This report will illustrate through high-level interaction use cases how to achieve interoperability for typical dental imaging tasks. They are: (1) view images on removable media; (2) create interoperable removable media images; (3) share images among various networked multi-vendor storage and acquisition systems; (4) ability to exchange visible light photographic and endoscopic images within a dental image acquisition context; (5) create and exchange DICOM structured display objects; (6) perform scheduled workflow to integrate digital images with an electronic dental records system; (7) import and reconcile Images from outside the institution into the electronic dental records system; (8) securely transfer DICOM images via email, and; (9) access DICOM images via the Internet. These use cases show the DICOM requirements in context, describing them in clear relationship to the clinical tasks of the dental provider.

ADA Technical Report No. 1057—Interoperability of Imaging Technologies in Today's Dental Practice: 2010 (Reaffirmed 2013)

This report discusses the issues involving interoperability that arise when digital radiography and photography are integrated into a dental practice. The report describes the features of DICOM that facilitate resolution of these issues and allows a dental practice to achieve interoperability within their imaging and practice management systems and with outside healthcare data systems and networks. Descriptions of the components of a digital radiography system and guidelines on what to look for when choosing digital radiography components also are included.

ADA Technical Report No. 1059—Guidelines for the Application of the DICOM Standard to Radiographic Cephalometric Data: 2010 (Reaffirmed 2013)

In the current DICOM documentation, cephalograms are not addressed directly. This technical report (TR) was developed to fill the gap in such a way as to provide imaging equipment vendors an approved way of storing cephalograms, along with their clinically relevant data, in an interoperable way. In addition, this TR shall serve as a part of the foundation for the definition of ADA SCDI approved guidelines for the storage and transfer of orthodontic electronic patient records through the utilization of existing popular informatics standards. This TR shall be included in the definition of an ADA SCDI document to specify the integration of DICOM and HL7 standards for orthodontic data. This document was initially designed for scanned film-based cephalograms, but is intended to be used for digitally created cephalograms as well.

ADA Technical Report No. 1060—The Secure Exchange and Utilization of Digital Images in Dentistry: 2011

This report outlines methods for the secure electronic exchange and utilization of electronic digital image files, including those requiring diagnostic quality. Such images may include diagnostic radiographs, intraoral and extra-oral photographs, video, optical impressions and oral pathology photomicrographs. Caution is advised against the utilization of unsecure exchange transmission modes, such as unencrypted email attachments sent over the Internet or any other unsecured electronic exchange not conforming to accepted security transmission standards. Currently available practices and existing constraints to diagnostic image exchange are reviewed and potential solutions offered.

ADA Technical Report No. 1067—Electronic Dental Record System Standard Functional Requirements: 2013

The purpose of this document is to identify the minimum functionality required of an electronic dental system to perform effectively in an interoperable and coordinated.

Resolution No. 79 NewReport: NA Date Submitted: September 2015Submitted By: Fourteenth Trustee DistrictReference Committee: B (Dental Benefits, Practice and Related Matters)Total Net Financial Implication: None Net Dues Impact: Amount One-time Amount On-going FTE 0

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

How does this resolution increase member value: See Background

1 **INTERFERENCE IN THE DOCTOR/PATIENT RELATIONSHIP BY THIRD PARTY CARRIERS**
 2 **THROUGH THE PRACTICE OF "DISALLOWING" CLAIMS**

3 The following resolution was submitted by the Fourteenth Trustee District and submitted on September
 4 16, 2015, by Dr. Allison House, Fourteenth District Resolutions Chair.

5 **Background:** Through the years, third-party intrusion into the doctor/patient relationship has consistently
 6 been one of the primary concerns of ADA member dentists. The ADA's assistance in these matters is
 7 one of the most tangible benefits of membership. It is a benefit that will continue to solidify the
 8 membership of existing members, as well as build long-lasting relationships with new and future members.

9 On this note, it has come to be recognized that third-party payers will, at times, send a letter to providers
 10 stating that, not only will the claim not be paid, but, "the provider may not collect any fee for the service
 11 and any fee previously collected must be refunded to the patient." This practice is commonly referred to
 12 as "disallowing" a claim. Furthermore, the patient receives an EOB from the third-party payer stating that
 13 the treatment completed by the dentist now has a zero balance and their portion for the treatment is zero.
 14 When speaking to third-party payers, they state that this practice is their way of protecting the patient
 15 from unnecessary treatment, or treatment below the standard of care. Payment still may be collected
 16 from the patient, but only if the treating dentist writes a letter and receives permission from the third-party
 17 payer.

18 There are many instances where the best care for the patient may deviate from a blanket "standard of
 19 care." It has always been the prerogative of the patient to continue with care that their third-party payer
 20 has denied payment for based on contract restrictions. Sure, the third-party payer is well within their right
 21 to deny payment, and the dentist should not interfere in the contract provisions of a dental benefit
 22 contract. This is a contract between the benefit purchaser and the benefit provider. However, the
 23 relationship between the dentist and patient should also be respected and not intruded upon by the third-
 24 party payer.

25 Currently, there are numerous ADA policies related to third-party intrusion into the doctor/patient
 26 relationship, and a specific policy related to this matter is definitely needed. But it is time to do more than
 27 just simply adopt policy. ADA members don't want "empty" policies. We want a voice and we want
 28 action. We want a strong ADA that fights for its members' needs. This is a membership opportunity for
 29 the ADA. It is an opportunity for the ADA to show its members, as well as non-members, why
 30 membership matters.

1 **Resolution**

2 **79. Resolved**, that the appropriate agency of the American Dental Association draft a specific
3 policy proposal opposing dental provider contracts that permit the practice of disallowing claims
4 by third-party payers for consideration by the 2016 House of Delegates, and be it further

5 **Resolved**, that the American Dental Association pursue lawful remedies that will seek to prevent
6 third-party payers from utilizing provider contracts, or dental benefit plans, that allow restriction of
7 payments directly from the patient to the provider in situations where dental benefit payments
8 have been denied.

9 **BOARD RECOMMENDATION: Vote Yes.**

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

Resolution No. None N/AReport: Council on Dental Practice Supplemental Report 2 Date Submitted: October 2015Submitted By: Council on Dental PracticeReference Committee: B (Dental Benefits, Practice and Related Matters)Total Net Financial Implication: None Net Dues Impact: _____Amount One-time _____ Amount On-going _____ FTE 0

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

How does this resolution increase member value: See Background

**COUNCIL ON DENTAL PRACTICE SUPPLEMENTAL REPORT 2 TO THE HOUSE OF DELEGATES:
RESPONSE TO RESOLUTION 28H—CHAIRSIDE MEDICAL SCREENINGS****Background:** Resolution 28H-2014 (*Trans.*2014:452) reads as follows:

28H-2014. Resolved, the appropriate ADA agencies research the implications of incorporating appropriate medical screening methods into patient evaluations, and report back to the 2015 House of Delegates.

In response to Resolution 28H, articles and resources were collected, reviewed and discussed by the Council on Dental Practice throughout the year. This report is a summary of findings.

Interest in the potential role of dentists to perform health screenings and to engage patients who may not be receiving regular preventive health services is growing.¹ In 2012, 46 dental school Associate Deans were surveyed. Thirteen of the deans said medical screening was part of the dentists' professional role and 33 stated it might be a part of the dentists' future. The Associate Deans estimated 24% of graduates have the skills necessary to currently screen patients. Dental students currently have a two week primary care module measuring vital sign and biological interrelationships of systemic diseases.²

Health care providers, the public health community, payers and health services researchers are increasingly recognizing oral health as a crucial component of the medical home. The increasing evidence of the link between oral and systemic health has increased the potential role of dentists in early identification and referral of patients with possible chronic medical conditions and collaboration with other health professionals for comprehensive patient care.

Health Screening: Diseases frequently begin long before symptoms occur. The goal of screening is to reduce morbidity or mortality from a disease by detecting it in its earliest stages, when treatment is usually more successful. Screening refers to the medical procedure or test of individuals whom have no symptoms of a particular disease, for the purpose of determining their likelihood of having the disease.³

Screening procedures are not diagnostic procedures. Persons with a positive result from a screening test will need further evaluation and referral for subsequent diagnostic tests or procedures. Screenings should target a subset of the population that is likely to have a higher prevalence of a disease. The utilization of health risk appraisals targets the individuals who are at higher risk of developing the disease.

Dentists have assumed responsibility for some patient medical screenings for many years. Practicing dentists are treating an ever aging population with significant medical issues. Detailed patient medical

1 histories are routinely taken and reviewed to assess the relative risks of medical comorbidities and patient
2 medications during dental care. Dentists are alert to clinical evidence that indicates a possible underlying,
3 undiagnosed illness. Blood pressure, oral cancer and nutritional screenings are performed regularly in
4 dental offices with referral to primary health providers for medical evaluation and diagnosis when
5 appropriate.⁴ Some dentists offer counseling to patients for smoking cessation.

6 The Council reviewed the proportion and characteristics of patients who do not regularly visit general
7 health care providers but do visit dentists. The 2008 Medical Expenditure Panel Survey (MEPS) indicated
8 that of the 26 percent of children and 24.1 percent of adults who did not have contact with a general
9 health care provider, a sizable proportion (34.7 percent of children and 23.1 percent of adults) visited a
10 dental practice that year.⁵ These groups are estimated to represent 19.5 million individuals. The majority
11 of these adults and children had some form of health insurance. This suggests that many of those who
12 did not interact with a general health care provider may have had access to general health care but opted
13 not to seek this care. For these and other individuals, dentists are in a key position to assess and detect
14 oral signs and symptoms of systemic health disorders that may otherwise go unnoticed.⁵ Other research
15 demonstrates high dental care utilization among key populations such as smokers, individuals at elevated
16 risk for HIV, and individuals at risk for diabetes. Many at-risk individuals use dental services even when
17 they do not regularly receive primary medical care services.⁶

18 Demand for medical primary care services is projected to increase through 2020, largely because of
19 population aging, population growth and insurance coverage for the uninsured as the Affordable Care Act
20 is fully implemented (15 million patients will become eligible for Medicare and 32 million will be newly
21 insured through the Affordable Care Act). The Association of American Medical College's Center for
22 Workforce Studies estimates that by 2020, the United States will face a shortage of 45,000 primary care
23 physicians and 46,100 medical specialists.⁷ These workforce estimates take into account an aging
24 physician workforce.

25
26 Rural and urban inner city areas already have an inadequate physician workforce or are experiencing
27 difficulty with access. Across the United States there are 5,800 designated medical primary care Health
28 Professional Shortage Areas (HPSA) according to 2013 U.S. Department of Health and Human Services
29 data.⁶ Since the primary care physician workforce is projected to be inadequate to meet demand in 2020,
30 the dental profession may be positioned with an opportunity to practice at its full scope.⁸ The dental
31 setting could serve as an early resource for identification of patients at increased risk of chronic diseases
32 and serve as an entry point in the medical care system.

33 **Prevalence of Chronic Disease:** Chronic conditions and diseases are the leading cause of death and
34 disability in the United States. The most common costly and preventable chronic diseases are diabetes,
35 obesity, heart disease, stroke, cancer and arthritis. Forty-seven percent of U.S. adults had at least one of
36 the risk factors for heart disease or stroke (uncontrolled high blood pressure, high Low-Density
37 Lipoprotein (LDL) cholesterol or smoking).⁹ As of 2012, 50% of all adults (17 million people) had one or
38 more chronic health conditions.¹⁰ One in four Americans has multiple chronic disease conditions,
39 requiring ongoing medical attention.¹¹ That number increases to three in four Americans aged 65 and
40 older. Having multiple chronic conditions is also associated with substantial health care costs.
41 Approximately 71% of the total health care spending in the United States is associated with care for
42 Americans with more than one chronic condition.¹²

43 According to the Centers for Disease Control and Prevention's (CDC's) 2014 National Diabetes Statistics
44 Report, 29.1 million Americans, or one out of every eleven people have diabetes, and, of these, one out
45 of four people do not know they have diabetes.¹³ The CDC states 86 million people have pre-diabetes, or
46 more than one out of three adults; of these, nine out of ten do not know they have pre-diabetes. Fifteen to
47 thirty percent of the people with pre-diabetes will develop Type 2 diabetes within five years.¹³ A recent
48 ADA study found that federal and state health care savings could reach \$42.4 million to \$102.6 million
49 each year by having dentists conduct screenings for diabetes, high blood pressure and cholesterol in the

dental practice. The estimated health care savings was dependent on patients completing their referral to a physician and starting pharmacological treatment.

Screening Methods: Medical screenings can be accomplished through health risk appraisals or risk assessments, simple biometric data collection, medical testing or any combination of these techniques.

Risk assessment tools are available for many of the chronic disease conditions prevalent in the U.S. In April 2015, the American Medical Association (AMA) and CDC announced their *Prevent Diabetes STAT: Screen, Test, Act - Today*TM initiative, a multi-year program designed to reach more Americans with pre-diabetes and stop their progression to Type 2 diabetes. Risk assessments for pre-diabetes and other chronic medical conditions are available in Appendix 1.

Biometric screening is defined as the measurement of physical characteristics such as height, weight, body mass index, blood pressure, blood cholesterol, and blood glucose that can be part of a health assessment to benchmark and evaluate changes in health status over time, according to the CDC. In the dental office, height and weight are normally not measured and may be self-reported by the patient. Participation in national high blood pressure programs has been ADA policy since 1973.

Point of care testing (POCT) is a form of medical testing, and refers to tests that are performed at or near the site where the patient is located, outside the physical facilities of the clinical laboratories. The tests often do not require permanent dedicated office space. Test developers and manufacturers have made tests that are valid, relatively easy to perform and have low risk of false results.

Simple POCTs are offered by non-traditional operators in non-medical facilities.¹⁴ Consumer driven health care has impacted the increased availability of direct access testing (DAT). According to Centers for Medicare and Medicaid Services (CMS), DAT is defined as “consumer (as opposed to physician) initiated testing of human specimens.” These tests are paid for by the patient directly (out of pocket) since no coverage is available through insurance plans.¹⁵ One study, from the American Society for Clinical Laboratory Science, found that 35 states allow direct access testing in some form (Appendix 2). In 20 of these states there are no limitations on DAT, because there are no laws limiting ordered testing.¹⁶ The remaining 15 states have limitations on the types of DAT allowed. These limits involve restricting the types of test that may be ordered via direct access.

A broad variety of tests have been developed for POCT. Diabetes related tests include HbA1c and fasting blood glucose testing (FGS or FBS). HbA1c, or glycated hemoglobin, measures the average plasma glucose concentration over prolonged periods of time. Patients do not have to fast prior to this test. FGS or FBS measures glucose levels present in the specimen and requires a fasting period of eight hours. Both tests use blood obtained via a finger-stick.

Cholesterol tests available include total cholesterol, low-density lipoprotein cholesterol (LDL-C), high-density lipoprotein cholesterol (HDL-C), and triglycerides. Low-density lipoprotein cholesterol and triglycerides can be affected by what was recently eaten, so fasting is recommended for these tests. Total cholesterol and HDL-C levels do not require fasting. For all of these, a specimen of blood obtained from a finger-stick is used.

Other tests can be performed to screen for diseases which may have an impact on oral health. Oral Human Papilloma Virus (HPV) testing is performed using a saliva sample. Three specific biomarkers that play a role in cancer development including cancers of the tongue, floor of the mouth, cheek lining, gingiva, palate, salivary glands, and tissues that line the mouth and lips are measured.

Rapid Human Immunodeficiency Virus (HIV) testing is performed using oral fluid or finger-stick sample. Oral fluid HIV screening¹⁷ can detect antibodies to both HIV1 and HIV type 2, and can provide test results in 20 minutes.

Hepatitis C (HCV) testing is performed using serum, whole blood or oral fluid sample and detects anti-HCV antibodies.¹⁸ HCV Rapid Antibody Tests utilize an indirect lateral flow immunoassay to detect antibodies against the recombinant core as well as NS3 and NS4 antigens with synthetic HCV peptides.¹⁸

Regulatory Requirements

POCT Regulatory Requirements: Any dental practice that performs tests on human tissues (including saliva, plaque, blood, or hard or soft tissue) is defined as a laboratory in the Clinical Laboratory Improvement Amendments of 1988 (CLIA). CLIA requires certification by the state and CMS before an office can accept samples for laboratory testing. CLIA is only the minimum required of all laboratories and local and/or state laws may be more stringent and override the CLIA requirements.

Three federal agencies have responsibilities under CLIA. The Food and Drug Administration (FDA) categorizes laboratory tests by their complexity, from the least to the most complex. Waived tests are considered the least complex type of test. These tests are simple to use, and there is little chance the test will provide wrong information or cause harm if it is done incorrectly. Tests that are cleared by the FDA for home or over-the-counter use are automatically assigned a waived categorization. *Most tests that may be performed by dentists in their offices are waived tests under CLIA.* Several states allow for direct access testing only for tests classified as waived.

CMS issues laboratory certificates. Performance of waived tests requires a Certificate of Waiver (COW), a two-year certificate issued for a \$150 fee. There are no additional registration or compliance fees. Once a CLIA COW has been obtained, requirements include performance of only waived tests (Appendix 3) and that the current manufacturer's instructions for the waived tests are followed, without any changes. An office is required to notify the state agency of any changes in ownership, name, address, or director within 30 days of the change. Addition of more complex tests may require another certification.

CMS may conduct announced or unannounced on-site inspections. Although not routinely done, an inspection may be triggered if a complaint has been filed, to determine if the testing site is only performing waived tests, if there is a risk of harm to a patient due to inaccurate testing, and to collect information about practices being used at waived testing sites.

CDC provides analysis, research and technical assistance.

State and Local Government Requirements: State and local jurisdictions vary in how they regulate laboratory testing. Some have requirements governing testing, personnel licensure or phlebotomy. Often there are specific regulations for which practice personnel can administer tests. Some states do not allow dental hygienists to administer tests (Appendix 4). It should also be noted that some states prohibit dental practices from performing HIV testing. Biohazard safety or the handling and disposal of medical waste is also state specific.

Requirements for Confidentiality and Patient Privacy: The Health Insurance Portability and Accountability Act of 1996 (HIPAA) addresses the protection and privacy of personal health information. Testing sites are required to establish policies and procedures to protect the confidentiality of health and personal information about their patients, including patient identification, test results, and all records of testing. All personnel should receive training on maintaining the confidentiality of patient information. Several states have medical privacy laws that apply to testing sites.

Issues to Consider: The Council's research suggests that dentists can play an important role in primary prevention of disease. Such an undertaking can improve the overall health of patients, but may involve tasks that are not performed routinely in dental offices. Patient acceptance, dentists' perceptions, liability, patient referrals, costs, reimbursement, and additional training should be assessed by each dentist before determining whether medical screening should be incorporated into routine evaluation visits.¹⁹

Dentists' Perception: Data from a national survey among practicing general dentists showed that 90% of the respondents felt it was important for dentists to screen for medical conditions. Most were willing to conduct chairside screening and discuss the results with their patients, with appropriate referral to a physician for follow-up care. Among the survey respondents, most felt it was important for dentists to screen for hypertension (86%), cardiovascular disease (CVD) (77%), diabetes mellitus (DM) (77%), human immunodeficiency virus (HIV) (72%), and hepatitis C (69%). These dentists were willing to refer patients to physicians (96%), collect saliva samples (88%), conduct screening that yields immediate results (83%), and collect finger-stick blood (56%).²⁰

Dentists' willingness to conduct medical screening varies by test. In another research study, private practice dentists were interviewed regarding Rapid HIV testing. Seventy-five percent of the participants were ADA members.²¹ The dentists understood the benefits of offering the test as well as the public health value but expressed multiple concerns. The principle concerns regarding offering the test were false results, offending patients, scope of licensure issues, low patient acceptance, inadequate reimbursement and any potential negative impact on the dental practice. The conclusion of the study suggested that a cultural change may be required to engage dentists and patients in primary prevention screening in the traditional dental practice.²¹ Within Greenberg's 2010 survey, 87% of the 1,945 US general dentists surveyed recognized the importance of conducting medical screening for diseases with high public health concern.²¹ A majority of the respondents also expressed willingness to conduct screening in their practices if it generated immediate results. They preferred collecting saliva to serum for diagnostic purposes.

Other studies have found screening in dental offices to be effective. One study demonstrated the efficacy of chairside screening by dental professionals in identifying patients at high risk of cardiovascular disease (CVD), which especially benefited those who were unaware of their conditions.²³ A pilot study was conducted to screen for type 2 diabetes risk in dental practice settings. The pilot study suggests that individuals with high risk factors for type 2 diabetes could be identified in dental settings as well as primary and other community settings. The challenges facing dental staff were time constraints, limited manpower, and the low number of patients (20%) who visited their physician for follow-up.²⁴

Patients' Perception: Patients are willing to have a dentist screen for common medical conditions about which they were unaware, or to monitor existing conditions. Convenience plays a role, as patients can directly access medical screening without a physician order. Research shows that dental practice patients (DP) and clinic patients (CP) are willing to have screenings in dental settings for DM (CP: 83.3%, PP: 57.4%), hepatitis (CP: 80.8%, PP: 56.8%), heart disease (CP: 81.7%, PP 57.3%) and HIV (CP: 80.0%, PP: 54.8%).² The majority of CP and PP respondents said they would provide blood pressure measurements (CP: 94%, PP: 80%), weight and height (CP: 89%, PP: 77%), oral fluids (CP: 87%, PP: 79%) and finger-stick blood (CP: 77%, PP: 60%) for chairside medical screenings in dental settings.⁴

Liability: If medical screenings are incorporated into evaluations, referrals to appropriate health care providers must be tracked and documented. Failure to provide referrals may lead to liability issues. Currently no liability is incurred for not providing screenings.

Based on informal discussions with leading insurers of dental malpractice, there is currently no data to support that the medical screenings performed in dental offices has contributed to a higher incidence of malpractice claims or severity in cost. Most dental professional liability insurance policies are structured to protect dentists within their scope of practice, as defined under the Dental Practice Act and State Dental Board. It was noted that the basic screening performed by a dentist prompts a referral back to a primary care provider. The subject of expanded medical screenings in dental offices raised some interesting questions for further discussion regarding integration with the broader healthcare delivery model, protocols for administering medical screenings or tests, risk management of patient expectations, etc. among the insurers.

However, at this time, there were no concerns expressed regarding any potential increase risk of professional liability.

Cost: Risk assessments may not increase direct costs, while medical testing will increase costs. Before incorporating medical screening, the dental practice may wish to consider factors that contribute to total cost. These include personnel time, consumable products and durable goods, additional training of personnel, additional safety and biohazard supplies, record keeping associated with good laboratory practices and the maintenance and storage of these records, certification fees, counseling and education of patients, and referral/tracking of referrals of patients.

Reimbursement: In a 2014 study of the attitudes of dental insurers toward medical screening, it was found that limited insurance reimbursement is another barrier to broad implementation of medical screening in the dental setting. From a payer perspective, the feasibility and cost-effectiveness of broad dental chairside screenings remain unclear.⁴ All survey respondents (insurers) supported incorporation of preventive screening into dental practice as an ideal model for integrated delivery of health care. Yet insurers were hesitant and skeptical in translating such generalized support into actual reimbursement for specific screenings.

Hypertension and oral cancer screening were the most widely implemented and reimbursed wellness initiatives, viewed by insurers as already within the dental professional's scope of practice. Insurers reported that many dentists participating in their plans provided smoking cessation services and diabetes screening; however, it was less clear that such support readily translated into actual reimbursement, because only a few insurer participants said their companies provided some type of reimbursable risk assessment and referral service. Diabetes screening had lower levels of support, with minimal financial coverage. No insurer participants reported reimbursing for either cholesterol or HIV screening.¹

Compared with standard medical coverage, dental insurance has a low annual maximum benefit—usually \$1000 to \$1500 per person per year. A survey conducted by Feinstein-Winitzer, et.al. found respondents emphasized that any funds spent on preventive screening would be deducted from a patient's maximum dental benefit and therefore limit the amount available for other services, including expensive procedures.¹¹ Screenings, such as cholesterol and HIV may be covered by a patient's medical insurance plan, and if they are, a dental practitioner can help a patient afford them by filing a cross coded claim. Dental-medical cross coding is becoming more necessary in dental practices for many medically necessary procedures, and these screenings may also be included. To file a cross coded medical claim the dental practitioner would need Current Procedural Terminology (CPT) codes, ICD-9 or ICD-10 diagnosis codes, and the CMS-1500 (08/05) claim form. As with dental claims, filing a claim with a medical insurance company does not guarantee coverage for the service. If covered, dentists would most likely be considered out of network, further limiting any reimbursement available.

The movement toward empowerment of the consumer to take responsibility for their own healthcare may provide a model for payment. Survey data shows that most patients medically screened in the dental practice would pay up to \$20 for chairside medical screening. When examining clinical (CP) verses private practice (PP) patients, 65% of clinic patients vs. 34% of private practice patients would pay out of pocket for medical screening services.⁴ Point-of-care medical testing providers follow a model of direct payment.

Summary: The dentist's expertise and network of delivery points provides a unique opportunity to demonstrate that the dental profession is an essential part of health care by monitoring health risks and by expanding preventive services and screening for specific conditions. Patients do not perceive the dentist-provider as a barrier; their opinion of the dental professional's knowledge, expertise and compassion could be enhanced by chairside medical screening. Therefore, while recognizing the potential issues of liability, limited and/or accessible reimbursement, and state-specific limitations on medical testing, the addition of chairside medical screenings to the dental practice may still be considered beneficial.

