ADA American Dental Association®

America's leading advocate for oral health

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Supplement to

Annual Reports and Resolutions

Volume 1

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Credentials, Rules and Order

Resolution No. 56 New

Report: Board Report 1 Date Submitted: July 2021

Submitted By: Board of Trustees

Reference Committee: Board Report 1/Credentials, Rules and Order

Total Net Financial Implication: None Net Dues Impact:

Amount One-time Amount On-going

ADA Strategic Plan Objective: None

How does this resolution increase member value: Not Applicable

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 162nd Annual Meeting of the American Dental Association.*

Appreciation to the Advisory Committee on Annual Meetings: The American Dental Association is pleased to have its first SmileCon™ conference in Las Vegas, Nevada, October 11-13, 2021.

The Board of Trustees wishes to express its sincere gratitude to the Committee, and the exceptional leadership of Dr. George R. Shepley, 2020-2021 committee chair; Dr. H. Charles McKelvey, 2020-2021 meeting chair; and Dr. Robert L. Skinner, 2020-2021 continuing education chair.

Committee Members: Dr. Robert L. Blackwell; Dr. Michael J. Goulding (2022 CLA general chair-designate); Dr. Chad R. Leighty (2021-2022 committee chair-designate); Dr. Melanie R. Love (2023 meeting chair-designate); Dr. R. David Resch; Dr. David A. Schimmel; Dr. Peter C. Shatz (2022 continuing education chair-designate); Dr. Nanette C. Tertel (2023 continuing education chair-designate); Dr. Lauren E. Vitkus (2021 New Dentist Member); Dr. Deborah W. Weisfuse; Ms. Casey A. White (2021 ASDA Liaison); and Dr. Bradley A. Wilbur (2021 Las Vegas CLA general chair) are all to be recognized for their commendable achievement.

The Board also extends its sincere appreciation and thanks for those chairpersons who so capably assisted Dr. Bradley A Wilbur, general chair of the 2021 Las Vegas Committee on Local Arrangements, in preparation and support of SmileCon™: Dr. George F. Rosenbaum, vice chair; Dr. George J. McAlpine, program co-chair; Dr. Stephen C. Rose, program co-chair; Dr. Tina M. Brandon Abbatangelo, operations co-chair; and Dr. Amy S. Tongsiri, operations co-chair.

Without the diligent work from these dedicated volunteer leaders, and their efforts working as a team, the development, planning and execution of SmileCon™ 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. Marjorie K. Jeffcoat, former JADA Editor, 2001-2004; Dr. Walter F. Lamacki, former trustee, 1990-1994; Dr. Patrick S. Metro, former trustee, 1996-2000; Dr. James H. Pearce, Jr., former trustee, 1991-1995; Dr. Donald L. Seago, former trustee, 2009-2013; Dr. Jonathan D. Shenkin, former vice president, 2013-2015; Dr. J. Thomas Soliday, Sr., former speaker, 2002-2012; and Dr. Charles E. Wilson, former vice president, 1988-1989.

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:

Mr. Jerome K. Bowman
Mr. Fred J. Leviton
Mr. Stephen O'Loughlin
Mr. Richard D. Stevens

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 these newest honorary members.

Distinguished Service Award: Established in 1970, the Distinguished Service Award is the highest honor conferred by the Association's Board of Trustees. Each year the Board may select one recipient for the Award. The Board is pleased to announce that the recipient of the 2021 Distinguished Service Award is Rear Admiral Timothy Ricks.

Timothy Ricks, D.M.D., M.P.H., F.I.C.D. RADM Ricks currently serves as the Chief Dental Officer of the U.S. Public Health Service (USPHS). RADM Ricks advises the Office of the Surgeon General and the U.S. Department of Health and Human Services (HHS) on the recruitment, assignment, deployment, retention, and career development of oral health professionals. He is also responsible for overseeing the development of the second-ever Surgeon General's Report on Oral Health, and he chairs the USPHS Oral Health Coordinating Committee.

In addition to his role as Chief Dental Officer, RADM Ricks serves concurrently in numerous national roles within the Indian Health Service (IHS) including continuing dental education coordinator, oral health promotion/disease prevention consultant, oral health surveillance coordinator, dental lead for the Government Performance and Results Act, and IHS representative to the Healthy People 2020/2030 oral health workgroup.

RADM Ricks has served in the U.S. Public Health Service for over 20 years. Prior to this service, he was an associate dentist, independent contractor, and sole proprietor, and he also served as a military police officer in the Army National Guard. He has served in numerous leadership capacities within the U.S. Public Health Service, led multiple national initiatives, and is the recipient of numerous USPHS and IHS national awards.

The ability of the dental profession to successfully navigate the COVID- 19 pandemic is in part due to the efforts he made on behalf of all of dentistry to bring together everyone who has a stake in the profession. He convened public-private partnership meetings early in the pandemic to allow for exchange of information and collaborative thought. What started out with less than ten organizations has now become more than fifty. These organizations include federal agencies, U.S. Dental Corps, professional member organizations, specialty groups, research entities, trade industry representatives, and many others. Collaborative work by all who have participated greatly influenced the success our profession experienced as we moved through this pandemic. The resources provided through his organization and guidance will continue to move us forward for years to come. Lessons learned about the benefits of collaborative action has benefitted us all.

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. Jay F. Harrington, Jr., trustee, Fifth District; Dr. Linda K. Himmelberger, trustee, Third District; Dr. Vincent U. Rapini, first vice president; Dr. Julio H. Rodriguez, trustee, Ninth District; and Dr. George R. Shepley, trustee, Fourth District.

Appreciation of Employees: The Board of Trustees is pleased to bring to the attention of the House of Delegates 54 members of the Association staff for their years of service.

Forty Years of Service

Tyree Hayden, Finance and Operations

Thirty Five Years of Service

My Tran, Finance and Operations

Twenty Five Years of Service

April Kates-Ellison, Member and Client Services
GraceAnn Pastorelli, Practice Institute
Beth Pawlowski, Technology

Twenty Years of Service

Cesar Barradas, Business Group
Paul Bralower, Practice Institute
Nicole Catral, Administrative Services
Sheila McDonnell, Technology
Spiro Megremis, ADA Science Research Institute
Cheryl Mezydlo, Member and Client Services
Michael Tiefenthaler, Technology
Matthew Warren, Member and Client Services

Fifteen Years of Service

Lisa Brazier, Member and Client Services
Kathleen Dennis, Conferences and Continuing Education
Jennifer Fisher, Government Affairs, Washington Office
Jennifer Garvin, Publishing, Washington Office
Kathleen Hinshaw, Education
C. Michael Kendall, Legal
Tammie Lollis, Education
David Preble, Practice Institute

Ten Years of Service

Kelly Dobson, Conferences and Continuing Education
Marjorie Hooper, Education
Debbie Labinger, Publishing
Radina Pugh, Finance and Operations
Parinaz Safavi, Technology
Nick Salerno, Education
Elizabeth Shapiro, Administrative Services
Marko Vujicic, Health Policy Institute
David Waldschmidt, Education
Robert Zinn, Finance and Operations

Five Years of Service

Joselyn Arteaga, Education
Cole Chickering, Education

Tina Collier, Education
Hillary DeLong, ADA Science Research Institute
Narcisa Despoiu, Conferences and Continuing Education
Anna Fleming, Education
Sara Green, Education
Ryan Hennigan, Business Group
Jeffrey Huber, ADA Science Research Institute
Carlos Jones, Government Affairs
Kyle Keltner, Finance and Operations
Jane Long, Human Resources
Heidi Nickisch Duggan, Education
Molly Potnick, Administrative Services
Kristi Seibert, Conferences and Continuing Education
Niki Shah, Communications
Daniel Sloyan, Education
Kyle Smith, Administrative Services
Michelle Smith, Education
Jennifer Sutherland, Communications
Bryan Svendby, Education
Olivia Urquhart, ADA Science Research Institute
Xiaohong Wang, ADA Science Research Institute

Nominations to Councils: The Board of Trustees annually submits to the House of Delegates nominations for membership to ADA councils. Based on the ADA *Governance Manual*, the nominees for ADA open positions on the Council on Members Insurance and Retirement Programs and Council on Scientific Affairs were selected by the Board from nominations open to all trustee districts. In addition, with the adoption of Resolution 47H-2017, the composition of each council includes one New Dentist Member recommended by the New Dentist Committee and nominated by the Board of Trustees.

In accordance with a long-standing House directive, the Board is providing a brief narrative on each nominee's qualifications. The *Governance Manual*, Chapter XVII, Conflict of Interest, requires nominees for Councils 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.

ADVOCACY FOR ACCESS AND PREVENTION
Molly E. Conlon, Wisconsin
*Brooke Fukuoka, Idaho
Huong N. Le, California
Jackie Nord, North Dakota
Jessica L. Robertson, Arizona

COMMUNICATIONS
T. Stotts Isbell, Arkansas
Lindsey D. Jackson, New Hampshire
Rachel L. Lewin, Pennsylvania
*Tanya Sue Maestas, Texas
Rhett E. Raum, Tennessee

DENTAL BENEFIT PROGRAMS
*J. Luke Andrew, Colorado
Adrian J. Carrington, California
Susan D. Jolliff, Texas
Mark A. Moats, Kentucky
Vishruti Patel, Illinois

DENTAL EDUCATION AND LICENSURE
*Jarod Johnson, Iowa
Jason A. Tanguay, Montana
Najia Usman, Ohio

DENTAL PRACTICE
David L. Fried, Connecticut
Michael J. Korch, Pennsylvania
Shane A. Ricci, Texas
Michael Saba, New Jersey
*ArNelle Wright, Florida

ETHICS, BYLAWS AND JUDICIAL AFFAIRS
Karen D. Foster, Colorado
Leslie E. Grant, Maryland
*Alex Mellion, Ohio
Kelly A. Roth, Ohio
Richard Serchuk, New York
Debra S. West, Nebraska, *ad interim*

GOVERNMENT AFFAIRS
Darren D. Chamberlain, Utah
Doug Erickson, Minnesota
*Steve Feldman, Washington, D.C.
Leigh W. Kent, Alabama, *ad interim*
John R. Roberts, Indiana
James A.H. Tauberg, Pennsylvania

MEMBERS INSURANCE AND RETIREMENT PROGRAMS
*Stephanie Ganter Briggs, Texas
Sami, M. Ghareeb, West Virginia, *ad interim*
Hubert J. Jacob, Jr., Ohio
Joseph E. Sokolowski, Missouri
C. Rieger Wood, III, Oklahoma

MEMBERSHIP
Ensy A. Atarod, Texas
Renuka R. Bijoor, New York
Nathaniel W. Kunzman, Colorado
Terri S. Tiersky, Illinois
*Benjamin Youel, Illinois

SCIENTIFIC AFFAIRS
Juliana da Costa, Oregon
*Mai-Ly Duong, Arizona
Ashraf F. Fouad, Alabama
William A. MacDonnell, Connecticut
Alessandro Villa, California

**New Dentist Member*

Resolution

56. Resolved, that the nominees put forward for membership on ADA councils be elected.

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

ADVOCACY FOR ACCESS AND PREVENTION
Irene V. Hilton, California
Jessica A. Meeske, Nebraska
Carol M. Morrow, Colorado
Jehan Wakeem, Michigan

ANNUAL MEETINGS
Robert L. Blackwell, Illinois
George R. Shepley, Maryland
*Lauren E. Vitkus, New York
Deborah P. Weisfuse, New York
Bradley A. Wilbur, Nevada

COMMUNICATIONS
*Kevin Y. Kai, California
Sam Mansour, Pennsylvania
Stephen M. Pitmon, Vermont
Rhett E. Raum, Tennessee
Stephanie B. Weaver, Louisiana

CONTINUING EDUCATION PROVIDER RECOGNITION
Gary M. DeWood, Arizona
Steven E. Parker, Ohio

DENTAL ACCREDITATION
Christopher M. Hasty, Georgia

DENTAL BENEFIT PROGRAMS
Yvonne E. Maldonado, Texas
Randall C. Markarian, Illinois
*Amrita R. Patel, New York
Hope E. Watson, Tennessee
Walter G. Weber, California

DENTAL EDUCATION AND LICENSURE
*Daniel A. Hammer, California
Jun S. Lim, Illinois
William M. Litaker Jr., North Carolina
Linda C. Niessen, Missouri
Jacqueline M. Plemons, Texas

DENTAL PRACTICE
Jeffrey S. Berkley, Connecticut
*Lindsay M. Compton, Colorado
Duc M. Ho, Texas
Christopher G. Liang, Maryland
Cary J. Limberakis, Pennsylvania

ETHICS, BYLAWS AND JUDICIAL AFFAIRS
Jill M. Burns, Indiana
Guenter J. Jonke, New York
Onika R. Patel, Arizona
Robert J. Wilson, Jr., Maryland

GOVERNMENT AFFAIRS
Matthew J. Messina, Ohio
John V. Reitz, Pennsylvania
David M. White, Nevada
Emily S. Willett, Nebraska

MEMBERS INSURANCE AND RETIREMENT PROGRAMS
John P. Ahern, New Hampshire
Wilma Luquis-Aponte, Texas
*Britany F. Matin, Alabama
Paul T. Olenyn, Virginia
Michael R. Thompson, Arizona

MEMBERSHIP
Bryan C. Blew, Illinois
Jeffrey A. Kahl, Colorado
Summer Ketron Roark, Texas
Jay Skolnick, New York

NATIONAL DENTAL EXAMINATIONS
Kanthasamy K. Ragunanthan, Ohio

NEW DENTIST
Lindsay M. Compton, Colorado
Daniel W. Hall, South Carolina
Lauren E. Vitkus, New York
Benjamin C. Youel, Illinois

RECOGNITION OF DENTAL SPECIALTIES AND CERTIFYING BOARDS
Joseph A. Battaglia, New Jersey
James D. Benz, Illinois
Charles H. Norman, III, North Carolina

SCIENTIFIC AFFAIRS
Tara L. Aghaloo, California
Satish B. Alapati, Illinois
Ana K. Bedran-Russo, Wisconsin
Parthasarathy A. Madurantakam, Virginia
Lauren L. Patton, North Carolina

*New Dentist Member

ADA INSTITUTE FOR DIVERSITY AND 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. The program's faculty are Liz Howard Livingston from Northwestern University's Kellogg School of Management and Dr. Ashleigh Shelby Rosette from Duke University's Fuqua School of Business. They have been with the program since its inception. (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 along with a project management/communication tool called Basecamp.

Enrollment: Since 2003, the program has admitted 266 dentists (including one dentist sponsored by the Asociación Dental Mexicana). During its July meeting, 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:

Ansensi, Gabriela, Coral Gables, FL
Alvarez, Boris, Bloomfield, NJ
Bergeron, Brittany, Baltimore, MD
Bujnoski, Emily, Scottsdate, AZ
Burdette, Kerin, Waxahachie, TX

Cheek, Nicole, Washington, D.C
Cummings, Zazell, Koezebue, AK
Fleming, Eleanor, Franklin, TN
Lagreca, Gabriela, Framinghan, MA
Lee, Austin, San Antonio, TX
Lopez, Esther, Oak Park, IL
Martinsen Seifert, Valerie, LaPorte, IN
Nunez, Natali, Boston, MA
Oubaidin, Maysaa, Chicago, IL
Rathore, Sonali, Glen Allen, VA
Rawal, Kady, Boston, MA
Rodriguez, Nicholas, McAllen, TX
Sergie, Susan, Bethel, AK
Stuefen, Sara, Vinton, IA
Taylor-Bishop, Dorienne, Bowie, MD
White, Lawrence, Chicago, IL

Sponsorship: The ADA Institute for Diversity in Leadership is made possible through the generous support of Henry Schein, Inc. and Crest + Oral B.

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

- At the national level, service has included:
  - ADA First Vice President, the ADA Strategic Planning Committee, Council on Membership, Council on Communications, Council on Government Affairs, Council on Advocacy for Access and Prevention, New Dentist Committee, Board of Trustees Standing Committee on Diversity and Inclusion, ADA House of Delegates, and ADA Success Program speakers.
  - Officers and leaders at the national levels of the Society of American Indian Dentists, National Dental Association, Hispanic Dental Association, and American Association of Women Dentists.
- With a variety of state and local dental societies, Institute alumni have served as presidents, council members and chairs, as board members, and as House delegates at the state and local level. In an Institute alumni survey, alumni volunteered to share expertise with dental societies on a wide range of topics in strategic planning, membership development, continuing education, mentoring for students and new dentists, government affairs, access, prevention, and dentists' collaborating with physicians and nurses.
- Over the past several years, alumni have mobilized a growing number dentists from across the country for annual events to serve U.S. military veterans.
- Alumni have also served on boards of community organizations.

STATEMENT OF QUALIFICATIOINS OF NOMINEES TO COUNCILS

ADVOCACY FOR ACCESS AND PREVENTION

Conlon, Molly E., Wisconsin, 2025. Dr. Molly Conlon is a third-generation dentist from Wisconsin, and she has recently joined a private practice in her hometown. She obtained her undergraduate degree in social policy with a focus on education and health policy with the intention to assist with access and community issues in dentistry.

Dr. Conlon's experience has revolved around access issues in medicine and social program creation and implementation with community targeting. She worked as an intern for the Council on Access, Prevention, and Interprofessional Affairs as a college student in 2012 and assisted with Give Kids a Smile Academy and program analysis with grant selection. Her college thesis was based on analysis of this council's work, Oral Health America, and several other programs and their ability to reach intended populations and improve overall oral health with focus on continuity of care.

Dr. Conlon's master's thesis analyzed the epidemiological considerations of Native American oral health and the physical, social, and economic barriers to care in this population. She has spent a considerable amount of time working on several community service projects including Mission of Mercy, veterans groups, senior centers, and pediatric education programs.

Growing up, she consistently observed her father and other practitioners attempting to fill gaps in care in their communities, and it has been her passion since then. She spent the last year working at Froedtert Hospital doing oral surgery treating primarily Medicare, Medicaid, and special needs populations. As the program closed, she experienced first-hand the difficulty her patients had finding new dental providers due to their access, insurance, and special needs requirements, which further instilled in her the need for improved access to affordable, local care. As one of the only facilities in the state, this program's closing was very difficult for the dental community and has put a considerable burden on the remaining providers available to this group of patients.

While working in a hospital, Dr. Conlon learned to manage dental issues within a large level 1 medical facility, working with patients' facilities, guardians, families, and primary care or specialist physicians to ensure their care needs were met in the safest, quickest possible manner; and she spent a considerable amount of time on advocacy issues within dentistry, including water fluoridation issues, dental therapy programs, and state health reimbursements. Previously, she advocated for the removal of patient-based licensing exams for the state of Massachusetts and for dental therapy considerations in Vermont.

Although she is a young dentist, Dr. Conlon has considerable experience in organized dentistry as she has been encouraged to participate from a young age. She served on the American Student Dental Association (ASDA) Board of Trustees as the District 1 Trustee and on the ASDA Council on Sessions as a trustee; additionally she served on her dental school's ASDA executive board for all four years and served in several other roles at the district level prior to trustee.

In 2018, Dr. Conlon served as the ASDA delegate to ADA Annual Session and served on the ADA Council on Members Insurance and Retirement Programs as the ASDA representative. Throughout her four years, she also served on two Massachusetts Dental Society Councils and as chair of ADEA as well. Dr. Molly Conlon will be an asset to the Council on Advocacy for Access and Prevention.

Fukuoka, Brooke, Idaho, 2022. Dr. Brooke Fukuoka, the owner of Dentist Your Special Smiles PLLC, a mobile/hospital/teledental practice where she focuses on the treatment of adults with special needs and geriatric patients with mobility issues. In addition to her practice, Dr. Fukuoka is also a Federally Qualified Health Center Employee Dentist at Family Health Services Idaho. There, she works with Refugee and Spanish speaking patients. Dr. Fukuoka holds a Bachelor's of Science in Zoology from Idaho State University, DMD from the University of Louisville, GPR Certificate from the University of Louisville Hospital- University Hospital, and FSCD from Special Care Dental Association. Dr. Fukuoka has also given face-to-face courses on "The Wonderful World of Special Care", "Who, What, When, Where, How and Why of Silver Diamine Fluoride", "Updates on Silver Diamine Fluoride", "Silver Diamine Fluoride/ SMART Restorations Choose Your Own Adventure", "Medical/Dental Integration and Forming

Interdisciplinary Programs in Special Care." She is also an ADA Success Speaker and District 11 representative to the ADA New Dentist Committee. When not practicing, Dr. Fukuoka is a Dental Director with Special Olympics Idaho and the Founder, President of Special Care Dentists of Idaho. This appointment would be Dr. Fukouka's second term on CAAP.

Le, Huong N., California, 2025. Dr Huong Le is chief dental officer of Asian Health Services (AHS), a Federally Qualified Health Center (FQHC) located in Oakland, California. Dr. Le joined community health centers in 1989. During all these years she has also worked as an associate/consultant for a private practice in northern California. She was a member of the Board of Directors for 16 years and eventually served as president of National Network for Oral Health Access in 2014. Dr. Le was appointed to Dental Board of California in 2009 and served for nine years under three administrations. She is well known not only for her outstanding service through many innovative projects in medical-dental integration, but also for her continuous efforts in advocacy to insure access to care to the underserved at the state and national levels.

Dr. Le's integration of behavioral health into oral health has been featured in many media sources and afforded her an opportunity to be a speaker at a national Mayor Coalition conference hosted by the First Lady of New York City. Her integration model has also been recognized as best practice by assistant surgeon general, Dr. Tim Ricks and the Health Resources and Services Administration. Besides being active at Alameda County Dental Society, former delegate to California Dental Association and the ADA, Dr. Le serves as a member of the Clinical Practice Committee at National Association of Community Health Centers, an organization representing over 1000 health centers in the country. She also serves on the Clinicians Committee at California Primary Care Association. Dr. Le is very well versed in the Medicaid program in her state where she has served on various workgroups discussing scope of benefits, educational curriculum for providers, program integrity and audits. She has been invited to speak at state and national conferences on Medicaid topics such as private contracting and audits.

Dr. Le's work in advocacy and access to care for the underserved has earned her many awards and recognitions including an ADA Presidential Citation, American College of Dentists Northern California Fleming Meritorious Award and most recently, the 2020 Myron Allukian Lifetime Achievement Award given by the American Association of Dental Community Programs. At the present, Dr. Le is working with Physicians for Healthy Californians as consultant for their loan repayment program and several other organizations in state on Medicaid health literacy materials to insure the educational materials are appropriate for the patient population. Dr. Le is a Fellow of the American College of Dentists, International College of Dentists and the Pierre Fauchard Academy.

Nord, Jackie, North Dakota, 2025. For the past 10 years, Dr. Jackie Nord has served as director of a community based health center in Grand Forks, North Dakota. In that same time frame, she has also served as Flight Commander/Dentist for the North Dakota Air National Guard. In both capacities, Dr. Nord has overseen the providing of care and has served in leadership positions. Her experiences have helped her to develop a knowledge of current health care practices with funding streams, as well as oral health care/disease prevention systems in the private and public sectors. She also has experience providing oral health care to underserved populations. Dr. Nord's community health center experience and knowledge should lend itself well to the mission of the Council on Advocacy for Access and Prevention.