1 **Resolution**

2 This report is informational and no resolutions are presented.

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

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

REFERENCES

1. Rebecca T. Feinstein-Winitzer, Harold A. Pollack, Carrigan L. Parish, Margaret R. Pereyra, Stephen N. Abel, and Lisa R. Metsch. "Insurer Views on Reimbursement of Preventive Services in the Dental Setting: Results From a Qualitative Study." American Journal of Public Health: May 2014, Vol. 104, No. 5, pp. 881-887.
2. LL Patton, VA Santos, RG McKaig, DC Shugars, and RP Strauss. "Education in HIV risk screening, counseling, testing and referral: survey of U.S. dental schools." Journal of Dental Education: 2002, 66:1169-1177.
3. Disease Screening-Statistics Teaching Tools;-New York State Department of Health 1999; <https://www.health.ny.gov/diseases/chronic/discreen.htm>
4. Bowen, Denise M. "Linking research to clinical practice: Medical screenings in dental settings." Fall 2012. Vol. 86 (4); The Journal of Dental Hygiene.
5. Straus, S.M., Alfano, M.C., Shelly, D., and Fulner, T. "Identifying unaddressed systemic health conditions at dental visits: patients who visited dental practices but no general health care providers in 2008." February 2012. Vol 102, No. 2. American Journal of Public Health.
6. Pollack HA, Metsch LR, Abel Sn. "Dental examinations as an untapped opportunity to provide HIV testing for high-risk individuals." American Journal of Public Health. 2010; 100(1):88-89.
7. Gallegos, Alicia. "Medical experts say physician shortage goes beyond primary care." AAMC Reporter. February 2014. <https://www.aamc.org/newsroom/reporter/february2014/370350/physician-shortage.html>
8. Projecting the supply and demand for primary care practitioners through 2020. November 2013. <http://bhpr.hrsa.gov/healthworkforce/supplydemand/usworkforce/primarycare/>
9. Centers for Disease Control and Prevention. Death and Mortality. NCHS Fast Stats Website. December 20, 2013. <http://www.cdc.gov/nchs/fastats/deaths.htm>
10. Ward BW, Schiller JS, Goodman RA. Multiple chronic conditions among US adults: a 2012 update. Prev Chronic Dis. 2014;11:130389. DOI: <http://dx.doi.org/10.5888/pcd11.130389>
11. Multiple Chronic Conditions—A Strategic Framework: Optimum Health and Quality of Life for Individuals with Multiple Chronic Conditions. U.S. Dept. of Health and Human Services; 2010.
12. Gerteis J, Izrael D, Deitz D, LeRoy L, Ricciardi R, Miller T, Basu J. Multiple Chronic Conditions Chartbook. Agency for Healthcare Research and Quality; 2014.
13. Centers for Disease Control and Prevention. National Diabetes Statistics Report: Estimates of Diabetes and Its Burden in the United States, 2014. Atlanta, GA: US Department of Health and Human Services; 2014.
14. Paula J. Santrach MD, Mayo Clinic, <http://wwwn.cdc.gov/cliac/pdf/addenda/cliac0207/addendumf.pdf>
15. American Society for Clinical Laboratory Science. Consumer access to laboratory testing and information. July 2012. <http://www.ascls.org/position-papers/177-direct-access-testing/139-direct-access-testing>
16. American Society for Clinical Pathology Policy Statement. Direct Access Testing (Policy Number 01-02). <https://www.ascp.org/pdf/DirectAccessTesting.aspx>

17. Harper, M. "Are we doing enough? The "how to" of medical coding for screening performed in dental practices." Dental Economics. 2013. <http://www.dentaleconomics.com/articles/print/volume-103/issue-4/features/are-we-doing-enough-the-how-to-of-medical-coding-for-screenings-performed-in-dental-practices.html>
18. Young, J., Quehn, P., Eun-Suk, K., Byung, C., Kyoung, U., Jin-Wook, K., Yoo-Sung, H., and Myung H. "Performance Evaluation of the OraQuick Hepatitis C Virus Rapid Antibody Test. *Annals of Laboratory Medicine*." 2013 May;33(3):184-189. Published online April 17, 2013. <http://dx.doi.org/10.3343/alm.2013.33.3.184>
19. Glick M, Greenberg BL. "The potential role of dentists in identifying patients' risk of experiencing coronary heart disease events." *Journal of the American Dental Association*. 2005; 136:1541-1546.
20. Greenberg BL, Glick M. "Assessing systemic disease risk in a dental setting." *Dental Clinics of North America*. 2012; 56:863-874.
21. Siegel, Karolynn, Stephen N. Abel, Margaret Pereyra, Terri Liguori, Harold A. Pollack, and Lisa R. Metsch. "Rapid HIV Testing in Dental Practices." *American Journal of Public Health*. 2012; 102(4): 625-632.
22. Greenberg BL, Glick M, Frantsve-Hawley J, Kantor ML. "Dentists' attitudes toward chairside screening for medical conditions." *J Am Dent Assoc*. 2010;141:52—56.
23. Greenberg BL, Glick M, Goodchild J, Duda PW, Conte NR, Conte M. "Screening for cardiovascular risk factors in a dental setting." *J Am Dent Assoc*. 2007;138:798—804.
24. Wright, D, Muirhead, V, Weston-Price, S., Fortune, F Br. *Dent J* 2014 APR; 216(7):E15.
25. Batteh-Freiha, J. Diabetes detection in the dental office. American Association of Clinical Endocrinologists Annual Meeting Press Release. 2014, May. <http://media.aace.com/press-release/aace-annual-meeting-press-releases/diabetes-detection-dental-office>
26. Boston University School of Public Health, Screening for Disease, http://sphweb.bumc.bu.edu/otlt/MPH-Modules/EP/EP713_Screening/EP713_Screening_print.html
27. Bureau of Labor Statistics; Occupational Outlook Handbook, Medical and Clinical Laboratory Technologists and Technicians, <http://www.bls.gov/ooh/healthcare/medical-and-clinical-laboratory-technologists-and-technicians.htm>

ADDITIONAL RESOURCES

- Jakubek, Kelly. New AMA, CDC initiative aims to "Prevent Diabetes STAT". CDC News Room: March 15, 2015. Link: <http://www.cdc.gov/media/releases/2015/p0311-diabetes-stat.html>
- Centers for Disease Control and Prevention (CDC) Human papillomavirus associated cancers 2004-2008; *MMWR*2012;61(15):258-261.
- Wright, D, Muirhead, V, Weston-Price, S., Fortune, F Br. *Dent J* 2014 APR; 216(7):E15.

Appendix 1

Risk Assessment tool links:

- Heart Attack Risk Assessment
http://www.heart.org/HEARTORG/Conditions/HeartAttack/HeartAttackToolsResources/Heart-Attack-Risk-Assessment_UCM_303944_Article.jsp
- Diabetes Mellitus (Type 2) in Adults: Screening
<http://www.uspreventiveservicestaskforce.org/Page/Document/UpdateSummaryFinal/diabetes-mellitus-type-2-in-adults-screening>
- Type 2 Diabetes Risk Test
<http://www.diabetes.org/are-you-at-risk/tools-to-know-your-risk/>
- Blood Pressure in Adults (Hypertension): Screening
<http://www.uspreventiveservicestaskforce.org/Page/Document/UpdateSummaryFinal/blood-pressure-in-adults-hypertension-screening>
- Hepatitis C: Screening
<http://www.uspreventiveservicestaskforce.org/Page/Document/UpdateSummaryFinal/hepatitis-c-screening>

1

Appendix 2

2 A study from the American Society for Clinical Laboratory Science found 35 states allow direct access
 3 testing in some form. In 20 of these states there are no limitations on DAT, because there are no laws
 4 limiting ordered testing.¹⁵ The remaining 15 states have limitations on the types of DAT allowed. These
 5 limits involve restricting the types of test that may be ordered via direct access.

States with no limitations on DAT	State with limitations on the type of DAT allowed
Alaska	Arizona
Colorado	Arkansas
Delaware	California
District of Columbia	Illinois
Indiana	Kansas
Louisiana	Maine
Minnesota	Maryland
Montana	Michigan
Nebraska	Mississippi
New Hampshire	Missouri
New Mexico	Nevada
Ohio	New Jersey
Oklahoma	New York
South Dakota	Puerto Rico
Texas	Utah
Vermont	
Virginia	
Washington	
West Virginia	
Wisconsin	

6

Source: American Society for Clinical Pathology Policy Statement. Direct Access Testing (Policy Number 01-02).

7

<https://www.ascp.org/pdf/DirectAccessTesting.aspx>

Appendix 3**CLIA - Clinical Laboratory Improvement Amendments - Currently Waived Analytes**

The following is a list of analytes that are used in laboratory test systems that have been "waived". Under the current process, waiver may be granted to: 1) any test listed in the regulation, 2) any test system for which the manufacturer or producer applies for waiver if that test meets the statutory criteria and the manufacturer provides scientifically valid data verifying that the waiver criteria have been met, and 3) test systems cleared by the FDA for home use. The waived analytes below are linked to waived test systems. Select an analyte of interest below to view test systems that are waived for the analyte.

Analyte Name[FERN TEST, SALIVA](#)¹¹[URINE QUALITATIVE DIPSTICK NITRITE](#)¹²[URINE QUALITATIVE DIPSTICK PH](#)¹³[HEMOGLOBIN BY COPPER SULFATE, NONAUTOMATED](#)¹⁴[HELICOBACTER PYLORI](#)¹⁵[ETHANOL \(ALCOHOL\)](#)¹⁶[HIV-1 ANTIBODY](#)¹⁷[LDL CHOLESTEROL](#)¹⁸[OVULATION TEST \(LH\) BY VISUAL COLOR COMPARISON](#)¹⁹[PROTEIN, TOTAL](#)²⁰[SPUN MICROHEMATOCRIT](#)²¹[HDL CHOLESTEROL](#)²²[ERYTHROCYTE SEDIMENTATION RATE, NONAUTOMATED, WAIVED](#)²³[ALCOHOL, SALIVA](#)²⁴[CARBON DIOXIDE, TOTAL \(CO2\)](#)²⁵[URINE QUALITATIVE DIPSTICK GLUCOSE](#)²⁶[COLLAGEN TYPE I CROSSLINK, N-TELOPEPTIDES \(NTX\)](#)²⁷[VAGINAL PH](#)²⁸[URIC ACID](#)²⁹[ADENOVIRUS](#)³⁰[GLUCOSE MONITORING DEVICES \(PRESCRIPTION USE ONLY\)](#)³¹

[FOLLICLE STIMULATING HORMONE \(FSH\)](#)³²

[AMYLASE](#)³³

[HIV-1 AND HIV-2 ANTIBODIES](#)³⁴

[EDDP \(METHADONE METABOLITE\)](#)³⁵

[ALANINE AMINOTRANSFERASE \(ALT\) \(SGPT\)](#)³⁶

[LUTEINIZING HORMONE \(LH\)](#)³⁷

[URINE QUALITATIVE DIPSTICK KETONE](#)³⁸

[RESPIRATORY SYNCYTIAL VIRUS](#)³⁹

[SODIUM](#)⁴⁰

[TREPONEMA PALLIDUM \(SYPHILIS\) ANTIBODIES](#)⁴¹

[HIV ANTIBODIES](#)⁴²

[HCG, URINE](#)⁴³

[INFLUENZA A/B](#)⁴⁴

[B-TYPE NATRIURETIC PEPTIDE \(BNP\)](#)⁴⁵

[URINARY PROTEIN, QUALITATIVE](#)⁴⁶

[GLUCOSE](#)⁴⁷

[ALBUMIN, URINARY](#)⁴⁸

[URINE QUALITATIVE DIPSTICK ASCORBIC ACID](#)⁴⁹

[METHADONE](#)⁵⁰

[MATRIX METALLOPROTEINASES-9 \(MMP-9\)](#)⁵¹

[GLYCOSYLATED HEMOGLOBIN \(HGB A1C\)](#)⁵²

[STREPTOCOCCUS, GROUP A](#)⁵³

[PHOSPHORUS](#)⁵⁴

[PLATELET AGGREGATION](#)⁵⁵

[METHAMPHETAMINE/AMPHETAMINE](#)⁵⁶

[URINE QUALITATIVE DIPSTICK UROBILINOGEN](#)⁵⁷

[ALBUMIN](#)⁵⁸

[TRICHOMONAS](#)⁵⁹

[URINE QUALITATIVE DIPSTICK BILIRUBIN](#)⁶⁰

[GAMMA GLUTAMYL TRANSFERASE \(GGT\)](#)⁶¹

[ALKALINE PHOSPHATASE \(ALP\)](#)⁶²

[LITHIUM](#)⁶³

[LYME DISEASE ANTIBODIES \(BORRELIA BURGDORFERI ABS\)](#)⁶⁴

[GLUCOSE, FLUID \(APPROVED BY FDA FOR PRESCRIPTION HOME USE\)](#)⁶⁵

[URINE DIPSTICK OR TABLET ANALYTES, NONAUTOMATED](#)⁶⁶

[POTASSIUM](#)⁶⁷

[URINE HCG BY VISUAL COLOR COMPARISON TESTS](#)⁶⁸

[OXYCODONE](#)⁶⁹

[CALCIUM, IONIZED](#)⁷⁰

[AEROBIC/ANAEROBIC ORGANISMS - VAGINAL](#)⁷¹

[HERPES SIMPLEX I AND/OR II ANTIBODIES](#)⁷²

[LEUKOCYTE ESTERASE, URINARY](#)⁷³

[GASTRIC PH](#)⁷⁴

[URINE QUALITATIVE DIPSTICK PROTEIN](#)⁷⁵

[GLUCOSE MONITORING DEVICES \(FDA CLEARED/HOME USE\)](#)⁷⁶

[CHLORIDE](#)⁷⁷

[URINE QUALITATIVE DIPSTICK CHEMISTRIES](#)⁷⁸

[ASPARTATE AMINOTRANSFERASE \(AST\) \(SGOT\)](#)⁷⁹

[HELICOBACTER PYLORI ANTIBODIES](#)⁸⁰

[SEMEN](#)⁸¹

[HEPATITIS C VIRUS ANTIBODY](#)⁸²

[TRIGLYCERIDE](#)⁸³

[KETONE, URINE](#)⁸⁴

[CANNABINOIDS \(THC\)](#)⁸⁵

[LEAD, BLOOD](#)⁸⁶

[NICOTINE AND/OR METABOLITES](#)⁸⁷

[CATALASE, URINE](#)⁸⁸[HGB, SINGLE ANALYTE INST. W/SELF-CONT.](#)⁸⁹[PH](#)⁹⁰[OPIATES](#)⁹¹[BENZODIAZEPINES](#)⁹²[PH, URINE](#)⁹³[METHYLENEDIOXYMETHAMPHETAMINE \(MDMA\)](#)⁹⁴[OSMOLALITY, TEARS](#)⁹⁵[URINE QUALITATIVE DIPSTICK BLOOD](#)⁹⁶[AMINES](#)⁹⁷[URINE QUALITATIVE DIPSTICK SPECIFIC GRAVITY](#)⁹⁸[MICROALBUMIN](#)⁹⁹[CREATININE](#)¹⁰⁰[CALCIUM, TOTAL](#)¹⁰¹[FRUCTOSAMINE](#)¹⁰²[INFLUENZA B](#)¹⁰³[CREATINE KINASE \(CK\)](#)¹⁰⁴[LACTIC ACID \(LACTATE\)](#)¹⁰⁵[AMPHETAMINES](#)¹⁰⁶[PHENCYCLIDINE \(PCP\)](#)¹⁰⁷[URINE QUALITATIVE DIPSTICK CREATININE](#)¹⁰⁸[BUPRENORPHINE](#)¹⁰⁹[INFLUENZA A](#)¹¹⁰[HEMOGLOBIN](#)¹¹¹[PROPOXYPHENE](#)¹¹²[INFECTIOUS MONONUCLEOSIS ANTIBODIES \(MONO\)](#)¹¹³[CHOLESTEROL](#)¹¹⁴[HIV-1 AND HIV-2 ANTIGENS AND ANTIBODIES](#)¹¹⁵

[URINE QUALITATIVE DIPSTICK LEUKOCYTES](#)¹¹⁶

[MORPHINE](#)¹¹⁷

[TRICYCLIC ANTIDEPRESSANTS](#)¹¹⁸

[KETONE, BLOOD](#)¹¹⁹

[ESTRONE-3 GLUCURONIDE](#)¹²⁰

[BILIRUBIN, TOTAL](#)¹²¹

[UREA \(BUN\)](#)¹²²

[COCAINE METABOLITES](#)¹²³

[FECAL OCCULT BLOOD](#)¹²⁴

[THYROID STIMULATING HORMONE \(TSH\)](#)¹²⁵

[GASTRIC OCCULT BLOOD](#)¹²⁶

[HEMATOCRIT](#)¹²⁷

[GLYCATED HEMOGLOBIN, TOTAL](#)¹²⁸

[BLADDER TUMOR ASSOCIATED ANTIGEN](#)¹²⁹

[NITRITE, URINE](#)¹³⁰

[METHAMPHETAMINES](#)¹³¹

[BARBITURATES](#)¹³²

[WHOLE BLOOD QUALITATIVE DIPSTICK GLUCOSE](#)¹³³

[PROTHROMBIN TIME \(PT\)](#)¹³⁴

1 **Appendix 4**

- 2 Clinical Laboratory Improvement Amendments (CLIA) State Survey Agency Contacts (PDF)
3 <https://www.cms.gov/Regulations-and-Guidance/Legislation/CLIA/Downloads/CLIASA.pdf>

Resolution No. 94 New

Report: N/A Date Submitted: October 2015

Submitted By: Seventh Trustee District

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

Total Net Financial Implication: \$37,260 Net Dues Impact: 0.35

Amount One-time \$37,260 Amount On-going FTE 0.3

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

How does this resolution increase member value: See Background

1 INVESTIGATE ENHANCEMENTS TO TRIPARTITE'S PRODUCT AND SERVICE OFFERINGS TO
2 MEET THE NEEDS OF MEMBER DENTISTS

3 The following resolution was adopted by the Seventh Trustee District and transmitted on October 29,
 4 2015, by Michelle Blackman, executive assistant/director of Governance and Operations, Ohio Dental
 5 Association.

6 **Background:** Dental services organizations (DSOs) provide valuable services to many dentists, often in
 7 large group practices, including regulatory compliance and third-party payer assistance, practice
 8 management guidance, marketing, group purchasing discounts, human resources assistance, team
 9 building strategies, best practices for risk management, information technology support, etc. Most
 10 dentists – whether in solo or group practices – would benefit from the provision of these services.
 11 Evaluating what DSOs and large group practices offer their dentists would provide a framework from
 12 which organized dentistry can better help solo and small group practices succeed. Much of this may be
 13 simply re-packaging and marketing what the ADA Center for Professional Success (CPS) and many state
 14 dental societies already offer into a convenient, user-friendly package. In areas where organized
 15 dentistry does not or cannot offer such services, organized dentistry may be able to direct members to the
 16 best-in-class providers of those services, hopefully at a negotiated discount.

17 Resolution

18 **94. Resolved,** that the appropriate ADA agencies investigate the dental services organization model
 19 and determine how the tripartite may be able to enhance its product and service offerings to meet the
 20 needs of all dentists, including those who do not participate with DSOs, and be it further

21 **Resolved,** that the appropriate ADA agencies investigate whether organized dentistry can
 22 recommend to members best-in-class providers of services that the ADA and state dental societies
 23 cannot provide to the membership on their own, and be it further

24 **Resolved,** that the appropriate ADA agencies report their findings and any recommendations related
 25 to these matters to the 2016 ADA House of Delegates.

26 **BOARD RECOMMENDATION: Received after the October Board of Trustees meeting.**

Resolution No. 95 New

Report: N/A Date Submitted: November 2015

Submitted By: Seventeenth Trustee District

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

Total Net Financial Implication: None Net Dues Impact: _____

Amount One-time _____ Amount On-going _____ FTE .25

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

How does this resolution increase member value: See Background

INCREASING MEMBER VALUE PROPOSITION THROUGH THE CENTER FOR PROFESSIONAL SUCCESS

The following resolution was adopted by the Seventeenth Trustee District and submitted on November 5, 2015, by Dr. Jolene Paramore, Delegation Chair.

Background: Paramount to achieving professional success is access to information and the implementation of that information. Our members feel an increasing demand on their time, talents and financial resources. Their needs and wants from their American Dental Association (ADA) membership dues are also increasing. The Center for Professional Success (CPS) is an existing ADA website that offers all our members easy access to relevant, valuable, ready-to-use information. This resolution also supports ADA Strategic Plan Objective 3: 10% increase in assessment of member value and Objective 5: Non-dues revenue at least 65% of revenue.

The ADA's CPS has the potential to be a game changer for the ADA. We hear often from members that they would like to see more of what is offered in the ADA catalog be made available at no additional charge. However, we know that not all members have the same needs – so what to offer as part of the base membership dues “package” and what to charge members for can be economically challenging.

However, other organizations have begun offering what the members want (some of it for free) and ADA will continue suffering membership loss if the members of today and the members of tomorrow's needs are not addressed by the ADA. The CPS should be viewed as a top tier member benefit that will fulfill the ADA's mission and truly help our members succeed, rather than its monetary potential.

Of course, not all ADA materials can be given away, both for economical and legal reasons. However, the ADA, through its appropriate volunteer councils and committees, should evaluate the needs of its diverse membership and determine what might make sense to make available for free via the CPS. The options could range anywhere from a handful of products available to all members or a valuable product for members based on their current practice situation (solo practitioner, large group practice, nearing retirement, etc.).

Many constituencies rely on the ADA for their resources which is the Power of Three support from the top down. CPS could be a vehicle for the constituencies to give their information to the ADA to share on CPS rather than asking the states to open their websites as some have requested. Many job postings are on the states' sites as well as licensure info. If these were all in one place, it would be a huge member benefit and assist with portability. This is the Power of Three from the middle up and down.

1 After its first year, CPS achieved a market penetration of 27%, which exceeded expectations. CPS Web
2 traffic is currently up 75% over 2014. The site will become mobile-enabled in 2016 addressing a
3 recommendation made by the New Dentist Committee to Board of Trustees. Focus groups have been
4 conducted and their recommendations will guide the CPS site modifications scheduled for the first quarter
5 of 2016. Now is the perfect time to incorporate the input of all appropriate ADA volunteer agencies to
6 build the CPS into the incredible member value that it was designed to be.

7 **Resolution**

8 **95. Resolved**, that the Center for Professional Success shall exist to fulfill the ADA's mission to help
9 all members succeed, and be it further

10 **Resolved**, that the Center for Professional Success shall have content of significant member value in
11 order to retain ADA members and recruit non-members and be marketed as a member benefit, and
12 be it further

13 **Resolved**, that the appropriate ADA volunteer agencies conduct a review of ADA Salable and other
14 available materials to evaluate select items of significant member value that could be offered at no
15 charge on the Center for Professional Success and report to the 2016 ADA House of Delegates.

16 **BOARD RECOMMENDATION: Received after the October Board of Trustees meeting.**

Dental Education, Science and Related Matters

Resolution No. 13 NewReport: N/A Date Submitted: August 2015Submitted By: Council on Dental Education and LicensureReference Committee: C (Dental Education, Science and Related Matters)Total Net Financial Implication: None Net Dues Impact: _____Amount One-time _____ Amount On-going _____ FTE 0

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

How does this resolution increase member value: See Background

AMENDMENT OF THE POLICY, DENTISTRY**Background:** (*Annual Reports:44*)**Amendment of the Policy, Dentistry:** The Council believes that the policy Dentistry should be amended by deleting the second and third resolving clauses which are directives related to implementation and not declarative policy statements.**Resolution****13. Resolved,** that the ADA policy, Dentistry (*Trans.1997:687*) be amended as follows (additions are underscored; deletions are ~~stricken~~):**Dentistry****Resolved,** that dentistry is defined as the evaluation, diagnosis, prevention and/or treatment (nonsurgical, surgical or related procedures) of diseases, disorders and/or conditions of the oral cavity, maxillofacial area and/or the adjacent and associated structures and their impact on the human body; provided by a dentist, within the scope of his/her education, training and experience, in accordance with the ethics of the profession and applicable law, ~~and be it further~~~~**Resolved,** that the approved definition of dentistry, adopted by the 1997 House of Delegates be incorporated into the beginning of the Association's published list with the definitions of dental specialties following in alphabetical order and distributed to the communities of interest, and be it further~~~~**Resolved,** that the Council on Dental Education and Licensure have responsibility for the periodic review and revision of the definition of dentistry, in a manner consistent with its established procedures for revision of a dental specialty definition.~~**BOARD RECOMMENDATION: Vote Yes.****BOARD VOTE: UNANIMOUS. (BOARD OF TRUSTEES CONSENT CALENDAR ACTION—NO BOARD DISCUSSION)**

Resolution No. 14 NewReport: N/A Date Submitted: August 2015Submitted By: Council on Dental Education and LicensureReference Committee: C (Dental Education, Science and Related Matters)Total Net Financial Implication: None Net Dues Impact: _____Amount One-time _____ Amount On-going _____ FTE 0

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

How does this resolution increase member value: See Background

AMENDMENT OF THE POLICY, CONTINUED RECOGNITION OF DENTAL PUBLIC HEALTH AS A DENTAL SPECIALTY**Background:** (*Annual Reports:45*)**Resolution**

14. Resolved, that the ADA policy, Continued Recognition of Dental Public Health as a Dental Specialty (*Trans.1986:512*) be amended as follows (additions are underscoring; deletions are ~~stricken~~):

~~Continued~~ Recognition of Dental Public Health as a Dental Specialty

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's request for continued recognition of dental public health as a dental specialty be approved.

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

Resolution No. 15 NewReport: N/A Date Submitted: August 2015Submitted By: Council on Dental Education and LicensureReference Committee: C (Dental Education, Science and Related Matters)Total Net Financial Implication: None Net Dues Impact: Amount One-time Amount On-going FTE 0

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

How does this resolution increase member value: See Background

AMENDMENT OF THE POLICY, CERTIFYING BOARD IN DENTAL PUBLIC HEALTH**Background:** (*Annual Reports*:45)**Resolution**

15. Resolved, that the ADA policy approving the requirements of the American Board of Dental Public Health (*Trans.*1951:180) be amended as follows (additions are underscored; deletions are ~~stricken~~):

Certifying Board in Dental Public Health

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

BOARD RECOMMENDATION: Vote Yes.

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

Resolution No. 16 New

Report: N/A Date Submitted: August 2015

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 each element of the tripartite clearly defined and agreed upon

How does this resolution increase member value: See Background

**AMENDMENT OF THE POLICY, RECOGNITION OF ENDODONTICS AS A SPECIALTY AND
RESCISSION OF THE POLICY, CONTINUED RECOGNITION OF ENDODONTICS AS A DENTAL
SPECIALTY**

Background: (*Annual Reports*:45)

Resolution

16. Resolved, that the ADA policy, Recognition of Endodontics as a Specialty (*Trans.*1963:244) be amended as follows (additions are underscored; deletions are ~~stricken~~):

Recognition of Endodontics as a Dental Specialty

Resolved, that endodontics is a dental specialty ~~be recognized by the American Dental Association and sponsored by the American Association of Endodontists as a special area of dental practice.~~

and be it further

Resolved, that the ADA policy, Continued Recognition of Endodontics as a Dental Specialty (*Trans.*1989:521), be rescinded.

BOARD RECOMMENDATION: Vote Yes.

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

1 *Appendix 1.*

2 **Policies to be Rescinded**

3 **As Recommended by the Council on Dental Education and Licensure**

4 **Continued Recognition of Endodontics as a Dental Specialty (*Trans.*1989:521)**

5 **Resolved**, that the American Association of Endodontists' request for continued recognition of
6 endodontics as a dental specialty be approved.

Resolution No. 17 NewReport: N/A Date Submitted: August 2015Submitted By: Council on Dental Education and LicensureReference Committee: C (Dental Education, Science and Related Matters)Total Net Financial Implication: None Net Dues Impact: _____Amount One-time _____ Amount On-going _____ FTE 0

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

How does this resolution increase member value: See Background

1 **AMENDMENT OF THE POLICY, CERTIFYING BOARD IN ENDODONTICS**2 **Background:** (*Annual Reports:45*)3 **Resolution**4 **17. Resolved**, that the ADA policy, Certifying Board in Endodontics (*Trans.1964:251*) be amended as
5 follows (additions are underscored; deletions are ~~stricken~~):6 **Certifying Board in Endodontics**7 **Resolved**, that the American Dental Association approves the American Board of Endodontics ~~be~~
8 ~~approved~~ as the national certifying board ~~in this~~ for the special area of dental practice specialty of
9 endodontics.10 **BOARD RECOMMENDATION: Vote Yes.**11 **BOARD VOTE: UNANIMOUS. (BOARD OF TRUSTEES CONSENT CALENDAR ACTION—NO**
12 **BOARD DISCUSSION)**

Resolution No. 18 NewReport: N/A Date Submitted: August 2015Submitted By: Council on Dental Education and LicensureReference Committee: C (Dental Education, Science and Related Matters)Total Net Financial Implication: None Net Dues Impact: Amount One-time Amount On-going FTE 0

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

How does this resolution increase member value: See Background

RESCISSION OF THE POLICY, REQUIREMENTS FOR ENDODONTISTS**Background:** (*Annual Reports:45*)

Rescission of the Policy, Requirements for Endodontists: Two additional policies related to Endodontics are recommended for rescission. Both policies are obsolete. The eligibility requirement for the American Board of Endodontics mandates that candidates must be graduates of advanced specialty education programs accredited by the Commission on Dental Accreditation. The American Association of Endodontists and the American Board of Endodontics agreed with the Council that these policies should be rescinded.

Resolution**18. Resolved,** that the ADA policy, Requirements for Endodontists (*Trans.1966:346*) be rescinded.**BOARD RECOMMENDATION: Vote Yes.****BOARD VOTE: UNANIMOUS. (BOARD OF TRUSTEES CONSENT CALENDAR ACTION—NO BOARD DISCUSSION)**

Appendix 1.

Policies to be Rescinded

As Recommended by the Council on Dental Education and Licensure

Requirements for Endodontists (*Trans.1966:346*)

Resolved, that in order to eliminate inequities still existing toward practitioners of endodontics who graduated from dental school during and after 1957, the requirements of two years advanced formal education should not be applied to candidates applying for certification to The American Board of Endodontics who have graduated from dental school in 1964 or prior thereto, provided such candidates meet all other requirements of the American Board of Endodontics.

Resolution No. 19 NewReport: N/A Date Submitted: August 2015Submitted By: Council on Dental Education and LicensureReference Committee: C (Dental Education, Science and Related Matters)Total Net Financial Implication: None Net Dues Impact: Amount One-time Amount On-going FTE 0

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

How does this resolution increase member value: See Background

RESCISSION OF THE POLICY, REQUIREMENTS FOR ENDODONTICS

Background: (*Annual Reports*:45)

Rescission of the Policy, Requirements for Endodontics: Two additional policies related to Endodontics are recommended for rescission. Both policies are obsolete. The eligibility requirement for the American Board of Endodontics mandates that candidates must be graduates of advanced specialty education programs accredited by the Commission on Dental Accreditation. The American Association of Endodontists and the American Board of Endodontics agreed with the Council that these policies should be rescinded.

Resolution

19. Resolved, that the ADA policy, Requirements for Endodontics (*Trans.*1976:897) be rescinded.

BOARD RECOMMENDATION: Vote Yes.

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

Appendix 1.

Policies to be Rescinded

As Recommended by the Council on Dental Education and Licensure

Requirements for Endodontics (*Trans.1976:897*)

Resolved, that in compliance with the intent of Resolution 36-1966-H (*Trans.1966:346*) candidates who do not possess the required formal education and who did not apply to the American Board of Endodontics for examination prior to December 31, 1974 are ineligible for examinations, and be it further

Resolved, that candidates who do not possess the formal education requirement but applied for examination prior to December 31, 1974 are ineligible for reapplication upon expiration of their board eligibility.

Resolution No. 20 NewReport: N/A Date Submitted: August 2015Submitted By: Council on Dental Education and LicensureReference Committee: C (Dental Education, Science and Related Matters)Total Net Financial Implication: None Net Dues Impact: _____Amount One-time _____ Amount On-going _____ FTE 0

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

How does this resolution increase member value: See Background

AMENDMENT OF THE POLICY, CONTINUED RECOGNITION OF ORAL PATHOLOGY AS A DENTAL SPECIALTY AND RESCISSION OF THE POLICY, REDESIGNATION OF THE SPECIALTY OF "ORAL PATHOLOGY" TO "ORAL AND MAXILLOFACIAL PATHOLOGY"**Background:** (*Annual Reports*:45-46)**Resolution****20. Resolved**, that the ADA policy, Continued Recognition of Oral Pathology as a Dental Specialty (*Trans.*1987:510) be amended as follows (additions are underscored; deletions are ~~stricken~~):**Continued Recognition of Oral and Maxillofacial Pathology as a Dental Specialty****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's request for continued recognition of oral pathology as a dental specialty be approved.

and be it further

Resolved, that the ADA policy, Redesignation of the Specialty of "Oral Pathology" to "Oral and Maxillofacial Pathology" (*Trans.*1995:632), be rescinded.**BOARD RECOMMENDATION: Vote Yes.****BOARD VOTE: UNANIMOUS. (BOARD OF TRUSTEES CONSENT CALENDAR ACTION—NO BOARD DISCUSSION)**

Appendix 1.

Policies to be Rescinded

As Recommended by the Council on Dental Education and Licensure

**Redesignation of the Specialty of “Oral Pathology” to “Oral and Maxillofacial Pathology”
(Trans.1995:632)**

Resolved, that the specialty currently designated “oral pathology” be redesignated “oral and maxillofacial pathology,” and be it further

Resolved, that the documents and policies approved by the House of Delegates of the American Dental Association which refer to “oral pathology” be amended to reflect the change in designation to “oral and maxillofacial pathology,” and be it further

Resolved, that the communities of interest be advised of the change in designation and be encouraged to utilize the new designation when referring to the specialty, and be it further

Resolved, that the *ADA Principles of Ethics and Code of Professional Conduct* be amended by deleting the second paragraph of Section 5-C, Announcement of Specialization and Limitation of Practice, in its entirety and substituting the following new second paragraph:

The special areas of dental practice approved by the American Dental Association and the designation for ethical specialty announcement and limitation of practice are: dental public health, endodontics, oral and maxillofacial pathology, oral and maxillofacial surgery, orthodontics and dentofacial orthopedics, pediatric dentistry, periodontics and prosthodontics.

Resolution No. 21 NewReport: N/A Date Submitted: August 2015Submitted By: Council on Dental Education and LicensureReference Committee: C (Dental Education, Science and Related Matters)Total Net Financial Implication: None Net Dues Impact: _____Amount One-time _____ Amount On-going _____ FTE 0

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

How does this resolution increase member value: See Background

**AMENDMENT OF THE POLICY, CERTIFYING BOARD IN ORAL AND MAXILLOFACIAL
PATHOLOGY****Background:** (*Annual Reports:46*)**Resolution****21. Resolved**, that the ADA policy approving the requirements of the American Board of Oral Pathology (*Trans.1950:29-30*) be amended as follows (additions are underscored; deletions are ~~stricken~~):**Certifying Board in Oral and Maxillofacial Pathology****Resolved**, that the American Dental Association approves the American Board of Oral and Maxillofacial Pathology ~~the requirements of the American Board of Oral Pathology~~ as the national certifying board for the specialty of oral and maxillofacial pathology.**BOARD RECOMMENDATION: Vote Yes.****BOARD VOTE: UNANIMOUS. (BOARD OF TRUSTEES CONSENT CALENDAR ACTION—NO BOARD DISCUSSION)**

Resolution No. 22 NewReport: N/A Date Submitted: August 2015Submitted By: Council on Dental Education and LicensureReference Committee: C (Dental Education, Science and Related Matters)Total Net Financial Implication: None Net Dues Impact: _____Amount One-time _____ Amount On-going _____ FTE 0

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

How does this resolution increase member value: See Background

AMENDMENT OF THE POLICY, RECOGNITION OF ORAL AND MAXILLOFACIAL RADIOLOGY AS A DENTAL SPECIALTY**Background:** (*Annual Reports:46*)**Resolution****22. Resolved**, that the ADA policy, Recognition of Oral and Maxillofacial Radiology as a Dental Specialty (*Trans.1999:898*) be amended as follows (additions are underscored; deletions are ~~stricken~~):**Recognition of Oral and Maxillofacial Radiology as a Dental Specialty****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's request for the recognition of oral and maxillofacial radiology as a dental specialty ~~be approved.~~**BOARD RECOMMENDATION: Vote Yes.****BOARD VOTE: UNANIMOUS. (BOARD OF TRUSTEES CONSENT CALENDAR ACTION—NO BOARD DISCUSSION)**

Resolution No. 23 NewReport: N/A Date Submitted: August 2015Submitted By: Council on Dental Education and LicensureReference Committee: C (Dental Education, Science and Related Matters)Total Net Financial Implication: None Net Dues Impact: _____Amount One-time _____ Amount On-going _____ FTE 0

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

How does this resolution increase member value: See Background

1 CERTIFYING BOARD IN ORAL AND MAXILLOFACIAL RADIOLOGY**2 Background:** (*Annual Reports:46*)**3 Resolution****4**
5 23. Resolved, that the proposed ADA policy, Certifying Board in Oral and Maxillofacial Radiology be
6 adopted as follows:**7 Certifying Board in Oral and Maxillofacial Radiology****8 Resolved,** that the American Dental Association approves the American Board of Oral and
9 Maxillofacial Radiology as the national certifying board for the specialty of oral and maxillofacial
10 radiology.**11****12****13 BOARD RECOMMENDATION: Vote Yes.****14 BOARD VOTE: UNANIMOUS. (BOARD OF TRUSTEES CONSENT CALENDAR ACTION—NO**
15 BOARD DISCUSSION)

Resolution No. 24 NewReport: N/A Date Submitted: August 2015Submitted By: Council on Dental Education and LicensureReference Committee: C (Dental Education, Science and Related Matters)Total Net Financial Implication: None Net Dues Impact: _____Amount One-time _____ Amount On-going _____ FTE 0

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

How does this resolution increase member value: See Background

1 **AMENDMENT OF THE POLICY, CONTINUED RECOGNITION OF ORAL AND MAXILLOFACIAL**
 2 **SURGERY AS A DENTAL SPECIALTY AND RESCISSION OF THE POLICY, CONTINUED**
 3 **RECOGNITION OF ORAL SURGERY AS A DENTAL SPECIALTY**

4 **Background:** (*Annual Reports*:46)5 **Resolution**

6
 7 **24. Resolved**, that the ADA policy, Continued Recognition of Oral and Maxillofacial Surgery as a
 8 Dental Specialty (*Trans.*1990:554) be amended as follows (additions are underscored; deletions are
 9 ~~stricken~~):

10 **~~Continued~~ Recognition of Oral and Maxillofacial Surgery as a Dental Specialty**

11
 12 **Resolved**, that oral and maxillofacial surgery is a dental specialty recognized by the American
 13 Dental Association and sponsored by the American Association of Oral and Maxillofacial
 14 Surgeons. ~~continue to recognize the dental origins and derivations of the specialty of oral and~~
 15 ~~maxillofacial surgery, and be it further~~

16 ~~**Resolved**, that the American Dental Association continue to maintain its vigilance in cooperation~~
 17 ~~with appropriate specialty organizations to ensure that in the interests of the public, it continue to~~
 18 ~~be recognized by the public and the health care system that oral and maxillofacial surgery is best~~
 19 ~~delivered by surgically trained dentists regardless of additional degree qualifications.~~

20 and be it further

21
 22 **Resolved**, that the ADA policy Continued Recognition of Oral Surgery as a Dental Specialty
 23 (*Trans.*1988:491), be rescinded.

24
25 **BOARD RECOMMENDATION: Vote Yes.**

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

Appendix 1.

Policies to be Rescinded

As Recommended by the Council on Dental Education and Licensure

Continued Recognition of Oral Surgery as a Dental Specialty (*Trans.*1988:491)

Resolved, that the American Association of Oral and Maxillofacial Surgeons' request for continued recognition as a dental specialty be approved.

Resolution No. 25 NewReport: N/A Date Submitted: August 2015Submitted By: Council on Dental Education and LicensureReference Committee: C (Dental Education, Science and Related Matters)Total Net Financial Implication: None Net Dues Impact: _____Amount One-time _____ Amount On-going _____ FTE 0

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

How does this resolution increase member value: See Background

1 **CERTIFYING BOARD IN ORAL AND MAXILLOFACIAL SURGERY**2 **Background:** (*Annual Reports:47*)3 **Resolution**4
5 **25. Resolved**, that the proposed ADA policy approving the American Board of Oral and
6 Maxillofacial Surgery be adopted as follows:7 **Certifying Board in Oral and Maxillofacial Surgery**8 **Resolved**, that the American Dental Association approves the American Board of Oral and
9 Maxillofacial Surgery as the national certifying board for the specialty of oral and maxillofacial
10 surgery.

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

Resolution No. 26 NewReport: N/A Date Submitted: August 2015Submitted By: Council on Dental Education and LicensureReference Committee: C (Dental Education, Science and Related Matters)Total Net Financial Implication: None Net Dues Impact: _____Amount One-time _____ Amount On-going _____ FTE 0

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

How does this resolution increase member value: See Background

AMENDMENT OF THE POLICY, CONTINUED RECOGNITION OF ORTHODONTICS AS A DENTAL SPECIALTY AND RESCISSION OF THE POLICY, REDESIGNATION OF THE SPECIALTY "ORTHODONTICS" TO "ORTHODONTICS AND DENTOFACIAL ORTHOPEDICS"

Background: (*Annual Reports*:47)

Resolution

26. Resolved, that the ADA policy, Continued Recognition of Orthodontics as a Dental Specialty (*Trans.*1989:519) be amended as follows (additions are underscored; deletions are ~~stricken~~):

~~Continued~~ **Recognition of Orthodontics and Dentofacial Orthopedics as a Dental Specialty**

Resolved, that orthodontics and dentofacial orthopedics is a dental specialty recognized by the American Dental Association and sponsored by the American Association of Orthodontists' ~~request for continued recognition as a dental specialty be approved.~~

and be it further

Resolved, that the ADA policy Redesignation of the Specialty of "Orthodontics" to "Orthodontics and Dentofacial Orthopedics" (*Trans.*1994:611), be rescinded.

BOARD RECOMMENDATION: Vote Yes.

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

Appendix 1.

Policies to be Rescinded

As Recommended by the Council on Dental Education and Licensure

**Redesignation of the Specialty “Orthodontics” to “Orthodontics and Dentofacial Orthopedics”
(*Trans.* 1994:611)**

Resolved, that the specialty currently designated “orthodontics” be redesignated “orthodontics and dentofacial orthopedics,” and be it further

Resolved, that the documents and policies approved by the House of Delegates of the American Dental Association which refer to “orthodontics” be amended to reflect the change in designation to “orthodontics and dentofacial orthopedics” and be it further

Resolved, that the communities of interest be advised of the change in designation and be encouraged to utilize the new designation when referring to the specialty, and be it further

Resolved, that the Association’s *Principles of Ethics and Code of Professional Conduct* be amended by deleting the second paragraph of Section 5-C, Announcement of Specialization and Limitation of Practice, in its entirety and substituting the following new second paragraph:

The special areas of dental practice approved by the American Dental Association and the designation for ethical specialty announcement and limitation of practice are: dental public health, endodontics, oral pathology, oral and maxillofacial surgery, orthodontics and dentofacial orthopedics, pediatric dentistry, periodontics and prosthodontics.

Resolution No. 27 NewReport: N/A Date Submitted: August 2015Submitted By: Council on Dental Education and LicensureReference Committee: C (Dental Education, Science and Related Matters)Total Net Financial Implication: None Net Dues Impact: _____Amount One-time _____ Amount On-going _____ FTE 0

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

How does this resolution increase member value: See Background

**AMENDMENT OF THE POLICY, CERTIFYING BOARD IN ORTHODONTICS AND DENTOFACIAL
ORTHOPEDICS****Background:** (*Annual Reports:47*)**Resolution****27. Resolved**, that the ADA policy approving the American Board of Orthodontics
(*Trans.1950:189*) be amended as follows (additions are underscoring; deletions are ~~stricken~~):**Certifying Board in Orthodontics and Dentofacial Orthopedics****Resolved**, that the American Dental Association approves ~~the requirements of the American~~
Board of Orthodontics as the national certifying board for the specialty of orthodontics and
dentofacial orthopedics.**BOARD RECOMMENDATION: Vote Yes.****BOARD VOTE: UNANIMOUS. (BOARD OF TRUSTEES CONSENT CALENDAR ACTION—NO
BOARD DISCUSSION)**

Resolution No. 28 NewReport: N/A Date Submitted: August 2015Submitted By: Council on Dental Education and LicensureReference Committee: C (Dental Education, Science and Related Matters)Total Net Financial Implication: None Net Dues Impact: _____Amount One-time _____ Amount On-going _____ FTE 0

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

How does this resolution increase member value: See Background

**AMENDMENT OF THE POLICY, CONTINUED RECOGNITION OF PEDIATRIC DENTISTRY AS A
DENTAL SPECIALTY AND RESCISSION OF THE POLICY, REDESIGNATION OF THE SPECIALTY
OF "PEDODONTICS" TO "PEDIATRIC DENTISTRY"**

Background: (*Annual Reports:47*)**Resolution**

28. Resolved, that the ADA policy, Continued Recognition of Pediatric Dentistry as a Dental Specialty (*Trans.1990:549*) be amended as follows (additions are underscored; deletions are ~~stricken~~):

~~Continued~~ Recognition of Pediatric Dentistry as a Dental Specialty

Resolved, that pediatric dentistry is a dental specialty recognized by the American Dental Association and sponsored by the American Academy of Pediatric Dentistry's request for ~~continued recognition of pediatric dentistry as a dental specialty be approved.~~

and be it further

Resolved, that the ADA policy Redesignation of the Specialty of "Pedodontics" to "Pediatric Dentistry" (*Trans.1985:591*), be rescinded.

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

Appendix 1.

Policies to be Rescinded

As Recommended by the Council on Dental Education and Licensure

Redesignation of the Specialty of “Pedodontics” to “Pediatric Dentistry” (*Trans.1985:591*)

Resolved, that the specialty currently designated “pedodontics” be redesignated “pediatric dentistry,” and be it further

Resolved, that dental educational institutions consider redesignating departments of “pedodontics” as departments of “pediatric dentistry,” and be it further

Resolved, that state boards of dentistry consider changing their identification of the specialty of “pedodontics” to “pediatric dentistry,” and be it further

Resolved, that the documents and policies approved by the House of Delegates of the American Dental Association which refer to “pedodontics” be amended to reflect the change in designation to “pediatric dentistry,” and be it further

Resolved, that the Association’s *Principles of Ethics and Code of Professional Conduct* be amended by deleting the second paragraph of Section 5-C, Announcement of Specialization and Limitation of Practice, in its entirety and substitution of the following new second paragraph:

The special areas of dental practice approved by the American Dental Association and the designation for ethical specialty announcement and limitation of practice are: dental public health, endodontics, oral pathology, oral and maxillofacial surgery, orthodontics, pediatric dentistry, periodontics and prosthodontics.

Resolution No. 29 NewReport: N/A Date Submitted: August 2015Submitted By: Council on Dental Education and LicensureReference Committee: C (Dental Education, Science and Related Matters)Total Net Financial Implication: None Net Dues Impact: _____Amount One-time _____ Amount On-going _____ FTE 0

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

How does this resolution increase member value: See Background

1 **CERTIFYING BOARD IN PEDIATRIC DENTISTRY**2 **Background:** (*Annual Reports:47*)3 **Resolution**4
5 **29. Resolved**, that the proposed ADA policy approving the American Board of Pediatric Dentistry
6 be adopted as follows:7 **Certifying Board in Pediatric Dentistry**8
9 **Resolved**, that the American Dental Association approves the American Board of Pediatric
10 Dentistry as the national certifying board for the specialty of pediatric dentistry.

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

Resolution No. 30 NewReport: N/A Date Submitted: August 2015Submitted By: Council on Dental Education and LicensureReference Committee: C (Dental Education, Science and Related Matters)Total Net Financial Implication: None Net Dues Impact: _____Amount One-time _____ Amount On-going _____ FTE 0

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

How does this resolution increase member value: See Background

AMENDMENT OF THE POLICY, CONTINUED RECOGNITION OF PERIODONTICS AS A DENTAL SPECIALTY**Background:** (*Annual Reports*:48)**Resolution****30. Resolved**, that the ADA policy, Continued Recognition of Periodontics as a Dental Specialty (*Trans*.1988:490) be amended as follows (additions are underscoring; deletions are ~~stricken~~):**Continued Recognition of Periodontics as a Dental Specialty****Resolved**, that periodontics is a dental specialty recognized by the American Dental Association and sponsored by the American Academy of Periodontology's request for continued recognition of periodontics as a dental specialty be approved.**BOARD RECOMMENDATION: Vote Yes.****BOARD VOTE: UNANIMOUS. (BOARD OF TRUSTEES CONSENT CALENDAR ACTION—NO BOARD DISCUSSION)**

Resolution No. 31 NewReport: N/A Date Submitted: August 2015Submitted By: Council on Dental Education and LicensureReference Committee: C (Dental Education, Science and Related Matters)Total Net Financial Implication: None Net Dues Impact: _____Amount One-time _____ Amount On-going _____ FTE 0

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

How does this resolution increase member value: See Background

CERTIFYING BOARD IN PERIODONTICS**Background:** (*Annual Reports*:48)**Resolution****31. Resolved**, that the ADA policy approving the American Board of Periodontology be adopted as follows:**Certifying Board in Periodontics****Resolved**, that the American Dental Association approves the American Board of Periodontology as the national certifying board for the specialty of periodontics.**BOARD RECOMMENDATION: Vote Yes.****BOARD VOTE: UNANIMOUS. (BOARD OF TRUSTEES CONSENT CALENDAR ACTION—NO BOARD DISCUSSION)**

Resolution No. 32 NewReport: N/A Date Submitted: August 2015Submitted By: Council on Dental Education and LicensureReference Committee: C (Dental Education, Science and Related Matters)Total Net Financial Implication: None Net Dues Impact: _____Amount One-time _____ Amount On-going _____ FTE 0

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

How does this resolution increase member value: See Background

AMENDMENT OF THE POLICY, CONTINUED RECOGNITION OF PROSTHODONTICS AS A DENTAL SPECIALTY**Background:** (*Annual Reports:48*)**Resolution**

32. Resolved, that the ADA policy, Continued Recognition of Prosthodontics as a Dental Specialty (*Trans.1987:510*) be amended as follows (additions are underscored; deletions are ~~stricken~~):

~~Continued~~ Recognition of Prosthodontics as a Dental Specialty

Resolved, that prosthodontics is a dental specialty recognized by the American Dental Association and sponsored by the American College of Prosthodontists ~~the Federation of Prosthodontic Organizations' request for continued recognition of prosthodontics as a dental specialty be approved.~~

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

Resolution No. 33 NewReport: N/A Date Submitted: August 2015Submitted By: Council on Dental Education and LicensureReference Committee: C (Dental Education, Science and Related Matters)Total Net Financial Implication: None Net Dues Impact: _____Amount One-time _____ Amount On-going _____ FTE 0

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

How does this resolution increase member value: See Background

1 **CERTIFYING BOARD IN PROSTHODONTICS**2 **Background:** (*Annual Reports:48*)3 **Resolution**4
5 **33. Resolved**, that the ADA policy approving the American Board of Prosthodontics be adopted
6 as follows:7 **Certifying Board in Prosthodontics**8
9 **Resolved**, that the American Dental Association approves the American Board of
10 Prosthodontics as the national certifying board for the specialty of prosthodontics.

11

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

Resolution No. 34 NewReport: N/A Date Submitted: August 2015Submitted By: Council on Dental Education and LicensureReference Committee: C (Dental Education, Science and Related Matters)Total Net Financial Implication: None Net Dues Impact: Amount One-time Amount On-going FTE 0

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

How does this resolution increase member value: See Background

**RESCISSION OF THE POLICY, STATEMENT OF STATUTORY REGULATION OF DENTAL
SPECIALTY PRACTICE AND DENTAL SPECIALISTS****Background:** (*Annual Reports*:48)**Resolution****34. Resolved**, that the ADA policy Statement of Statutory Regulation of Dental Specialty Practice and Dental Specialists (*Trans.*1959:192, 205; 1994:615), be rescinded.**BOARD RECOMMENDATION: Vote Yes.****BOARD VOTE: UNANIMOUS. (BOARD OF TRUSTEES CONSENT CALENDAR ACTION—NO
BOARD DISCUSSION)**

Appendix 1.

Policies to be Rescinded

As Recommended by the Council on Dental Education and Licensure

**Statement of Statutory Regulation of Dental Specialty Practice and Dental Specialists
(*Trans.*1959:192:205) (1994:615)**

Provisions specifically regulating dental specialty practice and dental specialists have been incorporated within various dental laws. These statutory provisions are intended to ensure high standards of competency from dentists who hold themselves out as specialists in order to serve best the dental health needs of the public.

Although the purpose and objectives of the so-called specialty laws are worthy aims, there is unquestionably an inherent danger of conflict between what might well develop into an inelastic legal system for regulating dental specialty practice and the much more flexible private regulatory system as reflected within Association-approved requirements and ethical principles. If, for example, the law in a particular state prescribes postgraduate requirements for a specialty practice license inferior to those approved by the Association, the result may well be a legal grant of authority to specialty licenses which, if exercised, would bring them in conflict with Association policy and even professional ethics.

Again, a state specialty law may recognize specialty areas for licensure not approved by the Association. The dentist authorized to hold himself out in a nonapproved specialty area, then, could not exercise his legal privilege without exposing himself to a charge of unethical conduct

The American Dental Association recognizes that specialty licensure can be a fair and equitable means of expediting the free movement of specialists among various states. However, in creating specialty licensure laws, it is prudent to recognize that the creation and control of dental specialties is best handled by the profession acting through the American Dental Association in consultation with the specialty organizations, state boards of dentistry, and dental schools with proper regard for the protection of the dental health of the public.

Should it be determined by a constituent society that statutory regulation of specialty practice is required because of a particular local situation, the American Dental Association further recommends that the society take all precautions to ensure that the specialty provisions will permit the state board of dental examiners (1) to prescribe regulations to conform with Association requirements, and (2) to amend those regulations whenever it is necessary to conform them with changes in Association requirements.

The American Dental Association also recommends that those constituent societies representing states which now have specialty practice provisions within their dental practice acts urge their dental examining boards to (1) bring the board regulations for, and administration of, the dental specialty laws in conformity with existing Association requirements, and (2) prescribe new regulations and make appropriate administrative changes whenever it is necessary to conform with any future changes in Association requirements.

Resolution No. 39 NewReport: N/A Date Submitted: August 2015Submitted By: Joint Commission on National Dental ExaminationsReference Committee: C (Dental Education, Science and Related Matters)Total Net Financial Implication: None Net Dues Impact: _____Amount One-time _____ Amount On-going _____ FTE 0

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

How does this resolution increase member value: Not Applicable

REVISIONS TO THE STANDING RULES OF THE JOINT COMMISSION ON NATIONAL DENTAL EXAMINATIONS**Background:** (*Annual Reports*:88)

Revision to the *Standing Rules* of the Joint Commission on National Dental Examinations: At its April 2015 meeting the Joint Commission adopted proposed revisions to the Joint Commission's *Standing Rules*. These revisions included editorial modifications to clarify language within the document and align language more closely with prior Joint Commission decisions. The following is also noteworthy:

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.

The Joint Commission recommends that the following resolution be adopted by the 2015 House of Delegates:

Resolution

39. Resolved, that the *Standing Rules* of the Joint Commission on National Dental Examinations be approved as revised in Appendix 1 of the Joint Commission's 2015 annual report.

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

Appendix 1

Revisions to the Standing Rules of the Joint Commission on National Dental Examinations

STANDING RULES

April 2014 2015

A publication of the Joint Commission on National Dental Examinations

American Dental Association Building

211 East Chicago Avenue, ~~Suite 600~~

Chicago, Illinois 60611-2637

1 The Joint Commission on National Dental Examinations operates within the limits imposed by
2 ~~three~~ four documents, listed here in order of precedence:

- 3 1. Bylaws of the American Dental Association
- 4 2. Bylaws of the Joint Commission on National Dental Examinations
- 5 3. Standing Rules for Councils and Commissions
- 6 4. Standing Rules of the Joint Commission on National Dental Examinations

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

10



TABLE OF CONTENTS

1		
2	Election of a Public Member	3
3	Qualifications.....	3
4	Term.....	3
5	Identification of Nominees.....	3
6	Roles of Committees	3
7	Assignments.....	4
8	Committee on Administration	4
9	Committee on Dental Hygiene.....	4
10	Committee on Examination Development.....	4
11	Committee on Research and Development.....	5
12	Committee Actions.....	5
13	Reporting.....	5
14	Test Constructor Selection Criteria	6
15	Detection of Irregularities Based on Forensic Analyses	6
16	Limited Right of Appeal for Examination Candidates	6
17	Conflict of Interest Policy	7
18	Assistance to Other Agencies	7
19	Availability.....	7

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.

Assignments

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

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

Committee on Administration

This committee's responsibility relates to both National Board Dental Examinations and the National Board Dental Hygiene Examination. The committee deals with operations. Specific topics to be considered include:

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

Committee on Dental Hygiene

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

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

Committee on Examination Development

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

- a. Examination content and specifications
- b. Test construction procedures, including nomination of test constructors and establishment of qualification requirements

- c. Information circulated to publicize or explain the testing program
- d. Portions of Examination Regulations that affect dental candidates
- e. Matters pertaining to finances, ADA and Joint Commission Bylaws, and Joint Commission Standing Rules that affect the National Board Dental Examinations

Committee on Research and Development

This committee's responsibility relates to both the National Board Dental Examinations and the National Board Dental Hygiene Examination. Topics considered by this Committee include any research 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 ~~circulated~~ provided to all Commissioners and all Committee members. Exceptions ~~include, for example,~~ the following: 1) information about a nominee to a test construction committee 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 ~~in written or electronically form.~~ Topics are discussed in the order they are listed on the Joint Commission's agenda, and background information related to each topic is identified. For each recommendation, 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 Dental and Dental Hygiene Test Construction Committees. A test constructor is appointed for a one-year term and may be reappointed to four consecutive terms. To be considered for appointment, candidates must possess appropriate qualifications and must submit a completed personal data form. Test constructor qualifications are published in the following document: Joint Commission's JCNDE Test Construction Committees and Member Selection Criteria ~~Qualification Requirements for National Board Dental and Dental Hygiene Test Constructors.~~ Test constructors who have completed five years of service on a committee will not be considered for reappointment to the same committee.