Robertson, Jessica L., Arizona, 2025. Dr. Jessica Robertson received her dental degree at Oregon Health & Science University in 2004. She received additional training at University of California Los Angeles (UCLA) where she received an advanced degree at UCLA in Pediatric Dentistry, graduating in 2006. She is in private practice in Flagstaff, Arizona.

Dr. Robertson is a strong voice of change serving on the Council of Government Affairs for the Arizona Dental Association since 2014. She is also the sitting secretary/treasurer for the Arizona Dental Association. In addition to her state leadership roles, Dr. Robertson also serves as the chair of the Council of Government Affairs for the American Academy of Pediatric Dentistry where she advocates for initiatives that improve access to care.

Dr. Robertson is a strong and vocal leader in District 14 and her experience and talents will serve the

Council on Advocacy for Access and Prevention well.

COMMUNICATIONS

Isbell, T. Stotts, Arkansas, 2025. Dr. T. Stotts Isbell has served at all levels in Arkansas State Dental Association and is currently serving as president and serves as an elected alternate delegate. Dr. Isbell has been involved in numerous PR campaigns in Arkansas dentistry to increase membership. Being an early mid-career dentist also serves well for this appointment

Jackson, Lindsey D., New Hampshire, 2025. Dr. Lindsey Jackson has served five years in New Hampshire Dental Society state executive leadership. Her experience also includes active use of social media platforms, involvement in state strategic planning committee and five New England Dental Leadership Conferences discussing various leadership skills including public affairs and management.

Lewin, Rachel L., Pennsylvania, 2025. Dr. Rachel Lewin is an energetic, enthusiastic new dentist with strong, straightforward communication skills who has practiced general dentistry in suburban Philadelphia since early 2019. She has established herself as a leader with exceptional organizational skills. She is currently serving as the editor of the Montgomery-Bucks Dental Society Bulletin (local) and as an associate editor of the Second District Valley Forge Dental Association Journal (component). Moreover, Dr. Lewin has been elected as a first-time delegate to the 2021 ADA House of Delegates. She is active on Facebook, Instagram, Twitter, and LinkedIn.

Maestas, Tanya Sue, Texas, 2022. Dr. Tanya Sue Maestas is a 2018 graduate from the University of Texas Health Science Center School of Dentistry. During dental school, Dr. Maestas served as National ASDA President and the University of Texas School of Dentistry at Houston's ASDA President. Leading up to these roles, she served on the National ASDA Communications Committee where she hosted a variety of events, webinars, and programming to connect with the general membership. She currently attends AT Still University College of Graduate Health Studies where she will receive her Master of Public Health. Simultaneously, she serves as the Director and Social Media Manager for the El Paso District Dental Society where she helps manage the communications of the society. The recipient of numerous honors and awards including the ASDA Award of Excellence and the Texas Dental Association Outstanding Senior Dental Student Award, Dr. Maestas has also completed the ADA Institute for Diversity in Leadership and currently serves as an ADA Success speaker. This appointment marks Dr. Maestas' first term as the new dentist member to CC.

Raum, Rhett E., Tennessee, 2025. Dr. Rhett Raum has served on the Council on Communications since being elected to the Council by the 2019 House of Delegates. He is eligible to be elected to serve a full four-year term (2021-2025). He has represented the Sixth District and the ADA in an exemplary fashion and is re-nominated to continue his work and experience for the Association.

DENTAL BENEFIT PROGRAMS

Andrew, John Luke, Colorado, 2022. Dr. John Luke Andrew received a Doctor of Dental Surgery from the University of Colorado School of Dental Medicine in 2018. Upon completion, Dr. Andrew went on to receive his Certificate of Postdoctoral Training in 2019. During dental school he served as the ASDA liaison to the Council on Dental Benefit Programs where he provided the student perspective on discussions pertaining to ADA initiatives. Currently, Dr. Andrew is a partner at Comfort Dental Green Mountain and serves as volunteer faculty in the department of surgical dentistry at the University of Colorado School of Dental Medicine. This is Dr. Andrew's first appointment to CDBP.

Carrington, Adrian J., California, 2025. Dr. Adrian Carrington received his dental education at Howard University, College of Dentistry, graduating 1988 with a doctor of dental surgery degree and was admitted to the Omicron Kappa Upsilon dental honor society. He subsequently completed a general practice residency at Long Island College Hospital, Brooklyn, New York, where he gained extensive experience working in clinical settings with multiple doctors and support staff. While in residency, Dr. Carrington also gleaned experience in hospital-based multidisciplinary complex case dentistry. He treated patients for dental pathologies and complications which required in-patient and out-patient services as well as

operating room services. He specifically chose this residency because there were no specialist residents. The clinical treatment and case management was squarely on the shoulders of the general practice resident dentists, who were supervised by specialist attending staff. This also afforded Dr. Carrington hands-on experience and insight into managing the daily schedules and on-call emergency schedules of multiple dentists. Employee reviews of the assistants and other clinic support staff was conducted with the input of the residents. This provided an environment for employee-management training. Since that time, he has had countless hours of continuing education in practice management, staff development and training.

In addition, Dr. Carrington has been fortunate over the course of his dental career to have received training in a variety of leadership development workshops. He has been very active in the tripartite of the American Dental Association (ADA), California Dental Association (CDA) and the Sacramento District Dental Society (SDDS). He has attended several of the CDA leadership development programs and workshops, which are designed to develop leadership skills and groom volunteers who have been identified as future leaders.

Dr. Carrington has had experience in the growth and management of organizations outside his personal practice of dentistry and CDA. He was the president of the Sacramento Chapter of the National Dental Association (SCNDA) and was instrumental in revitalizing the SCNDA; making their voices count at the national level. As president of the SCNDA, Dr. Carrington was the facilitator and organizer of monthly meetings. He saw the advent of the annual scholarship golf tournament, which is the premier fund-raising event and has grown to include the physicians of the local National Medical Association.

Dr. Carrington was chairman of the Sacramento District Dental Society, Peer Review Committee for two years and served on the CDA Peer Review Council for three years. During that time, he was involved in revising the peer review manual, updating policies and procedures, doing the early work of centralizing the state-wide process of peer review and fielding all appeals cases for the State. This afforded him experience in analyzing and solving complex and potentially litigious problems as well as critically assessing and improving statewide peer review policy documents. Subsequently, he wrote the Peer Review chapter of the 2010 Policy and Procedures Manual of the California Department of Correction and Rehabilitation (CDCR). He also developed and coded the scoring metrics for the peer review grading and reporting process for CDCR.

Dr. Carrington was employed by CDCR for twelve (12) years. The first ten years of employment was as a Regional Headquarters dentist. In that capacity, he had a pivotal role in guiding the Dental Department out of the Perez Law Suit and establishing performance metrics, sanctioned by the court, which are currently being utilized to measure the performance of each clinic. He was the Regional Dental Director, Region I, for his last two years with the State. In that capacity, he lead a team of four dentists, four dental assistants and three administrative staff members. Their charge was to ensure the dental clinics in the nine institutions of their charge were performing, meeting and/or exceeding the metrics established. They were responsible for trouble shooting and problem solving for each institution dental clinic leadership, assisting with staff hiring, equipment issues, scheduling concerns and patient complaints to name a few.

Dr. Carrington also brings inherent and learned skills which have been instrumental in his success as a leader and as a manager. He has an approachable personality, which has served him well in communicating with his subordinates and peers. This allows for a transparent management style which fosters trust in the work environment. He has the ability to motivate staff and provide a low stress work environment. He has been blessed with the ability to quickly comprehend information and convert it to action. This has been a tremendous asset in his clinical and management development. He values the input of his peers and subordinates when making decisions. This approach allows all involved to become a part of the process and to play a more productive role. Dr. Carrington has proven himself to be an able meeting facilitator and able to keep participants on task, an aspect of his character, which continues to be developed as he progresses in his career.

Jolliff, Susan D., Texas, 2025. Dr. Susan Jolliff has held numerous positions within both her local component and at the constituent level which more than qualifies her for the Council on Dental Benefit Programs. She served as a consultant for four years to the Texas Dental Association (TDA) Committee

on Access, Medicaid and CHIP and the Council on Public Health and Access to Care. While serving on the TDA Board of directors, she was the Board liaison to both of these entities bringing a wealth of knowledge from her private practice background where she continues to serve both fee for service patients as well as Medicaid and CHIP children. She continues to make a difference in her community and across the state of Texas by participation in both the Texas Mission of Mercy programs as well as Give Kids a Smile. Dr. Jolliff brings a fresh perspective to every organization she is involved with as she provides a thoughtful but enlightened viewpoint. She would make a wonderful addition to the Council.

Moats, Mark A., Kentucky, 2025. Dr. Mark Moats is a solo private-practicing general dentist from Kentucky and is the immediate past-president of the Kentucky Dental Association. He is a United State Navy Veteran and has had an exemplary professional career serving at all levels achieving Fellowship in both the American College of Dentists and International College of Dentists. He will bring his experience as a solo practitioner and small business owner to the Council on Dental Benefit Programs as the appointee from the Sixth District.

Patel, Vishruti, Illinois, 2025. Dr. Vishruti Patel currently serves as a trustee of the Illinois State Dental Society (ISDS). She practices general dentistry in Plainfield, Illinois, and Darien, Illinois, where she navigates the challenges of both public and private dental benefit plans. Prior to her trustee term, Dr. Patel was a member of the ISDS Governmental Affairs Committee. Her five years on the committee gave her a depth of understanding of both the opportunities and limitations of legislative action in the dental benefit arena.

Dr. Patel is a former member of the Council on Ethics, Bylaws and Judicial Affairs and is an alumna of the ADA Institute for Diversity in Leadership. She has been elected to five terms on the 8th District's ADA delegation and is respected as a thoughtful, collaborative, knowledgeable and results-driven leader within the State. Through her participation in the ADA/Kellogg Executive Management Program, her commitment to professional growth in the area of practice management, and her experience as a dental practice owner, Dr. Patel has developed an outstanding skill set that is ideally matched to the Council on Dental Benefit Programs.

DENTAL EDUCATION AND LICENSURE

Johnson, Jarod W., Iowa, 2022. A private practice pediatric dentists and an Adjunct Assistant Professor at the University of Iowa in Pediatric Dentistry, Dr. Johnson graduated from the University of Iowa where he received his Doctor of Dental Surgery in 2013. He went on to complete his residency from the University of Las Vegas, Nevada, School of Dental Medicine, graduating in 2015. Dr. Johnson's practice is a CODA Accredited site for students to received education through their extramural rotation as senior dental students and he is an advocate for a licensure process that eliminates live patients as exam subjects. Dr. Johnson also lectures throughout the year at various conferences and meetings and is a member of the AAPD Lecture Bureau with a mission of delivering educational content to help dentist treat unreserved patients. Dr. Johnson is the District 10 representative to the ADA New Dentist Committee. This is Dr. Johnson's first term as the new dentist member to CDEL.

Tanguay, Jason A., Montana, 2025. Dr. Jason Tanguay is an exceptional individual who won the 10 Under 10 New Dentist Award two years ago and has just completed his term as Montana State Dental Association President. He is a 2010 Graduate from the University of Washington School of Dentistry. He has been an alternate delegate to the ADA House of Delegates for three years.

During dental school Dr. Tanguay was the chair of the American Dental Education Association (ADEA) Council of Students from 2009 to 2010 and President of the ADEA Student Chapter from 2006 to 2009. He taught high school biology from 2001to 2006 prior to dental school. Dr. Tanguay is involved as a speaker on radiography, fluoride, caring for the aging and Medicare. His volunteer record is impressive: Dental Lifeline, oral screenings and sealant programs in the schools, emergency care for the homeless and he spent three weeks in Bethel, Alaska, in 2007 as a volunteer assistant. He won first and third places at the CASE presentation competition at the University of Washington and won the Pierre Fauchard Academy Senior Student Award. He is also involved with the Mountaineers winning an award from the American Alpine Club. With all this behind him he is still one of the most genuine and humble dentists one would have the pleasure to meet.

Usman, Najia, Ohio, 2025. Dr. Najia Usman is an endodontist in private practice in Medina, Ohio. She will be a delegate at the 2021 ADA House of Delegates meeting and has served as an ADA delegate and alternate delegate in previous years as well.

Dr. Usman is the past secretary of the Ohio Dental Association (ODA) and past president of the Medina County Dental Society. As a former officer of the ODA from 2018 to 2020, she dealt with multiple issues related to dental education, licensure and testing. In addition, Dr. Usman served on the ODA Council on Membership's Faculty and Student Relations Working Group in 2017-2018. She also has served as a guest lecturer with Oregon Health and Sciences University and Case Western Reserve University School of Dental Medicine.

She is a current member of the ODA's Annual Session Committee and Judicial Affairs Subcommittee and is a guest editorial columnist for *ODA Today.* Dr. Usman has served in many capacities at the ODA, including as former chair of the Council on Membership Services, former liaison to the Council on Dental Care Programs and Dental Practice, former member of the Finance Committee, and former member of the Task Force on Diversity and Inclusion.

DENTAL PRACTICE

Fried, David L., Connecticut, 2025. Dr. David Fried is from Connecticut and has served both his state and district in many capacities. He has served the Connecticut State Dental Association on various councils including dental benefits and legislation as well as Connecticut Dental Political Action Committee, many times culminating as chair. He also served as president in 2016. He holds a teaching position in general dentistry at University of Connecticut School of Dental Medicine where he attended dental school. He also served in the United States Air Force as a general dentist. He has been an ADA delegate since 2016 and currently serves ADA District One as chair of the District Task Force on House of Delegates Engagement.

Korch, Michael J., Pennsylvania, 2025. Dr. Michael Korch has a breadth of knowledge and experience which he brings to this position, having practiced as a general dentist for twelve years before returning to graduate school to specialize in endodontics. He now practices endodontics, as well as teaching part-time in the Department of Endodontics at the University of Pittsburgh School of Dental Medicine. He is committed to the health and well-being of patients, other dentists and dental team members. Dr. Korch has a history of community involvement, having volunteered at both Give Kids a Smile Day for his school district and MOM-n-PA (Dental Missions of Mercy). Dr. Korch is dedicated to lifelong learning, as evidenced by his pursuit of and attainment of Mastership in the Academy of General Dentistry. He has been a leader for both his local and district dental societies and is currently serving as president of the Dental Society of Western Pennsylvania.

Ricci, Shane A., Texas, 2025. Dr. Shane Ricci has held numerous positions both at his local component, serving as its president in 2017-2018. He continues to serve at the constituent level serving on the Texas Dental Association's Council on Dental Education, Trade and Ancillaries, a council that deals with issues that affect the practice of dentistry including serving on the Teledentistry Subcommittee, a subject that the Council on Dental Practice has been actively involved with over the last several years. Dr. Ricci brings a plethora of experience with him as the range of his experiences are wide and all-encompassing as he has served as chair of the ADA reference committee that dealt with eldercare, and currently serves on the Texas Dental Association Council on Dental Licensing, Standards and Education as a consultant. Dr. Ricci maintains a large multi dentist practice in Frisco, Texas that embraces the small group practice model. He also brings with him experience in dealing with DSO dentistry. His expertise would be a tremendous asset to the Council on Dental Practice.

Saba, Michael, New Jersey, 2025. Dr. Michael Saba has been an active member of organized dentistry since attending Temple University Kornberg School of Dentistry beginning in 2010. He has served on the New Dentist Committee from 2015 to 2018, served as new dentist member of the Council on Dental Practice in 2018 and 2019, and currently serves on the New Jersey Political Action Committee Board (2018-present). He is a general dentist owning a private practice.

Wright, ArNelle, Florida, 2022. As a Doctor of Dental Medicine graduate from the University of Florida in 2017, Dr. ArNelle Wright is a general dentist at Coast Dental and Orthodontics where she provides comprehensive and emergent treatment to patients all while serving as an Admissions Committee Member at the University of Florida College of Dentistry. There, Dr. Wright participates in the admissions cycle kickoff, application review, and interviews potential dental students. During dental school, Dr. Wright served as the National Regional Director of Communications and the local Vice President in 2015-2016. Dr. Wright is the 17th District ADA New Dentist Committee member. This appointment marks Dr. Wright's first term to CDP.

ETHICS BYLAWS AND JUDICIAL AFFAIRS

Foster, Karen D., Colorado, 2025. Dr. Karen Foster received her dental degree at Baylor College of Dentistry followed by advance training at the University of Texas Health Sciences Center in Houston (2002), where she received her Certificate in Pediatric Dentistry (2004). Dr. Foster is in private practice as well as being a clinical associate professor at the School of Dental Medicine at the University of Colorado in Denver.

She is a past president of the Colorado Dental Association (2018-2019) and is the current regent for District 14 for the International College of Dentists. She also serves on the leadership ladder at her local component—Metro Denver Dental Society.

Dr. Foster continues to be a well-respected and balanced leader at all levels of our profession. She has a keen eye for detail and is a strong advocate for always doing what is right, even when it might not be popular.

Grant, Leslie E., Maryland, 2025. Dr. Leslie Grant will be an outstanding nominee for the ADA Council on Ethics, Bylaws and Judicial Affairs. She has a wealth of experience in governance, ethics, and the dental association world. She will also be representative of our diverse membership.

Some examples of Dr. Grant's experience include serving the National Dental Association as president in 2006, speaker of the house from 1999 to 2003 and Constitution and Bylaws Committee from 1994 to 2000, including chair (1997-1998). She also served the Organization for Safety, Asepsis and Prevention as chair of its Board of Directors (2012-2013) and on the Bylaws Committee (2015-2017) including as chair (2015-2016). Dr. Grant serves on the Dr. Edward Shils Entrepreneurial Fund Board of Directors Governance Committee (2018-present) and served as chair of the DentaQuest Foundation Governance Committee (2016-2017).

Presentations that Dr. Grant has given include "Navigating Through Politics, Policy and Regulation" for the National Dental Association in July 2016 and "Ethical Considerations and Infections Control" for the Society of American Indian Dentist in July 2015. She also wrote an article titled "Ethical Oral Health Care and Infection Control," which was published in the Journal of Dental Education in May 2015.

Mellion, Alex, Ohio, 2022. Dr. Alex Mellion, a member of the American Dental Association, Ohio Dental Association, Akron Dental Society, Stark County Dental Society, and Ohio Dental Political Action Committee, and received his Orthodontics, Master of Science in Dentistry from the Center for Advanced Dental Education. A practice owner, Dr. Mellion opened Mellion Orthodontics upon graduation. The recipient of Case Western Reserve School of Dental Medicine Outstanding New Dentist Award, Craniofacial Team Fellow and Barnes Jewish Hospital, and Alpha Sigma Nu Jesuit Honors Society inductee, Dr. Mellion is a volunteer instructor at Case Western Reserve University Department of Orthodontics, and lecturer at Summa Health GPR Orthodontic Lectures. He is the District 7 representative to the ADA New Dentist Committee. This is his second appointment as the new dentist member to CEBJA.

Roth, Kelly A., Ohio, 2025. Dr. Kelly Roth is a general dentist in private practice in Canton, Ohio. Nationally, she has been a member of the National Association of Parliamentarians since 2009 and at the ADA she has served as a delegate in 2020 and as an alternate delegate in 2015, 2018 and 2019.

Dr. Roth is a past chair of the Ohio Dental Association (ODA) Ethics Subcommittee, and was responsible for promoting the highest ethical standards and educating ODA members about the ADA

Principles of Ethics and Code of Professional Conduct, as well as reviewing and mediating ethical complaints received about members. Dr. Roth is also the past chair of the ODA Credentials, Rules and Order Committee, and was responsible for the conduct of elections at the ODA House of Delegates meeting as well as ensuring the order of business was carried out effectively during the annual governance meeting. Additionally, she is a former member of the ODA Council on Membership Services and ADA Leadership Nomination Committee.

Dr. Roth is a past president of the Stark County Dental Society and held various positions within the society, including as chair of the Membership Services Council, chair of the Long Range Planning Committee, chair of the Necrology Subcouncil and member of the Dental Education and Programs group.

Serchuk, Richard, New York, 2025. Dr. Richard Serchuk has been a member of the ADA since 1982. Dr. Serchuk maintained a position on the New York State Dental Association (NYSDA) Council of Ethics for 22 years in two separate components of the New York State Dental Association. He served as council chair 2013-2015. He has continued his service on his component Ethics Committee in Nassau County, New York.

Dr. Serchuk was instrumental in reviewing and updating the NYSDA Code of Ethics, and continues to lecture on ethics and dental forensics locally and nationally. Dr. Serchuk has sustained a great reputation of fairness and a non-biased ability in deliberating ethical misconduct hearings and is well respected by members of our profession everywhere. Dr. Serchuk will represent the membership with the highest standards and flourish on the Council on Ethics, Bylaws and Judicial Affairs given his experiences throughout his career.

West, Debra S., Nebraska, 2024. In June 2021, Dr. Debra West was appointed *ad interim* to replace Dr. Valerie Peckosh as a member of the Council on Ethics, Bylaws and Judicial Affairs. Dr. West is nominated to complete the unexpired term of Dr. Peckosh, which expires at the close of the 2024 House of Delegates. Dr. West served as speaker of the House of Delegates for the Nebraska Dental Association for ten years. In that role, she was responsible for ensuring that the conduct of business was carried out according to parliamentary procedure and in accordance with the constitution and bylaws of the Association. During those 10 years, Dr. West demonstrated a judicious and non-biased temperament during deliberations before the House. Among the delegates, leadership and staff of the association, Dr. West earned a reputation for fairness and sound judgment. Dr. West has also served as president of the Omaha District Dental Society and the Nebraska Dental Association. She has also served as a delegate to the ADA House of Delegates.

GOVERNMENT AFFAIRS

Chamberlain, Darren D., Utah, 2025. Dr. Darren Chamberlain completed his dental training at Virginia Commonwealth University (2002), followed by a Pediatric Dental Residency at New York University (2004). He has been in private practice in Springville, Utah, since 2004.

Dr. Chamberlain has attended multiple Washington Leadership Conferences/Dentist/Student Lobby Days over the years and has been a strong advocate for issues pertaining to private practice, as well as those pertaining to access to care.

He is a recent past president of the Utah Dental Association and helped Utah negotiate through the COVID-19 pandemic. He has been a member of the 14th District delegation for several years–most recently chairing the subcommittee on Dental Education, Science and Related Matters. He is known throughout the District and beyond as a strong, vocal leader with excellent communication skills.

Erickson, Doug, Minnesota, 2025. Dr. Doug Erickson has had significant experience with the legislative process at the state level in Minnesota. From tracking and shepherding legislation to lobbying for dentistry in Minnesota (Minnesota Lobby Day), Dr. Erickson understands the process of how legislation becomes law. His understanding demeanor, ability to actively listen, administrative skills, military experience and decision making capabilities should make him an excellent addition to the Council on Government Affairs.