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 ~~scores~~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 JNCDE's operations and the impartiality of its decision-making process is an organizational and personal duty to avoid real or perceived conflicts of interest. The potential for a conflict of interest arises when one's duty to make decisions in the public's interest is compromised by competing interests of a personal or private nature, including but not limited to pecuniary interests. Conflicts of interest can result in a partiality or bias which might interfere with objectivity in decision-making with respect to policy, or the evaluation of candidate appeals.

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

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

To safeguard the objectivity of the Joint Commission, it is the responsibility of any Commissioner to disclose any potential conflicts. Any member with a direct conflict of interest must recuse himself/herself from the decision making process regarding candidate appeals, or

1 from discussions involving policies that impact the fairness and impartiality of the JCNDE's
2 examination programs.

3 **ASSISTANCE TO OTHER AGENCIES**

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

8 **Availability**

9
10 Operation of the National Board Examinations is the Joint Commission's primary charge.
11 Assistance is provided to state boards of dentistry or national dental organizations only upon
12 request and only if the Joint Commission possesses the resources to fulfill the request.
13

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

Resolution No. 40 NewReport: N/A Date Submitted: August 2015Submitted By: Joint Commission on National Dental ExaminationsReference Committee: C (Dental Education, Science and Related Matters)Total Net Financial Implication: None Net Dues Impact: _____Amount One-time _____ Amount On-going _____ FTE 0

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

How does this resolution increase member value: Not Applicable

REVISIONS TO THE BYLAWS OF THE JOINT COMMISSION ON NATIONAL DENTAL EXAMINATIONS

Background: (*Annual Reports*:89)

Revision to the *Bylaws* of the Joint Commission on National Dental Examinations: At its April 2015 meeting the Joint Commission adopted proposed revisions to the *Joint Commission's Bylaws*, contingent upon approval by the ADA House of Delegates. These revisions were editorial in nature, updating the *Bylaws* to 1) properly reflect the name of the American Association of Dental Boards, and 2) reference the *American Institute of Parliamentarians Standard Code of Parliamentary Procedure* as the replacement for *Sturgis Standard Code of Parliamentary Procedures*. The Joint Commission recommends that the following resolution be adopted by the 2015 House of Delegates:

Resolution

40. Resolved, that the *Bylaws* of the Joint Commission on National Dental Examinations be approved as revised in Appendix 2 of the Joint Commission's 2015 annual report.

BOARD RECOMMENDATION: Vote Yes.

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

Appendix 2

Revisions to the Bylaws of the Joint Commission on National Dental Examinations

**JOINT COMMISSION ON NATIONAL
DENTAL EXAMINATIONS**

BYLAWS

~~September 2002~~ November 2015

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 ~~three~~ four documents.
2 In order of precedence, they are:

3 *Bylaws of the American Dental Association*

4 *Bylaws of the Joint Commission on National Dental Examinations*

5 *Standing Rules for Councils and Commissions*

6 *Standing Rules of the Joint Commission on National Dental Examinations*

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

9 Joint Commission *Bylaws* were adopted in 1980 and amended since. Additional modifications
10 may be 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, here and after referred to as National Board Dental 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, here and after referred to as the National Board Dental Hygiene Examinations.
- C. To make rules and regulations for the conduct of National Board Dental and Dental Hygiene Examinations and for the issuance of National Board Dental and Dental Hygiene Certificates.
- 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 ~~Examiners~~ Boards from its active membership no one of whom is a member of a faculty of an accredited dental school.
 - a. For the purpose of these Bylaws, the active membership of the American Association of Dental ~~Examiners~~ 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.

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

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

Section 3. Term of Office

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

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

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

Section 4. Powers

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

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

Section 5. Duties

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

1. Develop, publish and periodically review specifications for National Board Dental and Dental Hygiene Examinations.
2. Appoint consultants with appropriate qualifications to assist in the construction of National Board Dental and Dental Hygiene Examinations.

3. Develop, publish and periodically review rules and regulations for the fair and orderly administration of National Board Dental and Dental Hygiene Examinations.
4. Cause National Board Dental and Dental Hygiene Examinations to be administered at least annually at locations throughout the United States.
5. Cause ~~scores~~ results from National Board Dental and Dental Hygiene Examinations to be reported in a timely fashion to candidates and/or their schools and to state boards of dentistry identified by candidates.
6. Cause a permanent record of National Board dental and dental hygiene scores to be maintained so that such ~~scores~~ results may be reported to individuals or institutions identified by candidates.
7. Protect the security of National Board Dental and Dental Hygiene Examinations and the integrity of National Board dental and dental hygiene ~~scores~~ results.

B. Liaison: The Board of Commissioners shall:

1. Submit an annual report of the activities and future plans of the Joint Commission on National Dental Examinations to appropriate officials of the American Association of Dental ~~Examiners~~ Boards, the American Dental Education Association, the American Dental Association, the American Dental Hygienists' Association and the American Student Dental Association.
2. Conduct an annual forum for representatives of state boards of dentistry for the purposes of providing information about and receiving recommendations for National Board Dental and Dental Hygiene Examinations.

C. Financial Management: The Board of Commissioners shall:

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

D. Miscellaneous: The Board of Commissioners shall monitor these *Bylaws* for consistency with the *Bylaws of the American Dental Association*. When or if a conflict exists, the Board of Commissioners shall describe such conflict in its annual report to sponsoring associations and recommend changes to achieve conformity.

Section 6. Meetings

1 **A. Regular Meetings:** There shall be one (1) regular meeting of the Board of
2 Commissioners each year.

3 **B. Special Meetings:** A special meeting of the Board of Commissioners may be called at
4 any time by the Chair of the Joint Commission on National Dental Examinations. The
5 Chair shall call a special meeting at the request of nine (9) of the fifteen (15) members of
6 the Board of Commissioners. Members of the Board of Commissioners shall be notified
7 at least ten (10) days in advance of the convening of a special meeting.

8 **Section 7. Quorum**

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

10 **ARTICLE III. COMMITTEES**

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

12 The Joint Commission on National Dental Examinations shall have a standing Committee on
13 Dental Hygiene.

14 **A. Composition:** The Committee on Dental Hygiene shall be composed of eight (8)
15 members to be selected as follows:

16 1. One (1) Commissioner appointed by the Chair who is a representative of the
17 American Association of Dental ~~Examiners~~Boards.

18 2. One (1) Commissioner appointed by the Chair who is a representative of the
19 American Dental Education Association.

20 3. One (1) Commissioner appointed by the Chair who is a representative of the
21 American Dental Association.

22 4. The Commissioner who is a representative of the American Dental Hygienists'
23 Association plus three (3) additional dental hygienists who are selected by the
24 American Dental Hygienists' Association. Of the four (4) dental hygienist
25 members, two (2) members shall be faculty members of accredited dental
26 hygiene programs and two (2) members shall represent practicing dental
27 hygienists.

28 5. One (1) dental hygiene student who is selected by the American Dental
29 Hygienists' Association.

30 **B. Meetings:** The Committee on Dental Hygiene shall have one (1) regular meeting each
31 year. This meeting shall precede the regular, annual meeting of the Board of
32 Commissioners. Special meetings of the Committee on Dental Hygiene shall be
33 convened at the request of the Board of Commissioners or at the request of a majority of
34 Committee members subject to approval by the Board of Commissioners.

35 **C. Duties:** The Committee on Dental Hygiene shall consider matters related to the

1 National Board Dental Hygiene Examination.

2 **Section 2. Test Construction Committee**

3 The Joint Commission on National Dental Examinations shall establish and convene regular
4 meetings of such committees as are necessary to construct National Board Dental and Dental
5 Hygiene Examinations.

6 **Section 3. Other Committees**

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

14 **Section 4. Authority**

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

16 **ARTICLE IV. OFFICERS**

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

19 **B. Election:** The Chair of the Joint Commission on National Dental Examinations shall be
20 elected by the Board of Commissioners during its regular, annual meeting. The term of
21 the Chair shall be one (1) year beginning and ending with adjournment of the closing
22 session of the annual meeting of the House of Delegates of the American Dental
23 Association.

24 **C. Duties:** The Chair of the Joint Commission on National Dental Examinations shall:

- 25 1. Appoint members and chairmen of such committees as are necessary for the
26 orderly conduct of business except as otherwise provided in these *Bylaws*.
- 27 2. Circulate or cause to be circulated an announcement and an agenda for each
28 regular or special meeting of the Board of Commissioners.

3. Preside during meetings of the Board of Commissioners.
4. Prepare or supervise the preparation of an annual report of the Joint Commission on National Dental Examinations.
5. Prepare or supervise the preparation of an annual appropriation request for the Joint Commission on National Dental Examinations.
6. Represent the Joint Commission on National Dental Examinations during sessions of the House of Delegates of the American Dental Association.

Section 2. Vice Chair

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

Section 3. Secretary:

- A. Appointment:** The Secretary of the Joint Commission on National Dental Examinations shall be an employee of the American Dental Association selected by the Executive Director of that Association.
- B. Evaluation:** The performance of the Secretary may be evaluated by the Board of Commissioners. If the Board of Commissioners exercises this option, written evaluation including recommendations signed by the Chair shall be forwarded to the Executive Director of the American Dental Association.
- C. Duties:** The Secretary of the Joint Commission on National Dental Examinations shall:
 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 ~~Examiners~~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* ~~Sturgis Standard Code of Parliamentary Procedures~~ 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.

ARTICLE VI. AMENDMENT

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

Resolution No. 60 NewReport: N/A Date Submitted: August 2015Submitted By: Second Trustee DistrictReference Committee: C (Dental Education, Science and Related Matters)Total Net Financial Implication: \$22,000 Net Dues Impact: \$0.21Amount One-time Amount On-going \$22,000 FTE 0

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

How does this resolution increase member value: See Background

ADA SPONSORED DENTAL LICENSURE MEETING

1 The following resolution was adopted by the Second Trustee District and submitted on August 12, 2015,
2 by Dr. Mark J. Feldman, executive director, New York State Dental Association.

3 **Background:** The New York State Dental Association (NYSDA) has once again led the way to the ADA's
4 stated goal of eliminating live patient testing as part of the dental examination process. The "PGY1" year
5 of additional training or completion of a CODA approved ADA specialty program as a pathway for initial
6 licensure in NY has been a long standing success that we are not looking to change. The dentists who
7 have completed the post graduate year have practiced in NY now for over a decade with no adverse
8 statistics to indicate any increased risk to the public. But the fact is that the PGY1 model will not work in
9 many states (only 7 currently accept that pathway) as there are not enough post graduate spots to
10 accommodate all dental school graduates. In addition, most states have refused to recognize dentists
11 who have completed a PGY1 year for licensure by credentials, causing dental students to take a clinical
12 licensure examination to assure portability options.

13
14 NY has long supported the ADA policy that seeks to have licensure examinations based on a Curriculum
15 Integrated Format (CIF) as follows:

16 "The ADA has voiced its position regarding the use of patients in clinical examinations through a
17 series of resolutions culminating with the adoption of the 2005 House of Delegates' Resolution
18 20H-2005.8-10 This resolution reaffirms ADA support for the elimination of patients in the
19 clinical licensure examination process while giving exception to a more recent methodology for
20 testing known as the curriculum-integrated format (CIF). The 2006 ADA House of Delegates
21 directed the ADA Council on Dental Education and Licensure to develop a definition of CIF and
22 present it to the 2007 House of Delegates. The 2007 House adopted the following definition
23 (Resolution 1H-2007):

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

28 If such a process includes patient care as part of the assessment, it should be performed by
29 candidates on patients of record, whenever possible, within an appropriately sequenced

1 treatment plan. The competencies assessed by the clinical examining agency should be
2 selected components of current dental education program curricula.

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

7 This examination, described above, had never been successfully implemented and the phrase "whenever
8 possible" in the definition has been the excuse that allowed the regular clinical examination to continue-
9 until now.

10 As of January 2015, the NYSDA has successfully piloted a true CIF examination in cooperation with the
11 CDCA/ADEX and the University at Buffalo School of Dental Medicine. Preparation for this exam took
12 place over a series of meetings between the New York Dental School Deans, NYSDA and the Dental
13 Examiners and when all sat down together in a spirit of cooperation there was no issue that could not be
14 resolved.

15 All logistical challenges inherent to this modality have been addressed and the exam has been given four
16 times at the school. Treatment is done on dental school patients of record during the regular school day
17 on lesions pre-approved by the faculty. If a candidate is not successful, the patient is remediated on the
18 spot by the faculty and student, just as would occur in a normal treatment plan at the school. In fact, for
19 the first time in any examination process the patient leaves with a permanent restoration as opposed to
20 having a temporary placed in a non-successful procedure. Students have found this exam much less
21 stressful and overall it has been a big success. The model allows for the student to satisfy both an
22 independent evaluation of performance by a third party and the dental school competency review since
23 faculty are also present throughout the CIF model. It changes the nature of the experience from a testing
24 process to a learning experience for the student as all care is done on their patients of record in a normal
25 treatment sequence as would occur during the regular dental school year.

26 The time has come to bring this format to all states, and allow for universal recognition (only eighteen
27 states accept the results of all clinical examinations for initial licensure) either via credentials (in a PGY1
28 state like NY) or for initial licensure. Other than the elimination of student debt, there is no one issue more
29 important to our young members than freedom of movement. The CIF exam is possible and this has been
30 proven. There is no longer the need to offer it whenever possible. It should be the standard for ethical
31 practice and evaluation in a licensing process.
32

33 Resolution

34 **60. Resolved**, that the ADA convene a meeting inviting representatives from the American
35 Association of Dental Boards, the American Dental Education Association, the ADA Council on
36 Dental Education, the ADA Council on Ethics, Bylaws and Judicial Affairs, the American Student
37 Dental Association and all testing agencies with the stated goal of developing and implementing a
38 universally acceptable true curriculum integrated format (CIF) licensing examination, and be it
39 further

40 **Resolved**, that the ADA help state societies advocate for acceptance of the CIF examination as
41 satisfying the clinical licensing evaluation for those states that require a clinical examination, and
42 be it further

43 **Resolved**, that a report with progress and further recommendations be presented to the 2016
44 House of Delegates.

BOARD COMMENT: The Board supports the intent of this resolution, but believes that efforts to fully support the CIF examination model are already underway. In March 2015, the Board established the Licensure Task Force with representatives from the American Student Dental Association (ASDA), American Association of Dental Boards (AADB), American Dental Education Association (ADEA), Council on Dental Education and Licensure (CDEL), New Dentist Committee (NDC) and the clinical testing agencies. The Task Force was charged to develop a plan to address issues relating to portability of dental licensure, alternatives to current licensure assessments, the fragmentation of the current licensure administrative processes and implementation of agreed upon change including accountabilities and timelines.

The Board agrees with the suggestions of the Task Force and supports the following concepts for further collaboration among the stakeholder groups through the Task Force in 2016:

- Formally request all regional clinical testing agencies and dental schools to pilot the new CIF examination in 2016
- Establish a goal for full implementation of the CIF examination that complies with ADA policy within the next eight years, taking advantage of the constant clinical assessments conducted in dental schools during the third and fourth years as part of initial licensure requirements
- In accord with current policy, advocate with state dental associations for universal acceptance of any regional clinical examination (i.e., CRDTS, CDCA, CITA, SRTA and WREB).
- Monitor progress of acceptance and utilization of non-patient based licensing examinations, e.g., California's Portfolio Model and Canada's Objective Structured Clinical Examination.

Because the Board has recommended that the President reappoint the Licensure Task Force in 2016 to continue promoting the CIF examination, the Board believes the resolution is duplicative of current efforts.

BOARD RECOMMENDATION: Vote No.

Vote: Resolution 60

ASAI	No	DOW	No	JEFFERS	No	STEVENS	No
BITTER	No	FAIR	No	KWASNY	No	SUMMERHAYS	No
BUCKENHEIMER	No	GAMBA	Yes	ROBERTS	No	YONEMOTO	Yes
COLE	No	GEHANI	Yes	ROBINSON	No	ZENK	No
CROWLEY	No	ISRAELSON	Yes	SHENKIN	No	ZUST	Yes

Resolution No. None N/AReport: Board Report 9 Date Submitted: August 2015Submitted By: Board of TrusteesReference Committee: C (Dental Education, Science and Related Matters)Total Net Financial Implication: None Net Dues Impact: _____Amount One-time _____ Amount On-going _____ FTE 0

ADA Strategic Plan Objective: None

How does this resolution increase member value: See Background

**REPORT 9 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 August 2015 meeting, the Board of Trustees approved the appended Annual Report of the Library and Archives Advisory Board for transmittal to the 2015 House of Delegates. This report supports the following strategic plan goals:

- Membership: The ADA will increase member value and engagement.
Objective 2.1: Develop and implement collaborative programs with entities that have access to large pools of potential members
- Finance: The ADA will be financially sustainable.
Objective 5.2: Increase member utilization of existing products and services and pursue new markets
- Organizational Capacity Goal: All levels of the ADA will have sufficient organizational capacity necessary to meet member needs.
Objective 6.1: Act in the best interest of the member, rather than the organization when designing processes, programs and services

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

Fair III, Julian, H., 2016, Board of Trustees, 16th district, chair
Asai, Rickland, D., 2017, Board of Trustees, 11th district
Abt, Elliot, 2016, Illinois, Council on Scientific Affairs
Booth, H., Austin, New York, Special Librarian
Hart, Thomas, C., 2016, Illinois, Council on Scientific Affairs
Hammer, Christine, L., 2016, Maryland, at-large Member
Holm, Stephen, J., 2016, Indiana, Council on Dental Education and Licensure
Mahler, Harvey, J., 2016, Illinois, at-large Member
Sahota, D., Ruchi, 2016, California, at-large Member (resigned in late 2014)
Sarrett, David, C., 2017, Virginia, Council on Dental Education and Licensure
Hart, Karen, M., Senior Director, Education Operations
Gartman, Jeffrey, G., Senior Reference and OnLine Resources Librarian

Areas of Responsibility

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

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

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

In support of the Strategic Plan, Members First 2020, the following objectives have been pursued with the intent of increasing member value and engagement:

Objective	Initiative/Program	Success Measure	Target	Range	Outcome
Achieve a 10% increase in member value	Ensure public confidence and professional integrity adhering to best practices in special library operations	Meet the expectations and directives of the Library and Archives Advisory Board	100% compliance with Board directives and requests	80-100% compliance with Board directives and requests	Meeting directives of LAAB **
Achieve a 10% increase in member value	Support members by marketing library services and resources	Increase usage of electronic resources by members	25% increase in service utilization	15-35% increase in service utilization	12% decrease in e-service utilization projected as of June 2015**

**Results are as of the date of report preparation and do not reflect full-year results.

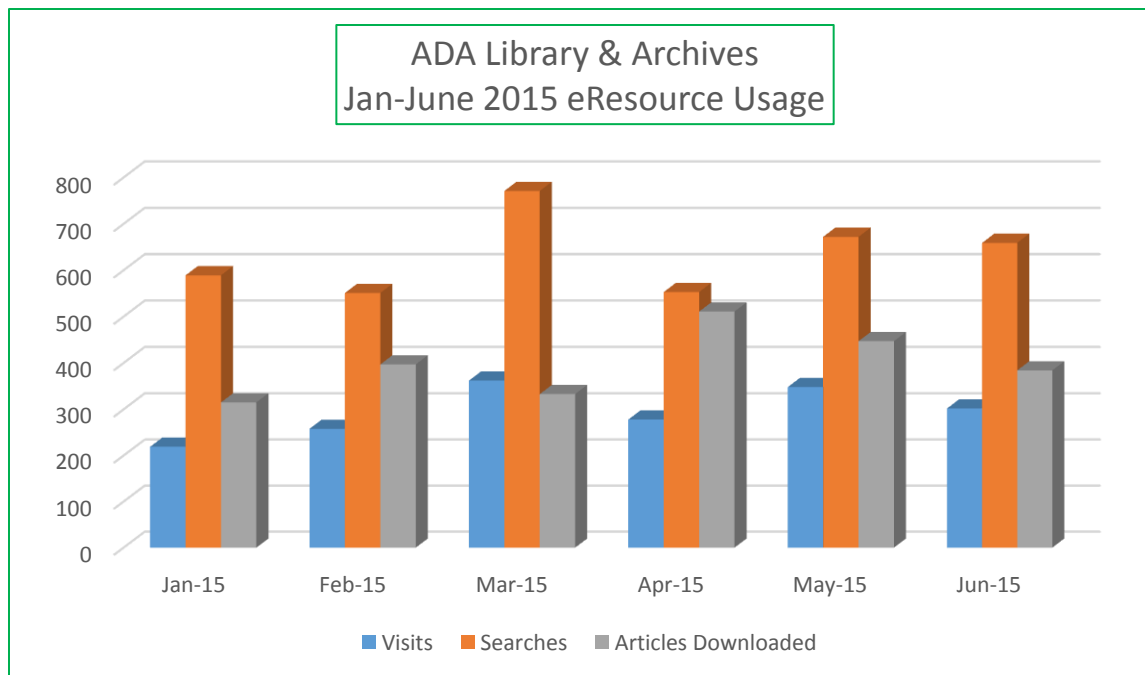
- Statistics collected in the first half of 2015 indicate that members continue to use the Library eResources and other services. Using the first 6 months of 2015 as a baseline, members are projected to complete 7,590 searches and download 4,774 articles (this may result in a 12% decrease from the 5252 searches and 5452 downloads in 2014).
- Library staff are projected to handle 1,948 patron requests in 2015. In 2014, 1589 requests were processed.

ADA Library & Archives

eResource Usage January - June 2015

Month	Visits	Searches Done	Articles Downloaded
January 2015	219	589	315
February 2015	258	551	397
March 2015	362	771	333
April 2015	278	553	511
May 2015	348	672	447
June 2015	302	659	384
Average per month	294	632	397
Projected 2015 totals	3534	7590	4774

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ADA Member & Staff Contacts January – June 2015

6

	Reference Requests	Article Requests	Quick Fact Finding	Historical Requests	Total Requests
ADA Members	338	90	21	41	490
ADA Staff	45	89	27	47	208
Other Libraries	3	244	24	5	276
Jan-Jun 2015 Total	386	423	72	93	974
Projected 2015 Totals	772	846	144	186	1948

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- At the end of 2014, the LAAB invited members of the Australian Dental Association, British Dental Association, and the Canadian Dental Association who were interested in accessing the Library & Archives eResources to become Affiliate ADA Members. To date, 130 new Affiliate Members have joined the ADA.
- As of June 1, 2015, ADA Members who are interested, now have access to and may use the resources of the University of Illinois at Chicago (UIC) Library of the Health Sciences. Using their ADA Membership cards, members can physically enter the UIC Library of the Health Sciences

and check out books, read current journals, and access the UIC database collection. Instructions on how to access and use UIC resources were announced in ADA News on May 18, 2015.

- 1024 books which were removed from the library catalog and not chosen by the UIC Library of the Health Sciences were shipped to Better World Books (Indianapolis, IN) in April of 2015. 3116 books chosen by the UIC Library of the Health Sciences were shipped to UIC in June of 2015. In addition, 5592 books were weeded from the current and legacy/historic collection for removal from the library catalog and future disposition.
- The Library & Archives Landing page was changed in May 2015. It has a cleaner look and is much easier to use. In addition, a series of library rotators have been operating on ADA.org since April 2015. These and regular ADA News articles have been used to market the Library & Archive eResources to ADA members.

Emerging Issues and Trends

Libraries continue to go through the process of maximizing 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.
- Maintaining and developing a comprehensive collection of information sources for ADA members in various formats.
- Continuous support of evidence-based dentistry.
- Developing new success measures that emphasize impact on policy outcomes, impact on clinical practice, and the research productivity of ADA members and staff.

Policy Review

The LAAB developed and approved the Library Archives Deaccession Policy and Guidelines in 2015.

Summary of Resolutions

This report is for informational purposes only.

Resolution No. 53 NewReport: CODA Supplemental Report 1 Date Submitted: October 2015Submitted By: Commission on Dental AccreditationReference Committee: C (Dental Education, Science and Related Matters)Total Net Financial Implication: None Net Dues Impact: _____Amount One-time _____ Amount On-going _____ FTE 0

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

How does this resolution increase member value: Not Applicable

COMMISSION ON DENTAL ACCREDITATION SUPPLEMENTAL REPORT 1 TO THE HOUSE OF DELEGATES: REQUEST TO TRANSFER THE JOINT ADVISORY COMMITTEE ON INTERNATIONAL ACCREDITATION FROM ITS CURRENT ADA-CODA STRUCTURE TO A STANDING COMMITTEE OF THE COMMISSION ON DENTAL ACCREDITATION

Background: In 2005, the ADA adopted Resolution 39H developing a joint advisory committee to provide guidance to the Commission on Dental Accreditation with fee-based international consultation and accreditation services. Since its inception, the Joint Advisory Committee on International Accreditation (JACIA) has acted as an advisory committee external to the Commission and includes three representatives of the Association, with one from the ADA Board of Trustees as chair and two at large members from the practicing community, and two representatives of the Commission. The Committee also includes a consultant who is a former CODA Commissioner. JACIA's revenue is generated from application and consultative fees paid by international predoctoral dental education programs and varies from year-to-year based upon interest. JACIA revenue is retained in the ADA's operational fund. Expenses result from an allocated 0.6 FTE of CODA staff salaries and benefits, along with travel costs associated with consultative site visits. Application and consultation fees cover the staff salaries and benefits, while international programs pay all actual consultative site visit expenses resulting in an expense neutral budget.

The Commission's primary source of revenue is through fees paid by accredited programs such as the annual accreditation fee and application fees. Staff salaries are a direct expense to the Commission's annual operating budget and since the JACIA has a separate budget from the Commission, the Commission does not receive compensation for the 0.6 FTE staff support it provides to the joint advisory committee. In essence, under the current structure, CODA-accredited programs' annual fees support the CODA and CODA staff resources that support the JACIA.

The current structure of the JACIA as an advisory committee external to the Commission was discussed by the ADA-CODA Workgroup during its 2015 meeting. The Workgroup concluded that the current structural and financial relationship of JACIA to the Association should be reevaluated. In summer 2015, the Commission's Standing Committees on Finance and Quality Assurance and Strategic Planning also discussed the current structure of JACIA and recommended to the Commission, and the Commission concurred, that the Commission submit a resolution to the 2015 ADA House of Delegates (HOD) calling for the JACIA to become a standing committee of the Commission, and support the establishment of a Standing Committee on International Accreditation under the purview of the Commission with budget allocations incorporated within the Commission's annual budget. The Commission believes that this

1 request requires the House to sunset the current structure of the JACIA. The membership structure of
2 the new CODA Standing Committee on International Accreditation would remain the same; members
3 currently serving on the committee would complete their terms.

4 **Resolution**

5 **53. Resolved**, that the Joint Advisory Committee on International Accreditation (JACIA) be sunset as
6 requested by the Commission on Dental Accreditation; and be it further

7 **Resolved**, that the Commission on Dental Accreditation's proposal to establish a Standing
8 Committee on International Accreditation be supported, with a committee composition identical to the
9 former JACIA membership.

10 **BOARD RECOMMENDATION: Vote Yes.**

11 **BOARD VOTE: UNANIMOUS.**

Resolution No. 54 NewReport: CODA Supplemental Report 2 Date Submitted: October 2015Submitted By: Commission on Dental AccreditationReference Committee: C (Dental Education, Science and Related Matters)Total Net Financial Implication: None Net Dues Impact: Amount One-time Amount On-going FTE 0

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

How does this resolution increase member value: Not Applicable

COMMISSION ON DENTAL ACCREDITATION SUPPLEMENTAL REPORT 2 TO THE HOUSE OF DELEGATES: REVISION OF THE RULES OF THE COMMISSION ON DENTAL ACCREDITATION

Background: In summer 2015, the Commission directed that the *Rules of the Commission on Dental Accreditation* be revised to grant the Commission authority to choose among other accreditors who may be invited to CODA's closed session meeting, for example a representative(s) of the Dental Council of New Zealand, which recently requested the Commission's assistance with revalidation of the existing prescribed qualifications in New Zealand. Additionally, the Commission directed several editorial changes to the CODA *Rules*.

In accordance with ADA *Bylaws*, Section 130, Duties, the Commission may submit amendments to its *Rules* to the ADA House of Delegates for approval by vote either through or in cooperation with the Council on Dental Education and Licensure (CDEL). The Commission notified CDEL of its revisions on August 18, 2015 and was subsequently notified of the Council's support of the revisions on August 31, 2015. Appendix 1 includes the proposed revisions, with additions underscored and deletions ~~stricken~~.

Resolution

54. Resolved, that the *Rules* of the Commission on Dental Accreditation be revised as noted in Appendix 1 of the Commission's Supplemental Report 2 to the House of Delegates.

BOARD RECOMMENDATION: Vote Yes.

BOARD VOTE: UNANIMOUS.

Appendix 1: Rules of the Commission on Dental Accreditation**Article I. MISSION**

The Commission on Dental Accreditation serves the oral health care needs of the public through the development and administration of standards that foster continuous quality improvement of dental and dental related educational programs.

Article II. BOARD OF COMMISSIONERS

Section I. LEGISLATIVE AND MANAGEMENT BODY: The legislative and management body of the Commission shall be the Board of Commissioners.

Section 2. COMPOSITION: The Board of Commissioners shall consist of:

Four (4) members shall be selected from nominations open to all trustee districts from the active, life or retired members of this association, no one of whom shall be a faculty member working more than one day per week of a school of dentistry or a member of a state board of dental examiners or jurisdictional dental licensing agency. These members shall be nominated by the Board of Trustees and elected by the American Dental Association House of Delegates.

Four (4) members who are active, life or retired members of the American Dental Association shall be selected by the American Association of Dental Boards from the active membership of that body, no one of whom shall be a member of a faculty of a school of dentistry.

Four (4) members who are active, life or retired members of the American Dental Association shall be selected by the American Dental Education Association from its active membership. These members shall hold positions of professorial rank in dental schools accredited by the Commission on Dental Accreditation and shall not be members of any state board of dental examiners.

The remaining Commissioners shall be selected as follows: one (1) certified dental assistant selected by the American Dental Assistants Association from its active or life membership, one (1) licensed dental hygienist selected by the American Dental Hygienists' Association, one (1) certified dental laboratory technician selected by the National Association of Dental Laboratories, one (1) student selected jointly by the American Student Dental Association and the Council of Students of the American Dental Education Association, one (1) dentist for each ADA recognized dental specialty who is board certified in the respective special area of practice and is selected by the respective specialty sponsoring organization, one (1) dentist representing postdoctoral general dentistry who is jointly appointed by the American Dental Education Association and the Special Care Dentistry Association and four (4) consumers who are neither dentists nor allied dental personnel nor teaching in a dental or allied dental education institution and who are selected by the Commission, based on established and publicized criteria. In the event a Commission member sponsoring organization fails to select a Commissioner, it shall be the responsibility of the Commission to select an appropriate representative to serve as a Commissioner. A member of the Standing Committee on the New Dentist (when assigned by the ADA Board of Trustees) and the Director of the Commission shall be ex-officio members of the Board without the right to vote.

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

Section 4. POWERS:

- A. The Board of Commissioners shall be vested with full power to conduct all business of the Commission subject to the laws of the State of Illinois, these *Rules* and the *Constitution and*

1 *Bylaws* of the American Dental Association.

- 2
3 B. The Board of Commissioners shall have the power to establish rules and regulations not
4 inconsistent with these *Rules* to govern its organization and procedures.

5 Section 5. DUTIES:

- 6
7 A. The Board of Commissioners shall prepare a budget at its winter meeting each year for
8 carrying on the activities of the Commission for the ensuing fiscal year and shall submit said
9 budget to the Board of Trustees of the American Dental Association for funding in accordance
10 with Chapter XIV of the *Bylaws* of the American Dental Association.
11
12 B. The Board of Commissioners shall submit an annual report of the Commission's activities to
13 the House of Delegates of the American Dental Association and interim reports, on request,
14 to the Board of Trustees of the American Dental Association.
15
16 C. The Board of Commissioners shall appoint special committees of the Commission for the
17 purpose of performing duties not otherwise assigned by these *Rules*.
18
19 D. The Board of Commissioners shall appoint consultants to assist in developing accreditation
20 standards and conducting accreditation evaluations, including on-site reviews of predoctoral,
21 advanced dental educational and allied dental educational programs and to assist with other
22 duties of the Commission from time to time as needed.

23 Section 6. MEETINGS:

- 24
25 A. REGULAR MEETINGS: There shall be two (2) regular meetings of the Board of
26 Commissioners each year.
27
28 B. SPECIAL MEETINGS: Special meetings of the Board of Commissioners may be called at
29 any time by the Chairman of the Commission. The Chairman shall call such meetings on
30 request of a majority of the voting members of the Board provided at least ten (10) days
31 notice is given to each member of the Board in advance of the meeting. No business shall be
32 considered except that provided in the call unless by unanimous consent of the members of
33 the Board present and voting.
34
35 C. LIMITATION OF ATTENDANCE DURING MEETINGS: In keeping with the confidential
36 nature of the deliberations regarding the accreditation status of individual educational
37 programs, a portion of the meetings of the Commission, and its committees shall be
38 designated as confidential, with attendance limited to members, the American Dental
39 Association Trustee Liaison, selected staff of the Commission and affiliated ~~accreditors~~ or
40 other accreditors as the Commission deems appropriate. During this part of the meeting, only
41 confidential accreditation actions may be considered.

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

44
45 Article III. APPEAL BOARD

46 Section 1. APPEAL BOARD: The appellate body of the Commission shall be the Appeal Board which
47 shall have the authority to hear and decide appeals filed by predoctoral and advanced dental educational
48 and allied dental educational programs from decisions rendered by the Board of Commissioners of the
49 Commission denying or revoking accreditation.

Section 2. COMPOSITION: The Appeal Board shall consist of four (4) permanent members. The four (4) permanent members of the Appeal Board shall be selected as follows: one (1) selected by the Board of Trustees of the American Dental Association from the active, life or retired membership of the American Dental Association giving special consideration whenever possible to former members of the Council on Dental Education and Licensure, one (1) member selected by the American Association of Dental Boards from the active membership of that body, one (1) member selected by the American Dental Education Association from the active membership of that body and one (1) consumer member who is neither a dentist nor an allied dental personnel nor teaching in a dental or allied dental educational program and who is selected by the Commission, based on established and publicized criteria. In addition, a representative from either an allied or advanced education discipline would be included on the Appeal Board depending upon the type and character of the appeal. Such special members shall be selected by the appropriate allied or specialty organization. Since there is no national organization for general practice residencies and advanced education programs in general dentistry, representatives of these areas shall be selected by the American Dental Education Association and the Special Care Dentistry Association. 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 1. 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.

1 If the Board of Commissioners decides to deny, for the first time, accreditation to a new educational
2 program or to withdraw accreditation from an existing program, the Board of Commissioners shall first
3 notify the educational program of its intent to deny or withdraw accreditation. Such notice, together with
4 announcement of the date of the next meeting of the Board of Commissioners, shall be sent to the
5 educational program by ~~certified mail, return receipt requested~~ tracked mail or courier service signature
6 required, within fourteen (14) days following the intent to deny or withdraw decision of the Board of
7 Commissioners. Within thirty (30) days after receipt of such notice, the educational program may, in
8 writing, request a hearing before the Board of Commissioners at its next meeting. Within fifteen (15) days
9 after receipt of the request, the Board of Commissioners shall schedule a hearing and notify the
10 educational program of the date, time and place of such hearing. A request for a hearing due to the
11 Board of Commissioner's decision to deny for the first time, accreditation to a new program, shall
12 automatically stay the decision to deny accreditation. In the event the educational program that has been
13 denied initial accreditation for the first time does not make a timely request for a hearing, the Board of
14 Commissioners' findings and proposed decision to deny accreditation shall become final.

15 Section 3. HEARING: Upon completion of an evaluation for accreditation status, the Board of
16 Commissioners shall notify the predoctoral, advanced or allied dental educational program (hereinafter
17 called "educational program") of its findings and decision regarding the program's accreditation status.
18 Two types of hearings can be held to review the appropriateness of the decision made by the
19 Commission:
20

21 A. CHALLENGE: This type of hearing is available to a program/institution that wishes to
22 challenge the decision of the Commission to change its accreditation status or to a new
23 program that wishes to challenge the decision of the Commission to deny, for the first time,
24 initial accreditation. When an institution/program believes that the Commission has made an
25 error in judgment, a hearing may be requested. The hearing before the Commission would
26 be held at the next regularly scheduled meeting. Representatives of the institution/program
27 may present arguments that the Commission, based on the information available when the
28 decision was made, made an error in judgment in determining the accreditation status of the
29 program. The educational program need not appear in person or by its representatives at the
30 hearing. Legal counsel may represent the educational program at the hearing. During the
31 hearing, the educational program may offer evidence and argument in writing or orally or both
32 tending to refute or overcome the factual findings of the Board of Commissioners. The
33 Director of the Board of Commissioners must receive any written evidence or argument at
34 least thirty (30) days prior to the hearing. No new information regarding correction of the
35 deficiencies may be presented.
36

37 B. SUPPLEMENT: An institution/program may request a hearing in order to supplement written
38 information, which has already been submitted to the Commission. A representative of the
39 institution would be permitted to appear in person before the Commission to present this
40 additional information.
41

42 When a hearing to provide supplemental information is desired, a written request is to be
43 made to the Director of the Commission thirty (30) days prior to the meeting. The chairman
44 and the Director of the Commission determine the disposition of the request and inform the
45 requestor of the date, hour and amount of time which will be allocated for the hearing.
46

47 Section 4. APPEAL: In the event the final decision of the Board of Commissioners is a denial or
48 withdrawal of accreditation, the educational program shall be informed of this decision within fourteen (14)
49 days following the Commission meeting. Within fourteen (14) days after receipt of the final decision of the
50 Board of Commissioners, the educational program may appeal the decision of the Board of
51 Commissioners by filing a written appeal with the Director of the Board of Commissioners. The filing of an
52 appeal shall automatically stay the final decision of the Board of Commissioners. The Appeal Board of
53 the Commission shall convene and hold its hearing within sixty (60) days after the appeal is filed. The

educational program filing the appeal may be represented by legal counsel and shall be given the opportunity at such hearing to offer evidence and argument in writing or orally or both tending to refute or overcome the findings and decision of the Board of Commissioners. No new information regarding correction of the deficiencies may be presented with the exception of review of new financial information if all of the following conditions are met: (i) The financial information was unavailable to the institution or program until after the decision subject to appeal was made. (ii) The financial information is significant and bears materially on the financial deficiencies identified by the Commission. The criteria of significance and materiality are determined by the Commission. (iii) The only remaining deficiency cited by the Commission in support of a final adverse action decision is the institution's or program's failure to meet the Commission's standard pertaining to finances. An institution or program may seek the review of new financial information described in this section only once and any determination by the Commission made with respect to that review does not provide a basis for an appeal. The educational program need not appear in person or by its representative at the appellate hearing. The Appeal Board may make the following decisions: to affirm, amend, remand, or reverse the adverse actions of the Commission. A decision to affirm, amend or reverse the adverse action is implemented by the Commission. In a decision to remand the adverse action for further consideration, the Appeal Board will identify specific issues that the Commission must address. The Commission must act in a manner consistent with the Appeal Board's decisions or instructions. The Appeal Board shall advise the appellant educational program of the Appeal Board's decision in writing by ~~registered or certified mail~~ tracked mail or courier service signature required. The decision rendered by the Appeal Board shall be final and binding. In the event the educational program does not file a timely appeal of the Board of Commissioners' findings and decision, the Board of Commissioners' decision shall become final.

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

Article V. OFFICERS

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

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

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

1 Article VI. MISCELLANEOUS

2 The rules contained in the current edition of "~~Sturgis Standard Code of Parliamentary Procedures~~" "The
3 American Institute of Parliamentarians Standard Code of Parliamentary Procedure (AIPSC)" shall govern
4 the deliberations of the Board of Commissioners and Appeal Board in all instances where they are
5 applicable and not in conflict with the *Rules* or the previously established rules and regulations of the
6 Board of Commissioners.

7
8 Article VII. AMENDMENTS

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

12 Reaffirmed: 8/12; Revised: 8/10, 10/02, 10/97, 10/87, 11/82

13 Adopted by the Commission on Dental Accreditation, February 1, 2002. Approved by the ADA House of
14 Delegates, October 2002. Revisions adopted by the Commission on Dental Accreditation, August 2010.
15 Approved by the ADA House of Delegates, October 2010. Revision of Mission Statement adopted by the
16 Commission on Dental Accreditation, August 2012. Approved by the ADA House of Delegates, October
17 2012.

Resolution No. 77 NewReport: CDEL Supplemental Report 1 Date Submitted: October 2015Submitted By: Council on Dental Education and LicensureReference Committee: C (Dental Education, Science and Related Matters)Total Net Financial Implication: None Net Dues Impact: _____Amount One-time _____ Amount On-going _____ FTE 0

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

How does this resolution increase member value: See Background

**COUNCIL ON DENTAL EDUCATION AND LICENSURE SUPPLEMENTAL REPORT 1 TO THE
HOUSE OF DELEGATES: PROPOSED AMENDMENTS TO THE SEDATION AND ANESTHESIA
GUIDELINES**

Background: The Council on Dental Education and Licensure and its Anesthesiology Committee have been considering revisions to the *ADA Guidelines for the Use of Sedation and General Anesthesia by Dentists* (Use Guidelines) and the *ADA Guidelines for Teaching Pain Control and Sedation to Dentists and Dental Students* (Teaching Guidelines) (collectively referred to as Anesthesia Guidelines) since September 2014. The Council relies on the expertise of the members of its Anesthesiology Committee to assist in anesthesiology related matters and appreciates the contributions made by the following Committee members and their organizations:

Dr. Daniel Gesek, Committee Chair and CDEL Vice-Chair
Dr. Edwin Ginsberg, American Academy of Periodontology
Dr. Joseph Giovannitti, American Society of Dentist Anesthesiologists
Dr. Andrew Herlich, American Society of Anesthesiologists
Dr. Lawrence Palmer, American Dental Association
Dr. Daniel Sarasin, American Dental Society of Anesthesiology
Dr. Sarat (Bobby) Thikkurissy, American Academy of Pediatric Dentistry
Dr. Antwan Treadway, American Association of Oral and Maxillofacial Surgeons

Consideration of Comments on Proposed Revisions to the Anesthesia Guidelines: The Council circulated the current Guidelines to the communities of interest* first in November 2014-January 2015 calling for general comments and suggestions for change. Proposed revisions to the Guidelines then were circulated in May-June 2015 via direct email notifications. Notices also were published in the *ADA NEWS* and in the ADA e-publication Leadership Update.

*CDEL Dental Anesthesiology Communities of Interest:

ADA Council on Dental Practice
ADA Council on Scientific Affairs
ADA Council on Access, Prevention and Interprofessional Relations
ADA Council on Government Affairs
ADA New Dentist Committee
State dental societies
Local dental societies
State boards of dentistry
Recognized dental specialties
Certifying boards of recognized dental specialties
American Dental Education Association

1 American Association of Dental Boards
2 Special Care Dentistry
3 Academy of General Dentistry
4 American Student Dental Association
5 American Society of Dentist Anesthesiologists
6 American Dental Society of Anesthesiology
7 American Society of Anesthesiologists

8 The Council considered 284 letters and emails, including those from the following national and state
9 professional organizations: the American Dental Education Association, American Society of Dentist
10 Anesthesiologists, American Dental Society of Anesthesiology, ADA Council on Dental Practice, ADA
11 Council on Dental Benefit Programs, California Association of Oral and Maxillofacial Surgeons, Academy
12 of General Dentistry, American Academy of Pediatric Dentistry, American Society of Anesthesiologists,
13 American Academy of Pediatrics, Virginia Board of Dentistry, American Association of Oral and
14 Maxillofacial Surgeons, and American Academy of Periodontology. Comments were also received from
15 practicing general dentists and dental specialists as well as dental educators and a continuing education
16 provider.

17 The Council reviewed a press release and email blasts regarding the proposed revisions to the
18 Anesthesia Guidelines, which were sent directly to dentist sedation providers from an organization known
19 as TEAM (Trust for Equal Access Medicine) 1500. The TEAM 1500 communications encouraged
20 individuals to write to CDEL. It appeared to the Council that most of those commenting had not studied
21 the proposed changes as distributed by CDEL and did not provide specific comments noting line and
22 page number as requested. The Council wishes to clarify the points made by TEAM 1500 for the Board
23 of Trustees and the House of Delegates:

TEAM 1500 Message	Council Response
CDEL rushed its review of the Anesthesia Guidelines, not providing adequate time for comment by the communities of interest	The comprehensive review process began in September 2014. Two comment periods were provided to the communities: <ul style="list-style-type: none"> • November 19, 2014 - January 7, 2015 • May 1, 2015 - June 29, 2015
Not enough CE courses available to meet proposed guidelines, particularly related to course content and duration.	At least 7 CE courses are available throughout the U.S. currently offering the course content and duration as proposed. The Council is confident that providers of CE on the subject of sedation and anesthesia will enrich their educational offerings to reflect current practice in accord with the proposed guidelines and state regulatory requirements.
A dentist's sedation permit will be taken away.	State dental boards issue sedation permits, based on their state laws, rules and regulations. While many dental boards do over time incorporate current versions of the ADA Guidelines into rulemaking, or cite the ADA Guidelines in their statutes, adoption of new Guidelines by the ADA does not immediately affect any state board or dentist permit holder. To be clear, the following language is in the current Anesthesia Guidelines and remains unchanged in the proposed revised document (lines 290-294): <i>"For all levels of sedation and anesthesia, dentists, who are currently providing sedation and anesthesia in compliance with their state rules and/or regulations prior to adoption of this document, are not subject to [herein specified] educational requirements."</i>

Proposed guidelines will not increase safety any more than existing guidelines, will reduce access to dental care and make dental care more expensive.	Given current standards of care, comments received and scientific evidence, the Council believes the proposed changes, (especially regarding, monitoring end-tidal CO ₂ and altering training duration for some moderate sedation providers) will help ensure public safety without overburdening dentist providers or dental educators.
Many anecdotes related to providing sedation to patients in need; concern expressed that the proposed changes will decrease access to sedation and anesthesia services.	Standards of care, guidelines of other professional medical and dental organizations, the scientific literature, current state regulations for sedation, and the expertise of practitioners, academicians and state dental board members were relied upon to make these recommendations. The proposed changes are intended to support public safety.

The Council also noted the letters received from the American Academy of Pediatric Dentistry (AAPD), American Academy of Pediatrics (AAP) and American Dental Society of Anesthesiology (ADSA) suggesting the need for the ADA to establish new guidelines focused on the provision of sedation and anesthesia to children age 12 and under by dentists who are not pediatric dentists or dental anesthesiologists by education and training. These organizations suggested that the ADA enhance its Anesthesia Guidelines in this regard, rather than referencing the AAP/AAPD "Guideline for Monitoring and Management of Pediatric Patients During and After Sedation for Diagnostic and Therapeutic Procedures." The ADSA offered its belief that such enhanced ADA guidance for administering sedation and anesthesia to children age 12 and under could better assist dentists and regulatory agencies and support access to oral health care for children. The AAP offered pediatric physician volunteers to participate in review and development of such guidelines, as appropriate. The Council concluded that the *Guideline for Monitoring and Management of Pediatric Patients During and After Sedation for Diagnostic and Therapeutic Procedures* should be carefully studied in 2016 by the Anesthesiology Committee and the Council prior to proposing additional amendments to the Guidelines.

Rationale for Proposed Revisions: Throughout their deliberations, the Council and its Anesthesiology Committee remained committed to and focused on the importance of standard of care, patient safety, public protection and risk management. They agreed that the ADA Guidelines must reflect the current standard of care to guide practitioners, educators and regulatory agencies in assuring patient safety and managing risk. They also reflected on data collected during both comment periods noting that, although there was some opposition to the use of end-tidal CO₂ monitoring during moderate and deep sedation, capnography is considered to be a standard of care for anesthesiologists and oral surgeons as well as other health care professionals. Further, end-tidal CO₂ monitoring is already required in the anesthesia regulations of at least 14 state dental boards. The Council and the Committee unanimously agreed that pursuit of the proposed changes to the ADA Guidelines is prudent regarding end-tidal CO₂ monitoring, as well as consistent with the spirit of the policies of the American Society of Anesthesiologists and the American Association of Oral and Maxillofacial Surgeons.

Finally, given the required course objectives and content for moderate sedation in the proposed Teaching Guidelines, and given changes in technology and practice over the last seven years since the 2007 comprehensive review, the Council and Committee unanimously agreed to include one course duration statement for all training in moderate sedation: "A minimum of 60 hours of didactic instruction, plus administration of sedation for at least 20 individually-managed dental patients by any route per participant, including intravenous administration, is required to demonstrate competency in moderate sedation techniques. Of the 20 cases, all must be managed by the anesthesia operator dentists."

The following summarizes the Council's proposed revisions. Appendix 1 presents the Council's proposed amendments with deletions ~~stricken~~ and additions underlined.

Guidelines for the Use of Sedation and General Anesthesia by Dentists

- Lines 70-77: Added statements regarding sedation of children 12 and under, consistent with the American Academy of Pediatric Dentistry (AAPD) and American Academy of Pediatrics (AAP) guidelines.
- 213-224: Added a reference, citing the American Society of Anesthesiologists' Preoperative Fasting Guidelines.
- Lines 230, 252, 264, 274-275, and 282: Amended the Educational Requirements to include a statement about competency, and for moderate and deep sedation including certification in Pediatric Advanced Life Support as an alternative to Advanced Cardiac Life Support.
- Lines 314-319, 334-336, 403-408, 417-422, 438-440, 530-550, and 575-577: Amended the Clinical Guidelines for all levels of sedation and anesthesia to enhance preoperative recording of vital signs, maintain a log of equipment maintenance, and conduct a pre-anesthesia evaluation for moderate and deep sedation.
- Lines 445-448, 472-477, 585-589, and 603-607: For moderate sedation clinical guidelines, added a statement that the dentist must monitor ventilation by monitoring end-tidal CO₂ unless precluded or invalidated by the nature of the patient, procedure or equipment. (Note: the current 2012 Anesthesia Guidelines require the monitoring of end-tidal CO₂ for deep sedation and general anesthesia.)
- Lines 659-699: Deleted Section V. Additional Sources of Information per the recommendation of the ADA Speaker of the House. Current additional sources of information to support these Guidelines will be maintained on ADA.org, ensuring currency and relevancy.

Guidelines for Teaching Pain Control and Sedation to Dentists and Dental Students

- Lines 823-829: Added statements regarding sedation of children 12 and under, consistent with the American Academy of Pediatric Dentistry (AAPD) and American Academy of Pediatrics (AAP) guidelines.
- Lines 977-988: Added a reference, citing the American Society of Anesthesiologists' Preoperative Fasting Guidelines
- Lines 1157-1158: Added a new course objective to Section IV. Teaching Administration of Minimal Sedation, "Demonstrate the ability to diagnose and treat emergencies related to the next deeper level of anesthesia to be delivered." (Note: the current Guidelines include the following statements: "Because sedation and general anesthesia are a continuum, it is not always possible to predict how an individual patient will respond. Hence, practitioners intending to produce a given level of sedation should be able to diagnose and manage physiologic consequences (rescue) for patients whose level of sedation becomes deeper than initially intended." This responsibility is now proposed as a required course objective.)
- Lines 1353-1354: Added a new course objective to Section V. Teaching Administration of Moderate Sedation, "Demonstrate the ability to diagnose and treat emergencies related to the next deeper level of anesthesia to be delivered." (Note: the current Guidelines include the following statements: "Because sedation and general anesthesia are a continuum, it is not always possible to predict how an individual patient will respond. Hence, practitioners intending to produce a given level of sedation should be able to diagnose and manage physiologic consequences (rescue) for patients whose level of sedation becomes deeper than initially intended." This responsibility is now proposed as a required course objective.)
- Lines 1386-1415: Merged the Moderate Enteral Sedation Course Duration and Moderate Parenteral Sedation Course Duration sections into one section, "Moderate Sedation Course Duration."
- Lines 1402-1407: Revised the moderate sedation course duration to "A minimum of 60 hours of didactic instruction, plus administration of sedation for at least 20 individually-managed dental patients by any route per participant, including intravenous administration, is required to demonstrate competency in moderate sedation techniques. Of the 20 cases, all must be managed by the anesthesia operator dentist."

- Lines 1447-1489: Deleted Section V. Additional Sources of Information. Current additional sources of information to support these Guidelines will be maintained on ADA.org, ensuring currency and relevancy.

The Council has concluded its review of the *Guidelines for the Use of Sedation and General Anesthesia by Dentists* and the *Guidelines for Teaching Pain Control and Sedation to Dentists and Dental Students* and presents the following resolution to the House of Delegates:

Resolution

77. Resolved, that the *Guidelines for the Use of Sedation and General Anesthesia by Dentists* and the *Guidelines for Teaching and Pain Control and Sedation to Dentists and Dental Students* be amended as presented in Appendix 1 of the Council's Supplemental Report 1 to the House of Delegates.

BOARD RECOMMENDATION: Vote Yes.

Vote: Resolution 77

ASAI	Yes	DOW	Yes	JEFFERS	Yes	STEVENS	No
BITTER	Yes	FAIR	Yes	KWASNY	Yes	SUMMERHAYS	Yes
BUCKENHEIMER	Yes	GAMBA	Yes	ROBERTS	Yes	YONEMOTO	Yes
COLE	No	GEHANI	Yes	ROBINSON	Yes	ZENK	Yes
CROWLEY	Yes	ISRAELSON	Yes	SHENKIN	Yes	ZUST	Yes

Council on Dental Education and Licensure

Appendix 1 - August 2015

Proposed Revisions:

Guidelines for the Use of Sedation and General Anesthesia by Dentists

Underscore denotes proposed additions
Strikethrough denotes proposed deletions

I. Introduction

The administration of local anesthesia, sedation and general anesthesia is an integral part of dental practice. The American Dental Association is committed to the safe and effective use of these modalities by appropriately educated and trained dentists. The purpose of these guidelines is to assist dentists in the delivery of safe and effective sedation and anesthesia.

Dentists providing sedation and anesthesia in compliance with their state rules and/or regulations prior to adoption of this document are not subject to *Section III. Educational Requirements*.

II. Definitions

Methods of Anxiety and Pain Control

~~analgesia~~ – the diminution or elimination of pain. [moved to Terms section]

~~conscious sedation~~[†] – a minimally depressed level of consciousness that retains the patient's ability to independently and continuously maintain an airway and respond appropriately to physical stimulation or verbal command and that is produced by a pharmacological or non-pharmacological method or a combination thereof.

In accord with this particular definition, the drugs and/or techniques used should carry a margin of safety wide enough to render unintended loss of consciousness unlikely. Further, patients whose only response is reflex withdrawal from repeated painful stimuli would not be considered to be in a state of conscious sedation.

~~combination inhalation-enteral conscious sedation~~ (combined conscious sedation) – conscious sedation using inhalation and enteral agents. [moved to Terms section]

When the intent is anxiolysis only, and the appropriate dosage of agents is administered, then the definition of enteral and/or combination inhalation-enteral conscious sedation (combined conscious sedation) does not apply. [moved to Terms section]

~~local anesthesia~~ – the elimination of sensation, especially pain, in one part of the body by the topical application or regional injection of a drug. [Moved to Terms section]

~~Note:~~ Although the use of local anesthetics is the foundation of pain control in dentistry and has a long record of safety, dentists must be aware of the maximum, safe dosage limits for each patient. Large doses of local anesthetics in themselves may result in central nervous system depression, especially in combination with sedative agents. [Moved to Terms section]

[†]–Parenteral conscious sedation may be achieved with the administration of a single agent or by the administration of more than one agent.