Feldman, Steven G., Washington, D.C., 2022. Private practice owner and general practice dentist at the Spanish Catholic Center, Archdiocese of Washington, D.C., Dr. Steven G. Feldman is a 2017 graduate of

the University of Maryland School of Dentistry. A former Student Ambassador and Research Fellow, Dr. Feldman has engaged in networking with other dentists, dental students, and healthcare professionals. The 2019 recipient of AGD Region 5 James G. Richeson, Jr. Leadership Scholarship Award, Dr. Feldman has articles featured in AGD Impact, ASDA Contour, ASDA News, and General Dentistry, the Peer-Reviewed Journal of the AGD. Dr. Feldman has also done presentations on Direct-To-Consumer Dentistry at the AGD Advocacy Conference, and How to Involve Young Dentists in Advocacy and Framework for an Effective Testimony at the AGD Midlevel Provider Conference. He has participated in ADA and Student Lobby Day and is actively involved in legislative activities. Dr. Feldman is the District 4 representative to the ADA New Dentist Committee. He also serves as the 2020 new dentist representative on the CE Committee for CDEL; this is his second appointment to CGA.

Kent, Leigh W., Alabama, 2024. In April 2021, Dr. Leigh Kent was appointed *ad interim* to replace Dr. Gregory Goggans as a member of the Council on Government Affairs. Dr. Kent is nominated to complete the unexpired term of Dr. Goggans, which expires at the close of the 2024 House of Delegates. Dr. Leigh Kent is a periodontist in solo practice in Birmingham, Alabama. She has served as an ADA delegate and has an excellent understanding of the ADA's council structure and reporting requirements to the House of Delegates. She currently serves on the Alabama Dental Association Political Action Committee Board of Directors and the Candidate Selection Committee. Dr. Kent is politically astute and is an active supporter financially of the Alabama Dental Political Action Committee of the Alabama Dental Association.

Roberts, John R., Indiana, 2025. Dr. John Roberts is a career long member of organized dentistry and has served in leadership at the national, state and local level. His primary passion has been in the area of governmental affairs. He is a past president of the Indiana Dental Association (IDA) and served as chair of the IDA Council on Governmental Affairs for 13 years. He continues to serve on the IDA Council on Governmental Affairs, and as an IDA legislative contact dentist. He also serves as an ADA Action Team Leader and lobby day volunteer at the state and national level.

Tauberg, James A.H., Pennsylvania, 2025. Throughout his professional career, Dr. James Tauberg, an oral surgeon practicing in Pittsburgh, has been active at all levels of the tripartite. He has served on the ADA Council on Communications and as a liaison from that Council to the Council on Dental Practice. He has capably served on various local and state committees which focused on third party payer, scope of practice and workforce issues. Dr. Tauberg has served on a number of boards of both professional and civic organizations, including exemplary service as the president of the Pennsylvania Dental Association during the year of COVID-19. At the onset of the pandemic, he rallied and led a broad-based coalition of dental organizations, including the Pennsylvania Academy of General Dentistry, Pennsylvania Academy of Pediatric Dentistry, Pennsylvania Dental Hygiene Association, Pennsylvania Dental Association Political Action Committee, and the deans of Pennsylvania's three dental schools, to advocate with the legislature, the Governor and the Department of Health for dentists return to work, for the authority to administer vaccines, and for prioritization of dentists, dental hygienists and dental students to be classified as 1A to receive the vaccine.

Prior to the pandemic, he was actively involved with lobbying efforts relating to third party payer issues, most notably Assignment of Benefits legislation and has a broad-based knowledge of the issues facing the profession. In addition, Dr. Tauberg has reliably contributed to ADPAC and the Pennsylvania Dental Association Political Action Committee. He is an effective, inclusive, passionate spokesperson who advocates tirelessly and effectively on behalf of the profession and the patients we serve.

MEMBER INSURANCE AND RETIREMENT PROGRAMS, COUNCIL ON MEMBERSHIP

Briggs, Stephanie R., Texas, 2022. Stephanie Briggs graduated from Stephen F. Austin State University in 2008 with a Bachelor of Science degree in Biology where she received her Doctor of Dental Surgery at Texas A&M University Baylor College of Dentistry, graduating in 2016. During dental school, she was involved with ASDA at the local, district, and national level serving as the liaison in the Council on Advocacy. Following dental school, she went on to complete her Master of Science in Oral Biology, receiving her graduate certificate in Periodontics in 2019. During this time, she served as Chief Resident where she coordinated lunch and learns with dental and surgical suppliers and coordinated applicant interviews. Currently, Dr. Briggs is enrolled at the University of Arizona School of Medicine Integrative

Medicine Fellowship where she will received her IMF Certificate in Integrative Medicine while advocating for the ADA Student Disability Plan. This is Dr. Brigg's first appointment to CMIRP.

Ghareeb, Sami M., West Virginia, 2023. In November 2021, Dr. Sami Ghareeb was appointed *ad interim* to serve in a position on the Council on Members Insurance and Retirement Programs that had been vacated shortly before the 2020 House of Delegates meeting, when a nominee for the 2020-2023 term withdrew their nomination. Dr. Ghareeb is nominated to complete the remainder of the term for this position, which expires at the close of the 2023 House of Delegates. Dr. Sami Ghareeb has been a long-standing member of the American Dental Association and has been active in the small constituent of West Virginia for his career. His crossover talent has been shared at the national level with other organizations of which he is a member. Dr. Ghareeb has built a very successful general dental practice and has mentored four dentists within his family, some of which are his children and others which are spouses of his children. Three other children and/or their spouses are physicians and two are dental hygienists. Professionalism at its highest level is a core value within his family.

Dr. Ghareeb is a sharing and philanthropic individual. Much of his success is from prudent financial planning and attention. His family of dentists manage three practice locations. Dr. Ghareeb is still an active practitioner and sees dentistry clearly through the eyes of the multigenerational professionals with which he associates. His intimate association with this variety of ages of dentists gives him a unique perspective on the Council on Members Insurance and Retirement Programs and insight into how our younger colleagues feel about insurance and retirement issues.

Jacob, Hubert J., Jr., Ohio, 2024. Dr. Hubert Jacob will have completed one three-year term on the Council on Members Insurance and Retirement Programs at the close of the 2021 House of Delegates and is eligible to serve a second three-year term on the Council. Dr. Jacob is a retired, general dentist in Cincinnati, Ohio. He has a strong background in the finances of component and state dental associations and is knowledgeable about insurance and retirement planning as well.

As stated above Dr. Jacob is a current member of the Council on Members Insurance and Retirement Programs and his first three-year term concludes in 2021. He is an excellent candidate to serve a second three-year term on the Council. He has also previously served as an alternate delegate to the ADA House of Delegates.

At the Ohio Dental Association (ODA), Dr. Jacob previously served as treasurer and as a member of the Finance Committee, and he is a former chair of the Ohio Dental Association Services Corp, which oversees the multitude of insurance products available to ODA members. He participated in the creation of the Ohio Dental Association Wellness Trust, which provides health insurance benefits to dentists, their employees and dependents. At the Cincinnati Dental Society, he served as president and served on the Society's Finance Committee and Insurance Committee.

Sokolowski, Joseph E., Missouri, 2024. Dr. Joseph Sokolowski will have completed one three-year term on the Council on Members Insurance and Retirement Programs at the close of the 2021 House of Delegates and is eligible to serve a second three-year term on the Council. Dr. Sokolowski has served the 6th District and the ADA in an exemplary fashion and it is intended that he be reappointed to continue his work. Dr. Sokolowski brings experience and passion to this Council.

Wood, C. Rieger, III, Oklahoma, 2024. Dr. C. Reiger Wood will have completed one three-year term on the Council on Members Insurance and Retirement Programs at the close of the 2021 House of Delegates and is eligible to serve a second three-year term on the Council. He would be invaluable as a resource in serving a second term. He serves in many capacities in Oklahoma and excels in all.

MEMBERHSIP

Atarod, Ensy A., Texas, 2025. Dr. Ensy Atarod has been a tremendous asset to the Texas Dental Association since she became a member. She has served on the ADA Institute for Diversity in Leadership and has been an active member on the Texas Dental Association's Membership Committee for five years. She is a young dentist that is living in Austin, one of the fastest growing cities in Texas and her component dental society, Capital Area Dental Society (CADS), is a great example of the type of

component that encourages young dentists to become involved. Dr. Atarod is also an active mentor in the dental community, having received the James R. Fricke, Jr. Mentoring Award.

Bijoor, Renuka R., New York, 2025. Dr. Renuka Bijoor has been involved in all aspects of membership at the local and state levels. She first served as chairperson for the New Dentist Committee for the Ninth District Dental Association in New York, and transitioned from there to the Membership and Communications Committee, a position that she continues to hold. She represents her district at New York State Dental Association (NYSDA) Membership Council where she was vice-chair and then chair representing the entire Second Trustee District.

Dr. Bijoor has worked tirelessly to recruit and retain members over the past eight years. In addition to organizing several events to engage new dentists, residents, and students, her home district held the first ever event to directly engage the program director and the residents at WMC, which paved the way for many more such events. She has also made many efforts in retaining existing members in all career times by expressing gratitude for their loyalty and focusing on their needs. During the pandemic, she took the initiative to organize frequent town halls where member dentists could air their concerns, their fears, and their frustrations. We, as leaders, could help resolve their issues and that friendly approach was welcome to many of our members.

Dr. Bijoor set up a flagship event “Frills and Drills”, celebrating women dentists that has continued and this year was the sixth one held. This is an immensely popular event. Dr. Bijoor has been an important and influential contact with the opening of the new Dental School at Touro College from the very first days it opened. As an ADA GKAS Ambassador, and with the support of Dean Myers, she started a collaborative GKAS event cohosted by Touro and the Ninth District Dental Association and now is a completely self-running event.

Membership continues to be the backbone of our ADA and Dr. Bijoor will always strive to increase our numbers. She will be an excellent addition and resource to the Council on Membership.

Kunzman, Nathaniel W., Colorado, 2025. Dr. Nate Kunzman achieved concurrently both a dental degree and Masters of Business Administration degree at Temple University, graduating in 2010. He then trained at Albert Einstein Medical Center in a GPR program where he was chief resident for his second year. He completed his GPR training in 2012.

Dr. Kunzman is in private practice in Greeley, Colorado. He chaired the Colorado Dental Association’s Membership committee from 2017to 2020. Colorado was recognized for many innovative programs that boosted some of the strongest membership growth for a state of its size under his leadership.

Dr. Kunzman is currently president of the Colorado Dental Association and will serve in this role until June 2022. Dr. Kunzman has proven himself within the State of Colorado as well as the Fourteenth District to be an innovative, strong and vocal leader who is not afraid to challenge the status quo. He most recently chaired the District Committee on Budget, Business, Membership and Administrative Matters.

Tiersky, Terri S., Illinois, 2025. Dr. Terri Tiersky served as 2020 president of Chicago Dental Society (CDS) and was general chair of the CDS Midwinter Meeting in 2011. She is an experienced state volunteer and has been an Illinois State Dental Society (ISDS) trustee and delegate at the ISDS House. She has served as liaison to both ISDS and CDS Membership committees; Dr. Tiersky is well-versed in both state and local dental society member resources and has been actively engaged in membership recruitment and retention.

In her high-stakes roles in CDS–the largest component society in the ADA–Dr. Tiersky gained a broad understanding of how critical-to-mission it is to address the diverse needs and expectations of all dentists to build membership (and meeting attendance–in the case of CDS, the Midwinter Meeting is its #1 member benefit). She is a past ADA council representative, having served on the Council on Ethics, Bylaws and Judicial Affairs from 2007to 2011 and has been a member of the 8th District’s ADA delegation more than a dozen times. Dr. Tiersky welcomes this opportunity to once again serve the ADA.

Youel, Benjamin C., Illinois, 2022. Dr. Youel earned his D.D.S. from the University of Illinois at Chicago (UIC) and was inducted into the Omicron Kappa Upsilon honor society just before graduation. He completed a General Practice Residency at Advocate Illinois Masonic Medical Center a year later. After practicing for two years, he came back to UIC to start his orthodontic residency, where he graduated in May 2019. Upon graduation, Dr. Youel went on to practice Orthodontics at Grayslake Orthodontics and North Shore Center of Dental Health. He is an active member of the American Dental Association, Illinois State Dental Association and Chicago Dental Association. Dr. Youel will complete his term as the 8th District representative to the ADA New Dentist Committee in 2021 and is also a Chicago AGD Officer with the Academy of General Dentistry, New Dentist Committee Member in Illinois State Dental Society, and Membership Committee Member with Chicago Dental Society. A 2017 American College of Dentists Fellow, Dr. Youel is a regular volunteer at Chicago Dental Society Foundation Clinic and a member of the American Dental Political Action Committee, Delta Sigma Delta International Dental Fraternity – Rho Chapter, Omicron Kappa Upsilon Honor Society – Sigma Chapter, and American Association of Orthodontics. This appointment marks Dr. Youel's third term with the Council on Membership.

SCIENTIFIC AFFAIRS

da Costa, Juliana, Oregon, 2025. Dr. Juliana da Costa received her D.D.S. degree from the Universidade Paulista School of Dentistry in Sao Paulo, Brazil in 2001, and her certificate and M.S. degree in operative dentistry from the University of Iowa in 2004.

Dr. da Costa has an extensive research background, including participation in 21 grants (14 of which she was principal investigator), and more than 23 articles in peer-reviewed journals. Her research interests include composite development, polishing, tooth whitening and non-surgical caries treatment.

Dr. da Costa joined the Restorative Dentistry Department faculty at Oregon Health and Science University School of Dentistry in 2004, where she currently serves as vice chair, professor and preclinical director. She splits her time between clinical research, teaching and patient care. Dr. da Costa is passionate about her students and their development within the profession, and she developed a program to assist students who need additional help with restorative coursework.

Dr. da Costa is an ADA consultant and currently sits on the Council on Scientific Affairs ADA Clinical Evaluators (ACE) Panel Oversight Subcommittee, assisting in the development of ACE Panel reports, which are published quarterly in the *Journal of the American Dental Association*. She has been an enthusiastic member of the Subcommittee and a valuable voice in the area of restorative dentistry.

Duong, Mai-Ly, Arizona, 2022. As an Associate Professor at A.T. Still University, Arizona School of Dentistry and Oral Health and an Associate Dentist at a dental office in Phoenix, Arizona, Dr. Duong has experience in all general dentistry procedures, including CAD/CAM dentistry, implant dentistry, periodontal hard tissue and soft tissue surgical procedures, and special care dentistry. Outside of her faculty appointment and practice setting, Dr. Duong is an active volunteer at the state and national level, and has served as the New Dentist Member to the Council on Scientific Affairs since 2020 where she is also a contributor to the ACE Panel Oversight Subcommittee and the CSA Self-Assessment Workgroup. Currently, Dr. Duong serves as the President of the Arizona Academy of General Dentistry and is the editor of their quarterly publication, "The Whole Tooth". In 2018, Dr. Duong was named an ADA 10 Under 10 Award winner and received the ADA New and Emergent Speaker Series at the ADA Annual Meeting.

Fouad, Ashraf F., Alabama, 2025. Dr. Ashraf Fouad is an endodontist who has served as tenure-track or tenured professor in five dental schools in the U.S. with a career focused on education, research and service. After receiving his B.D.S. from Cairo University, he went on to obtain a Certificate in Endodontics, M.S., and D.D.S. from the University of Iowa.

Dr. Fouad has been a successful researcher with many National Institutes of Health (NIH) and non-NIH grants, numerous publications and presentations, and extensive prior service on research and organized dentistry groups. He has also contributed to–and participated with–several national and international groups on generating guidelines, position papers and status reports.

Dr. Fouad's expertise includes aspects of endodontic research in microbiology, pain, antibiotics and the relationship of oral and systemic disease. He has previously participated as consultant to the Council

on Scientific Affairs for generating the systematic review and guidelines on the use of antibiotics for dental pain and infections.

MacDonnell, William A., Connecticut, 2025. Dr. William MacDonnell received his D.D.S. from Georgetown, followed by an anesthesiology residency and fellowship (neuro-anesthesiology) at the University of Pittsburgh. He served as a staff anesthesiologist/assistant professor at the John Dempsey University Hospital, University of Connecticut School of Dental Medicine and School of Medicine prior to entering private practice. Since then, he has spent more than forty years in private practice, with extensive clinical experience in dental anesthesiology. He currently teaches at the University of Connecticut, and previously taught at Tufts School of Dental Medicine.

Dr. MacDonnell has extensive experience in organized dentistry. He currently serves as the president of the Connecticut Society of Dental Anesthesiologists and in addition to various memberships and positions in state and national associations he was previously president of both the American Society of Dentist Anesthesiologists and the Connecticut State Dental Association. He is a current consultant for the ADA Council on Scientific Affairs.

In 2009, Dr. MacDonnell was awarded the Leonard M. Monheim Distinguished Service Award from the American Society of Dentist Anesthesiologists for his outstanding contributions to the discipline of anesthesiology. Dr. MacDonnell is passionate and knowledgeable about the clinical experience and is a fierce advocate for furthering the profession of dental anesthesiology.

Villa, Alessandro, California, 2025. Dr. Alessandro Villa is a board-certified specialist in oral medicine with recognition for his clinical expertise in oral complications of cancer therapy and HPV prevention. He received his D.D.S and Ph.D. in Italy and completed his residency in oral medicine at Harvard School of Dental Medicine (HSDM)/Brigham and Women's Hospital (BWH) in Boston in 2013. To complement his oral medicine training, Dr. Villa also completed a Masters Degree in Dental Public Health at A.T. Still University.

Before joining University of California San Francisco (UCSF), Dr. Villa spent six years as an associate surgeon in the Division of Oral Medicine and Dentistry at Brigham and Women's Hospital in Boston. He has taught in both the clinical and classroom settings, including time spent as an assistant professor and program director for the Oral Medicine Residency and Oral Oncology Fellowship at Harvard School of Dental Medicine; and an assistant professor in oral medicine at Boston University (BU) Henry Goldman School of Dental Medicine from 2013 to 2014, where he implemented a new oral medicine clinic, which focused on treatment of oral mucosal diseases, salivary gland disorders and oral complications from cancer therapy.

Dr. Villa has a demonstrated research background, which is currently focused on oropharyngeal cancers and the role of HPV involvement in tumor development. As a National Cancer Institute-NIH post-doctoral fellow he gained valuable research experience on the epidemiology of oral human papillomavirus (HPV) infection; and screening and natural history of head and neck cancers. He is currently collaborating with researchers from UCSF, New York University, Harvard Medical School and Dana-Farber Cancer Institute to develop a predictive model for oropharyngeal cancer, and to increase HPV awareness among dental and medical providers. At Harvard, he was a co-primary investigator on a phase II clinical trial testing the safety and effectiveness of nivolumab in the management of proliferative verrucous leukoplakia. The study is a collaboration among medical oncologists, oral medicine specialists and pathologists.

Dr. Villa has been an active and engaged contributor to the Council on Scientific Affairs as a consultant. He has provided meaningful contributions to ADA members through his work on HPV research, and currently serves as the ADA spokesperson on HPV and oral cancer.

Resolution No. 56 New

Report: Board Report 1 Date Submitted: July 2021

Submitted By: Board of Trustees

Reference Committee: Board Report 1/Credentials, Rules and Order

Total Net Financial Implication: None Net Dues Impact:

Amount One-time Amount On-going

ADA Strategic Plan Objective: None

How does this resolution increase member value: Not Applicable

NOMINATIONS TO COUNCILS

Background: (See page 1006 for qualifications of nominees)

ADVOCACY FOR ACCESS AND PREVENTION
Molly E. Conlon, Wisconsin
*Brooke Fukuoka, Idaho
Huong N. Le, California
Jackie Nord, North Dakota
Jessica L. Robertson, Arizona

COMMUNICATIONS
T. Stotts Isbell, Arkansas
Lindsey D. Jackson, New Hampshire
Rachel L. Lewin, Pennsylvania
*Tanya Sue Maestas, Texas
Rhett E. Raum, Tennessee

DENTAL BENEFIT PROGRAMS
*J. Luke Andrew, Colorado
Adrian J. Carrington, California
Susan D. Jolliff, Texas
Mark A. Moats, Kentucky
Vishruti Patel, Illinois

DENTAL EDUCATION AND LICENSURE
*Jarod Johnson, Iowa
Jason A. Tanguay, Montana
Najia Usman, Ohio

DENTAL PRACTICE
David L. Fried, Connecticut
Michael J. Korch, Pennsylvania
Shane A. Ricci, Texas
Michael Saba, New Jersey
*ArNelle Wright, Florida

ETHICS, BYLAWS AND JUDICIAL AFFAIRS
Karen D. Foster, Colorado
Leslie E. Grant, Maryland
*Alex Mellion, Ohio
Kelly A. Roth, Ohio
Richard Serchuk, New York
Debra S. West, Nebraska, *ad interim*

GOVERNMENT AFFAIRS
Darren D. Chamberlain, Utah
Doug Erickson, Minnesota
*Steve Feldman, Washington, D.C.
Leigh W. Kent, Alabama, *ad interim*
John R. Roberts, Indiana
James A.H. Tauberg, Pennsylvania

MEMBERS INSURANCE AND RETIREMENT PROGRAMS
*Stephanie Ganter Briggs, Texas
Sami, M. Ghareeb, West Virginia, *ad interim*
Hubert J. Jacob, Jr., Ohio
Joseph E. Sokolowski, Missouri
C. Rieger Wood, III, Oklahoma

MEMBERSHIP
Ensy A. Atarod, Texas
Renuka R. Bijoor, New York
Nathaniel W. Kunzman, Colorado
Terri S. Tiersky, Illinois
*Benjamin Youel, Illinois

SCIENTIFIC AFFAIRS
Juliana da Costa, Oregon
*Mai-Ly Duong, Arizona
Ashraf F. Fouad, Alabama
William A. MacDonnell, Connecticut
Alessandro Villa, California

**New Dentist Member*

Resolution

56. Resolved, that the nominees put forward for membership on ADA councils be elected.

BOARD RECOMMENDATION: Vote Yes.

BOARD VOTE: UNANIMOUS.

Resolution No. 98-101 New

Report: Credentials, Rules and Order Date Submitted: September 2021

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 _____

ADA Strategic Plan Objective: None

How does this resolution increase member value: Not Applicable

REPORT OF THE STANDING COMMITTEE ON CREDENTIALS, RULES AND ORDER

Background: In accordance with the *Manual of the House of Delegates and Supplemental Information*, section "Standing Committees of the House of Delegates," the Standing Committee on Credentials, Rules and Order of the House of Delegates is charged with the following duties:

> It is the duty of the Committee to present the agenda and recommend for approval such rules as are necessary for the conduct of the business of the House of Delegates. The report of this committee is prepared in collaboration with the officers of the House of Delegates and is presented at the opening of the first meeting of the House. In addition, this Committee has the duty to conduct hearings and to make recommendations on the eligibility of delegates and alternate delegates to a seat in the House of Delegates when a seat is contested, maintains a continuous roll call and periodically reports on the roll call to the House of Delegates, determines the presence of a quorum and supervises voting and election procedures. The Committee also has the responsibility to consult with the Speaker and Secretary of the House of Delegates, on matters relating to the order of business and special rules of order as required. It is on duty throughout the annual session.

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

Approval of Certified Delegates: A list of certified Delegates and Alternate Delegates as of October 6 has been posted in the HOD Supplemental Information library on the House of Delegates community of ADA Connect. Any subsequent changes will be reported out at the beginning of each meeting of the House of Delegates by the CRO chair.

> **98. Resolved,** that the list of certified delegates and alternate delegates posted in the HOD Supplemental Information library on the House of Delegates community of ADA Connect be approved as the official roster of voting delegates and alternate delegates that constitute the 2021 House of Delegates of the American Dental Association.

Minutes of the 2020 Session of the House of Delegates: The minutes of the 2020 session of the House of Delegates will be posted in September in the HOD Supplemental Information library on the House of Delegates community of ADA Connect.

Questions or corrections regarding the minutes may be forwarded to Kyle Smith, manager, House of Delegates at smithk@ada.org. The Committee presents the following resolution for House action.

> **99. Resolved,** that the minutes of the 2020 session of the House of Delegates be approved.

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

100. Resolved, that the agenda as presented in the *2021 Manual of the House of Delegates and Supplemental Information* be adopted as the official order of business for this session, and be it further

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

To maintain a quorum, members of the House of Delegates should plan to stay in Las Vegas until close of business Saturday, October 16, which could be later than 5:00 p.m.

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

This preliminary list of referrals (circulated in the form of an All Inclusive General Index to resolution worksheets) will be provided with the second posting of resolution worksheets in September and updated and posted again on Tuesday, October 12. 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 Thursday morning, October 14.

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

Rules of Order: The business of the House of Delegates will be conducted formally in accordance with accepted rules of parliamentary procedure. Adopted as the parliamentary authority for the Association, the *American Institute of Parliamentarians Standard Code of Parliamentary Procedure* is the document that governs all deliberations of the House of Delegates in which it is applicable and not in conflict with the *Manual of the House of Delegates*, *Governance Manual* or the *Bylaws* of the Association.

Annual Reports, Manual of the House of Delegates and Resolution Worksheets: The publication, *Annual Reports, 2021,* will be posted in September 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 was posted on ADA Connect and ADA.org on Friday, July 23. Per 74H-2012, effective in 2013, all materials of the House of Delegates are provided in an electronic format only, with the exception of reference committee reports and agendas; no paper copies of worksheets will be distributed.

The second set of resolution worksheets will become available shortly after the Board of Trustees' September 12-14 session and should be posted on ADA Connect and ADA.org by end of day, Friday, September 17.

In advance of the 2021 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* contains 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).

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 2022.

Reference Committees Hearings: The reference committees of the House of Delegates will hold hearings on Thursday, October 14 in various rooms in Mandalay Bay. The list of reference committee hearing rooms appears in the *Manual of the House of Delegates and Supplemental Information.*

Thursday, October 14

7:00 a.m. to 9:00 a.m.	Committee D (Legislative, Health, Governance and Related Matters)
9:00 a.m. to 10:30 a.m.	Committee B (Dental Benefits, Practice and Related Matters)
10:30 a.m. to Noon	Committee A (Budget, Business, Membership and Administrative Matters)
Noon to 1:30 p.m.	Committee C (Dental Education, Science and Related Matters)

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

In accordance with the *Manual of the House of Delegates*, section "General Procedures for Reference Committees," any member of the Association, whether or not a member of the House of Delegates, is privileged to attend and participate in the discussion during the reference committee hearings. Nonmembers of the Association are also welcome to attend reference committee hearings provided they identify themselves to the committee. Nonmembers of the Association may participate at hearings with the consent of a majority of the reference committee. Members who are not members of the House of Delegates, and nonmembers of the Association can submit written testimony in advance via designated Reference Committee A, B, C, and D email addresses that will be published in ADA News and ADA.org in early October. At reference committee hearings, everyone (individuals/members) will be obligated to disclose any personal or business relationship that they or their immediate family may have with a company or individual doing business with the ADA, when such company is being discussed, prior to speaking on an issue related to such a conflict of interest.

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

Reports of Reference Committees: Printed copies of reference committee reports will be made available to the chair of record of each delegation on Friday, October 15. A sufficient number of copies of each report will be provided for each delegation's delegates, alternate delegates, secretary, executive director, trustee and editor. Reference committee reports will also be posted on ADA Connect and will be available early morning on October 15.

Delegates must bring their copies of reference committee reports to the meetings of the House of Delegates since additional printed copies will be limited. However, if using an electronic version of the reference committee report during the meetings of the House, it is imperative that the documents be downloaded prior to the Saturday, October 16 meeting. The Speaker would like to remind everyone that this is a paperless House of Delegates. Wi-Fi is available in the House of Delegates as a convenience, but members do not need to be online to participate. Advance preparation is extremely important.

Nominations of Officers: The nominations of officers (president-elect, second vice president and treasurer) will take place at the first meeting of the House on Wednesday afternoon, October 13. Candidates for elective office will be nominated from the floor of the House by a simple declaratory statement, which may be followed by an acceptance speech not to exceed four minutes by the candidate. Seconding nominations is not permitted.

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

Presentation of Incoming Trustees: Election results for the incoming members of the Board of Trustees as determined by Trustee Districts 3, 4, 5 and 9 shall be read by the Speaker of the House of Delegates during the first meeting of the House. Because there is only a single nominee provided by each trustee district, following the reading of the names, the Speaker shall declare the nominees elected. The Speaker of the House of Delegates reads the name of each nominee, reported by the nominee's trustee district, during the first meeting of the House.

Nominations to Councils and Commissions: The Board of Trustees presents the list of its nominations to councils in Report 1, which appears on the appropriate resolution worksheet.

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, non-voting members will be asked to leave the delegate seating area. Once the area is clear of all non-voting members, the Speaker will request all delegates 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 Officer Elections will take place in the House of Delegates through electronic voting on the House floor and will be taken up as one of the first items of business on Saturday morning, October 16. Only properly certified delegates will be permitted to access the delegate section of the House floor on Saturday morning from the time the doors open at 6:30 a.m. until the final election results have been announced. All entrances to the delegate section of the House floor will be monitored by members of the Standing Committee on Credentials, Rules and Order (CRO). During this time, non-voting members of the House will not be allowed in the delegate section of the House floor.

To expedite the check-in and voting process, it is strongly recommended that any delegation changes be made no later than the end of the day on Friday, October 15. Delegate registration hours for Friday, October 15, are from 8:00 a.m. to Noon and delegate changes can be made at the Information and Resources Office up until 6 p.m. Friday evening. Delegate changes made on Saturday morning, prior to voting, may be delayed until after all other delegates have checked-in. Therefore, to avoid long delays, please make delegation changes on Friday.

To check-in, delegates must bring their officer election card to access the House floor and receive a smart card for voting. Voting keypads will be on the delegate tables on the House floor. Upon entering the House floor, delegates should insert their smart card into their voting keypad. It is recommended that delegates do not leave the House floor until after the election results have been finalized. If a delegate must leave the House floor before final election results have been announced, the delegate must surrender both the smart card and officer election card to a CRO member upon exiting through the designated exit door and then reclaim the cards for reentry by showing his or her badge to the CRO member upon return to the designated exit door. Any delegate absent from the House floor during a vote may lose their chance to vote. For the security of the election, it is essential that each delegate maintain

possession of his or her smart card, unless surrendered to a CRO member. **If a delegate loses their smart card, they will not be able to vote.**

Voting will take place as one of the first items of business. The Standing Committee on Credentials, Rules and Order oversees the confirmation and reporting of election results. The results will be 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. In the event a second balloting is necessary, the vote will take place shortly after the Speaker has announced a runoff.

Standing Order of Business—Installation of New Officers and Trustees: The installation ceremony for new officers and trustees will take place at the third meeting of the House of Delegates on Saturday, October 16, 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 *Manual of the House of Delegates and Supplemental Information,* section "Rules of the House of Delegates" which states:

> No new business shall be introduced into the House of Delegates less than 15 days prior to the opening of the annual session, except when such new business is submitted by a Trustee District or the American Student Dental Association Delegation and is permitted to be introduced by a majority 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.
>
> Any resolution that the Speaker refers to a reference committee must be made available to all members of the House before adjournment of the first meeting. For this reason, resolutions received in the Headquarters Office before the House officially convenes its first meeting will be processed, referred to a reference committee, and made available to all members of the House at that meeting. Resolutions received after the first meeting has convened will not be referred to a reference committee. They will be accepted as new business, posted on ADA Connect, and taken up when the Speaker calls for new business.

New Business resolutions received prior to the first session of the House of Delegates on Wednesday, October 13, will be presented by the Speaker *en bloc*. If a member wants a separate vote on any of these resolutions he or she will request it by resolution number and ask that it be voted on separately; the remaining ones will be voted on *en bloc* with a majority vote allowing them to be considered. Those approved will be referred to a reference committee.

Items that come as new business after the first meeting of the House of Delegates has convened will not be assigned to a reference committee; the House will vote on them individually as to whether they will be considered. A majority vote is required for the resolution to be considered. If it receives the majority vote, the House will proceed to consider the resolution.

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 shall 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 members of the House of Delegates, 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 (except for former presidents) and former trustees do not have the privilege of access to the floor. Alternate delegates will be seating in a special area reserved for them.

Admission to the House will be granted to delegates with the appropriately numbered card, which must be handed to the attendant at the door for each meeting so that the official attendance record may be maintained. Former officers and former trustees who wish to observe the proceedings of the House of Delegates may do so via a livestream broadcast. All observers must register in advance of the Annual Meeting for permission to access the link to the livestream broadcast. Registration will be available on ADA.org in late-September.

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.

Seating of Component Executive Directors in the Alternate Section of the House of Delegates: In 2015, the House of Delegates adopted Resolution 48H-2015 to provide component executive directors and secretaries seating in the Alternate Delegate section as space is available. Based on seating capacity at the 2021 House of Delegates, the floor of the House has been expanded into a second ballroom to seat alternate delegates. **No additional seating is available.** However, a livestream broadcast of the meetings of the House of Delegates will be available to all those who register on ADA.org.

Replacement of Alternate Delegates for Delegates: Delegates wanting to replace themselves with an alternate delegate from their delegation as the credentialed delegate during a meeting of the House of Delegates must complete the appropriate delegate-alternate substitution form. The constituent's executive director or secretary is required to sign the form and the delegate must surrender his or her admission cards for the meeting or meetings not attended before admission cards will be issued to the alternate delegate by the Committee on Credentials, Rules and Order. Substitution of alternate delegates may be made during all three meetings of the House of Delegates. In order for a complete and accurate attendance record for all meetings of the 2021 House of Delegates, submission of these completed substitution forms is essential. Only credentialed delegates may vote for the Officers of the Association.

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. For these temporary substitutions, the switch can take place at the designated doors staffed at the House of Delegates. This will be in effect for the Second and Third 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, past presidents and general counsel of the Association. In consultation with the Secretary of the House, the Speaker may invite other persons with an interest in the subject matter to remain during the closed session. In addition to senior staff, this is likely to include members and staff of the council(s) or commission(s) involved with the matter under discussion and executive directors of constituent societies and the American Student Dental Association. No official action may be taken nor business conducted during a closed session.

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

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

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

Manual of the House of Delegates: Each member of the House of Delegates has access to the *2021 Manual of the House of Delegates* through ADA Connect. The *Manual* contains the standing rules of the House of Delegates and the pertinent provisions of the *Bylaws* and *Governance Manual.*

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

Distribution of Materials in the House of Delegates: In 2016, the House adopted Resolution 6H-2016, to prohibit the distribution of campaign literature in the House of Delegates. The Committee calls attention to the procedures to be followed for distributing materials in the House of Delegates: (1) no material may be distributed in the House without obtaining permission from the Secretary of the House; (2) material to be distributed must relate to subjects and activities that are proposed for House action or information.

Media Representatives at Meetings of the House of Delegates: On occasion, representatives of the press and other communications media may be watching the livestream broadcast of the House and in attendance at the reference committee hearings.

House of Delegates Information and Resource Office: An Information and Resource Office will be open Tuesday, October 12 through Friday, October 15, and will be located at the Mandalay Bay, North Convention Center, Captain's Board Room, near Delegate Registration. This office will be open to delegates, alternates, constituent society officers and staff. The office will be equipped with computers with printing capability, a copy machine, and general information about the meetings of the House of Delegates and related activities. Everyone is urged to use the Information and Resources Office when drafting resolutions or testimony.

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

Resolutions

(Resolution 98:Worksheet:1030)
(Resolution 99:Worksheet: 1031)
(Resolution 100-Worksheet:1032)
(Resolution 101-Worksheet:1033)

Resolution No. 98 New

Report: Credentials, Rules and Order Date Submitted: September 2021

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

ADA Strategic Plan Objective: None

How does this resolution increase member value: Not Applicable

APPROVAL OF CERTIFIED DELEGATES

Background: A list of certified Delegates and Alternate Delegates as of October 6 has been posted in the HOD Supplemental Information library on the House of Delegates community of ADA Connect. Any subsequent changes will be reported out at the beginning of each meeting of the House of Delegates by the CRO chair.

Resolution

98. Resolved, that the list of certified delegates and alternate delegates posted in the HOD Supplemental Information library on the House of Delegates community of ADA Connect be approved as the official roster of voting delegates and alternate delegates that constitute the 2021 House of Delegates of the American Dental Association.

Resolution No. 99 New

Report: Credentials, Rules and Order Date Submitted: September 2021

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

ADA Strategic Plan Objective: None

How does this resolution increase member value: Not Applicable

MINUTES OF THE 2020 SESSION OF THE HOUSE OF DELEGATES

Background: The minutes of the 2020 session of the House of Delegates will be posted in September in the HOD Supplemental Information library on the House of Delegates community of ADA Connect.

Questions or corrections regarding the minutes may be forwarded to Kyle Smith, manager, House of Delegates at smithk@ada.org. The Committee presents the following resolution for House action.

Resolution

99. Resolved, that the minutes of the 2020 session of the House of Delegates be approved.

Resolution No. 100 New

Report: Credentials, Rules and Order Date Submitted: September 2021

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

ADA Strategic Plan Objective: None

How does this resolution increase member value: Not Applicable

ADOPTION OF AGENDA AND ORDER OF AGENDA ITEMS

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

Resolution

100. Resolved, that the agenda as presented in the *2021 Manual of the House of Delegates and Supplemental Information* be adopted as the official order of business for this session, and be it further

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

Resolution No. 101 New

Report: Credentials, Rules and Order Date Submitted: September 2021

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

ADA Strategic Plan Objective: None

How does this resolution increase member value: Not Applicable

REFERRALS OF REPORTS AND RESOLUTIONS

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

This preliminary list of referrals (circulated in the form of an All Inclusive General Index to resolution worksheets) will be provided with the second posting of resolution worksheets in September and updated and posted again on Tuesday, October 12. 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 Thursday morning, October 14.

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

Budget, Business, Membership and Administrative Matters

Resolution No. 44 New

Report: N/A Date Submitted: June 2021

Submitted By: Board of Trustees

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

Total Net Financial Implication: None Net Dues Impact:

Amount One-time Amount On-going

ADA Strategic Plan Objective: Membership Obj-1: Increase membership market share of lagging demographics by 2% per year.

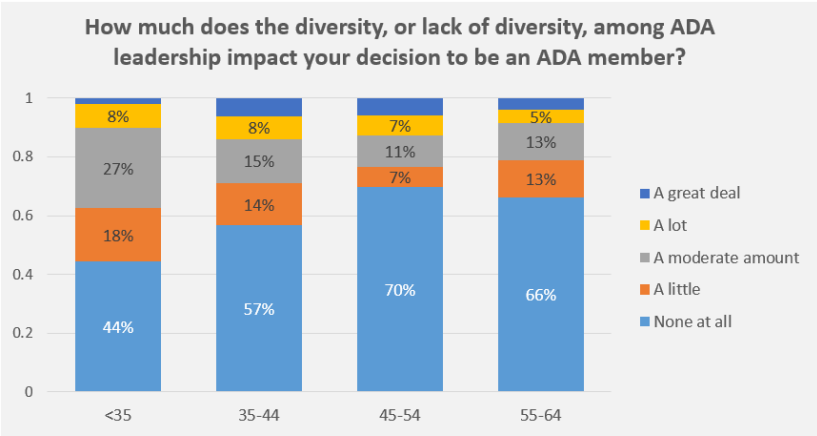
How does this resolution increase member value: See Background

SUSTAINING THE PIPELINE OF VOLUNTEER LEADERSHIP

Background: Dentists who graduated from dental school less than 10 years ago comprise 29% of ADA membership, which represents more than 37,000 members. New dentists who complete the conversion period and enter full dues membership are retained year-to-year at rates over 90%, but non-membership is highly resistant to change, making it a risk if new dentists do not join or stay members in their first five years in practice. This was evident in 2020 when the market share for dentists 4-6 years out of school dipped down to an all-time low of 52%, well below the average market share of 60.7% for all dentists.

A 2021 ADA Advisory Circle survey of ADA members showed that 38% of dentists under age 35 said that the diversity of leadership impacted their decision to be a member by at least a moderate amount, compared to just 21% of those 55-64. (Exhibit A).

Exhibit A

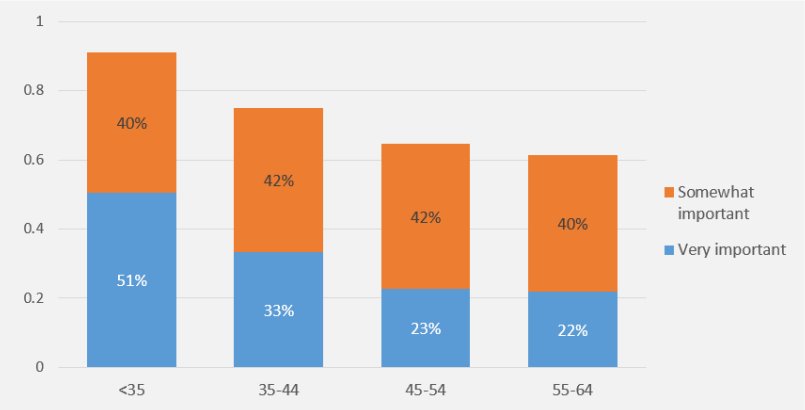


Online survey fielded to ADA members in the Advisory Circle research panel in May 2021. Yielded 722 responses.

In the same survey, 91% of members under 35 also reported that ADA leadership reflecting *generational age ranges* is very or somewhat important, compared to 62% of dentists 55-64 (Exhibit B).

Exhibit B

What do you think about having ADA leadership (House of Delegates, Board of Trustees, Councils, etc.) reflect the generational age ranges of your state society?



Online survey fielded to ADA members in the Advisory Circle research panel in May 2021. Yielded 722 responses.

Additionally, a significantly higher percentage of the respondents under age 35 said it was important for leadership be reflective of the ethnic and gender balance of dentists overall.

The American Dental Education Association reports that today's graduates are about half women and about half white. As the profession grows and becomes more diverse, it's critical that the ADA intentionally invite new graduates into the organization to mitigate declining market share and sustain relevance among new dentists. As the ADA strives to live out its diversity and inclusion values, it can learn from research from companies across the globe that have realized the impact of increasing its leadership diversity. According to its May 2020 report *Diversity Wins: How Inclusion Matters*, McKinsey & Company cites that the profitability gap is accelerating between organizations that fully embracing D&I vs those who don't. (Appendix I) Further, the report mentions that organizations with the highest levels of diversity and profitability have increased diverse representation – particularly in leadership and critical roles.

The ADA is the largest dental association in the country and a policy-making body and, as such, it has a responsibility to represent the profession in the make-up of its leadership. Through these policies set by the House of Delegates, the ADA can affirm its values and clearly state its intentions. The New Dentist Committee (NDC) recommends, and the Board supports, updating the 2009 New Dentist Involvement in Volunteer Leadership policy, shown below in its current form, to reflect the vital role that new dentists bring to leadership.

New Dentist Involvement in Volunteer Leadership (*Trans*.2009:487)

Resolved, that new dentists (defined as dentists graduating less than ten years previously) be encouraged to become involved as volunteers in organized dentistry, and be it further

Resolved, that constituent dental societies be urged to include new dentists in the leadership development process, offer new dentists volunteer opportunities, and be inclusive of new dentists in the leadership education offered.

Strengthening this policy will underscore the value of building a pipeline of leadership and reinforce the ADA's investment into the future of the organization. Further, it will convey to the newest members of the profession that they belong and their voices are valued.

The Board applauds dental societies that offer leadership pipeline programs and have successfully integrated new dentists into their leadership structure. This revised policy will further support these programs at the local, state and national levels, and help to bolster leadership efforts across the tripartite.

The proposed resolution appears below for the House to consider. Because the revised policy is a substantial change from the original, should this revised policy be adopted, it would replace the original.

Resolution

44. Resolved, that the following policy titled "Sustaining the Pipeline of Volunteer Leadership" be adopted:

Sustaining the Pipeline of Volunteer Leadership

Resolved, that new dentists be considered as essential leaders in the tripartite, and be it further

Resolved, that constituent dental societies be urged to develop and implement strategies to grow and maintain new dentist participation in leadership, which may include:

- Leadership development
- Dedicated leadership positions for new dentists
- Programs that support the pathway to leadership for new graduates
- Other opportunities to foster leadership growth,

and be it further

Resolved, that the policy titled "New Dentist Involvement in Volunteer Leadership" (*Trans*.2009:487) be rescinded.

BOARD RECOMMENDATION: Vote Yes.

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

WORKHSEET ADDENDUM
BOARD OF TRUSTEES
ADA POLICY TO BE RESCINDED

New Dentist Involvement in Volunteer Leadership (Trans.2009:487)

Resolved, that new dentists (defined as dentists graduating less than ten years previously) be encouraged to become involved as volunteers in organized dentistry, and be it further

Resolved, that constituent dental societies be urged to include new dentists in the leadership development process, offer new dentists volunteer opportunities, and be inclusive of new dentists in the leadership education offered.

Resolution No. 69 New

Report: N/A Date Submitted: June 2021

Submitted By: Council on Membership

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

Total Net Financial Implication: None Net Dues Impact:

Amount One-time Amount On-going

ADA Strategic Plan Objective: Membership Obj-1: Increase membership market share of lagging demographics by 2% per year.

How does this resolution increase member value: See Background

PROPOSED POLICY ON ADA DIVERSITY AND INCLUSION

Background: For much of the ADA's history, members have been predominantly white and male. Only in the past few decades have there been significant increases in women and racially/ethnically diverse dentists, and now current dental school students are more than half female and almost 48% racially/ethnically diverse. However, women, diverse dentists, and those in large group practice settings currently lag ADA's overall membership market share (Exhibit A), while also representing the fastest growing segments in the dental market (Exhibit B).