~~combination inhalation-enteral conscious sedation (combined conscious sedation) - conscious sedation using inhalation and enteral agents.~~

~~When the intent is anxiolysis only, and the appropriate dosage of agents is administered, then the definition of enteral and/or combination inhalation-enteral conscious sedation (combined conscious sedation) does not apply.~~

minimal sedation - a minimally depressed level of consciousness, produced by a pharmacological method, that retains the patient's ability to independently and continuously maintain an airway and respond *normally* to tactile stimulation and verbal command. Although cognitive function and coordination may be modestly impaired, ventilatory and cardiovascular functions are unaffected.²

Note: In accord with this particular definition, the drug(s) and/or techniques used should carry a margin of safety wide enough never to render unintended loss of consciousness. Further, patients whose only response is reflex withdrawal from repeated painful stimuli would not be considered to be in a state of minimal sedation.

When the intent is minimal sedation for adults, the appropriate initial dosing of a single enteral drug is no more than the maximum recommended dose (MRD) of a drug that can be prescribed for unmonitored home use.

For children age 12 and under, ~~the use of preoperative sedatives for children (aged 12 and under) prior to arrival in the dental office, except in extraordinary situations,~~ must be avoided due to the risk of unobserved respiratory obstruction during transport by untrained individuals.

Prescription medications intended to accomplish procedural sedation for children age 12 and under must not be administered without the benefit of direct supervision by a trained dental/medical provider. (Source: the American Academy of Pediatrics/American Academy of Pediatric Dentistry *Guidelines for Monitoring and Management of Pediatric Patients During and After Sedation for Diagnostic and Therapeutic Procedures*)

Children (aged 12 and under) can become moderately sedated despite the intended level of minimal sedation; should this occur, the guidelines for moderate sedation apply.

For children 12 years of age and under, the American Dental Association supports the use of the American Academy of Pediatrics/American Academy of Pediatric Dentistry *Guidelines for Monitoring and Management of Pediatric Patients During and After Sedation for Diagnostic and Therapeutic Procedures*.

Nitrous oxide/oxygen may be used in combination with a single enteral drug in minimal sedation.

Nitrous oxide/oxygen when used in combination with sedative agent(s) may produce minimal, moderate, deep sedation or general anesthesia.

The following definitions apply to administration of minimal sedation via an enteral route:

maximum recommended (MRD) - maximum FDA-recommended dose of a drug, as printed in FDA-approved labeling for unmonitored home use.

incremental dosing - administration of multiple doses of a drug until a desired effect is reached, but not to exceed the maximum recommended dose (MRD).

² Portions excerpted from *Continuum of Depth of Sedation: Definition of General Anesthesia and Levels of Sedation/Analgesia, 2014* 2004, of the American Society of Anesthesiologists (ASA). A copy of the full text can be obtained from ASA, 520 N. Northwest Highway, Park Ridge, IL 60068-2573.

supplemental dosing - during minimal sedation, supplemental dosing is a single additional dose of the initial dose of the initial drug that may be necessary for prolonged procedures. The supplemental dose should not exceed one-half of the initial dose and should not be administered until the dentist has determined the clinical half-life of the initial dosing has passed. The total aggregate dose must not exceed 1.5x the MRD on the day of treatment. For the purpose of enteral or combination enteral/inhalation sedation, when the MRD of a drug is exceeded or more than one drug is used in combination, with or without the concomitant use of nitrous oxide, the guidelines for moderate sedation apply.

moderate sedation - a drug-induced depression of consciousness during which patients respond purposefully to verbal commands, either alone or accompanied by light tactile stimulation. No interventions are required to maintain a patent airway, and spontaneous ventilation is adequate. Cardiovascular function is usually maintained.³

Note: In accord with this particular definition, the drugs and/or techniques used should carry a margin of safety wide enough to render unintended loss of consciousness unlikely. Repeated dosing of an agent before the effects of previous dosing can be fully appreciated may result in a greater alteration of the state of consciousness than is the intent of the dentist. Further, a patient whose only response is reflex withdrawal from a painful stimulus is not considered to be in a state of moderate sedation.

The following definition applies to the administration of moderate or greater sedation:

titration - administration of incremental doses of an intravenous or inhalation drug until a desired effect is reached. Knowledge of each drug's time of onset, peak response and duration of action is essential to avoid over sedation. Although the concept of titration of a drug to effect is critical for patient safety, when the intent is moderate sedation one must know whether the previous dose has taken full effect before administering an additional drug increment.

deep sedation - a drug-induced depression of consciousness during which patients cannot be easily aroused but respond purposefully following repeated or painful stimulation. The ability to independently maintain ventilatory function may be impaired. Patients may require assistance in maintaining a patent airway, and spontaneous ventilation may be inadequate. Cardiovascular function is usually maintained.³

general anesthesia - a drug-induced loss of consciousness during which patients are not arousable, even by painful stimulation. The ability to independently maintain ventilatory function is often impaired. Patients often require assistance in maintaining a patent airway, and positive pressure ventilation may be required because of depressed spontaneous ventilation or drug-induced depression of neuromuscular function. Cardiovascular function may be impaired.

Because sedation and general anesthesia are a continuum, it is not always possible to predict how an individual patient will respond. Hence, practitioners intending to produce a given level of sedation should be able to diagnose and manage the physiologic consequences (rescue) for patients whose level of sedation becomes deeper than initially intended.³

For all levels of sedation, the qualified dentist practitioner must have the training, skills, drugs and equipment to identify and manage such an occurrence until either assistance arrives (emergency medical service) or the patient returns to the intended level of sedation without airway or cardiovascular complications.

Routes of Administration

enteral - any technique of administration in which the agent is absorbed through the gastrointestinal (GI) tract or oral mucosa [i.e., oral, rectal, sublingual].

³ Excerpted from *Continuum of Depth of Sedation: Definition of General Anesthesia and Levels of Sedation/Analgesia, 2004*, of the American Society of Anesthesiologists (ASA). A copy of the full text can be obtained from ASA, 520 N. Northwest Highway, Park Ridge, IL 60068-2573.

parenteral - a technique of administration in which the drug bypasses the gastrointestinal (GI) tract [i.e., intramuscular (IM), intravenous (IV), intranasal (IN), submucosal (SM), subcutaneous (SC), intraosseous (IO)].

transdermal - a technique of administration in which the drug is administered by patch or iontophoresis through skin.

transmucosal - a technique of administration in which the drug is administered across mucosa such as intranasal, sublingual, or rectal.

inhalation - a technique of administration in which a gaseous or volatile agent is introduced into the lungs and whose primary effect is due to absorption through the gas/blood interface.

Terms

analgesia – the diminution or elimination of pain [Moved from Definitions section]

local anesthesia - the elimination of sensation, especially pain, in one part of the body by the topical application or regional injection of a drug. [Moved from Definitions section]

Note: Although the use of local anesthetics is the foundation of pain control in dentistry and has a long record of safety, dentists must be aware of the maximum, safe dosage limits for each patient. Large doses of local anesthetics in themselves may result in central nervous system depression, especially in combination with sedative agents. [Moved from Definitions section]

qualified dentist - meets the educational requirements for the appropriate level of sedation in accordance with Section III of these *Guidelines*, or a dentist providing sedation and anesthesia in compliance with their state rules and/or regulations prior to adoption of this document.

operating dentist – dentist with primary responsibility for providing operative dental care while a qualifying dentist or independently practicing qualified anesthesia healthcare provider administers minimal, moderate or deep sedation or general anesthesia.

competency – displaying special skill or knowledge derived from training and experience

must/shall - indicates an imperative need and/or duty; an essential or indispensable item; mandatory.

should - indicates the recommended manner to obtain the standard; highly desirable.

may - indicates freedom or liberty to follow a reasonable alternative.

continual - repeated regularly and frequently in a steady succession.

continuous - prolonged without any interruption at any time.

time-oriented anesthesia record - documentation at appropriate time intervals of drugs, doses and physiologic data obtained during patient monitoring.

immediately available – on site in the facility and available for immediate use.

American Society of Anesthesiologists (ASA) Patient Physical Status Classification⁴

ASA I - A normal healthy patient.

ASA II - A patient with mild systemic disease.

ASA III - A patient with severe systemic disease.

ASA IV - A patient with severe systemic disease that is a constant threat to life.

ASA V - A moribund patient who is not expected to survive without the operation.

ASA VI - A declared brain-dead patient whose organs are being removed for donor purposes.

E - Emergency operation of any variety (used to modify one of the above classifications, i.e., ASA III-E).

American Society of Anesthesiologists Fasting Guidelines*

<u>Ingested Material</u>	<u>Minimum Fasting Period</u>
Clear liquids	2 hours
Breast milk	4 hours
Infant formula	6 hours
Nonhuman milk	6 hours
Light meal	6 hours
Fatty meal	8 hours

*American Society of Anesthesiologists: Practice Guidelines for preoperative fasting and the use of pharmacologic agents to reduce the risk of pulmonary aspiration: application to healthy patients undergoing elective procedures. *Anesthesiology* 114:495. 2011. Reprinted with permission.

III. Educational Requirements

A. Minimal Sedation

1. To administer minimal sedation the dentist must demonstrate competency by having ~~have~~ successfully completed:

a. training ~~to the level of competency~~ in minimal sedation consistent with that prescribed in the ADA *Guidelines for Teaching Pain Control and Sedation to Dentists and Dental Students*,

or

b. a comprehensive training program in moderate sedation that satisfies the requirements described in the Moderate Sedation section of the ADA *Guidelines for Teaching Pain Control and Sedation to Dentists and Dental Students* at the time training was commenced,

or

c. ~~b.~~ an advanced education program accredited by the ADA Commission on Dental Accreditation that affords comprehensive and appropriate training necessary to administer and manage minimal sedation commensurate with these guidelines;

and

c. a current certification in Basic Life Support for Healthcare Providers.

2. Administration of minimal sedation by another qualified dentist or independently practicing qualified anesthesia healthcare provider requires the operating dentist and his/her clinical staff to maintain current certification in Basic Life Support for Healthcare Providers.

B. Moderate Sedation

1. To administer moderate sedation, the dentist must demonstrate competency by having ~~have~~ successfully completed:

⁴ ASA Physical Status Classification System is reprinted with permission of the American Society of Anesthesiologists, 520 N. Northwest Highway, Park Ridge, IL 60068-2573.

- a. a comprehensive training program in moderate sedation that satisfies the requirements described in the Moderate Sedation section of the ADA *Guidelines for Teaching Pain Control and Sedation to Dentists and Dental Students* at the time training was commenced,
- or
- b. an advanced education program accredited by the ADA Commission on Dental Accreditation that affords comprehensive and appropriate training necessary to administer and manage moderate sedation commensurate with these guidelines;
- and
- c. 1) a current certification in Basic Life Support for Healthcare Providers and 2) either current certification in Advanced Cardiac Life Support (ACLS or equivalent, e.g., Pediatric Advanced Life Support) or completion of an appropriate dental sedation/anesthesia emergency management course on the same recertification cycle that is required for ACLS.
2. Administration of moderate sedation by another qualified dentist or independently practicing qualified anesthesia healthcare provider requires the operating dentist and his/her clinical staff to maintain current certification in Basic Life Support for Healthcare Providers.

C. Deep Sedation or General Anesthesia

1. To administer deep sedation or general anesthesia, the dentist must demonstrate competency by having have-completed:
- a. an advanced education program accredited by the ADA Commission on Dental Accreditation that affords comprehensive and appropriate training necessary to administer and manage deep sedation or general anesthesia, commensurate with Part IV.C of these guidelines;
- and
- b. 1) a current certification in Basic Life Support for Healthcare Providers and 2) either current certification in Advanced Cardiac Life Support (ACLS or equivalent, e.g., Pediatric Advanced Life Support) or completion of an appropriate dental sedation/anesthesia emergency management course on the same re-certification cycle that is required for ACLS.
2. Administration of deep sedation or general anesthesia by another qualified dentist or independently practicing qualified anesthesia healthcare provider requires the operating dentist and his/her clinical staff to maintain current certification in Basic Life Support (BLS) Course for the Healthcare Provider.

For all levels of sedation and anesthesia, dentists, who are currently providing sedation and anesthesia in compliance with their state rules and/or regulations prior to adoption of this document, are not subject to these educational requirements. However, all dentists providing sedation and general anesthesia in their offices or the offices of other dentists should comply with the Clinical Guidelines in this document.

IV. Clinical Guidelines

A. Minimal sedation

1. Patient Evaluation

Patients considered for minimal sedation must be suitably evaluated prior to the start of any sedative procedure. In healthy or medically stable individuals (ASA I, II) this ~~should~~ may consist of a review of their current medical history and medication use. ~~However,~~ In addition, patients with significant medical considerations (ASA III, IV) may require consultation with their primary care physician or consulting medical specialist.

2. Pre-Operative Preparation

- The patient, parent, guardian or care giver must be advised regarding the procedure associated with the delivery of any sedative agents and informed consent for the proposed sedation must be obtained.
- Determination of adequate oxygen supply and equipment necessary to deliver oxygen under positive pressure must be completed.
- Baseline vital signs (blood pressure, pulse and respiration rates) must be obtained unless invalidated by the nature of the patient, procedure or equipment ~~the patient's behavior prohibits such determination.~~
- A focused physical evaluation must be performed as deemed appropriate, including recording the patient's body weight and BMI. In addition, body temperature should be measured when clinically indicated.
- Preoperative dietary restrictions must be considered based on the sedative technique prescribed.
- Pre-operative verbal and written instructions must be given to the patient, parent, escort, guardian or care giver.

3. Personnel and Equipment Requirements

Personnel:

- At least one additional person trained in Basic Life Support for Healthcare Providers must be present in addition to the dentist.

Equipment:

- A positive-pressure oxygen delivery system suitable for the patient being treated must be immediately available.
- A log of equipment maintenance, including monitors and anesthesia delivery system, must be maintained. A pre-procedural check of equipment for each administration of sedation must be performed.
- When inhalation equipment is used, it must have a fail-safe system that is appropriately checked and calibrated. The equipment must also have either (1) a functioning device that prohibits the delivery of less than 30% oxygen or (2) an appropriately calibrated and functioning in-line oxygen analyzer with audible alarm.
- An appropriate scavenging system must be available if gases other than oxygen or air are used.

4. Monitoring and Documentation

Monitoring: A dentist, or at the dentist's direction, an appropriately trained individual, must remain in the operatory during active dental treatment to monitor the patient continuously until the patient meets ~~the~~ criteria for discharge to the recovery area. The appropriately trained individual must be familiar with monitoring techniques and equipment. Monitoring must include:

Consciousness:

- Level of sedation (e.g., responsiveness to verbal commands) must be continually assessed.

Oxygenation:

- Color of mucosa, skin or blood must be evaluated continually.
- Oxygen saturation by pulse oximetry must be used unless precluded or invalidated by the nature of the patient, procedure, or equipment ~~may be clinically useful and should be considered.~~

Ventilation:

- The dentist and/or appropriately trained individual must observe chest excursions continually.

- The dentist and/or appropriately trained individual must verify respirations continually.

Circulation:

- Blood pressure and heart rate should be evaluated pre-operatively, post-operatively and intraoperatively as necessary (unless the patient is unable to tolerate such monitoring).

Documentation: An appropriate sedative record must be maintained, including the names of all drugs administered, time administered and route of administration, including local anesthetics, dosages, and monitored physiological parameters.

5. Recovery and Discharge

- Oxygen and suction equipment must be immediately available if a separate recovery area is utilized.
- The qualified dentist or appropriately trained clinical staff must monitor the patient during recovery until the patient is ready for discharge by the dentist.
- The qualified dentist must determine and document that level of consciousness, oxygenation, ventilation and circulation are satisfactory prior to discharge.
- Post-operative verbal and written instructions must be given to the patient, parent, escort, guardian or care giver.

6. Emergency Management

- If a patient enters a deeper level of sedation than the dentist is qualified to provide, the dentist must stop the dental procedure until the patient ~~returns~~ is returned to the intended level of sedation.
- The qualified dentist is responsible for the sedative management, adequacy of the facility and staff, diagnosis and treatment of emergencies related to the administration of minimal sedation and providing the equipment and protocols for patient rescue.

7. Management of Children

For children 12 years of age and under, the American Dental Association supports the use of the American Academy of Pediatrics/American Academy of Pediatric Dentistry *Guidelines for Monitoring and Management of Pediatric Patients During and After Sedation for Diagnostic and Therapeutic Procedures*.

B. Moderate Sedation

1. Patient Evaluation

Patients considered for moderate sedation must undergo a pre-anesthesia evaluation prior to the administration of any sedative. ~~be suitably evaluated prior to the start of any sedative procedure. In healthy or medically stable individuals (ASA I, II) This should consist of at least a review at an appropriate time (ideally within the previous 30 days) of their current medical history and medication use. However, p-~~ In addition, patients with significant medical considerations (e.g., ASA III, IV) may also require consultation with their primary care physician or consulting medical specialist.

2. Pre-operative Preparation

- The patient, parent, legal guardian or care giver must be advised regarding the procedure associated with the delivery of any sedative agents and informed consent for the proposed sedation must be obtained.

- Determination of adequate oxygen supply and equipment necessary to deliver oxygen under positive pressure must be completed.
- Baseline vital signs including blood pressure, pulse and respiration rates, and blood oxygen saturation by pulse oximetry must be obtained unless precluded by the nature of the patient, procedure or equipment ~~the patient's behavior prohibits such determination.~~
- A focused physical evaluation must be performed, including recording the patient's body weight and BMI. In addition, body temperature should be measured when clinically indicated as deemed appropriate.
- ~~Preoperative dietary restrictions must be considered based on the sedative technique prescribed.~~
- Pre-operative verbal or written instructions must be given to the patient, parent, escort, guardian or care giver, including pre-operative fasting instructions based on the ASA Summary of Fasting and Pharmacologic Recommendations.

3. Personnel and Equipment Requirements

Personnel:

- At least one additional person trained in Basic Life Support for Healthcare Providers must be present in addition to the dentist.

Equipment:

- A positive-pressure oxygen delivery system suitable for the patient being treated must be immediately available.
- A log of equipment maintenance, including monitors and anesthesia delivery system, must be maintained. A pre-procedural check of equipment for each administration of sedation must be performed.
- When inhalation equipment is used, it must have a fail-safe system that is appropriately checked and calibrated. The equipment must also have either (1) a functioning device that prohibits the delivery of less than 30% oxygen or (2) an appropriately calibrated and functioning in-line oxygen analyzer with audible alarm.
- End tidal CO2 must be monitored unless precluded or invalidated by the nature of the patient, procedure, or equipment. In addition, ventilation may be monitored by evaluation by continual observation of qualitative signs, including auscultation of breath sounds with a precordial or pretracheal stethoscope.
- An appropriate scavenging system must be available if gases other than oxygen or air are used.
- The equipment necessary to establish intravenous access must be available.
- If parenteral sedation is administered, a secure intravenous access site must be maintained until the patient meets discharge criteria.

4. Monitoring and Documentation

Monitoring: A qualified dentist administering moderate sedation must remain in the operatory room to monitor the patient continuously until the patient meets the criteria for recovery. When active treatment concludes and the patient recovers to a minimally sedated level a qualified auxiliary may be directed by the dentist to remain with the patient and continue to monitor them as explained in the guidelines until they are discharged from the facility. The dentist must not leave the facility until the patient meets the criteria for discharge and is discharged from the facility. Monitoring must include:

Consciousness:

- Level of sedation consciousness (e.g., responsiveness to verbal command) must be continually assessed.

Oxygenation:

- Color of mucosa, skin or blood must be evaluated continually.

- Oxygen saturation must be evaluated by pulse oximetry continuously.

Ventilation:

- The dentist must observe chest excursions continually.
- The dentist must monitor ventilation and/or breathing by monitoring end-tidal CO₂ unless precluded or invalidated by the nature of the patient, procedure or equipment. In addition, ventilation may be monitored by continual observation of qualitative signs, including ~~chest excursion and~~ auscultation of breath sounds with a precordial or pretracheal stethoscope. ~~This can be accomplished by auscultation of breath sounds, monitoring end-tidal CO₂ or by verbal communication with the patient.~~

Circulation:

- The dentist must continually evaluate blood pressure and heart rate ~~(unless invalidated by the nature of the patient, procedure or equipment. the patient is unable to tolerate and this is noted in the time-oriented anesthesia record).~~
- Continuous ECG monitoring of patients with significant cardiovascular disease should be considered.

Documentation:

- Appropriate time-oriented anesthetic record must be maintained, including the names of all drugs, dosages and their administration times, including local anesthetics, dosages and monitored physiological parameters. (See Additional Sources of Information for sample of a time-oriented anesthetic record).
- Pulse oximetry, heart rate, respiratory rate, blood pressure and level of consciousness must be recorded continually.

5. Recovery and Discharge

- Oxygen and suction equipment must be immediately available if a separate recovery area is utilized.
- The qualified dentist or appropriately trained clinical staff must continually monitor the patient's blood pressure, heart rate, oxygenation and level of consciousness.
- The qualified dentist must determine and document that level of consciousness; oxygenation, ventilation and circulation are satisfactory for discharge.
- Post-operative verbal and written instructions must be given to the patient, and parent, escort, guardian or care giver.
- If a pharmacological reversal agent is administered before discharge criteria have been met, the patient must be monitored for a longer period than usual before discharge, since re-sedation may occur once the effects of the reversal agent have waned.

6. Emergency Management

- If a patient enters a deeper level of sedation than the dentist is qualified to provide, the dentist must stop the dental procedure until the patient ~~returns~~ is returned to the intended level of sedation.
- The qualified dentist is responsible for the sedative management, adequacy of the facility and staff, diagnosis and treatment of emergencies related to the administration of moderate sedation and providing the equipment, drugs and protocol for patient rescue.

7. Management of Children

For children 12 years of age and under, the American Dental Association supports the use of the American Academy of Pediatrics/American Academy of Pediatric Dentistry *Guidelines for*

C. Deep Sedation or General Anesthesia

1. Patient Evaluation

Patients considered for deep sedation or general anesthesia must undergo a pre-anesthesia evaluation prior to be suitably evaluated prior to the start the administration of any sedative procedure. In healthy or medically stable individuals (ASA I, II) This must consist of at least a review of their current medical history and medication use and NPO status. In addition, However, patients with significant medical considerations (e.g., ASA III, IV) may also require consultation with their primary care physician or consulting medical specialist.

2. Pre-operative Preparation

- The patient, parent, guardian or care giver must be advised regarding the procedure associated with the delivery of any sedative or anesthetic agents and informed consent for the proposed sedation/anesthesia must be obtained.
- Determination of adequate oxygen supply and equipment necessary to deliver oxygen under positive pressure must be completed.
- Baseline vital signs (including body weight, blood pressure, pulse rate, respiration rate, and blood oxygen saturation) must be obtained unless invalidated by the patient, procedure or equipment the patient's behavior prohibits such determination. In addition, body temperature should be measured when clinically appropriate.
- A focused physical evaluation must be performed including recording the patient's body weight and BMI. as deemed appropriate In addition, body temperature should be measured when clinically indicated.
- ~~Preoperative dietary restrictions must be considered based on the sedative/anesthetic technique prescribed.~~
- Pre-operative verbal and written instructions must be given to the patient, parent, escort, guardian or care giver, including pre-operative fasting instructions based on the ASA Summary of Fasting and Pharmacologic Recommendations.
- An intravenous line, which is secured throughout the procedure, must be established except as provided in part IV. C.6. Pediatric and Special Needs Patients.

3. Personnel and Equipment Requirements

Personnel: A minimum of three (3) individuals must be present.

- A dentist qualified in accordance with part III. C. of these Guidelines to administer the deep sedation or general anesthesia.
- Two additional individuals who have current certification of successfully completing a Basic Life Support (BLS) Course for the Healthcare Provider.
- When the same individual administering the deep sedation or general anesthesia is performing the dental procedure, one of the additional appropriately trained team members must be designated for patient monitoring.

Equipment:

- A positive-pressure oxygen delivery system suitable for the patient being treated must be immediately available.
- A log of equipment maintenance, including monitors and anesthesia delivery systems, must be maintained. A pre-procedural check of equipment for each administration must be performed.

- When inhalation equipment is used, it must have a fail-safe system that is appropriately checked and calibrated. The equipment must also have either (1) a functioning device that prohibits the delivery of less than 30% oxygen or (2) an appropriately calibrated and functioning in-line oxygen analyzer with audible alarm.
- An appropriate scavenging system must be available if gases other than oxygen or air are used.
- The equipment necessary to establish intravenous access must be available.
- Equipment and drugs necessary to provide advanced airway management, and advanced cardiac life support must be immediately available.
- End tidal CO₂ must be monitored unless precluded or invalidated by the nature of the patient, procedure, or equipment. In addition, ventilation may be monitored and evaluated by continual observation of qualitative signs, including auscultation of breath sounds with a precordial or pretracheal stethoscope. If volatile anesthetic agents are utilized, a capnograph must be utilized and an inspired agent analysis monitor should be considered.
- Resuscitation medications and an appropriate defibrillator must be immediately available.

4. Monitoring and Documentation

Monitoring: A qualified dentist administering deep sedation or general anesthesia must remain in the operatory room to monitor the patient continuously until the patient meets the criteria for recovery. The dentist must not leave the facility until the patient meets the criteria for discharge and is discharged from the facility. Monitoring must include:

Oxygenation:

- Color of mucosa, skin or blood must be continually evaluated.
- Oxygenation saturation must be evaluated continuously by pulse oximetry.

Ventilation:

- Intubated patient: End-tidal CO₂ must be continuously monitored and evaluated.
- Non-intubated patient: ~~Breath sounds via auscultation and/or e~~ End-tidal CO₂ must be continually monitored and evaluated unless precluded or invalidated by the nature of the patient, procedure, or equipment. In addition, ventilation may be monitored and evaluated by continual observation of qualitative signs, including auscultation of breath sounds with a precordial or pretracheal stethoscope.
- Respiration rate must be continually monitored and evaluated.

Circulation:

- The dentist must continuously evaluate heart rate and rhythm via ECG throughout the procedure, as well as pulse rate via pulse oximetry.
- The dentist must continually evaluate blood pressure.

Temperature:

- A device capable of measuring body temperature must be readily available during the administration of deep sedation or general anesthesia.
- The equipment to continuously monitor body temperature should be available and must be performed whenever triggering agents associated with malignant hyperthermia are administered.

Documentation:

- Appropriate time-oriented anesthetic record must be maintained, including the names of all drugs, dosages and their administration times, including local anesthetics and monitored physiological parameters. (See Additional Sources of Information for sample of a time-oriented anesthetic record)
- Pulse oximetry and end-tidal CO₂ measurements (if taken), heart rate, respiratory rate and blood pressure must be recorded continually.

5. Recovery and Discharge

- Oxygen and suction equipment must be immediately available if a separate recovery area is utilized.
- The dentist or clinical staff must continually monitor the patient's blood pressure, heart rate, oxygenation and level of consciousness.
- The dentist must determine and document that level of consciousness; oxygenation, ventilation and circulation are satisfactory for discharge.
- Post-operative verbal and written instructions must be given to the patient, and parent, escort, guardian or care giver.

6. Pediatric Patients and Those with Special Needs

Because many dental patients undergoing deep sedation or general anesthesia are mentally and/or physically challenged, it is not always possible to have a comprehensive physical examination or appropriate laboratory tests prior to administering care. When these situations occur, the dentist responsible for administering the deep sedation or general anesthesia should document the reasons preventing the recommended preoperative management.

In selected circumstances, deep sedation or general anesthesia may be utilized without establishing an indwelling intravenous line. These selected circumstances may include very brief procedures or periods of time, which, for example, may occur in some pediatric patients; or the establishment of intravenous access after deep sedation or general anesthesia has been induced because of poor patient cooperation.

7. Emergency Management

The qualified dentist is responsible for sedative/anesthetic management, adequacy of the facility and staff, diagnosis and treatment of emergencies related to the administration of deep sedation or general anesthesia and providing the equipment, drugs and protocols for patient rescue.