Exhibit A

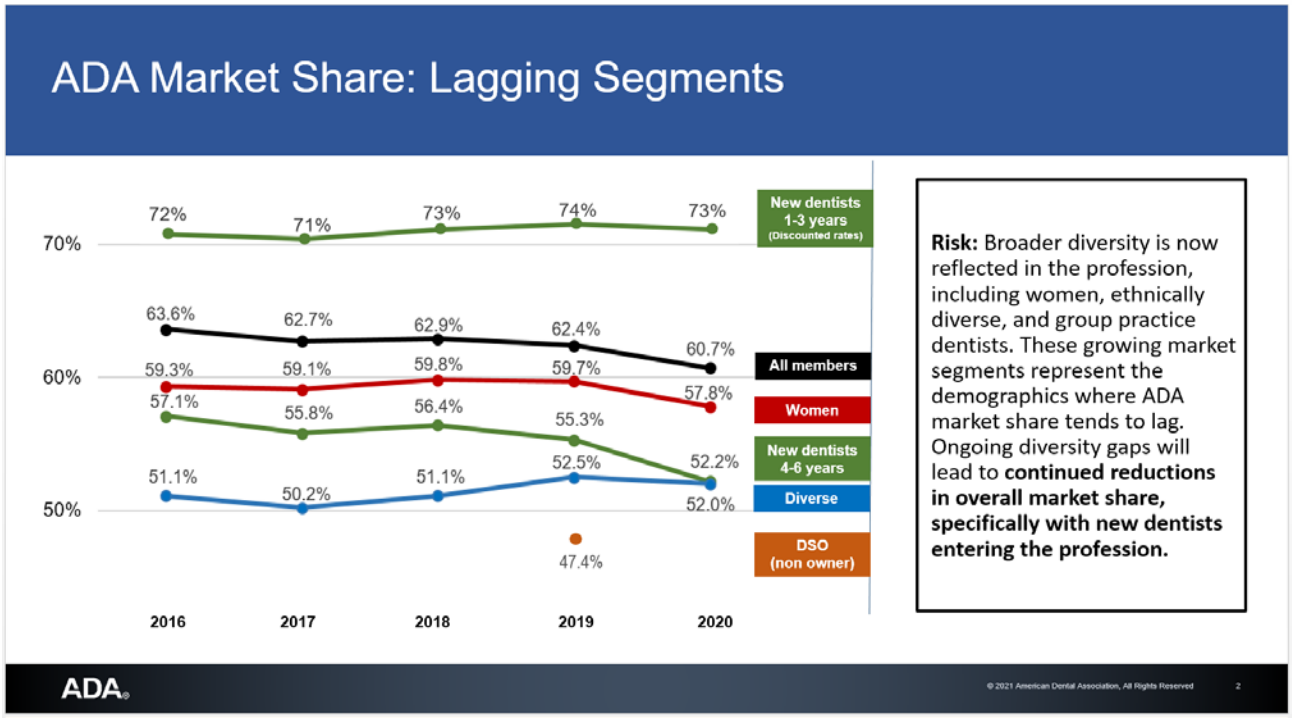
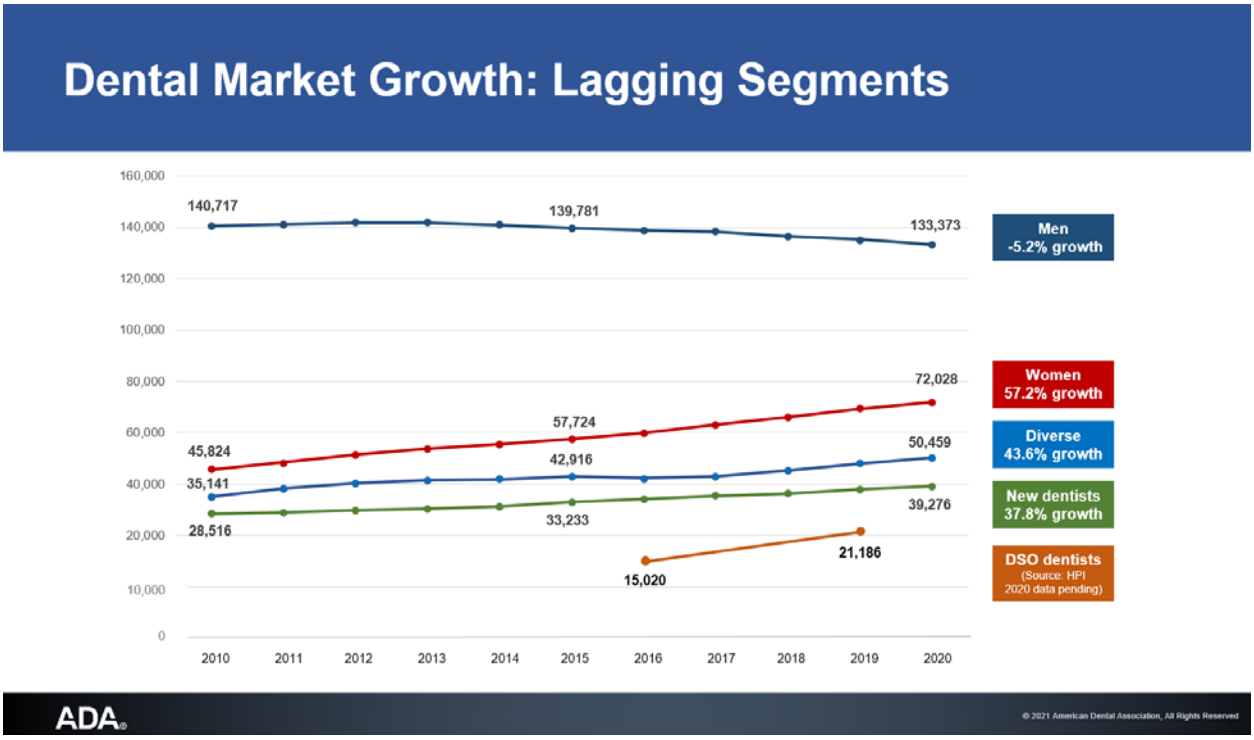


Exhibit B

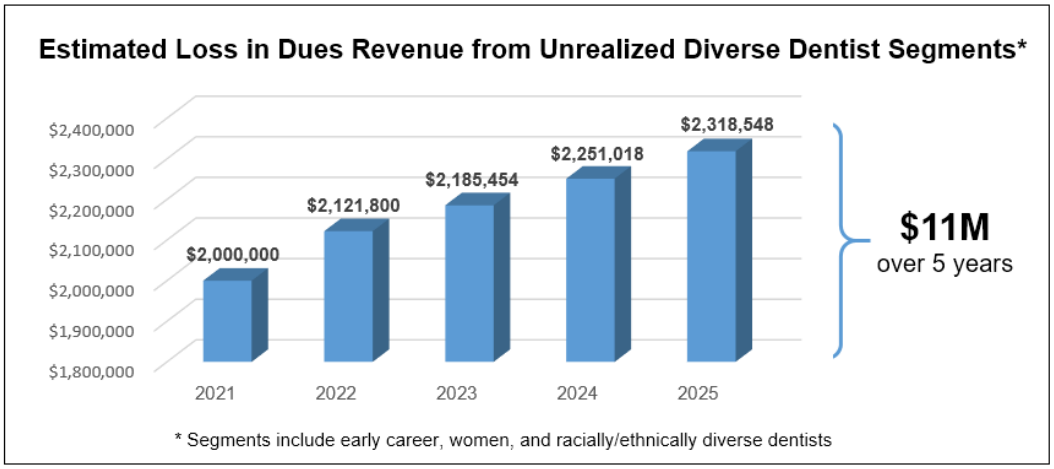


Sustainability Risk

A lack of membership diversity in the organization will lead to continued reductions in overall market share and risk plunging the ADA's overall market share below 50%. Once the ADA no longer represents the majority of dentists, its advocacy role on behalf of dentists and the public are jeopardized.

If current trends continue, the ADA's financial stability could also be significantly impacted. The gap in market share for these diverse and lagging segments is costing the ADA over $2,000,000 in lost dues revenue annually. Based on current membership performance, this revenue gap would increase by 3% annually as the market size of these segments continues to grow. As a result the cumulative loss in dues revenue could reach nearly $11 million within 5 years. (Exhibit C)

Exhibit C



Current ADA Diversity and Inclusion Initiatives

The ADA has made progress with its diversity and inclusion (D&I) initiatives over the past 20 years, including the development of a definition (Exhibit D) and statement (Exhibit E). However, the ADA does not have a current, comprehensive policy in support of D&I.

D

Definition of Diversity: (Trans.2019:245):

Resolved, that the ADA defines diversity through many dimensions, including, but not limited to race, ethnicity, national origin, gender identity, age, physical abilities/qualities, sexual orientation, religious and ideological beliefs, professional practice choices and personal lifestyle preference.

E

Diversity and Inclusion Statement

The American Dental Association strives to model diversity and inclusion in everything we do. We believe that these foster an innovative and dynamic culture and lead to sustainable results. They allow us to further advance the dental profession, improve the oral health of the public, and promote equity and access to oral health.

As a result, we serve and support the different identities, beliefs and perspectives of a diverse membership, leadership, workforce and staff, as well as a wide range of communities and organizations. The diversity experience of the ADA stems from long-running programs for engaging a wide range of members and non-members in Association affairs; reducing oral health disparities across population groups; leadership development for diverse dentists; and education for ADA leaders.

More efforts are needed to ensure the organization's relevancy and growth. A policy, supported by substantive strategies to advance inclusion while growing diversity will ensure a strong membership and reinforce ADA's leadership role within organized dentistry. In order to attract and sustain diverse members, inclusion is an imperative part of the equation. While diversity focuses on the demographic differences, inclusion promotes a culture of belonging where everyone, despite their differences, is represented, valued and heard.

Forward Movement

In 2021, a joint action team comprised of members from the Council on Membership, Diversity and Inclusion Committee and New Dentist Committee was formed to draft a D&I policy for the Association. The Action Team determined that a policy is imperative based on the following criteria:

Revenue:

- ADA membership overall is less diverse than the dental profession. Ongoing growth gaps across under represented segments (early career new dentists, women, ethnically/racially diverse, dentists in large group practice settings) will lead to continued reductions in ADA's overall market share and dues revenue, specifically as the Baby Boomers exit the market and Millennials and Generation Z cohorts steadily enter the profession.
- Non-dues revenue will be compromised without a commitment to diversity and inclusion. Vendors, advertisers, suppliers and sponsors more broadly consider an organization's diversity, inclusion and equity efforts as they make decisions regarding their company's endorsement for financial support, collaborative partnerships and other joint ventures.

Representation:

- Not securing dentists in underrepresented market segments may result in membership market share falling below 50% and compromise the ADA's credibility as the leading oral health care association that represents the profession and public oral care with the subsequent loss of influence in legislation, research, practice, and science.

Reputation:

- The ADA is at risk of being perceived by industry, current and prospective members, employees and the public as tone-deaf. This will have negative implications for the ADA's reputation in relation to its vision, mission, core values and brand.
- In 2020, the American Student Dental Association (ASDA) amended its policy on Sensitivity to Diversity (Appendix 1) which was originally established in 1993. Credibility and influence with ASDA is paramount if the ADA is to remain relevant with the 25,000+ dental students who are more diverse than any generation before them and have a lifetime of membership ahead of them. It's imperative for the ADA to align its values in support of diversity and inclusion to positively engage with its newest colleagues.
- Promoting diversity and inclusion values are key to establishing and maintaining credibility and influence with other healthcare organizations.
- The ADA must demonstrate its commitment to achieve optimal health for all as a diverse community of members is critical to meeting the oral health needs of a diverse population.

The ADA has the opportunity to change the course of its current market share trend and better position for success in meeting the membership and revenue goals of Common Ground 2025. A commitment to attracting and retaining the under-represented segments and building a strong culture of diversity and inclusion is critical to mitigating financial and reputational risk and positively impacting ADA's bottom-line. As a first step in this process, adopting a policy that clearly defines the ADA's commitment to D&I will serve as the foundation and guide for key actions and decisions across the organization, aligning with the mission, vision and core values.

Measuring Success

Numerous industry studies, including McKinsey & Company's latest report, Diversity Wins: How Inclusion Matters, published in May 2020, clearly illustrate how a strong profitability gap is accelerating between organizations that fully embrace D&I versus those who don't. Organizations that are adopting systemic, business-led approaches to D&I are now more likely than ever to outperform non-diverse organizations on profitability by up to 50%. Some proven successful actions include:

- Strengthening leadership accountability for delivering on D&I goals
- Enabling equal opportunity through fairness and transparency
- Building a strong culture of diversity

By adopting a D&I policy, the ADA can take the next step in building a strong foundation in support of the ADA's membership, financial and organizational, and capacity goals. To help measure the effectiveness of the ADA's progress going forward, the following success measures are proposed:

- 2% annual growth in market share of lagging segments (women, new dentists, racially/ethnically diverse, DSOs)
- 3% annual increase in agreement that the ADA is welcoming to dentists with diverse backgrounds (included in annual ADA member value survey)
- 3% annual increase in agreement that the ADA shows that inclusion is important through the action it takes (included in annual ADA member value survey)

The following policy was drafted by the joint action team and reviewed and supported by the full Council on Membership, Diversity and Inclusion Committee, and New Dentist Committee.

Resolution

69. Resolved, that the following Policy on Diversity and Inclusion be adopted:

The ADA is committed to a culture of diversity and inclusion to foster a safe and equitable environment for its membership. In this environment, representation matters and every member is provided intentional opportunities to make meaningful contributions. Diverse viewpoints and needs are heard, valued and respected.

The ADA embraces diversity and inclusion to drive innovation and growth, ensure a relevant and sustainable organization and deliver purposeful value to members, prospective members, and stakeholders. The ADA's commitment to diversity and inclusion will further advance the dental profession, improve the oral health of the public, and achieve optimal heath for all.

BOARD RECOMMENDATION: Vote Yes.

BOARD VOTE: UNANIMOUS.

Appendix 1

American Student Dental Association Policy on Sensitivity to Diversity

E-4 Sensitivity to Diversity (1993, revised 2002, 2014, 2017, 2019, 2020)

Policy Number: E-4
Policy Category: Dental School Admin Policies and Student Government
The American Student Dental Association believes dental schools should ensure all students, faculty, staff and administration are sensitive to the diversity of their colleagues and patients.

ASDA defines diversity as 'differences among individual characteristics, professional choices or demographics including, but not limited to: race, religion, ethnic background, gender, socioeconomic status, sexual orientation, gender identification and gender expression.' ASDA recognizes the unique challenges faced by these diverse populations.

ASDA believes dental schools should provide a safe and inclusive environment for all students, faculty, staff and administration. Sexist, discriminatory or insensitive language and practices are unacceptable.

ASDA supports and encourages the incorporation of diversity training and cultural competence as part of dental education. ASDA also encourages the recruitment and retention of diverse dental student populations in organized dentistry.

ASDA supports and encourages equity for all students within dental education, which includes equipment and facility accommodations where appropriate to ensure student safety and comfort.
ASDA supports reasonable academic accommodations for religious and cultural observances.

ASDA supports efforts to reduce barriers to care for diverse populations.

Resolution No. 75-76 New

Report: Board Report 2 Date Submitted: September 2021

Submitted By: Board of Trustees

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

Total Net Financial Implication: $47,070 Net Dues Impact: $9

Amount One-time _____ Amount On-going _____

ADA Strategic Plan Objective: None

How does this resolution increase member value: Not Applicable

REPORT 2 OF THE BOARD OF TRUSTEES: ADA 2022 BUDGET

CONTENTS:

1. Summary:

All dollar figures are in thousands unless otherwise indicated

In accordance with its Bylaws duties, the Board of Trustees is recommending a 2022 operating budget for the Association. The proposed budget reflects $143,879 in revenues and $143,831 in expenses and income taxes, generating a net income of $47. The budget assumes annual membership dues of $582 in 2022, an increase of $9 from 2021 in compliance with 14H-2019.

The budget includes two new income items that were previously reported in reserve funds rather than as part of the operating budget: $4,000 from a new Quasi-Endowment Reserve Fund created from the Insurance Royalty Reserve Fund, plus $3,000 for half of the annual royalties from ADA Member Insurance Plans. The changes to reserve funds are explained in the section below under the heading "Changes to Reserve Funds".

ADA Operations
Millions of Dollars

	2019 Act	2020 Act	2021 Budget	2022 Budget
Membership Dues	$55.8	$55.5	$58.0	$58.2
Non Dues Revenue	75.0	62.3	70.8	78.7
Quasi-Endowment	-	-	-	4.0
Insurance Royalty	-	-	-	3.0
Total Revenue	**130.8**	**117.8**	**128.8**	**143.9**
Depreciation	6.4	5.7	8.3	6.7
Other Expenses	126.9	113.1	125.9	136.2
Taxes	0.8	0.6	0.5	1.0
Total Expenses & Taxes	**134.1**	**119.4**	**134.7**	**143.8**
Net Income	**(3.3)**	**(1.6)**	**(5.9)**	**0.0**

2. Financial Budget Development, Review and Approval Process:

ADA *Bylaws* charge the Treasurer with oversight of the Association finances, the design of a budgetary process and development of a budget in concert with the Board of Trustees. The House of Delegates approves the budget. The overall planning process stretches almost 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 proposed budget and membership dues 30 days before the annual session.

Initial Budget Development: ADA management is tasked by the Board to draft a budget in the best interests of the Association that increases ADA net assets.

Budget and Finance Committee Review: At its review meeting, the Budget and Finance Committee studied the proposed 2022 budget and changes from the 2021 House approved budget, and considered other division assumptions and potential adjustments to fund key initiatives. Two House members also serve on the Committee and play an invaluable role in the analysis of the proposed budget. Final budget decisions are always in the hands of the ADA's volunteer leaders, who may also consider other factors.

This meeting is a milestone in the budget process and is where the responsibility for developing the budget passes from ADA management to the Budget and Finance Committee. Similarly, once the proposed 2022 budget reflecting changes approved by the Budget and Finance Committee is sent to the Board, responsibility for refinement of the budget passes from the Budget and Finance Committee to the Board.

Board of Trustees Review: Based on the work of the Budget & Finance Committee, the Finance Division staff developed the next iteration of the draft budget for review by the full Board. Budget summaries, including background on the Budget & Finance Committee's view of the merits of the proposed budget, were then prepared for the full Board of Trustees. In addition to the written material, the Treasurer provided guidance and comment to the Board. The Board thoroughly reviewed the work of the Committee and its recommendations, questioned staff on specific issues in the budget and discussed input received by the councils' trustee liaisons.

The Board reviewed, made changes, and approved its recommended budget which is now forwarded to the House.

Board Report 2 was reviewed with Chairs and Vice Chairs of Councils, Committees and Commissions. The Treasurer and appropriate Finance staff were also available to review the budget with the appropriate Council Leadership, as requested.

With this background, it should be noted that this 2022 budget represents the estimates of ADA revenue and expenses to deliver the planned initiatives and member 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-2021. 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 2022 budget, then those will be reported by the Treasurer to the House of Delegates 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 any budget process. Some budget estimates made long before the start of the budget period may be less accurate than those that are built later.

House of Delegates Review and Final Approval: In accordance with its *Bylaws* duties, the Board of Trustees presents the preliminary annual operating budget for the Association to the House of

Delegates through this document, Board Report 2. This background commentary and any analysis provided, together with Reference Committee testimony and the Reference Committee recommendations, serve as the basis for the House approval of the budget at its Annual Meeting. Following budget approval, resources may be reallocated as required, in an effort to maximize their effective use in executing the ADA's Strategic Plan.

If not funded in the draft budget, councils or caucuses may propose new initiatives which may have a financial impact by sending resolutions to the House of Delegates. State dental societies, trustee districts, the American Student Dental Association, as well as the branches of the federal dental services, may also submit resolutions which have a financial impact to the House of Delegates.

Requests to fund programs that were in the prior year's budget are handled differently than new programs. Programs that were funded in the 2021 budget but recommended for elimination or cost reduction by the Board in the 2022 budget as reflected in Board Report 2 require that the requestor refer the entire budget back to the Board for reconsideration with a recommendation to restore funding. If the House votes to refer the budget back to the Board for revision is passed, the Board will then meet separately during the annual meeting to decide on the change. The Board could adopt the change but also make other adjustments to pay for the program or vote to resubmit Board Report 2 to the House with no changes. After more testimony, the House could then a) vote again to either accept the budget or b) refer the budget back the Board again and this process would continue until the House approves a budget.

If approved by House vote, new resolutions for program spending would then be added into the budget and would have to be funded. The final actions of the House of Delegates at each annual session are:

1) Approval of the next year's annual operating budget, and
2) Approval of the dues, and
3) Approval of a special assessment, if any.

3. Operational Strategy Overview

The ADA exists to power the profession of dentistry and to assist our members in advancing the overall oral health of their patients. The 2022 budget aligns with the third year of the Common Ground 2025 five-year strategic plan developed by the Board of Trustees to support this mission. The Board recognizes that changing dentists' demographics, critical needs among constituents and components, advances in technology, emerging talent requirements, an evolving policy landscape and lingering effects of the COVID-19 pandemic shape the plan's priorities and operational strategies.

Goals & Objectives

Goals under the plan are to:

1. To have sufficient membership in order to remain the premier voice for oral health,
2. Financial sustainability,
3. Have sufficient organizational capacity for achieving the strategic plan, and
4. To support the advancement of the health of the public and the success of the profession.

Operational strategies under the plan are meant to help achieve the following 5-year objectives, summarized here by goal:

Membership Goal

Objective 1: Increase membership market share of growing demographics by 2% per year.

Objective 2: Maintain a net-positive gain in membership recruitment of all dentists within 70% or more of constituents.

Objective 3: Maintain an overall retention rate of 94%.

Objective 4: Increase overall average rates of conversion across membership categories by 1% per year.

Finance Goal

Objective 5: Total revenue, including dues and non-dues, will increase by 2-4% annually.

Objective 6: Total unrestricted reserves will be targeted at no less than 50% of annual operating expenses.

Capacity Goal

Objective 7: Improve overall organizational effectiveness at the national and state levels.

Objective 8: Support organizational effectiveness and alignment of ADA subsidiaries.

Public & Profession Goal

Objective 9: The ADA will be the preeminent driver of trusted oral health information for the public and profession.

Objective 10: Dental benefit programs will be sufficiently funded and efficiently administered.

Strategic Approach

Leveraging Dues Simplification and Stabilization to Drive Growth

Passed by the House of Delegates in 2019 and implemented starting in 2021, Dues Simplification (H.R.15/2019) and Dues Stabilization (H.R.14/2019) corrected for the downward pressure on dues revenue created by ADA's over-reliance on discounts to attract members and established a regular practice by the Board to consider market conditions and 5-year rolling averages of consumer price inflation in proposing dues rate increases. These actions by the House drive a fundamental shift from a discount strategy to a value strategy, moving 90% of our members toward full dues faster and over longer periods. However, they do not change our fundamental business problem: without addressing growing segments, the inflow of new dentist members does not offset the outflow to retirement. Instead, Dues Simplification and Stabilization create a window of opportunity (2-4 years starting from 2021) to make smart investments which can pay off now and in future periods as revenue, market share and influence.

Mitigating the Impact of COVID-19 on Growth

While overall performance showed strong signs of recovery in 2021, the impact of the 2020 shut-down will continue to be felt in 2022. The pandemic changed the way we work at national and put unprecedented pressure on state and local operations. The 2022 plan seeks to operationalize key learnings and efficiencies while investing in capabilities supporting membership, non-dues revenue growth and client services for states and locals that were constrained during times of uncertainty. Adequately resourcing initiatives for continued growth out of the pandemic is critical for recovery back to pre-pandemic levels and then beyond.