Note regarding Section V: Additional Sources of Information as well as references supporting the Guidelines will become available on the ADA's website and no longer listed within the policy document.

V. Additional Sources of Information

American Dental Association. Example of a time oriented anesthesia record at www.ada.org.

American Academy of Pediatric Dentistry (AAPD). *Monitoring and Management of Pediatric Patients During and After Sedation for Diagnostic and Therapeutic Procedures: An Update*. Developed through a collaborative effort between the American Academy of Pediatrics and the AAPD. Available at <http://www.aapd.org/policies>.

American Academy of Periodontology (AAP). *Guidelines: In-Office Use of Conscious Sedation in Periodontics*. Available at <http://www.perio.org/resources-products/posppr3-1.html>. The AAP rescinded this policy in 2008.

American Association of Oral and Maxillofacial Surgeons (AAOMS). *Parameters and Pathways: Clinical Practice Guidelines for Oral and Maxillofacial Surgery (AAOMS ParPath o1) Anesthesia in Outpatient Facilities*. Contact AAOMS at 1-847-678-6200 or visit <http://www.aaoms.org/index.php>

American Association of Oral and Maxillofacial Surgeons (AAOMS). *Office Anesthesia Evaluation Manual 7th Edition*. Contact AAOMS at 1-847-678-6200 or visit <http://www.aaoms.org/index.php>

American Society of Anesthesiologists (ASA). *Practice Guidelines for Preoperative Fasting and the Use of Pharmacological Agents to Reduce the Risk of Pulmonary Aspiration: Application to Healthy Patients*

~~Undergoing Elective Procedures. Available at <https://ecommerce.asahq.org/p-178-practice-guidelines-for-preoperative-fasting.aspx>~~

~~American Society of Anesthesiologists (ASA). *Practice Guidelines for Sedation and Analgesia by Non-Anesthesiologists*. Available at <http://www.asahq.org/publicationsAndServices/practiceparam.htm#sedation>. The ASA has other anesthesia resources that might be of interest to dentists. For more information, go to <http://www.asahq.org/publicationsAndServices/sgstoc.htm>~~

~~Commission on Dental Accreditation (CODA). *Accreditation Standards for Predoctoral and Advanced Dental Education Programs*. Available at <http://www.ada.org/115.aspx>.~~

~~National Institute for Occupational Safety and Health (NIOSH). *Controlling Exposures to Nitrous Oxide During Anesthetic Administration* (NIOSH Alert: 1994 Publication No. 94-100). Available at <http://www.cdc.gov/niosh/docs/94-100/>~~

~~Dionne, Raymond A.; Yagiela, John A., et al. Balancing efficacy and safety in the use of oral sedation in dental outpatients. JADA 2006;137(4):502-13. ADA members can access this article online at <http://jada.ada.org/cgi/content/full/137/4/502>~~

706
707
708 **Guidelines for Teaching Pain Control and Sedation to Dentists and Dental Students**

709 Underscore denotes proposed additions

710 ~~Strikethrough~~ denotes proposed deletions

711
712
713 **I. Introduction**

714
715 The administration of local anesthesia, sedation and general anesthesia is an integral part of the practice of
716 dentistry. The American Dental Association is committed to the safe and effective use of these modalities by
717 appropriately educated and trained dentists.

718
719 Anxiety and pain control can be defined as the application of various physical, chemical and psychological
720 modalities to the prevention and treatment of preoperative, operative and postoperative patient anxiety and
721 pain to allow dental treatment to occur in a safe and effective manner. It involves all disciplines of dentistry
722 and, as such, is one of the most important aspects of dental education. The intent of these *Guidelines* is to
723 provide direction for the teaching of pain control and sedation to dentists and can be applied at all levels of
724 dental education from predoctoral through continuing education. They are designed to teach initial
725 competency in pain control and minimal and moderate sedation techniques.

726
727 These *Guidelines* recognize that many dentists have acquired a high degree of competency in the use of
728 anxiety and pain control techniques through a combination of instruction and experience. It is assumed that
729 this has enabled these teachers and practitioners to meet the educational criteria described in this document.

730
731 It is not the intent of the *Guidelines* to fit every program into the same rigid educational mold. This is neither
732 possible nor desirable. There must always be room for innovation and improvement. They do, however,
733 provide a reasonable measure of program acceptability, applicable to all institutions and agencies engaged in
734 predoctoral and continuing education.

735
736 The curriculum in anxiety and pain control is a continuum of educational experiences that will extend over
737 several years of the predoctoral program. It should provide the dental student with the knowledge and skills
738 necessary to provide minimal sedation to alleviate anxiety and control pain without inducing detrimental
739 physiological or psychological side effects. Dental schools whose goal is to have predoctoral students achieve
740 competency in techniques such as local anesthesia and nitrous oxide inhalation and minimal sedation must
741 meet all of the goals, prerequisites, didactic content, clinical experiences, faculty and facilities, as described in
742 these *Guidelines*.

743
744 Techniques for the control of anxiety and pain in dentistry should include both psychological and
745 pharmacological modalities. Psychological strategies should include simple relaxation techniques for the
746 anxious patient and more comprehensive behavioral techniques to control pain. Pharmacological strategies
747 should include not only local anesthetics but also sedatives, analgesics and other useful agents. Dentists
748 should learn indications and techniques for administering these drugs enterally, parenterally and by inhalation
749 as supplements to local anesthesia.

750
751 The predoctoral curriculum should provide instruction, exposure and/or experience in anxiety and pain
752 control, including minimal and moderate sedation. The predoctoral program must also provide the knowledge
753 and skill to enable students to recognize and manage any emergencies that might arise as a consequence of

treatment. Predoctoral dental students must complete a course in Basic Life Support for the Healthcare Provider. Though Basic Life Support courses are available online, any course taken online should be followed up with a hands-on component and be approved by the American Heart Association or the American Red Cross.

Local anesthesia is the foundation of pain control in dentistry. Although the use of local anesthetics in dentistry has a long record of safety, dentists must be aware of the maximum safe dosage limit for each patient, since large doses of local anesthetics may increase the level of central nervous system depression with sedation. The use of minimal and moderate sedation requires an understanding of local anesthesia and the physiologic and pharmacologic implications of the local anesthetic agents when combined with the sedative agents

The knowledge, skill and clinical experience required for the safe administration of deep sedation and/or general anesthesia are beyond the scope of predoctoral and continuing education programs. Advanced education programs that teach deep sedation and/or general anesthesia to competency have specific teaching requirements described in the Commission on Dental Accreditation requirements for those advanced programs and represent the educational and clinical requirements for teaching deep sedation and/or general anesthesia in dentistry.

The objective of educating dentists to utilize pain control, sedation and general anesthesia is to enhance their ability to provide oral health care. The American Dental Association urges dentists to participate regularly in continuing education update courses in these modalities in order to remain current.

All areas in which local anesthesia and sedation are being used must be properly equipped with suction, physiologic monitoring equipment, a positive pressure oxygen delivery system suitable for the patient being treated and emergency drugs. Protocols for the management of emergencies must be developed and training programs held at frequent intervals.

II. Definitions

Methods of Anxiety and Pain Control

~~analgesia – the diminution or elimination of pain.~~ [Moved to Terms section]

~~conscious sedation[†] – a minimally depressed level of consciousness that retains the patient's ability to independently and continuously maintain an airway and respond appropriately to physical stimulation or verbal command and that is produced by a pharmacological or non-pharmacological method or a combination thereof.~~

~~In accord with this particular definition, the drugs and/or techniques used should carry a margin of safety wide enough to render unintended loss of consciousness unlikely. Further, patients whose only response is reflex withdrawal from repeated painful stimuli would not be considered to be in a state of conscious sedation.~~

~~combination inhalation-enteral conscious sedation (combined conscious sedation) – conscious sedation using inhalation and enteral agents.~~

~~When the intent is anxiolysis only, and the appropriate dosage of agents is administered, then the definition of enteral and/or combination inhalation-enteral conscious sedation (combined conscious sedation) does not apply.~~

~~local anesthesia – the elimination of sensation, especially pain, in one part of the body by the topical application or regional injection of a drug.~~ [Moved to Terms section]

[†]~~Parenteral conscious sedation may be achieved with the administration of a single agent or by the administration of more than one agent.~~

~~Note: Although the use of local anesthetics is the foundation of pain control in dentistry and has a long record of safety, dentists must always be aware of the maximum, safe dosage limits for each patient. Large doses of local anesthetics in themselves may result in central nervous system depression especially in combination with sedative agents.~~ [Moved to Terms section]

minimal sedation - a minimally depressed level of consciousness, produced by a pharmacological method, that retains the patient's ability to independently and continuously maintain an airway and respond *normally* to tactile stimulation and verbal command. Although cognitive function and coordination may be modestly impaired, ventilatory and cardiovascular functions are unaffected.²

Note: In accord with this particular definition, the drug(s) and/or techniques used should carry a margin of safety wide enough never to render unintended loss of consciousness. Further, patients whose only response is reflex withdrawal from repeated painful stimuli would not be considered to be in a state of minimal sedation.

When the intent is minimal sedation for adults, the appropriate initial dosing of a single enteral drug is no more than the maximum recommended dose (MRD) of a drug that can be prescribed for unmonitored home use.

~~For children age 12 and under, the use of preoperative sedatives for children (aged 12 and under) prior to arrival in the dental office, except in extraordinary situations, must be avoided due to the risk of unobserved respiratory obstruction during transport by untrained individuals.~~

Prescription medications intended to accomplish procedural sedation for children age 12 and under must not be administered without the benefit of direct supervision by a trained dental/medical provider. (Source: the American Academy of Pediatrics/American Academy of Pediatric Dentistry Guidelines for Monitoring and Management of Pediatric Patients During and After Sedation for Diagnostic and Therapeutic Procedures.

Children (aged 12 and under) can become moderately sedated despite the intended level of minimal sedation; should this occur, the guidelines for moderate sedation apply.

For children 12 years of age and under, the American Dental Association supports the use of the American Academy of Pediatrics/American Academy of Pediatric Dentistry *Guidelines for Monitoring and Management of Pediatric Patients During and After Sedation for Diagnostic and Therapeutic Procedures*.

~~Nitrous oxide/oxygen may be used in combination with a single enteral drug in minimal sedation.~~

Nitrous oxide/oxygen when used in combination with sedative agent(s) may produce minimal, moderate, deep sedation or general anesthesia.

The following definitions apply to administration of minimal sedation via an enteral route:

maximum recommended dose (MRD) - maximum FDA-recommended dose of a drug as printed in FDA-approved labeling for unmonitored home use.

incremental dosing - administration of multiple doses of a drug until a desired effect is reached, but not to exceed the maximum recommended dose (MRD).

supplemental dosing - during minimal sedation, supplemental dosing is a single additional dose of the initial dose of the initial drug that may be necessary for prolonged procedures. The supplemental dose should not exceed one-half of the initial total dose and should not be administered until the dentist has determined the clinical half-life of the initial dosing has passed. The total aggregate dose must not exceed 1.5x the MRD on the day of treatment. For the

² Portions excerpted from *Continuum of Depth of Sedation: Definition of General Anesthesia and Levels of Sedation/Analgesia, 2014*, of the American Society of Anesthesiologists (ASA). A copy of the full text can be obtained from ASA, 520 N. Northwest Highway, Park Ridge, IL 60068-2573.

purpose of enteral or combination enteral/inhalation sedation, when the MRD of a drug is exceeded or more than one drug is used in combination, with or without the concomitant use of nitrous oxide, the guidelines for moderate sedation apply.

moderate sedation - a drug-induced depression of consciousness during which patients respond *purposefully* to verbal commands, either alone or accompanied by light tactile stimulation. No interventions are required to maintain a patent airway, and spontaneous ventilation is adequate. Cardiovascular function is usually maintained.³

Note: In accord with this particular definition, the drugs and/or techniques used should carry a margin of safety wide enough to render unintended loss of consciousness unlikely. Repeated dosing of an agent before the effects of previous dosing can be fully appreciated may result in a greater alteration of the state of consciousness than is the intent of the dentist. Further, a patient whose only response is reflex withdrawal from a painful stimulus is not considered to be in a state of moderate sedation.

The following definition applies to administration of moderate and deeper levels of sedation:

titration - administration of incremental doses of an intravenous or inhalation drug until a desired effect is reached. Knowledge of each drug's time of onset, peak response and duration of action is essential to avoid over sedation. Although the concept of titration of a drug to effect is critical for patient safety, when the intent is moderate sedation one must know whether the previous dose has taken full effect before administering an additional drug increment.

deep sedation - a drug-induced depression of consciousness during which patients cannot be easily aroused but respond purposefully following repeated or painful stimulation. The ability to independently maintain ventilatory function may be impaired. Patients may require assistance in maintaining a patent airway, and spontaneous ventilation may be inadequate. Cardiovascular function is usually maintained.³

general anesthesia – a drug-induced loss of consciousness during which patients are not arousable, even by painful stimulation. The ability to independently maintain ventilatory function is often impaired. Patients often require assistance in maintaining a patent airway, and positive pressure ventilation may be required because of depressed spontaneous ventilation or drug-induced depression of neuromuscular function. Cardiovascular function may be impaired.³

Because sedation and general anesthesia are a continuum, it is not always possible to predict how an individual patient will respond. Hence, practitioners intending to produce a given level of sedation should be able to diagnose and manage the physiologic consequences (rescue) for patients whose level of sedation becomes deeper than initially intended.³

For all levels of sedation, the qualified dentist practitioner must have the training, skills, drugs and equipment to identify and manage such an occurrence until either assistance arrives (emergency medical service) or the patient returns to the intended level of sedation without airway or cardiovascular complications.

Routes of Administration

enteral - any technique of administration in which the agent is absorbed through the gastrointestinal (GI) tract or oral mucosa [i.e., oral, rectal, sublingual].

parenteral - a technique of administration in which the drug bypasses the gastrointestinal (GI) tract [i.e., intramuscular (IM), intravenous (IV), intranasal (IN), submucosal (SM), subcutaneous (SC), intraosseous (IO)].

³ Excerpted from *Continuum of Depth of Sedation: Definition of General Anesthesia and Levels of Sedation/Analgesia, 2014 2004*, of the American Society of Anesthesiologists (ASA). A copy of the full text can be obtained from ASA, 520 N. Northwest Highway, Park Ridge, IL 60068-2573.

transdermal - a technique of administration in which the drug is administered by patch or iontophoresis through skin.

transmucosal – a technique of administration in which the drug is administered across mucosa such as intranasal, sublingual, or rectal.

inhalation - a technique of administration in which a gaseous or volatile agent is introduced into the lungs and whose primary effect is due to absorption through the gas/blood interface.

Terms

analgesia – the diminution or elimination of pain [Moved from Definitions section]

local anesthesia - the elimination of sensation, especially pain, in one part of the body by the topical application or regional injection of a drug. [Moved from Definitions section]

Note: Although the use of local anesthetics is the foundation of pain control in dentistry and has a long record of safety, dentists must always be aware of the maximum, safe dosage limits for each patient. Large doses of local anesthetics in themselves may result in central nervous system depression especially in combination with sedative agents. [Moved from Definitions section]

qualified dentist – meets the educational requirements for the appropriate level of sedation in accordance with Section III of these *Guidelines*, or a dentist providing sedation and anesthesia in compliance with their state rules and/or regulations prior to adoption of this document.

must/shall - indicates an imperative need and/or duty; an essential or indispensable item; mandatory.

should - indicates the recommended manner to obtain the standard; highly desirable.

may - indicates freedom or liberty to follow a reasonable alternative.

continual - repeated regularly and frequently in a steady succession.

continuous - prolonged without any interruption at any time.

time-oriented anesthesia record - documentation at appropriate time intervals of drugs, doses and physiologic data obtained during patient monitoring.

immediately available – on site in the facility and available for immediate use.

Levels of Knowledge

familiarity - a simplified knowledge for the purpose of orientation and recognition of general principles.

in-depth - a thorough knowledge of concepts and theories for the purpose of critical analysis and the synthesis of more complete understanding (highest level of knowledge).

Levels of Skill

exposed - the level of skill attained by observation of or participation in a particular activity.

competent - displaying special skill or knowledge derived from training and experience.

~~*proficient* - the level of skill attained when a particular activity is accomplished with repeated quality and a more efficient utilization of time (highest level of skill).~~

American Society of Anesthesiologists (ASA) Patient Physical Status Classification⁴

ASA I - A normal healthy patient.

ASA II - A patient with mild systemic disease.

ASA III - A patient with severe systemic disease.

ASA IV - A patient with severe systemic disease that is a constant threat to life.

ASA V - A moribund patient who is not expected to survive without the operation.

ASA VI - A declared brain-dead patient whose organs are being removed for donor purposes.

E - Emergency operation of any variety (used to modify one of the above classifications, i.e., ASA III-E).

American Society of Anesthesiologists' Fasting Guidelines*

Ingested Material	Minimum Fasting Period
Clear liquids	2 hours
Breast milk	4 hours
Infant formula	6 hours
Nonhuman milk	6 hours
Light meal	6 hours
Fatty meal	8 hours

*American Society of Anesthesiologists: Practice Guidelines for preoperative fasting and the use of pharmacologic agents to reduce the risk of pulmonary aspiration: application to healthy patients undergoing elective procedures. Anesthesiology 114:495. 2011. Reprinted with permission.

Education Courses

Education may be offered at different levels (competency, update, survey courses and advanced education programs). A description of these different levels follows:

1. Competency Courses are designed to meet the needs of dentists who wish to become competent knowledgeable and proficient in the safe and effective administration of local anesthesia, minimal and moderate sedation. They consist of lectures, demonstrations and sufficient clinical participation to assure the faculty that the dentist understands the procedures taught and can safely and effectively apply them so that mastery of the subject is achieved. Faculty must assess and document the dentist's competency upon successful completion of such training. To maintain competency, periodic update courses must be completed.

2. Update Courses are designed for persons with previous training. They are intended to provide a review of the subject and an introduction to recent advances in the field. They should be designed didactically and clinically to meet the specific needs of the participants. Participants must have completed previous competency training (equivalent, at a minimum, to the competency course described in this document) and have current experience to be eligible for enrollment in an update course.

3. Survey Courses are designed to provide general information about subjects related to pain control and sedation. Such courses should be didactic and not clinical in nature, since they are not intended to develop clinical competency.

4. Advanced Education Courses are a component of an advanced dental education program, accredited by the ADA Commission on Dental Accreditation in accord with the *Accreditation Standards* for advanced dental

⁴ ASA Physical Status Classification System is reprinted with permission of the American Society of Anesthesiologists, 520 N. Northwest Highway, Park Ridge, IL 60068-2573.

education programs. These courses are designed to prepare the graduate dentist or postdoctoral student in the most comprehensive manner to be competent ~~knowledgeable and proficient~~ in the safe and effective administration of minimal, moderate and deep sedation and general anesthesia.

III. Teaching Pain Control

These *Guidelines* present a basic overview of the recommendations for teaching pain control.

A. General Objectives: Upon completion of a predoctoral curriculum in pain control the dentist must:

1. have an in-depth knowledge of those aspects of anatomy, physiology, pharmacology and psychology involved in the use of various anxiety and pain control methods;
2. be competent in evaluating the psychological and physical status of the patient, as well as the magnitude of the operative procedure, in order to select the proper regimen;
3. be competent in monitoring vital functions;
4. be competent in prevention, recognition and management of related complications;
5. ~~be familiar with~~ have in-depth knowledge of the appropriateness of and the indications for medical consultation or referral;
6. be competent in the maintenance of proper records with accurate chart entries recording medical history, physical examination, vital signs, drugs administered and patient response.

B. Pain Control Curriculum Content:

1. Philosophy of anxiety and pain control and patient management, including the nature and purpose of pain
2. Review of physiologic and psychologic aspects of anxiety and pain
3. Review of airway anatomy and physiology
4. Physiologic monitoring
 - a. Observation
 - (1) Central nervous system
 - (2) Respiratory system
 - a. Oxygenation
 - b. Ventilation
 - (3) Cardiovascular system
 - b. Monitoring equipment
5. Pharmacologic aspects of anxiety and pain control
 - a. Routes of drug administration
 - b. Sedatives and anxiolytics
 - c. Local anesthetics
 - d. Analgesics and antagonists
 - e. Adverse side effects
 - f. Drug interactions
 - g. Drug abuse
6. Control of preoperative and operative anxiety and pain
 - a. Patient evaluation
 - (1) Psychological status
 - (2) ASA physical status
 - (3) Type and extent of operative procedure
 - b. Nonpharmacologic methods
 - (1) Psychological and behavioral methods

- (a) Anxiety management
 - (b) Relaxation techniques
 - (c) Systematic desensitization
 - (2) Interpersonal strategies of patient management
 - (3) Hypnosis
 - (4) Electronic dental anesthesia
 - (5) Acupuncture/Acupressure
 - (6) Other
- c. Local anesthesia
 - (1) Review of related anatomy, and physiology
 - (2) Pharmacology
 - (i) Dosing
 - (ii) Toxicity
 - (iii) Selection of agents
 - (3) Techniques of administration
 - (i) Topical
 - (ii) Infiltration (supraperiosteal)
 - (iii) Nerve block – maxilla-to include:
 - (aa) Posterior superior alveolar
 - (bb) Infraorbital
 - (cc) Nasopalatine
 - (dd) Greater palatine
 - (ee) Maxillary (2nd division)
 - (ff) Other blocks
 - (iv) Nerve block – mandible-to include:
 - (aa) Inferior alveolar-lingual
 - (bb) Mental-incisive
 - (cc) Buccal
 - (dd) Gow-Gates
 - (ee) Closed mouth
 - (v) Alternative injections-to include:
 - (aa) Periodontal ligament
 - (bb) Intraosseous
- d. Prevention, recognition and management of complications and emergencies

C. Sequence of Pain Control Didactic and Clinical Instruction: Beyond the basic didactic instruction in local anesthesia, additional time should be provided for demonstrations and clinical practice of the injection techniques. The teaching of other methods of anxiety and pain control, such as the use of analgesics and enteral, inhalation and parenteral sedation, should be coordinated with a course in pharmacology. By this time the student also will have developed a better understanding of patient evaluation and the problems related to prior patient care. As part of this instruction, the student should be taught the techniques of venipuncture and physiologic monitoring. Time should be included for demonstration of minimal and moderate sedation techniques.

Following didactic instruction in minimal and moderate sedation, the student must receive sufficient clinical experience to demonstrate competency in those techniques in which the student is to be certified. It is understood that not all institutions may be able to provide instruction to the level of clinical competence in pharmacologic sedation modalities to all students. The amount of clinical experience required to achieve competency will vary according to student ability, teaching methods and the anxiety and pain control modality taught.

Clinical experience in minimal and moderate sedation techniques should be related to various disciplines of dentistry and not solely limited to surgical cases. Typically, such experience will be provided in managing healthy adult patients. The sedative care of pediatric patients and those with special needs requires advanced didactic and clinical training.

Throughout both didactic and clinical instruction in anxiety and pain control, psychological management of the patient should also be stressed. Instruction should emphasize that the need for sedative techniques is directly related to the patient's level of anxiety, cooperation, medical condition and the planned procedures.

D. Faculty: Instruction must be provided by qualified faculty for whom anxiety and pain control are areas of major proficiency, interest and concern.

E. Facilities: Competency courses must be presented where adequate facilities are available for proper patient care, including drugs and equipment for the management of emergencies.

IV. Teaching Administration of Minimal Sedation

The faculty responsible for curriculum in minimal sedation techniques must be familiar with the ADA Policy Statement: *Guidelines for the Use of Sedation and General Anesthesia by Dentists*, and the Commission on Dental Accreditation's *Accreditation Standards* for dental education programs.

These *Guidelines* present a basic overview of the recommendations for teaching minimal sedation. These include courses in nitrous oxide/oxygen sedation, enteral sedation, and combined inhalation/enteral techniques.

These *Guidelines* are not intended for the management of enteral and/or combination inhalation-enteral minimal sedation in children, which requires additional course content and clinical learning experience.

[Moved from Section C]

General Objectives: Upon completion of a competency course in minimal sedation, the dentist must be able to:

1. Describe the adult and pediatric anatomy and physiology of the respiratory, cardiovascular and central nervous systems, as they relate to the above techniques.
2. Describe the pharmacological effects of drugs.
3. Describe the methods of obtaining a medical history and conduct an appropriate physical examination.
4. Apply these methods clinically in order to obtain an accurate evaluation.
5. Use this information clinically for ASA classification ~~and~~ risk assessment, and pre-procedure fasting instructions.
6. Choose the most appropriate technique for the individual patient.
7. Use appropriate physiologic monitoring equipment.
8. Describe the physiologic responses that are consistent with minimal sedation.
9. Understand the sedation/general anesthesia continuum.
10. Demonstrate the ability to diagnose and treat emergencies related to the next deeper level of anesthesia than intended.

Inhalation Sedation (Nitrous Oxide/Oxygen)

A. Inhalation Sedation Course Objectives: Upon completion of a competency course in inhalation sedation techniques, the dentist must be able to:

1. Describe the basic components of inhalation sedation equipment.
2. Discuss the function of each of these components.
3. List and discuss the advantages and disadvantages of inhalation sedation.
4. List and discuss the indications and contraindications of inhalation sedation.
5. List the complications associated with inhalation sedation.
6. Discuss the prevention, recognition and management of these complications.
7. Administer inhalation sedation to patients in a clinical setting in a safe and effective manner.
8. Discuss the abuse potential, occupational hazards and other untoward effects of inhalation agents.

B. Inhalation Sedation Course Content:

1. Historical, philosophical and psychological aspects of anxiety and pain control.
2. Patient evaluation and selection through review of medical history taking, physical diagnosis and psychological considerations.
3. Definitions and descriptions of physiological and psychological aspects of anxiety and pain.
4. Description of the stages of drug-induced central nervous system depression through all levels of consciousness and unconsciousness, with special emphasis on the distinction between the conscious and the unconscious state.
5. Review of pediatric and adult respiratory and circulatory physiology and related anatomy.
6. Pharmacology of agents used in inhalation sedation, including drug interactions and incompatibilities.
7. Indications and contraindications for use of inhalation sedation.
8. Review of dental procedures possible under inhalation sedation.
9. Patient monitoring using observation and monitoring equipment (i.e., pulse oximetry), with particular attention to vital signs and reflexes related to pharmacology of nitrous oxide.
10. Importance of maintaining proper records with accurate chart entries recording medical history, physical examination, vital signs, drugs and doses administered and patient response.
11. Prevention, recognition and management of complications and life-threatening situations.
12. Administration of local anesthesia in conjunction with inhalation sedation techniques.
13. Description, maintenance and use of inhalation sedation equipment.
14. Introduction to potential health hazards of trace anesthetics and proposed techniques for limiting occupational exposure.
15. Discussion of abuse potential.

C. Inhalation Sedation Course Duration: While length of a course is only one of the many factors to be considered in determining the quality of an educational program, the course should be a minimum of *14 hours plus management of clinical dental cases, including a clinical component* during which clinical competency in inhalation sedation technique is achieved. The inhalation sedation course most often is completed as a part of the predoctoral dental education program. However, the course may be completed in a postdoctoral continuing education competency course.

D. Participant Evaluation and Documentation of Inhalation Sedation Instruction: Competency courses in inhalation sedation techniques must afford participants with sufficient clinical experience to enable them to achieve competency. This experience must be provided under the supervision of qualified faculty and must be evaluated. The course director must certify the competency of participants upon satisfactory completion of training. Records of the didactic instruction and clinical experience, including the number of patients treated by each participant must be maintained and available.

E. Faculty: The course should be directed by a dentist or physician qualified by experience and training. This individual should possess an active permit or license to administer moderate sedation in at least one state, have had at least three years of experience, including the individual's formal postdoctoral training in anxiety and pain control. In addition, the participation of highly qualified individuals in related fields, such as anesthesiologists, pharmacologists, internists, and cardiologists and psychologists, should be encouraged.

A participant-faculty ratio of not more than ten-to-one when inhalation sedation is being used allows for adequate supervision during the clinical phase of instruction; a one-to-one ratio is recommended during the early state of participation.

The faculty should provide a mechanism whereby the participant can evaluate the performance of those individuals who present the course material.