Improving Operational Agility

While the ADA maintains its divisional structure for management accountability and the delivery of highly-specialized work, under *Common Ground*, the Association has adopted Agile methodologies and frameworks that are more responsive to customer needs, changes in the environment and the accelerating pace of innovation. In 2022, we aim to improve organizational agility by enabling cross-functional collaboration among teams and co-creative activities involving our customers, including members, non-member prospects, volunteers, tripartite staff and partners. Priority strategies feature team sponsors, leads and members collaborating across divisions, focused on the achievement of higher-level goals and objectives outlined in *Common Ground*.

Investing in Talent and People

As shown in the summary section of this report (page 3), "Other Expenses" grow from $125.9 to $136.2. This growth is attributable to a variety of factors. Resources were added to provide the skill sets needed for revenue growth and capacity in shared services. Contributions to the employee 401K plan which were paused in 2021 are reinstated back to 4 % of salaries in 2022. Employee salary rate increases are 3 % for merit and 1 % for promotions or market adjustments.

Recognized by the Chicago Tribune as one of Chicago's top places to work, ADA seeks to foster both high performance and high engagement through its talent strategies. We also recognize an inclusive environment in our workplace provides a strategic advantage by increasing the diversity of thought, experience and perspective.

Digital Transformation

By investing in digital transformation we aim to use technology to better engage our members, improve client services and technical support to states and locals, modify critical business processes and shift more resources toward new product development and service innovation. As an umbrella, Digital Transformation encompasses specific strategies for: Digital Member Experience; Digital Services for States and Locals; Digital First Products & Services.

Optimization and Prioritization

During 2020 and 2021, ADA underwent a significant restructure driven in part by the velocity and magnitude of risk experienced during the pandemic. The Association also made the proactive decision to reimagine our technology service delivery model (Digital Transformation) to better serve the profession and the tripartite. These efforts produced challenges and opportunities, both of which shape strategy going forward. Reductions constrained our ability to provide services across divisions, slowed the rate at which we could develop new programs, products and services and impacted our ability to grow revenue. The Association did focus more sharply on priority programs aligned with the Strategic Plan, and rely more on cross-functional integration. While some highly specialized teams were not impacted, we continue to monitor for risk.

Priority Strategies

Priority strategies enabled in the 2022 budget, include:

Member Goal

1. Digital Member Experience (DMX) / Supports Objectives 1-4, 7, 9

   Through DMX, ADA curates and constantly improves the web, mobile and social experience of members and prospects, with a focus on the needs of the new dentist. DMX is a key strategy under ADA Digital Transformation. Primary funding for DMX comes from ADA reserves.

2. Growing/Emerging Segments / Supports Objectives 1-4, 5

Today's new dentist market is highly diverse across several dimensions. ADA has identified those key segments exhibiting the fastest rates of growth and gains in market share. *Growing/Emerging Segments* includes a set of programs, each designed to address the needs of the new dentist from a diverse perspective: Early Career New Dentist; Women; DSO & Group Practice Setting; and Racially/Ethnically Diverse.

Finance Goal

3. Dues Simplification & Stabilization (Indexing) / Supports Objectives 5, 7
   Implementation of HR14 and HR15 from the 2019 House to increase full dues payers, stabilize dues rates and collaborate with states to improve conversion of early career dentists from discount categories to full dues status.

4. Digital First Publishing / Supports Objectives 5, 1-2, 9
   Content sales strategy leveraging web, mobile, e-mail and print platforms providing advertisers alternatives to traditional print-only opportunities. This also is a strategy under ADA Digital Transformation.

5. Focused Face to Face / Supports Objectives 5, 1-2
   Delivering the right in-person learning, special event and interactive experiences to the new dentist at the right time leading to growth in sales and increased perceptions of member value.

6. Develop and launch a new high stakes testing program / Supports Objectives 5, 9
   Dental hygiene admission test program.

7. Data Monetization / Supports Objective 5
   Early stage research and discovery exploring opportunities to data analytics and other intelligence as well as reviewing ADA protocols regarding data sales/sharing.

Capacity Goal

8. Client Services: Net Growth by State Society / Supports Objectives 7, 2-4
   A holistic support strategy with elevated support across key functional areas supports state growth and recovery.

9. Enterprise Talent Strategy / Supports Objectives 7, 8
   Talent strategies are critical components in meeting organizational goals. In an adaptive, agile environment where flows seamlessly across the enterprise, training and professional development offerings are key factors under the talent strategy umbrella. These offerings prepare employees to meet current and future organizational goals and to address challenges which may arise. To ensure that we are retaining the right talent for the right roles, training and up-skilling are based on the results of ongoing skills assessment.

10. IT Strategic Sourcing Strategy / Supports Objectives 7, 8, 2
    Outsourcing to stabilize the expense of enterprise IT operations while freeing up capacity to invest in growth and innovation.

11. Data Governance Strategy / Supports Objectives 7, 8, 2
    Develop the architecture, policies and practices that make dentist data protected and useful in the current environment.

Public & Profession Goal

12. Advocacy / Supports Objectives 9, 10, 1-4
    Advocacy at the national level regarding policy effecting the practice and profession of dentistry. Also state government affairs.

13. Emerging Issues / Supports Objectives 9, 10, 1-4
    Proactive and reactive response to changes in the practice environment and health policy.

14. Third Party Payer (Dental Benefits) / Supports Objectives 9, 10
    - FIIST
    - Bento
    - Credentialing

15. Science Integration / Supports Objectives 9, 10, 8
    Integration of scientific content and insights generated by ADASRI into ADA thought leadership, practice content and product development.

16. The ADA Clinical Data Registry will continue as a key strategy for 2022

4. Major Financial Assumptions:

A. Beginning in 2022, Operations revenue will reflect an additional $7M per year from reserve funds: $4M from the Quasi-Endowment Fund and $3M from half of 2022 royalties on ADA Member Insurance Plans. This is explained in the section below entitled “Changes to Reserve Funds”. 2022 Operating Income excluding these two non-sales revenue items (i.e.--“Sales Revenue Net of Expenses”) is $(7.0)M.
B. The 2022 budget also includes a one-time dividend from the ADABEI subsidiary of $1.5M.
C. Membership dues rates increase by 1.6 % in 2022; the full dues rate increases by $9 to $582.
D. Contributions to the employee 401K plan which were paused in 2021 are reinstated back to 4 % of salaries in 2022.
E. Contributions to the employee pension fund are reduced by $1.6M in the 2022 budget compared to the 2021 budget, because higher inflation which appears to indicate rising interest rates in the future which will improve funding status without cash contributions.
F. Employee salary rate increases are 3 % for merit and 1 % for promotions or market adjustments.

5. 2022 Budget by Division and Account

Millions of Dollars

	Contingency	Admin Svcs	Central Admin	Int Mkt & Comm	Business Group	Education	Finance & Ops	Gov't Affairs	Health Policy Inst	Human Resources	Info Technology	Legal Affairs	Member & Client SVCS	Practice Institute	Total ADA Operations
Membership Dues	-	-	-	-	-	-	-	-	-	-	-	-	58.2	-	58.2
Advertising	-	-	-	-	6.5	-	-	-	-	-	-	-	0.0	-	6.5
Rental Income	-	-	-	-	0.1	-	7.0	0.0	-	-	-	-	-	-	7.1
Publication and Product Sales	-	-	-	-	5.9	0.0	-	-	-	-	-	-	-	0.0	5.9
Testing Fees & Accreditation	-	-	-	-	-	29.1	-	-	-	-	-	-	-	-	29.1
Meeting & Seminar Income	-	-	-	-	10.4	0.4	-	0.0	-	-	-	-	0.1	0.0	10.9
Grants, Contributions, Sprship	-	1.9	-	-	0.8	0.2	-	-	-	-	-	-	0.1	0.0	3.1
Royalties	-	-	3.1	-	6.1	-	3.0	-	-	-	-	-	-	0.0	12.3
Investment Income	-	-	5.5	-	-	-	1.7	-	-	-	-	-	-	-	7.2
Other Income	-	0.0	1.3	-	0.3	0.3	1.3	0.0	-	-	-	0.1	-	0.1	3.5
Total Revenue	**-**	**1.9**	**10.0**	**-**	**30.1**	**30.1**	**13.0**	**0.1**	**-**	**-**	**-**	**0.1**	**58.4**	**0.1**	**143.9**
Salaries and Temporary Help	-	3.2	1.2	3.4	6.0	6.8	3.3	3.3	1.6	1.0	2.0	2.7	4.8	3.0	42.3
Fringe Benefits	-	0.9	0.7	1.2	2.1	2.8	1.3	1.1	0.5	0.3	0.6	0.8	1.7	1.0	14.9
Consulting Fees & Outside Svcs	-	0.8	0.2	0.7	3.2	0.2	0.2	1.2	0.6	0.0	8.6	0.0	0.2	1.1	16.9
Print., Publicat. & Marketing	-	0.1	-	2.0	7.2	0.0	0.0	0.1	0.0	0.2	-	0.0	0.4	0.2	10.2
Meeting Expenses	-	0.2	-	0.0	2.6	0.0	-	0.5	0.0	-	-	0.0	0.2	0.0	3.6
Travel Expenses	-	1.6	-	0.1	0.8	1.4	0.1	0.9	0.0	0.0	0.0	0.1	0.7	0.5	6.2
Professional Services	-	1.5	0.0	-	0.8	6.1	0.4	0.0	-	-	-	0.9	0.1	0.0	10.0
Bank & Credit Card Fees	-	-	0.1	-	0.5	0.6	-	0.0	-	-	0.0	-	0.8	0.0	2.0
Office Expenses	-	0.8	0.1	0.0	1.8	0.4	0.1	0.3	0.0	0.0	1.7	0.0	0.1	0.2	5.6
Facility and Utility Costs	-	-	0.0	-	0.1	-	7.1	0.1	-	-	0.0	-	0.0	-	7.4
Grants and Awards	-	1.0	0.1	-	-	-	-	2.3	-	-	-	0.0	0.3	0.0	3.7
Grant to ADASRI and ADAF	-	-	10.3	-	-	-	-	-	-	-	-	-	-	-	10.3
Endorsement Costs	-	-	1.0	-	-	0.4	-	-	-	-	-	-	-	-	1.4
Depreciation and Amortization	-	-	0.3	0.0	0.0	-	3.4	0.3	0.0	-	2.7	-	-	-	6.7
Other Expenses	0.7	0.0	0.4	-	0.1	-	0.1	-	-	0.5	0.0	-	0.0	-	1.8
Total Expenses	**0.7**	**10.2**	**14.3**	**7.5**	**25.3**	**18.6**	**15.9**	**10.1**	**2.7**	**2.1**	**15.8**	**4.5**	**9.2**	**5.9**	**142.8**
Income Taxes	-	-	1.0	-	-	-	-	-	-	-	-	-	-	-	1.0
Net Income	**(0.7)**	**(8.3)**	**(5.4)**	**(7.5)**	**4.8**	**11.5**	**(2.8)**	**(10.1)**	**(2.7)**	**(2.1)**	**(15.8)**	**(4.4)**	**49.2**	**(5.8)**	**0.0**

1 # 6. Operating Budget by Account and Changes from Prior Year Budget

ADA Operations Statement of Activities by Account

Excludes Reserve Spending and Revenue

Thousands of Dollars

	2019 Act	2020 Act	2021 Budget	2022 Budget	2022 v 2020 Variance Fav / (Unfav) $	2022 v 2020 Variance Fav / (Unfav) CAGR %	2022 v 2021B Variance Fav / (Unfav) $	2022 v 2021B Variance Fav / (Unfav) %
Membership Dues	55,822	55,542	57,976	58,184	2,642	2.4%	208	0.4%
Advertising	5,990	5,193	5,459	6,494	1,301	11.8%	1,035	19.0%
Rental Income	6,806	6,773	7,124	7,115	342	2.5%	(8)	-0.1%
Publication and Product Sales	6,645	5,287	5,208	5,916	629	5.8%	709	13.6%
Testing Fees & Accreditation	27,839	25,002	27,388	29,139	4,137	8.0%	1,750	6.4%
Meeting & Seminar Income	10,415	1,607	8,465	10,922	9,315	160.7%	2,457	29.0%
Grants, Contributions, Sprship	1,700	1,583	3,419	3,141	1,558	40.9%	(279)	-8.1%
Royalties	9,695	8,814	9,058	12,287	3,473	18.1%	3,229	35.6%
Investment Income	2,051	1,060	1,425	7,200	6,140	160.6%	5,775	405.3%
Other Income	3,859	6,957	3,231	3,480	(3,476)	-29.3%	249	7.7%
Total Revenue	**130,823**	**117,817**	**128,753**	**143,879**	**26,061**	**10.5%**	**15,125**	**11.7%**
Employee Salaries	44,813	45,659	39,752	40,920	4,739	5.1%	(1,169)	-2.9%
Temporary Help	970	836	563	546	290	16.1%	17	3.1%
Compensation Adjustments	853	1,103	800	800	303	12.9%	-	0.0%
Employee Pension	6,184	7,073	7,034	5,548	1,525	10.3%	1,486	21.1%
Other Employee Benefits	6,863	6,159	4,872	6,751	(592)	-4.9%	(1,878)	-38.6%
Payroll Taxes	3,165	3,276	2,369	2,571	705	10.2%	(203)	-8.5%
Consulting Fees & Svcs	10,071	13,005	14,137	16,909	(3,905)	-16.3%	(2,772)	-19.6%
Print., Publicat. & Marketing	10,600	6,959	9,137	10,230	(3,270)	-27.2%	(1,093)	-12.0%
Meeting Expenses	4,566	848	2,256	3,579	(2,730)	-205.4%	(1,323)	-58.7%
Travel Expenses	7,288	1,321	5,757	6,210	(4,889)	-216.8%	(454)	-7.9%
Professional Services	9,962	8,179	9,265	9,971	(1,792)	-11.6%	(706)	-7.6%
Bank & Credit Card Fees	1,836	1,820	1,643	1,975	(155)	-4.4%	(332)	-20.2%
Office Expenses	5,598	3,359	5,063	5,558	(2,198)	-41.2%	(495)	-9.8%
Facility and Utility Costs	6,933	6,332	7,389	7,398	(1,066)	-8.8%	(10)	-0.1%
Grants and Awards	2,294	2,374	3,448	3,677	(1,302)	-32.8%	(229)	-6.6%
Endorsement Costs	1,598	1,345	1,367	1,436	(91)	-3.4%	(69)	-5.0%
Depreciation and Amortization	6,429	5,710	8,253	6,669	(959)	-8.8%	1,584	19.2%
Other Expenses	1,110	1,262	1,747	1,789	(527)	-23.7%	(42)	-2.4%
ADASRI Fee	2,198	2,200	9,332	10,295	(8,095)	-216.3%	(963)	-10.3%
Total Expenses	**133,332**	**118,821**	**134,182**	**142,831**	**(24,011)**	**-4.0%**	**(8,650)**	**-6.4%**
Income Tax Expense	768	557	534	1,000	(443)	-54.8%	(466)	-87.3%
Net Income	**(3,277)**	**(1,560)**	**(5,963)**	**47**	**1,607**		**6,010**	

Changes in 2022 Budget Versus 2021
Analysis by Account Category

"CAGR %" (*KAY gir*) in the table above and elsewhere in this report is the Compound Annual Growth Rate Percentage, the average growth rate per year over multiple-year intervals including the impact of compounding.

Revenues

Total revenues in the 2022 budget are $143,879, a $15,125 increase or 11.7 % versus the 2021 budget. Highlights of various revenue categories are provided below.

Membership Dues: The Division of Member and Client Services estimates the future membership levels for each of 21 dues paying categories and multiplies by the 21 dues rates. The 2022 budget anticipates dues of $58,184, which is $208 higher when compared to the 2021 budget total. These figures a reflect $9 inflationary dues increase which adds approximately $900 to the budget. The 2022 full dues rate is $582. The major components of this variance are explained by the division below:

Member and Client Services:

1. The 2022 Membership Dues revenue forecast number reflects the impacts of the 2020 COVID-19 pandemic and 2021 dues streamlining forecasted losses.

Advertising: This category primarily includes advertising sales in ADA publications and electronic media. The 2022 revenue of $6,494 is a $1,035 or 19 % increase from 2021 budget. The major components of this variance are explained by the division below:

Business Group:

1. Increases due to change in Huddle vendor and change in revenue-share arrangement, which allows ADA to book full gross revenue rather than 25% of gross.
2. ADA publishing is seeing an uptick in demand for large, custom content programs, a trend we expect to accelerate in the post-COVID environment.

Rental Income: This revenue category primarily includes rental income from the Chicago Headquarters and Washington, DC Buildings. Revenue of $7,115 shows a minimal variance when compared to 2021.

Publication and Product Sales: The account category, which includes sales across multiple divisions, anticipates an increase of $709 or 13.6 %. The major components of this variance are explained by division below:

Business Group:

1. Increase in CDT and Compliance print sales.

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 increase by $1,750 or 6.4 % versus 2021 budget. The major components of this variance are explained by division below:

Education:

1. Increase in Integrated National Board exam revenue.
2. Increase in Dental Admission Test revenue.
3. New Admission Test for Dental Hygiene (ATDH) is launched.
4. Increase in other outside client testing service revenue.

Meeting and Seminar Income: This account category included in multiple divisions projects a $2,457 or 29 % increase. The major components of this variance are explained by the division below:

Business Group:

1. Change in registration fee structure for SmileCon from an a la carte model to an all-inclusive model.
2. Exhibit revenue predicted to be down from 2021 budget.

Grants, Contributions, and Sponsorships: Grants, contributions, and sponsorships are projected to decrease by $279 or 8.1 %. The major components of this variance are explained by divisions below:

Administrative Services:

1. Reduction in grant money from the ADA Foundation to cover the charitable activities of the ADA's Department of Social Responsibility and Philanthropy due to a corresponding reduction in expenses.

Business Group:

1. Increase in sponsorship revenue from JJ Keller.
2. Budgeting lower conservative estimate in SmileCon as meeting participation by companies post-COVID is still largely unknown.

Practice Institute:

1. Sponsorships down due to a couple of rotating conferences not scheduled in 2022.
2. Elimination of sponsorship by ADABEI for CPS.

Royalties: Includes royalties received from the ADA Member Advantage program, *CDT* licenses, domestic and international product licenses, renting of mailing lists and JADA royalties to be paid by Elsevier. This category is projected to increase by $3,229 or 35.6 % in 2022. The major components of this variance are explained by the divisions below:

Finance and Operations:

1. Beginning in 2022, includes $ 3,000 in royalty income from ADA Member Insurance Plans formerly reported in reserve funds.

Central Administration:

1. Increase in ADA Member Advantage royalty revenue.

Business Group:

1. Increase in CDT royalties.
2. ADA Publishing expects royalty revenue to decline by $255 which is the royalty we used to get from the Huddles. Because of the change in arrangement with our vendor, ADA Publishing now books over $1M in advertising revenue, so essentially Huddle revenue has increased and has moved to the advertising revenue line.
3. DCCE budgeting conservative as Aramark (cafeteria, executive dining room and meeting catering) situation still being evaluated; projecting hotel usage down with the implementation of virtual governance meetings vs. Face-to-Face.

Investment Income: A projection for revenue of $7,200 which is an increase of $5,775 over 2021 and includes both interest and dividends on all reserve fund assets, including the quasi endowment fund and investment earnings on cash in the operating account. These amounts fluctuate annually.
The major components of this variance are explained by the divisions below:

Central Administration:

1. $4,000 included from creation of the new Quasi-Endowment fund.

2. Includes $1,500 in ADABEI dividend.

Finance and Operations:
1. Increase in reserve interest earnings.

Other Income: This category is composed of miscellaneous revenue, including such items as overhead reimbursement from subsidiaries and ADA Member Insurance Plans, Seal Program revenues, and miscellaneous income from continuing education. The major components of this variance are explained by the divisions below:

Central Administration:
1. Increase in overhead reimbursement from subsidiaries.

Association-Wide:
1. Minimal changes throughout the remaining divisions.

Expenses
Analysis by Account Category

Total operating expenses and income taxes are budgeted at $143,831, a $9,116 increase or 6.8 % versus the 2021 budget.

Highlights of various expense categories are provided below.

Salaries (Base Compensation): Base salary expenses are budgeted at $40,920 which is $1,169 or 2.9 % higher than the 2021 budget. As shown in the table below under “Number of Employees”, the number of full-time equivalent employees (“FTE”) at year end 2022 is projected at 354. This is an increase of 11 FTEs over 2021. See the table below for a breakdown of staffing changes by division. The 2022 budget includes a merit increase pool of 3 % and a 1 % pool for market adjustments. The budget also assumes that open positions are filled on July 1 rather than January 1, due to anticipated open positions throughout the year.

Temporary Help: This category includes temporary/interim staff for the annual meeting, as well as other division support to assist divisions when staff positions are open during the year and for specific needs in lieu of hiring additional full-time staff. This category is expected to see a minimal decrease of $17 when compared to the 2021 budget.

Compensation Adjustments: This category includes expense associated with severance pay and service awards. The 2022 budget is flat when compared to the 2021 budget.

Employee Pension Fund: This category is to cover annual contributions to the scaled back pension plan that went into effect January 1, 2012 as well as the liability of the full employee pension plan that was offered to employees prior to 2012. The cost reflected in this category represents estimated plan contributions required based on actuarial assumptions. This category is expected to decrease in 2022 by $1,486 when compared to 2021. The 2022 budget is utilizing part of an accumulated prefunding balance to offset the normal cash contribution to the fund.

All Other Benefit Costs: Expenses in this category include group medical premiums, dental direct reimbursement, life insurance, 401k contribution and workers compensation. The expenses in this category are expected to increase by $1,878 when comparing the 2021 budget to the 2022 budget. The increase is primarily due to the 2022 budget adding back the 401k contribution which was suspended as part of the

2021 budget reductions. The 401k contribution added $1,620 to the 2022 budget. Additionally, increases in staff levels contributed to increases in group medical, dental direct reimbursement and life insurance.

Payroll Taxes: This category includes expense associated with employer related taxes such as FICA, SUI and FUI. This category is expecting to increase due to increased staffing levels in 2022.

Consulting Fees and Outside Services: 2022 expenses in this area increased by $2,772 or 19.6 % when compared to the 2021 budget. The major components of this variance are explained by the divisions below:

Information Technology:

1. Increase in Capgemini consulting expenses.

Business Group:

1. The increase is due in part to the change in Huddle Vendor and the move to a fee-for-service model rather than a revenue-share royalty.
2. The increase also supports development on new platforms for custom content.
3. Increase in conference center contracted staffing due to higher conference center usage.
4. New agreement with JJ Keller labor law posters.