F. Facilities: Competency courses must be presented where adequate facilities are available for proper patient care, including drugs and equipment for the management of emergencies.

1227

1228 **Enteral and/or Combination Inhalation-Enteral Minimal Sedation**

1229

1230 **A. Enteral and/or Combination Inhalation-Enteral Minimal Sedation Course Objectives: Upon**

1231 completion of a competency course in enteral and/or combination inhalation-enteral minimal sedation

1232 techniques, the dentist must be able to:

- 1233 1. Describe the basic components of inhalation sedation equipment.
- 1234 2. Discuss the function of each of these components.
- 1235 3. List and discuss the advantages and disadvantages of enteral and/or combination inhalation-enteral
- 1236 minimal sedation (combined minimal sedation).
- 1237 4. List and discuss the indications and contraindications for the use of enteral and/or combination
- 1238 inhalation-enteral minimal sedation (combined minimal sedation).
- 1239 5. List the complications associated with enteral and/or combination inhalation-enteral minimal sedation
- 1240 (combined minimal sedation).
- 1241 6. Discuss the prevention, recognition and management of these complications.
- 1242 7. Administer enteral and/or combination inhalation-enteral minimal sedation (combined minimal
- 1243 sedation) to patients in a clinical setting in a safe and effective manner.
- 1244 8. Discuss the abuse potential, occupational hazards and other effects of enteral and inhalation agents.
- 1245 9. Discuss the pharmacology of the enteral and inhalation drugs selected for administration.
- 1246 10. Discuss the precautions, contraindications and adverse reactions associated with the enteral and
- 1247 inhalation drugs selected.
- 1248 11. Describe a protocol for management of emergencies in the dental office and list and discuss the
- 1249 emergency drugs and equipment required for management of life-threatening situations.
- 1250 12. Demonstrate the ability to manage life-threatening emergency situations, including current
- 1251 certification in Basic Life Support for Healthcare Providers.
- 1252 13. Discuss the pharmacological effects of combined drug therapy, their implications and their
- 1253 management. Nitrous oxide/oxygen when used in combination with sedative agent(s) may produce
- 1254 minimal, moderate, deep sedation or general anesthesia.
- 1255

1256 **B. Enteral and/or Combination Inhalation-Enteral Minimal Sedation Course Content:**

1257

- 1258 1. Historical, philosophical and psychological aspects of anxiety and pain control.
- 1259 2. Patient evaluation and selection through review of medical history taking, physical diagnosis and
- 1260 psychological profiling.
- 1261 3. Definitions and descriptions of physiological and psychological aspects of anxiety and pain.
- 1262 4. Description of the stages of drug-induced central nervous system depression through all levels of
- 1263 consciousness and unconsciousness, with special emphasis on the distinction between the conscious
- 1264 and the unconscious state.
- 1265 5. Review of pediatric and adult respiratory and circulatory physiology and related anatomy.
- 1266 6. Pharmacology of agents used in enteral and/or combination inhalation-enteral minimal sedation,
- 1267 including drug interactions and incompatibilities.
- 1268 7. Indications and contraindications for use of enteral and/or combination inhalation-enteral minimal
- 1269 sedation (combined minimal sedation).
- 1270 8. Review of dental procedures possible under enteral and/or combination inhalation-enteral minimal
- 1271 sedation).
- 1272 9. Patient monitoring using observation, monitoring equipment, with particular attention to vital signs and
- 1273 reflexes related to consciousness.
- 1274 10. Maintaining proper records with accurate chart entries recording medical history, physical
- 1275 examination, informed consent, time-oriented anesthesia record, including the names of all drugs
- 1276 administered including local anesthetics, doses, and monitored physiological parameters.
- 1277 11. Prevention, recognition and management of complications and life-threatening situations.
- 1278 12. Administration of local anesthesia in conjunction with enteral and/or combination inhalation-enteral
- 1279 minimal sedation techniques.
- 1280 13. Description, maintenance and use of inhalation sedation equipment.

- 1281 14. Introduction to potential health hazards of trace anesthetics and proposed techniques for limiting
1282 occupational exposure.
1283 15. Discussion of abuse potential.
1284

1285 **C. Enteral and/or Combination Inhalation-Enteral Minimal Sedation Course Duration:** Participants must
1286 be able to document current certification in Basic Life Support for Healthcare Providers and have completed a
1287 nitrous oxide competency course to be eligible for enrollment in this course. While length of a course is only
1288 one of the many factors to be considered in determining the quality of an educational program, the course
1289 should include a minimum of *16 hours*, plus clinically-oriented experiences during which competency in
1290 enteral and/or combined inhalation-ental minimal sedation techniques is demonstrated. Clinically-oriented
1291 experiences may include group observations on patients undergoing enteral and/or combination inhalation-
1292 enteral minimal sedation. Clinical experience in managing a compromised airway is critical to the prevention
1293 of life-threatening emergencies. The faculty should schedule participants to return for additional clinical
1294 experience if competency has not been achieved in the time allotted. The educational course may be
1295 completed in a predoctoral dental education curriculum or a postdoctoral continuing education competency
1296 course.
1297

1298 ~~These *Guidelines* are not intended for the management of enteral and/or combination inhalation-ental~~
1299 ~~minimal sedation in children, which requires additional course content and clinical learning experience.~~
1300 [Moved to Section IV]
1301

1302 **D. Participant Evaluation and Documentation of Instruction:** Competency courses in combination
1303 inhalation-ental minimal sedation techniques must afford participants with sufficient clinical understanding to
1304 enable them to achieve competency. The course director must certify the competency of participants upon
1305 satisfactory completion of the course. Records of the course instruction must be maintained and available.
1306

1307 **E. Faculty:** The course should be directed by a dentist or physician qualified by experience and training. This
1308 individual should possess a current permit or license to administer moderate sedation in at least one state,
1309 have had at least three years of experience, including the individual's formal postdoctoral training in anxiety
1310 and pain control. Dental faculty with broad clinical experience in the particular aspect of the subject under
1311 consideration should participate. In addition, the participation of highly qualified individuals in related fields,
1312 such as anesthesiologists, pharmacologists, internists, and cardiologists and psychologists, should be
1313 encouraged. The faculty should provide a mechanism whereby the participant can evaluate the performance
1314 of those individuals who present the course material.
1315

1316 **F. Facilities:** Competency courses must be presented where adequate facilities are available for proper
1317 patient care, including drugs and equipment for the management of emergencies.
1318

1319 V. Teaching Administration of Moderate Sedation

1320
1321 These *Guidelines* present a basic overview of the requirements for a competency course in moderate
1322 sedation. These include courses in enteral and parenteral moderate sedation ~~and parenteral moderate~~
1323 ~~sedation~~. The teaching guidelines contained in this section on moderate sedation differ slightly from
1324 documents in medicine to reflect the differences in delivery methodologies and practice environment in
1325 dentistry. ~~For this reason, separate teaching guidelines have been developed for moderate enteral and~~
1326 ~~moderate parenteral sedation.~~
1327

1328 Completion of a pre-requisite nitrous oxide-oxygen competency course is required for participants combining
1329 parenteral sedation with nitrous oxide-oxygen. [Moved from Section C]
1330

1331 **A. Course Objectives:** Upon completion of a course in moderate sedation, the dentist must be able to:
1332

- 1333 1. List and discuss the advantages and disadvantages of moderate sedation.
- 1334 2. Discuss the prevention, recognition and management of complications associated with moderate
1335 sedation.

3. Administer moderate sedation to patients in a clinical setting in a safe and effective manner.
4. Discuss the abuse potential, occupational hazards and other untoward effects of the agents utilized to achieve moderate sedation.
5. Describe and demonstrate the technique of intravenous access, intramuscular injection and other parenteral techniques.
6. Discuss the pharmacology of the drug(s) selected for administration.
7. Discuss the precautions, indications, contraindications and adverse reactions associated with the drug(s) selected.
8. Administer the selected drug(s) to dental patients in a clinical setting in a safe and effective manner.
9. List the complications associated with techniques of moderate sedation.
10. Describe a protocol for management of emergencies in the dental office and list and discuss the emergency drugs and equipment required for the prevention and management of emergency situations.
11. Discuss principles of advanced cardiac life support or an appropriate dental sedation/anesthesia emergency course equivalent.
12. Demonstrate the ability to manage emergency situations.
13. Demonstrate the ability to diagnose and treat emergencies related to the next deeper level of anesthesia than intended.

B. Moderate Sedation Course Content:

1. Historical, philosophical and psychological aspects of anxiety and pain control.
2. Patient evaluation and selection through review of medical history taking, physical diagnosis and psychological considerations.
3. Use of patient history and examination for ASA classification, risk assessment and pre-procedure fasting instructions.
4. Definitions and descriptions of physiological and psychological aspects of anxiety and pain.
5. Description of the sedation anesthesia continuum, with special emphasis on the distinction between the conscious and the unconscious state.
6. Review of pediatric and adult respiratory and circulatory physiology and related anatomy.
7. Pharmacology of local anesthetics and agents used in moderate sedation, including drug interactions and contraindications.
8. Indications and contraindications for use of moderate sedation.
9. Review of dental procedures possible under moderate sedation.
10. Patient monitoring using observation and monitoring equipment, with particular attention to vital signs, ventilation/breathing and reflexes related to consciousness.
11. Maintaining proper records with accurate chart entries recording medical history, physical examination, informed consent, time-oriented anesthesia record, including the names of all drugs administered including local anesthetics, doses, and monitored physiological parameters.
12. Prevention, recognition and management of complications and emergencies.
13. Description, maintenance and use of moderate sedation monitors and equipment.
14. Discussion of abuse potential.
15. Intravenous access: anatomy, equipment and technique.
16. Prevention, recognition and management of complications of venipuncture and other parenteral techniques.
17. Description and rationale for the technique to be employed.
18. Prevention, recognition and management of systemic complications of moderate sedation, with particular attention to airway maintenance and support of the respiratory and cardiovascular systems.

C. Moderate Enteral Sedation Course Duration: A minimum of 24 hours of instruction, plus management of at least 10 adult case experiences by the enteral and/or enteral-nitrous oxide/oxygen route are required to achieve competency. These ten cases must include at least three live clinical dental experiences managed by participants in groups no larger than five. The remaining cases may include simulations and/or video presentations, but must include one experience in returning (rescuing) a patient from deep to moderate

sedation. Participants combining enteral moderate sedation with nitrous oxide-oxygen must have first completed a nitrous oxide competency course.

Participants should be provided supervised opportunities for clinical experience to demonstrate competence in airway management. Clinical experience will be provided in managing healthy adult patients; **this course in moderate enteral sedation is not designed for the management of children (aged 12 and under).** Additional supervised clinical experience is necessary to prepare participants to manage medically compromised adults and special needs patients. This course in moderate enteral sedation does not result in competency in moderate parenteral sedation. The faculty should schedule participants to return for additional didactic or clinical exposure if competency has not been achieved in the time allotted.

Moderate Parenteral Sedation Course Duration: A minimum of 60 hours of didactic instruction, plus administration of sedation for management of at least 20 *individually-managed dental* patients by the intravenous any route per participant including intravenous administration, is required to demonstrate achieve competency in moderate sedation techniques. Of the 20 cases, all must be individually managed by the anesthesia operator dentist. Participants combining parenteral moderate sedation with nitrous oxide-oxygen must have first completed a nitrous oxide competency course.

Clinical experience in managing a compromised airway is critical to the prevention of emergencies. Participants should be provided supervised opportunities for clinical experience to demonstrate competence in management of the airway. Typically, clinical experience will be provided in managing healthy adult patients. **Additional supervised clinical experience is necessary to prepare participants to manage children (aged 12 and under) and medically compromised adults.** Successful completion of this course does result in clinical competency in moderate parenteral sedation. The faculty should schedule participants to return for additional clinical experience if competency has not been achieved in the time allotted.

D. Participant Evaluation and Documentation of Instruction: Competency courses in moderate sedation techniques must afford participants with sufficient clinical experience to enable them to achieve competency. This experience must be provided under the supervision of qualified faculty and must be evaluated. The course director must certify the competency of participants upon satisfactory completion of training in each moderate sedation technique, including instruction, clinical experience and airway management. Records of the didactic instruction and clinical experience, including the number of patients managed by each participant in each anxiety and pain control modality must be maintained and available for review.

E. Faculty: The course should be directed by a dentist or physician qualified by experience and training. This individual should possess a current permit or license to administer deep sedation and general anesthesia in at least one state, have had at least three years of experience, including formal postdoctoral training in anxiety and pain control. Dental faculty with broad clinical experience in the particular aspect of the subject under consideration should participate. In addition, the participation of highly qualified individuals in related fields, such as anesthesiologists, pharmacologists, internists, cardiologists and psychologists, should be encouraged.

A participant-faculty ratio of not more than ~~five-four~~ to-one when moderate enteral sedation is being taught allows for adequate supervision during the clinical phase of instruction. ~~A participant-faculty ratio of not more than three to one when moderate parenteral sedation is being taught allows for adequate supervision during the clinical phase of instruction;~~ a one-to-one ratio is recommended during the early stage of participation.

The faculty should provide a mechanism whereby the participant can evaluate the performance of those individuals who present the course material.

F. Facilities: Competency courses in moderate sedation must be presented where adequate facilities are available for proper patient care, including drugs and equipment for the management of emergencies. These facilities may include dental and medical schools/offices, hospitals and surgical centers.

Note regarding Section V: Additional Sources of Information as well as references supporting the Guidelines will become available on the ADA's website and no longer listed within the policy document.

VI. Additional Sources of Information

American Dental Association. ~~Example of a time oriented anesthesia record at www.ada.org.~~

American Academy of Pediatric Dentistry (AAPD). *Guidelines for Monitoring and Management of Pediatric Patients During and After Sedation for Diagnostic and Therapeutic Procedures: An Update*. Developed through a collaborative effort between the American Academy of Pediatrics and the AAPD. Available at <http://www.aapd.org/policies>

American Academy of Periodontology (AAP). *Guidelines: In-Office Use of Conscious Sedation in Periodontics*. Available at <http://www.perio.org/resources-products/posppr3-1.html>. ~~The AAP rescinded this policy in 2008.~~

American Association of Oral and Maxillofacial Surgeons (AAOMS). *Parameters and Pathways: Clinical Practice Guidelines for Oral and Maxillofacial Surgery (AAOMS ParPath o1) Anesthesia in Outpatient Facilities*. Contact AAOMS at 1-847-678-6200 or visit <http://www.aaoms.org/index.php>

American Association of Oral and Maxillofacial Surgeons (AAOMS). *Office Anesthesia Evaluation Manual 7th Edition*. Contact AAOMS at 1-847-678-6200 or visit <http://www.aaoms.org/index.php>

American Society of Anesthesiologists (ASA). *Practice Guidelines for Preoperative Fasting and the Use of Pharmacological Agents to Reduce the Risk of Pulmonary Aspiration: Application to Healthy Patients Undergoing Elective Procedures*. Available at <https://ecommerce.asahq.org/p-178-practice-guidelines-for-preoperative-fasting.aspx>

American Society of Anesthesiologists (ASA). *Practice Guidelines for Sedation and Analgesia by Non-Anesthesiologists*. Available at <http://www.asahq.org/Home/For-Members/Practice-Management/Practice-Parameters#sedation>

~~The ASA has other anesthesia resources that might be of interest to dentists. For more information, go to <http://www.asahq.org/publicationsAndServices/sgstoc.htm>~~

Commission on Dental Accreditation (CODA). *Accreditation Standards for Predoctoral and Advanced Dental Education Programs*. Available at <http://www.ada.org/115.aspx>.

National Institute for Occupational Safety and Health (NIOSH). *Controlling Exposures to Nitrous Oxide During Anesthetic Administration* (NIOSH Alert: 1994 Publication No. 94-100). Available at <http://www.cdc.gov/niosh/docs/94-100/>

Dionne, Raymond A.; Yagiola, John A., et al. Balancing efficacy and safety in the use of oral sedation in dental outpatients. JADA 2006;137(4):502-13. ADA members can access this article online at <http://jada.ada.org/cgi/content/full/137/4/502>

Resolution No. 78 NewReport: CODA Supplemental Report 3 Date Submitted: October 2015Submitted By: Commission on Dental AccreditationReference Committee: C (Dental Education, Science and Related Matters)Total Net Financial Implication: None Net Dues Impact: _____Amount One-time _____ Amount On-going _____ FTE 0

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

How does this resolution increase member value: Not Applicable

COMMISSION ON DENTAL ACCREDITATION SUPPLEMENTAL REPORT 3 TO THE HOUSE OF DELEGATES: AMENDMENT OF THE ADA BYLAWS REGARDING THE DUTIES OF THE COMMISSION ON DENTAL ACCREDITATION

Background: In summer 2015, the Commission on Dental Accreditation (CODA) directed that the proposed amendment to the ADA *Bylaws* duties of the Commission on Dental Accreditation be submitted to the House of Delegates to delete from duty “e” the phrase “either through or in cooperation with the Council on Dental Education and Licensure” when referring to submission of the Commission’s articles of incorporation and rules and amendments thereto to this Association’s House of Delegates. The Commission made the following conclusions in support of the resolution:

- Current and upcoming changes to federal regulations governing higher education and accreditation may have a significant effect on the Commission’s relationship with the American Dental Association, particularly related to governance matters. In particular, conflict of interest between the accrediting agency and its primary sponsoring organization is undergoing scrutiny by the federal government, and the Commission anticipates this proposed change will be mandated when the Higher Education Opportunity Act is reauthorized in 2016.
- The Commission believes that the current requirement to submit *Rules* changes through CDEL puts the Commission at increased risk of triggering a complaint of non-compliance with recognition criteria §602.15(a)(6) on conflict of interest. For instance, the American Dental Hygienists’ Association (ADHA) filed a formal complaint, through a third party comment, related to conflict of interest at the Commissions’ recognition compliance hearing in 2013. A determination that the criteria is not met could have profound consequences for the ADA-CODA governance relationship under terms dictated by the federal government.
- CDEL will continue to be the agency of the ADA that monitors CODA and provides ADA input and comments on CODA accreditation standards and actions. The Commission is required to solicit input from each of its communities of interest, including the ADA. The Commission views the requirement of acting through another ADA agency to change its *Rules* as an unnecessary step that has the potential to impede the efficient conduct of the Commission’s business.

Resolution

78. Resolved, that Chapter XV. COMMISSIONS, *Section 130. DUTIES*, Subsection A. COMMISSION ON DENTAL ACCREDITATION, of the ADA *Bylaws*, be amended as follows (deletions are ~~stricken~~):

1 *Section 130. DUTIES:*

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

- 4 a. Formulate and adopt requirements and guidelines for the accreditation of dental,
5 advanced dental and allied dental educational programs.
6 b. Accredite dental, advanced dental and allied dental educational programs.
7 c. Provide a means for appeal from an adverse decision of the accrediting body of the
8 Commission to a separate and distinct body of the Commission whose membership shall
9 be totally different from that of the accrediting body of the Commission.
10 d. Submit an annual report to the House of Delegates of this Association and interim
11 reports, on request, and the Commission's annual budget to the Board of Trustees of the
12 Association.
13 e. Submit the Commission's articles of incorporation and rules and amendments thereto to
14 this Association's House of Delegates for approval by majority vote ~~either through or in~~
15 ~~cooperation with the Council on Dental Education and Licensure.~~

16 **BOARD RECOMMENDATION: Vote Yes.**

BOARD VOTE: UNANIMOUS.

Resolution No. 91 NewReport: NA Date Submitted: October 2015Submitted By: First Trustee DistrictReference Committee: C (Dental Education, Science and Related Matters)Total Net Financial Implication: \$18,000 Net Dues Impact: \$0.17Amount One-time Amount On-going 3-year Period FTE .15

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

How does this resolution increase member value: See Background

1 EVALUATION OF CURRENT REFORMS IN INITIAL LICENSURE EXAMINATIONS FORMATS

2 The following resolution was adopted by the First Trustee District and transmitted on October 20, 2015,
3 by Dr. Judith M. Fisch, Caucus Chair, First Trustee District.

4 **Background:** The local, regional and national debate regarding the examination of candidates for dental
5 licensure through protocols that include the treatment of live patients has spanned several decades.
6 There is now strong evidence that there are alternative methods of examination available which provide
7 equal or greater validity and reliability and which address the other significant issues which underpin and
8 continue to fuel this debate. The emergence of a Curriculum Integrated Format examination at the
9 University at Buffalo School of Dental Medicine recently is an appropriate step in the evolution of initial
10 licensure process.

11 Resolution

12 **91. Resolved,** that the Council on Dental Education and Licensure evaluate the implementation and
13 outcomes of the Curriculum Integrated Format examination as it is being currently offered at several
14 dental schools and report annually to the ADA House of Delegates, with a three-year analysis of this
15 clinical testing modality, with continued consideration of alternatives to remove live patients from the
16 licensing process in line with current ADA policy on licensure.

17 **BOARD RECOMMENDATION: Received after the October Board of Trustees meeting.**

Resolution No. 96 New

Report: N/A Date Submitted: November 2015

Submitted By: Fifteenth Trustee District

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

Total Net Financial Implication: \$15,000 Net Dues Impact: .14

Amount One-time \$15,000 Amount On-going FTE 1.0

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

How does this resolution increase member value: See Background

1 DEVELOPMENT OF ADA POLICY ON DENTISTRY'S ROLE IN SLEEP RELATED BREATHING 2 DISORDERS

3 The following resolution was adopted by the Fifteenth Trustee District and submitted on November 6,
4 2015, by Dr. William Gerlach.

5 **Background:** Given their prevalence and effect on health, quality of life and safety, Sleep Related
6 Breathing Disorders (SRBD) have emerged as "a major public health issue" ¹ that requires a population
7 level response. Millions of people suffer from all degrees of SRBD from simple snoring without pathology
8 to severe Obstructive Sleep Apnea (OSA). SRBD, as currently defined by the International Classification
9 of Sleep Disorders – Version 3, ² is by far the largest category of sleep disorders, far outnumbering all
10 other sleep disorders combined, in lives affected. OSA alone affects ≥25% of the population between 30-
11 70 ³, with >85% of moderate to severe OSA syndrome cases undiagnosed ⁴ and a higher missed percent
12 when including milder forms of SRBD. Even when diagnosed, the lack of successful treatment outcomes
13 for OSA are high when using the gold standard, positive airway pressure (PAP) therapy, due to a 25%
14 long term compliance rate ⁵⁻⁸. Recent developments in healthcare policy and Medicare reimbursement
15 parameters have opened the eyes of clinicians and practitioners throughout the sleep industry that this
16 current standard of care of diagnosis and treatment is failing to meet the population's need for an
17 intervention. Sleep physicians are recognizing the need for others to diagnose and treat SRBD conditions
18 in order to manage this public health problem. ⁹

19 The first step in reducing the burden of SRBD in the United States is to create a primary care workforce
20 that can reach the numbers of people who need treatment. As healthcare professionals, the dentist is
21 perhaps positioned best to evaluate and treat a significant portion of patients, and make referrals as
22 necessary for more intervention. Dentists may be able to prevent development and long term affliction of
23 SRBD through early interventional orthodontics, and can manage SRBD long term through oral appliance
24 therapy (OAT). For recalcitrant cases, orthognathic surgery may need to be considered. Recent
25 information on mean disease alleviation shows OAT to be equal to CPAP ¹⁰⁻¹² for the vast majority of
26 OSA. Even primary snoring, now within the SRBD category, is readily addressed by OAT and is not
27 amenable to PAP therapy. Demographically, dentists are located in most communities whereas sleep
28 specialists are concentrated in urban areas. On average 70% of the US population visits the dentist
29 yearly ¹³ making dentistry an ideal profession to screen, treat and manage SRBD patients.

30 Finally, dentists are well positioned to collaborate with physicians to treat OSA. The overlap of treatment
31 modalities in medicine and dentistry for a particular diagnosis occurs frequently. Examples of this dental-
32 medical overlap include diagnosis and treatment of nocturnal bruxism, temporomandibular disorders,
33 orofacial neuropathic disorders, myofascial pain, headaches and oral cancer.

1 Currently, the ADA has no policy regarding SRBD. As state boards develop rules and regulations, there is
2 no information available from the ADA and minimal information available from non-conflicted sources. For
3 example, the leading SRBD organization has, as part of its stated goals, the development of Boarded
4 specialists as the primary means of delivering treatment to this population. Realizing the potential and
5 expanding paradigm of SRBD, the American Dental Association wrote in February 2015, "The ADA is
6 interested in the development of guidance on the complex, multidisciplinary subject of sleep medicine that
7 would benefit patients and providers..." As an emerging dental practice procedure, SRBD treatment could
8 have instant viability for both general dentists as well as specialists. OAT is medically considered a do-no-
9 harm therapy, and the ability to treat SRBD, often in conjunction with physicians, is within our training,
10 expertise and education.

11 The American Dental Association has been silent too long on this public health issue. As an unbiased
12 source, the ADA has become the recognized leader in a multitude of dental protocols. Therefore, it is
13 incumbent on the ADA to assume the leading role in guideline development for standardized education
14 and treatment protocols for this expanding and critical area of healthcare.

15 Resolution

16 **96. Resolved**, that the American Dental Association develop policy as to dentistry's role in Sleep
17 Related Breathing Disorders (SRBD), and be it further

18 **Resolved**, that the American Dental Association designate the appropriate agency to develop
19 suggested guidelines as to the dentist's role in airway management, and be it further

20 **Resolved**, that the designated agency report to the ADA House of Delegates at the 2016
21 Annual Session with recommendations for dentists' involvement in SRBD.

Appendix 1**Listing of References**

1. Love, A. L, Kuna S.T. *Home sleep testing and sleep apnea: a review for dentists*. Journal of Dental Sleep Medicine 2015;2(2):45–52.
2. Ito, E. and Y. Inoue, [*The International Classification of Sleep Disorders, third edition. American Academy of Sleep Medicine. Includes bibliographies and index*]. Nihon Rinsho, 2015. **73**(6): p. 916-23.
3. Peppard, P.E., et al., *Increased prevalence of sleep-disordered breathing in adults*. Am J Epidemiol, 2013. **177**(9): p. 1006-14.
4. Young, T., et al., *Estimation of the clinically diagnosed proportion of sleep apnea syndrome in middle-aged men and women*. Sleep, 1997. **20**(9): p. 705-6.
5. Stuck, B.A., S. Leitzbach, and J.T. Maurer, *Effects of continuous positive airway pressure on apnea-hypopnea index in obstructive sleep apnea based on long-term compliance*. Sleep Breath, 2012. **16**(2): p. 467-71.
6. Kushida, C.A., et al., *Practice parameters for the use of continuous and bilevel positive airway pressure devices to treat adult patients with sleep-related breathing disorders*. Sleep, 2006. **29**(3): p. 375-80.
7. McArdle, N., et al., *Long-term use of CPAP therapy for sleep apnea/hypopnea syndrome*. Am J Respir Crit Care Med, 1999. **159**(4 Pt 1): p. 1108-14.
8. Engleman, H.M. and M.R. Wild, *Improving CPAP use by patients with the sleep apnoea/hypopnoea syndrome (SAHS)*. Sleep Med Rev, 2003. **7**(1): p. 81-99.
9. Phillips, B., D. Gozal, and A. Malhotra, *What is the Future of Sleep Medicine in the US?* Am J Respir Crit Care Med, 2015.
10. Grote, L., et al., *Therapy with nCPAP: incomplete elimination of Sleep Related Breathing Disorder*. Eur Respir J, 2000. **16**(5): p. 921-7.
11. Vanderveken, O.M., et al., *Objective measurement of compliance during oral appliance therapy for sleep-disordered breathing*. Thorax, 2013. **68**(1): p. 91-6.
12. Dieltjens, M., et al., *Objectively measured vs self-reported compliance during oral appliance therapy for sleep-disordered breathing*. Chest, 2013. **144**(5): p. 1495-502.
13. *The Center for Disease Control and Prevention. Behavioral Risk Factor Surveillance System (BRFSS) Prevalence and Trends Data: Average number of people who visited the dentist or dental clinic within the past year for any reason 1999-2008; 2009.*