Legal Affairs:

1. Increase in audit fees.
2. Increase in external audit fees.

Administrative Services:

1. New contract with Freeman for HOD related expenses increased this line item by $24 when compared to 2021. With the new contract, Freeman is adjusting its billing to be more in line with the costs they are incurring.
2. Moving in early for a Pre-SmileCon HOD in 2022: $87 in increased labor costs.
3. Electrical charges at HOD: Increase by $35. Electric pricing in cities has continued to increase. Conference Services is asking the Marriott to review our needs to see if our 2022 estimate can come down, but this amount is the best estimate available at this time.
4. Security costs will increase by $4.

Government and Public Affairs:

1. Adding an additional consulting firm in 2022.

Printing, Publications and Marketing: In 2022, this category anticipates an increase of $1,093 or 12 % when compared to 2021. The major components of this variance are explained by the divisions below:

Member and Client Services:

1. The increase in the 2022 Print, Publication and Marketing expense compared to 2021 is attributed to the moving of expenses for Membership Brochures, ADA-State Co-Branded Applications, and SPI Mailers from the Division of Integrated Marketing and Communications into the Division of Member and Client Services.

Business Group:

1. Increase in Print revenue causes an increase in cost of goods sold.
2. Special event planned for SmileCon in 2022 and none were planned in 2021.
3. A reduction in ADA Pub is contingent on reductions in costs of paper and/or postage and may be reversed if these costs increase.

Administrative Services:

1. Reduction in GKAS marketing expenses.

Meeting Expenses: The 2022 budget anticipates an unfavorable variance of $1,323 or 58.7 %. The major components of this variance are explained by the divisions below:

Business Group:

1. PDS attending 4 meetings instead of 3.
2. TDA & GHDS site distribution payments in 2022. No payments to Nevada in 2021.
3. Higher meeting set-up costs.
4. Increase in shuttle service costs.

Government and Public Affairs:

1. Reinstate in-person Lobby Day Conference. Event was budgeted as a virtual event in 2021.

Travel Expenses: Travel expenses are usually comprised of about three quarters volunteer travel and one quarter staff travel. Budgeted expenses for travel are projected to increase by 7.9 % or $454 versus the 2021 budget. The major components of this variance are explained by the divisions below:

Association-Wide:

1. Councils are budgeted to have two in-person meetings in 2022.

Administrative Services:

1. BOT meetings all in-person in 2022.
2. Standing Committee meetings are budgeted for in-person in 2022.
3. Spouse travel expenses reinstated.

Professional Services: 2022 expenses are expected to increase by $706 or 7.6 % versus 2021. The major components of this variance are explained by the divisions below:

Education:

1. Increase in test administrations (increase in revenue) causes this category of expenses to be higher.
2. New Admission Test for Dental Hygiene (ATDH) is launched.

Business Group:

1. Increase due to CDT companion author services.
2. Slightly less honoraria in SmileCon.
3. Reduction is due to the decision to make the ADA News conference show daily an online-only publication, which reduces the necessity to hire a printer at the conference site to produce a daily print newspaper.

Legal Affairs:

1. Because outside legal fees for a future year cannot be predicted with any certainty, and are subject to many variables and unforeseen events, they are estimated based on average expenses over prior years. The estimate for 2022 is being reduced by $30 to be consistent with legal fees incurred in recent years.

Member and Client Services:

1. The increase in the 2022 Professional Services Expense compared to 2021 is attributed to the honoraria for the facilitation of the Institute for Diversity in Leadership conducts, ADA Accelerator Series, Amplifying Voices, Cultural Competency Webinars, Health Equity with CAAP Sessions, ADA Conference Week, and Miscellaneous Speakers.

Bank and Credit Card Fees: This category represents transaction fees paid to financial institutions and reimbursements to state and local societies for credit card fees related to ADA membership dues collection. Expenses in this category are expected to increase by $332 or 20.2 % versus the 2021 budget. The major components of this variance are explained by divisions below:

Business Group:
1. Higher due to an increase in SmileCon registration fees.
2. Increase in product sales.

Member and Client Services:
1. More membership dues transactions being paid via credit cards.

Office Expenses: 2022 expenses are projected to increase by $495 or 9.8 % versus 2021. The major components of this variance are explained by the divisions below:

Business Group:
1. Increase in SmileCon audio visual expense.

Information Technology:
1. Increase in system maintenance and support services.
2. Increase in telephone usage.

Administrative Services:
1. Increase in furniture and equipment rental for HOD.
2. Increase in FDI dues.

Facility and Utility Costs: These expenses represent costs for building management and operations, maintenance, and real estate taxes for the ADA Headquarters and Washington DC buildings. Expenses in this category are anticipated to be flat when comparing the 2022 budget to the 2021 budget.

Grants and Awards: The ADA distributes grants to support various organizations for specific functions and also support GKAS. The 2022 budget anticipates an increase of $229 when compared to the 2021 budget. The major component of this variance is explained by the division below:

Government and Public Affairs:
1. Increase in SPA grants to states.

Endorsement Costs: This category represents royalty payments to state dental societies that participate in the ADA Member Advantage program and to the AMA for use of medical codes in *CDT* related products. There is an increase of $69 in this category, and the major components of this variance is explained by the division below:

Central Administration:
1. Increase in royalty payments to states as a result of an increase in ADA Member Advantage revenue.

Depreciation and Amortization: Depreciation is calculated annually based on prior year and proposed current year capital acquisitions. There is an anticipated decrease of $1,584 in 2022. The major components of this variance are explained by the divisions below:

Central Administration:
1. Reduction due to Chicago building becoming fully depreciated.
2. Reduction as a result of most building equipment and improvement depreciation being moved to the division of Finance and Operations.

Finance and Operations:
1. Increase due to transfer of building equipment and improvement depreciation being transferred in from the division of Finance and Operations.
2. Reduction due to tenant improvement depreciation being lower in 2022 versus 2021.

Information Technology:

1. Reduction in computer hardware depreciation.
2. Increase in computer software depreciation due to DMX projects.

Other Expenses: Other expenses include general insurance, recruiting costs, staff development, and the Board contingency fund. This category showed a minimal increase of $42 in 2022. The major component of this variance is explained by the division below:

Central Administration:

1. Increase to bring the 2022 budget in line with actuals.

ADASRI Fee: The ADA agreed to fund the annual operating expenses of the ADA Science and Research Institute, LLC. ADASRI is a separate legal entity (a wholly owned subsidiary of the ADA) rather than a division of ADA Operations, and has a separate process for developing and reviewing its budgets with its own Board. The anticipated funding level in 2022 is expected to increase by $963 or 10.3 % versus the 2021 budget. Based on the services agreement between ADA and ADASRI, $1,055 of non-dues revenue generated by the ADA Seal of Acceptance program remains with the ADA (outside of the ADASRI) as part of the overall revenue goal.

Income Tax Expense: The increase in income taxes totaling $466 is a direct result of increases in advertising and testing fee revenue.

7. Number of Employees

ADA General Fund (Operations + Reserve Funds)
Budgeted Year End Number of Full Time Equivalent Employees

					2022 versus 2021 Variance	
	2020 Budget		**2021 Budget**	**2022 Budget**	**FTE**	**Notes**
Administrative Services	15.0		20.0	20.0	0.0	
Marketing & Communications	35.0		27.0	29.0	2.0	Social Media Manager and Web Ops Manager
Business Group	58.0		48.0	52.0	4.0	Dental Team CE, Product Line Manager, Publications Operations Director, Projects Coordinator
Education	72.0		71.0	76.0	5.0	Test Administration Associate, Test Administrator Svcs Lead, Coordinator CCEPR, 2 Frozen Positions in 2021 added back
Finance, Buildings & Operations	31.8		31.8	31.8	0.0	
Government Affairs	29.0		28.0	29.0	1.0	Frozen Position in 2021 added back
Health Policy Institute	13.0		13.0	13.0	0.0	
Human Resources	8.0		8.0	8.0	0.0	
Technology	50.0	*	15.0	14.0	(1.0)	Position transferred to DMX reserve fund
Legal Affairs	16.6		16.6	16.6	0.0	
Member & Client Services	43.0		41.0	41.0	0.0	
Practice Institute	29.0		24.0	24.0	0.0	
Subtotal Operations	400.4		343.4	354.4	11.0	
Reserve Funds (IT DMX)	0.0		0.0	5.0	5.0	4 IT positions working on DMX projects and 1 position transferred from IT operating budget
Total ADA General Fund	**400.4**		**343.4**	**359.4**	**16.0**	

* *Technology Division outsourced positions to a consulting firm effective in 2021.*

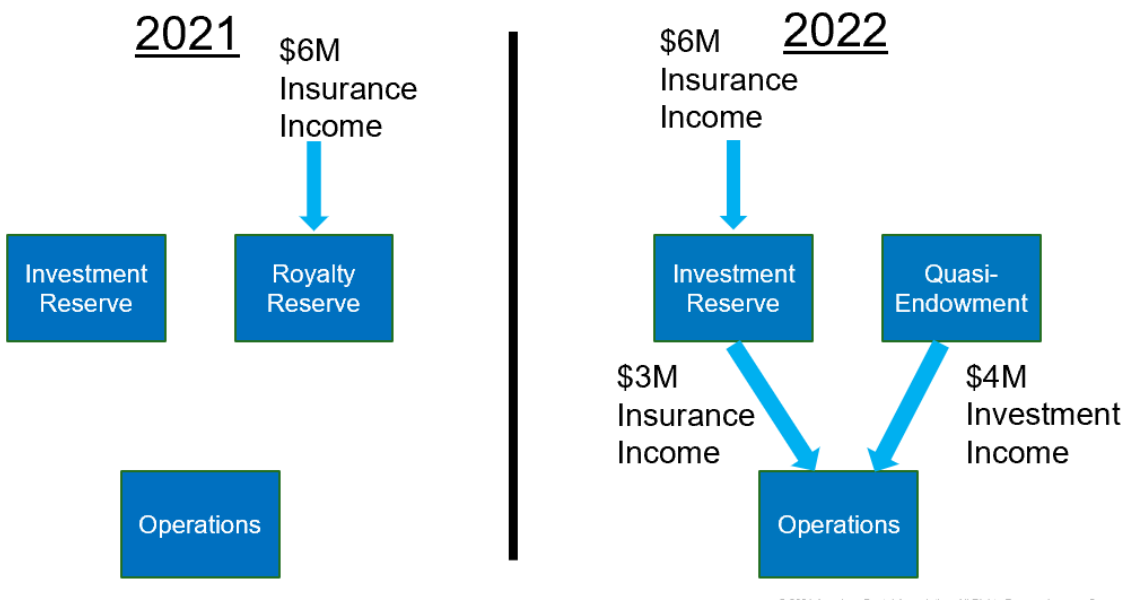
Science Institute is no longer in ADA Operations and is therefore not shown for past periods.

8. Changes to Reserve Funds

New Funds and Cash Transfers to Operations

An endowment is a donation of money or property to a nonprofit organization, which then uses the resulting investment income for a specific purpose. A quasi-endowment ("QE") is created by nonprofit organization board designation, rather than a donor, to serve a similar purpose: to generate expendable income. Principal and income of Quasi-Endowment funds may be utilized at the discretion of the organization's Board of Trustees which enables them to be considered unrestricted for accounting and reporting purposes.

The ADA's new Quasi-Endowment Reserve Fund, created by the Board of Trustees in 2021, fulfilled the intent of 84H-2013 and B81-2014 that set a goal to accumulate $100,000 to generate a stream of future income. This fund includes the balance from the former Insurance Royalty Reserve plus a one-time transfer from the Long Term Investment Fund to bring the total Quasi-Endowment Fund balance to $100,000. With the former Insurance Royalty Reserve Fund being replaced by the Quasi-Endowment fund, beginning in 2022 half of the royalties on ADA Member Insurance Plans received each year will be reported as operations revenue and the other half will be contributed to the Long Term Investment fund, as outlined in the diagram below.



As shown in the diagram, through 2021 no funds flow from reserves into the operating budget (except for a modest amount of dividends and interest only which is not shown in the diagram.) Beginning in 2022, the (Insurance) Royalty Reserve Fund will be converted into a Quasi-Endowment fund that provides expendable income to Operations. Also the Insurance Royalty income received by the ADA each year will be split, with half being deposited in the Long Term Investment Fund and the other half being transferred into Operations.

Rationale for the Changes

The House of Delegates and Board of Trustees created the Insurance Royalty Reserve fund in 2013 to serve as an eventual source of income for operations when the fund reached a target value of $100,000. In addition, unprecedented stock market investment returns helped grow the balance of the Long Term Investment fund, enabling the Board to accelerate the creation of the $100,000 Quasi-Endowment fund in 2021 by transferring $12,982 from the Long Term Investment Reserve into the Royalty Reserve.

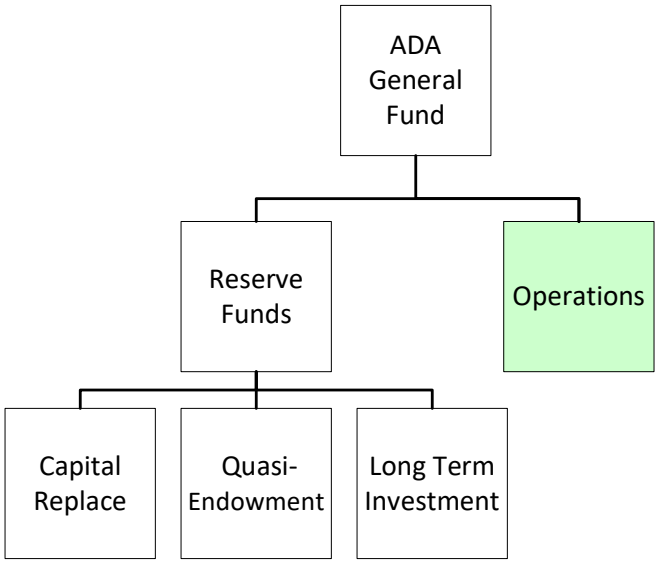
The $4,000 annual draw from the Quasi-Endowment fund into Operations will be 4 % of the principal balance, which is typical for endowment funds. Investment returns over the long term are expected to be equal or greater than 4 % per year, so that the principal balance is sustainable.

With the annual royalty income from Members Insurance Plans no longer needed to build the $100,000 Quasi-Endowment fund, the annual royalty income will be split, with half deposited into the Long Term Investment Fund and half into Operations. The reasons why half of the insurance royalty will be saved in reserves and only half will be spent on operations are as follows:

A. The Long Term Investment Fund pays for a variety of projects approved by the Board of Trustees, as outlined in the section below “Statement of Cash Flows”. Over the last five years (from the 2017 actual result through the 2021 forecast) spending from the Long Term reserve fund has averaged $10,008 per year. Retaining half of the $6,000 annual income from Members Insurance Plans ($3,000 per year retained) will partially offset the spending from the Long Term Investment fund.
B. Apart from the historical reserve spending of $10,008 per year, the ADA Board of Trustees or House of Delegates may in the future decide to make large additional investments, possibly to create new sources of non-dues revenue. Contribution of $3,000 into the Long Term Reserve fund will help sustain the fund for such future potential uses.
C. The excess reserves in the Members’ Insurance Plans are not an unlimited pool of resources and there is no guarantee that the income from Members Insurance Plans will continue at the $6,000 rate per year. Plan reserves were already adversely affected by claims resulting from the COVID pandemic. Given this uncertainty, allowing operations to consume only half of the royalty income rather than becoming dependent on the full amount will reduce the risk that any potential declines in the royalty income cause unexpected operating deficits.
D. ADA investment funds have recently benefited from outstanding stock market returns over the last several years. The Standard & Poor’s 500 Index has averaged 24.4 % annualized return from December of 2018 through June 2021. However, the ADA’s investment advisors expect much lower returns in the future, and the value of the ADA’s stock investments could potentially even decline at any time. Contributing half of the insurance income into the Long Term Investment Reserve will support the reserve fund even if stock markets falter.

9. Statement of Cash Flows

The budget proposed in this report is only for Operations, in the green box below.



However, as additional supplementary information, the Statement of Cash Flows below identifies the actual and projected cash moving in and out of both Operations and reserve funds within the ADA General Fund.

The figures in the table below are the actual 2020 and budgeted 2021 and 2022 cash flow. Finer detail on the reserve spending summarized below is provided in ADA monthly financial reports, which also identify the total project spend authorized by the Board of Trustees over the multi-year life of each project. The figures below reflect only income and spending within each calendar year.

The new transfers between funds that will begin in 2022 are identified in the cash flow statement below along with the additional transfers between funds that have been ongoing for several years.

The cash flow statement below identifies the estimated reserve spending for the ADA Business Innovation Group (ADABIG). ADABIG is a separate legal entity with its own Board of Trustees, budget process, and financial and operating reports. ADABIG is not part of the ADA Operating budget and the detail on ADABIG is available in the reports produced by the subsidiary.

ADA General Fund
Cash Flow: Sources/(Uses) of Cash
Millions of Dollars

	2020 Act	2021 B	2022 B	
Operations:				
Sales Revenue Less Expense	(1.6)	(6.0)	(7.0)	
Transfer From Insurance Royalty	-	-	3.0	*(A)*
Transfer from Quasi-Endowment	-	-	4.0	*(B)*
memo: Operations surplus/(deficit)	*(1.6)*	*(6.0)*	*0.0*	
Change In Receivables & Payables	(3.9)	-	-	
Add Back Depreciation (non-cash)	5.7	8.3	6.7	
Operating Capital Expenditures	(1.2)	(3.0)	(3.0)	
Transfer to Capital Repl Reserve	(4.5)	(5.3)	(3.7)	*(C)*
Total	**(5.5)**	**(6.0)**	**0.0**	
Long Term Investment Fund:				
Investment Income	7.2	-	2.2	
Insurance Royalty Revenue			6.0	
Half of Royalty to Operations			(3.0)	*(A)*
DMX Capital Expenditures	(2.1)	(2.4)	(0.4)	
DMX Operating Expenses	(1.6)	(1.6)	(2.2)	
Funding for ADABIG	(2.3)	(5.0)	(1.9)	
Restructuring Costs	(2.6)	-	-	
Other Reserve Spending	(0.8)	-	(0.9)	
Total	**(2.2)**	**(9.0)**	**(0.2)**	
Insurance/Quasi-Endowment Fund:				
Investment Income	9.2	-	4.0	
Royalty Revenue	6.3	6.3	-	
Transfer to Operations	-	-	(4.0)	*(B)*
Total	**15.5**	**6.3**	**-**	
Capital Replacement Fund:				
Replacement Capital Expenditures	(2.1)	(5.7)	(4.8)	
Transfer-in from Operations	4.5	5.3	3.7	*(C)*
Total	**2.4**	**(0.4)**	**(1.1)**	
Total General Fund	**10.2**	**(9.1)**	**(1.3)**	

10. Capital Expenditures and Capital Replacement Fund

Capital Replacement Reserve Fund (Established in 2013): This reserve fund was created by the 2012 House of Delegates to eliminate the need for special membership dues assessments to fund large asset replacements. Each year the excess of depreciation over operating capital is contributed to the capital reserve fund.

American Dental Association		
Budget Depreciation and Capital Expenditures		
$ 000		
	2021 Budget	**2022 Budget**
Depreciation/Amortization	**$8,253**	**$6,669**
Operating Capital Expenditures		
Division of Conferences and Continuing Education	(60)	(105)
Finance & Operations, Buildings	(1,090)	(553)
Information Technology	(1,825)	(2,289)
Total	**(2,975)**	**(2,947)**
Net-Contribution to Replacement Fund	**(5,278)**	**(3,722)**
Total Operating Capital + Contribution to Replacement Fund	**(8,253)**	**(6,669)**
Capital Replacement Fund		
Contributions	**(5,278)**	**(3,722)**
Replacement Fund Capital Expenditures		
Finance and Operations, Buildings	(5,657)	(4,804)
Replacement Fund Net Contributions Less Expenditures	**$ (379)**	**$ (1,082)**
Total Capital Expenditures	**$ (8,632)**	**$ (7,751)**

Note: the above schedule reflects capital expenditures from operations and the capital replacement fund, but not capital expenditures previously approved by the Board of Trustees to be funded from the Long Term Investment Reserve Fund.

11. 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. In August 2021, real estate transaction professionals in Chicago estimated a gross sale value (before transaction costs) of $80.2 million. This estimate represents the amount that a potential buyer would pay for the ADA Chicago HQ building for a sale leaseback as office space using mid-case assumptions. This valuation does not necessarily represent the "highest and best use" value of the building which may be substantially higher.

The income statement for the Headquarters building shows expenses exceeding revenue. This is because approximately half of the building space is occupied by ADA employees. Excluding the cost of the ADA occupied floors, revenue significantly exceeds expense for the tenant occupied floors. The expense of the ADA occupied floors replaces rent that the ADA would need to pay if its offices were located in a non-ADA owned building.

The ADA also owns the following three real estate properties in Washington DC:

- ADA office building on 14th Street which was valued by real estate professionals in August of 2021 at $15.9M before transaction costs.
- An office building at 400 C Street, NE, about 2.5 blocks from the Hart Senate Office Building
- A townhouse located at 137 C St. SE which regularly is the site of meetings with members of the House of Representatives and their staff.

12. Division and Department Detail

ADMINISTRATIVE SERVICES DIVISION

ADMINISTRATIVE SERVICES DIVISION

Administrative Services Division Summary by Natural Account In Thousands	FY2019 Actuals	FY2020 Actuals	FY2021 Budget	FY2022 Budget	2022 Budget vs. Act 2019	2022 Budget vs. Act 2020	2022 Budget vs. Budg 2021
Revenue							
Grants, Contributions, Sprship	50	770	2,226	1,944	1,894	1,174	(283)
Other Income	0	0	5	5	5	5	0
Total Revenue	50	770	2,231	1,949	1,898	1,179	(283)
Expense							
Salaries and Temporary Help	2,421	2,921	3,084	3,211	(790)	(290)	(127)
Fringe Benefits	641	703	795	883	(242)	(180)	(88)
Consulting Fees & Outside Svcs	618	296	666	850	(232)	(553)	(184)
Print., Publicat. & Marketing	51	45	379	133	(82)	(88)	246
Meeting Expenses	151	15	162	153	(2)	(138)	9
Travel Expenses	1,347	272	1,487	1,643	(296)	(1,371)	(156)
Professional Services	1,422	1,417	1,462	1,549	(127)	(132)	(87)
Office Expenses	596	402	716	774	(178)	(371)	(58)
Facility and Utility Costs	1	0	0	0	1	0	0
Grants and Awards	41	21	1,029	1,014	(973)	(993)	15
Other Expenses	6	9	12	17	(11)	(8)	(6)
Total Expense	7,294	6,102	9,791	10,226	(2,932)	(4,124)	(435)
Net Income After Taxes	(7,244)	(5,332)	(7,560)	(8,278)	(1,034)	(2,945)	(718)

Operational Changes

1. Pre-SmileCon HOD in 2022.

Administrative Services 2022 Budget								
Department Income Statements								
Thousands of Dollars								
Department			**Expense**					
	# of FTE	**Revenue**	**Employee Costs**	**Travel**	**Services**	**Deprec**	**Income Tax**	**Net Income**
1050000000 - Office of the Executive Director	9.0	-	2,101	75	50	-	-	(2,226)
1050050000 - Board of Trustees	5.0	-	658	-	1,473	-	-	(2,131)
1050050015 - BOT-Annual Meeting	0.0	-	-	77	-	-	-	(77)
1050050020 - BOT-Committee Meetings	0.0	-	-	486	44	-	-	(530)
1050050025 - BOT-Constituent Annual Meetings	0.0	-	-	63	-	-	-	(63)
1050050030 - BOT-In District Travel	0.0	-	-	27	-	-	-	(27)
1050050035 - BOT-Conferences	0.0	-	-	116	5	-	-	(121)
1050050050 - BOT-Liaison Activities	0.0	-	-	85	-	-	-	(85)
1050050055 - December Board Retreat	0.0	-	-	102	31	-	-	(133)
1050100000 - Office of the President	1.0	-	414	103	28	-	-	(544)
1050150000 - Office of the President-Elect	1.0	-	340	72	9	-	-	(421)
1050250000 - Office of the Treasurer	0.0	-	-	30	79	-	-	(109)
1050300000 - House of Delegates	0.0	-	-	53	1,054	-	-	(1,106)
1050650000 - Social Responsibility and Philanthropy	4.0	1,932	580	118	1,215	-	-	19
1300800000 - International Relations	0.0	-	-	31	24	-	-	(55)
1300800020 - FDI World Dntl Federation	0.0	17	-	206	479	-	-	(668)
AdminSvc - Administrative Services	**20.0**	**1,949**	**4,094**	**1,643**	**4,489**	**-**	**-**	**(8,278)**

Department Descriptions	
Level	**Cost Center Description**
1050000000 - Office of the Executive Director	The OED budget serves primarily as administrative infrastructure to the Association through implementation of actions and policies of the HOD and BOT; supervision of activities of Association staff and agencies by the Executive Director. Supports the President, President-elect and ED by coordinating schedules of meetings, travels and budget as well as Reference Committee, Honorary Membership, Distinguished Service Award Nominations and Presidential appointments.
1050050000 - Board of Trustees	This budget includes annual trustee stipends, spouse travel and office expenses related to the Board of Trustees including meetings that facilitate the work of the Board.
1050050015 - BOT-Annual Meeting	This budget includes travel funding for the Board for annual session, NDC and Diversity Conference, travel for New BOT and New Trustees and spouse travel.
1050050020 - BOT-Committee Meetings	This budget includes travel and meeting expenses to support the Board Standing Committees, Admin Review and New BOT orientation.
1050050025 - BOT-Constituent Annual Meetings	This budget includes travel related expenses for Board members to attend constituent society and caucus meetings.
1050050030 - BOT-In District Travel	This budget includes travel expenses for Board members attendance at in-district meetings.
1050050035 - BOT-Conferences	This budget includes Board funded conferences such as ASAE, Student Lobby Day, a conference of choice and PRC visit for new trustees and second VP.
1050050050 - BOT-Liaison Activities	This budget includes Board travel for activities related to their liaison duties.
1050050055 - December Board Retreat	This budget supports all expenses related to the Board Retreat and meeting including volunteer, spouse and staff travel, AV rental and consulting fees.
1050100000 - Office of the President	This budget supports the Office of the President including meeting travel, professional and office related services and expenses.
1050150000 - Office of the President-Elect	This budget supports the Office of the President Elect including meeting travel, professional and office related services and expenses.
1050250000 - Office of the Treasurer	This budget supports the Treasurer including meeting travel and annual stipend.
1050300000 - House of Delegates	This budget includes expenses related to the annual House of Delegates meeting including contracted meeting expenses, volunteer travel, HOD session refreshments, staff meals, outside services, furniture and equipment rental, telephone and Internet access and meeting supplies.
1050650000 - Social Responsibility and Philanthropy	The Department of Social Responsibility and Philanthropy houses the following ADA functions: Philanthropy, including GKAS, International (the Department maintains resources for dentists who wish to volunteer overseas; it does not run overseas relief programs), ADA's involvement in FDI.
1300800000 - International Relations	This budget includes ADA Humanitarian Award (prize funds, travel for winner and spouse to attend ceremony at annual meeting); hosting international VIP's at Chicago Midwinter Meeting and annual meeting; ADA President and spouse's travel to American Dental Society of Europe ADSE meeting.
1300800020 - FDI World Dntl Federation	This budget includes FDI membership dues, ADA/FDI Delegation travel and registration for the FDI Annual World Dental Congress.

BOARD CONTINGENCY

BOARD CONTINGENCY

Board Contingency Division Summary by Natural Account In Thousands	FY2019 Actuals	FY2020 Actuals	FY2021 Budget	FY2022 Budget	----------2022 Budget---------- vs. Act 2019	vs. Act 2020	vs. Budg 2021
Expense							
Consulting Fees & Outside Svcs	255	118	0	0	255	118	0
Print., Publicat. & Marketing	0	105	0	0	0	105	0
Meeting Expenses	0	3	0	0	0	3	0
Travel Expenses	32	6	0	0	32	6	0
Professional Services	0	8	0	0	0	8	0
Office Expenses	0	35	0	0	0	35	0
Facility and Utility Costs	0	19	0	0	0	19	0
Grants and Awards	80	70	0	0	80	70	0
Other Expenses	0	141	700	700	(700)	(559)	0
Total Expense	366	505	700	700	(334)	(195)	0
Net Income After Taxes	(366)	(505)	(700)	(700)	(334)	(195)	0

Board Contingency 2022 Budget Department Income Statements Thousands of Dollars								
Department			**Expense**					
	# of FTE	Revenue	Employee Costs	Travel	Services	Deprec	Income Tax	Net Income
0900000000 - Contingency General	0.0	-	-	-	700	-	-	(700)
ContFund - Board Contingency	0.0	-	-	-	700	-	-	(700)

BUSINESS GROUP

BUSINESS GROUP

Business Group Division Summary by Natural Account In Thousands	FY2019 Actuals	FY2020 Actuals	FY2021 Budget	FY2022 Budget	----------2022 Budget---------- vs. Act 2019	vs. Act 2020	vs. Budg 2021
Revenue							
Advertising	5,990	5,193	5,459	6,485	495	1,292	1,026
Rental Income	38	12	50	60	22	48	10
Publication and Product Sales	6,593	5,248	5,160	5,870	(724)	622	709
Meeting & Seminar Income	9,885	1,203	7,910	10,372	487	9,169	2,462
Grants, Contributions, Sprship	1,014	458	790	815	(199)	357	25
Royalties	6,382	6,053	6,333	6,130	(252)	77	(203)
Other Income	618	139	318	348	(270)	209	30
Total Revenue	30,521	18,306	26,021	30,080	(442)	11,774	4,059
Expense							
Salaries and Temporary Help	5,828	6,001	5,629	6,005	(177)	(4)	(376)
Fringe Benefits	2,045	2,037	1,968	2,101	(57)	(64)	(134)
Consulting Fees & Outside Svcs	3,301	2,286	2,711	3,162	139	(876)	(451)
Print., Publicat. & Marketing	6,700	5,119	5,989	7,162	(462)	(2,043)	(1,173)
Meeting Expenses	3,885	684	1,663	2,637	1,248	(1,953)	(974)
Travel Expenses	714	69	786	780	(66)	(711)	6
Professional Services	1,162	169	850	835	328	(666)	16
Bank & Credit Card Fees	437	216	315	504	(67)	(288)	(189)
Office Expenses	1,978	286	1,652	1,840	138	(1,554)	(189)
Facility and Utility Costs	37	0	160	124	(87)	(123)	36
Depreciation and Amortization	64	27	56	35	30	(8)	21
Other Expenses	114	144	92	76	37	68	16
Total Expense	26,264	17,038	21,870	25,260	1,004	(8,222)	(3,390)
Net Income After Taxes	4,257	1,268	4,151	4,820	562	3,552	669

Operational Changes

1. 1 FTE added in DCCE
2. 2 FTEs added in Product Development and Sales
3. 1 FTE added in Business Group Management

Business Group 2022 Budget								
Department Income Statements								
Thousands of Dollars								
Department			**Expense**					
	# of FTE	**Revenue**	**Employee Costs**	**Travel**	**Services**	**Deprec**	**Income Tax**	**Net Income**
1380250100 - PDS-Administrative	10.00	400	1,665	62	1,071	-	-	(2,397)
1380250105 - PDS-Patient Education	0.00	865	-	-	140	-	-	725
1380250120 - Compliance	0.00	1,665	-	-	305	-	-	1,360
1380250135 - PDS-Coding Insurance	0.00	6,250	-	-	375	-	-	5,875
1380250160 - PDS-Database Licensing	0.00	590	-	-	-	-	-	590
1380250200 - PDS Marketing	0.00	-	-	-	1,012	-	-	(1,012)
1810000000 - HPI Consult Srvs	0.00	452	-	-	-	-	-	452
1700000000 - Managing VP Publishing G & A	4.00	-	693	18	16	-	-	(726)
1700050000 - JADA	1.00	1,904	134	-	1,211	-	-	559
1700100000 - ADA News	7.00	2,049	1,035	6	1,700	-	-	(692)
1700100601 - ADA News International	0.00	-	-	-	10	-	-	(10)
1700200000 - AS ADA News Daily	0.00	15	-	-	4	-	-	12
1700250000 - Sales & Marketing	2.00	-	221	1	85	-	-	(308)
1700350000 - JADA Editorial Office	0.00	30	-	27	259	-	-	(256)
1700750000 - Digital Advertising	1.00	665	142	-	212	-	-	311
1700750010 - Digital Adv Vendor Showcase	0.00	1,500	-	-	375	-	-	1,125
1700750030 - Peer to Peer	0.00	55	-	-	19	-	-	36
1700750040 - ADA Morning Huddle	0.00	1,200	-	-	430	-	-	770
1700800000 - Dental Practice Success	0.00	40	-	-	19	-	-	21
1700800100 - JADA Foundational Science	0.00	33	-	13	127	-	-	(107)
1700040000 - Custom Content Programs	1.00	825	207	7	467	-	-	144
1350000000 - Managing VP Conference Servic	2.00	-	429	4	3	-	-	(435)
1350300000 - Advisory Committee On Annual Meetings	2.00	-	346	165	51	-	-	(561)
1350050000 - Council on ADA Meeting	4.00	9,255	557	76	7,628	-	-	994
1350050010 - Annual Meeting Staff Travel	0.00	35	2	193	-	-	-	(160)
1350150000 - Conference Services	5.00	135	782	8	127	1	-	(784)
1350200000 - Meeting_Management	0.00	130	0	-	53	34	-	43
1350500000 - ADA Video Studio	0.00	10	5	0	20	-	-	(15)
1350600000 - HOD Travel	0.00	-	-	170	4	-	-	(173)
1390200000 - CE Department	4.00	1,977	439	5	591	-	-	942
1850000000-Sr. VP Business Group	4.00	-	737	18	7	-	-	(762)
1850100000-Sales Enablement	5.00	-	714	4	2	-	-	(720)
1850200000 - Bus Analy & Improv	0.00	-	-	4	18	-	-	(22)
Business Group	**52.0**	**30,080**	**8,106**	**780**	**16,340**	**35**	**-**	**4,820**

Department Descriptions	
Level	**Cost Center Description**
1350000000 - Managing VP Conference Services	The Division of Conference Services and Continuing Education is responsible for developing, planning and implementing the ADA Annual Meeting under the volunteer oversight of the Advisory Committee on Annual Meetings as well as logistical arrangements for all other ADA meetings held outside Chicago. The division is also responsible for travel arrangements for staff and the Board of Trustees and oversight of the ADA volunteer travel program, the Chicago Hotel Program and other member travel benefits, management of the ADA Conference Center, including audiovisual services, catering, Aramark services and the Café. The division is also responsible for developing and supporting all ADA CE offerings and the management of the ADA Studios.
1350050000 - Council on ADA Meeting	The Committee on Annual Meetings (CAM) purpose is to provide oversight in a manner that provides an exceptional member experience at the annual meeting, provide meeting oversight in a manner that generates non-dues revenue, and to advise the Board on matters relating to the Committee's duties. This cost center tracks revenues and expenses allocated to the management of the committee and production of the annual meeting.
1350050010 - Annual Meeting Staff Travel	The Annual Meeting Staff Travel cost center covers the travel costs associated with all staff who help produce and support the annual meeting during the annual meeting. Some revenue is generated by this group in the form of hotel credit based on the number of rooms picked-up during the meeting.
1350150000 - Conference Services	The department is a shared service of the ADA, set up to provide meeting logistics, registration and hotel negotiation for various departments and divisions of the ADA.
1350200000 - Meeting_Management	The Meetings Management cost center is mainly for costs associated with running the conference center and cafe.
1350300000 - Advisory Committee On Annual Meetin	The Advisory Committee on Annual Meetings is to provide costs that are associated with administration for Advisory Committee on Annual meetings including travel costs associated for all CAM members travelling and working on, for, during the annual meeting.
1350500000 - ADA Video Studio	This costs center is for all costs associated with the video studio. No staff HR costs are associated with this cost center.
1350600000 - HOD Travel	The HOD staff travel cost center is for all the travel costs associated for all staff traveling and working on, for, during the annual House of Delegates. There is no HR costs allotted to this cost center
1380250100 - PDS-Administrative	The Sales Strategy and Product Development Division is responsible for publishing print and digital products in the areas of Coding, Compliance, Practice Management and Patient Education. These products are sold directly through ADAcatalog.org, the printed ADA Catalog, Resellers, Corporations, and Institutions,, as well as ADA corporate relations and sponsorships
1380250105 - PDS-Patient Education	Creation and development of PE Brochures, Chairside Instructor and PatientSmart.
1380250120 - Compliance	HIPAA and OSHA products for use in training for Dentists and their staff.
1380250135 - PDS-Coding Insurance	Coding products and CDT Licensing royalties
1380250160 - PDS-Database Licensing	PDS generates additional revenue by the rental of ADA member mailing lists.
1380250200 - PDS Marketing	Cost of marketing materials, social media and tracking, and reseller and conference expenses.
1390200000 - CE Department	The Department of Continuing Education and Industry Relations is the cost center for seven FTE's who's main responsibility is the development and management of content for all continuing education for the ADA - both annual meeting and non-annual meeting meetings, as well as online CE. Revenue for on-line CE and any other live CE is credited to this cost center as well as the sponsorship for those courses.
1700000000 - Managing VP Publishing G & A	The Publishing Division's mission is to produce and distribute, at a profit, credible, high-quality publications that inform the dental profession about the latest scientific, socioeconomic and political developments affecting dental practice and oral health care.
1700040000 - Custom Content Programs	Sponsored information, advertising, and programming on digital, print, video, audio platforms attached to all media brands (ADA News, JADA, JADA FS, NDN, and DPS).
1700050000 - JADA	The Journal of the American Dental Association, one of the most important and tangible member benefits at the ADA. The journal is a peer-reviewed journal reporting research advances in diagnostics and treatments that support clinical practice.
1700100000 - ADA News	Daily digital news service, website, digital digest, and 12x annually print newspaper reporting on issues about and for dentists and dentistry.

1700100601 - ADA News International	Servicing ADA News international subscribers
1700200000 - AS ADA News Daily	ADA News Daily reports from the annual meeting site on events each day at the convention, highlights of the ADA elections, continuing education and speakers. The digital newsletter is distributed electronically to the thousands of attendees each day of the conference.
1700250000 - Sales & Marketing	Sales and marketing efforts for all publications produced in Publishing.
1700350000 - JADA Editorial Office	To support the JADA Editor and his office and the editorial board.
1700750000 - Digital Advertising	Advertising sales on ADA.org
1700750010 - Digital Adv Vendor Showcase	The vendor showcase is an online marketing tool resides at ADA.org
1700750030 - New Dentist News	New Dentist News provides professional, business, financial and career information to support students and early-career dentists as they embark on their careers. The brand includes a website, a quarterly print publication, and a blog. NDN is an important recruitment tool, showcasing the value proposition of the ADA to possible new members.
1700750040 - ADA Morning Huddle	ADA Morning Huddle is a family of daily and weekly e-mail newsletters that includes summaries of national, regional and ADA media news and business information affecting dentists and dentistry.
1700800000 - Dental Practice Success	Dental Practice Success provides professional, business , financial, and career information to dentists throughout their careers. This brand includes a website and a print publication, and is being developed to support advertising and custom content around products and services that support the business of dentistry.
1700800100 - JADA Foundational Science	JADA FS is an open-access, peer reviewed, online only journal that reports on research that advances oral and craniofacial health through biology, chemistry, engineering and technology.
1810000000 - HPI Consult Srvs	The department creates and sells to corporations in the dental sector information based on HPI research.
1850000000-Sr. VP Business Group	The Senior Vice President oversees the ADA Business Group composed of Conference Services, Product Development Sales, Publishing, Sales Enablement, and Business Analysis and Improvements.
1850100000-Sales Enablement	The Sales Enablement team works with the ADA Business Group Units: Conference Services, Product Development Sales, Publishing, and Business Analytics to support those areas in achieving their non-dues revenue targets.
1850200000 - Bus Analy & Improv	This cost center is for the Business Analytics and Improvement Team. BAI is a service provider for the Business Group. The team provides data analytics and business improvements to support their non-dues revenue targets.

CENTRAL ADMINISTRATION

CENTRAL ADMINISTRATION

Central Administration Division Summary by Natural Account In Thousands	FY2019 Actuals	FY2020 Actuals	FY2021 Budget	FY2022 Budget	----------2022 Budget---------- vs. Act 2019	vs. Act 2020	vs. Budg 2021
Revenue							
Rental Income	0	-126	0	0	0	126	0
Grants, Contributions, Sprship	100	0	0	0	(100)	0	0
Royalties	3,261	2,723	2,698	3,130	(131)	406	432
Investment Income	0	0	0	5,500	5,500	5,500	5,500
Other Income	234	4,033	1,208	1,343	1,109	(2,690)	135
Total Revenue	3,595	6,631	3,906	9,973	6,378	3,342	6,067
Expense							
Salaries and Temporary Help	853	1,102	1,240	1,200	(347)	(98)	40
Fringe Benefits	528	922	535	673	(145)	249	(138)
Consulting Fees & Outside Svcs	183	3,687	182	180	3	3,507	2
Print., Publicat. & Marketing	0	79	0	0	0	79	0
Travel Expenses	7	0	0	0	7	0	0
Professional Services	51	53	51	40	11	13	11
Bank & Credit Card Fees	35	119	32	110	(75)	9	(78)
Office Expenses	100	81	52	60	40	21	(8)
Facility and Utility Costs	8	38	8	39	(31)	(1)	(31)
Grants and Awards	23	73	73	73	(50)	0	0
ADASRI Service Fee/ADA Health F	2,198	2,200	9,332	10,295	(8,097)	(8,095)	(963)
Endorsement Costs	1,200	1,018	952	1,021	179	(3)	(69)
Depreciation and Amortization	2,457	1,943	1,780	261	2,197	1,683	1,519
Other Expenses	380	402	331	382	(2)	20	(51)
Total Expense	8,020	11,716	14,567	14,333	(6,314)	(2,617)	234
Net Income Before Taxes	(4,425)	(5,085)	(10,661)	(4,360)	64	725	6,301
Income Tax Expense	768	557	534	1,000	(232)	(443)	(466)
Net Income After Taxes	(5,193)	(5,642)	(11,195)	(5,360)	(168)	282	5,835

Operational Changes

1. Investment income totaling $4M will come from the Quasi-Endowment Fund starting in 2022.

Central Administration 2022 Budget								
Department Income Statements								
Thousands of Dollars								
Department			**Expense**					
	# of FTE	**Revenue**	**Employee Costs**	**Travel**	**Services**	**Deprec**	**Income Tax**	**Net Income**
1410700000 - Grants to Related Health Groups	0	-	-	-	73	-	-	(73)
1410900010 - General Fund	0	9,973	1,293	-	12,127	261	1,000	(4,708)
1410900005 - Fringes & Taxes - Retirees	0	-	580	-	-	-	-	(580)
CentAdmin - Central Administration	**0**	**9,973**	**1,873**	**-**	**12,200**	**261**	**1,000**	**(5,360)**

Department Descriptions	
Level	**Cost Center Description**
1410700000 - Grants to Related Health Groups	This cost center houses the budget for grants to the, National Foundation of Dentistry and the Alliance of the ADA.
1410900005 - Fringes & Taxes - Retirees	This cost center holds the cost for retiree benefits.
1410900010 - General Fund	This cost center includes budget for ADABEI Royalty revenue, includes the fee paid by ADA Operations to the ADA Science & Research Institute, misc. income pre-2012 asset depreciation expense, association wide merit increase, and other misc. association-wide expenses.

EDUCATION DIVISION

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EDUCATION

Education Division Summary by Natural Account In Thousands	FY2019 Actuals	FY2020 Actuals	FY2021 Budget	FY2022 Budget	----------2022 Budget---------- vs. Act 2019	vs. Act 2020	vs. Budg 2021
Revenue							
Publication and Product Sales	30	24	35	35	5	11	0
Testing Fees & Accreditation	27,839	25,002	27,388	29,139	1,299	4,137	1,750
Meeting & Seminar Income	413	399	417	448	35	49	31
Grants, Contributions, Sprship	206	207	191	213	7	5	21
Other Income	191	166	210	274	83	108	63
Total Revenue	28,680	25,798	28,243	30,108	1,429	4,310	1,866
Expense							
Salaries and Temporary Help	6,141	6,106	6,331	6,754	(613)	(648)	(423)
Fringe Benefits	2,165	2,351	2,664	2,754	(589)	(403)	(89)
Consulting Fees & Outside Svcs	391	278	275	202	190	76	74
Print., Publicat. & Marketing	9	4	28	22	(13)	(18)	6
Meeting Expenses	19	6	24	28	(8)	(22)	(3)
Travel Expenses	1,997	347	1,445	1,364	633	(1,018)	80
Professional Services	5,712	5,283	5,360	6,101	(389)	(818)	(741)
Bank & Credit Card Fees	565	544	557	576	(11)	(32)	(20)
Office Expenses	313	409	354	403	(90)	6	(49)
Grants and Awards	20	13	0	0	20	13	0
Endorsement Costs	398	327	415	415	(17)	(88)	0
Other Expenses	20	2	0	0	20	2	0
Total Expense	17,751	15,668	17,453	18,618	(867)	(2,950)	(1,165)
Net Income After Taxes	10,928	10,131	10,789	11,490	562	1,359	700

Operational Changes

1. New Admission Test for Dental Hygiene (ATDH) is launched.
2. Canadian Dental Admission test transitioned from paper to computer based.
3. Three new positions added (One in CCEPER and two in DTS). Two positions frozen in 2021 were also included in 2022 budget.
4. All DTS test constriction meetings will permanently be remote, a significant savings in travel.
5. One of the two Council and Commission meetings are budgeted as remote, a savings in travel.

Education 2022 Budget								
Department Income Statements								
Thousands of Dollars								
Department			**Expense**					
	# of FTE	**Revenue**	**Employee Costs**	**Travel**	**Services**	**Deprec**	**Income Tax**	**Net Income**
1600000000 - Sr. VP Education/Prof Affairs	4.0	-	800	7	4	-	-	(811)
1600050000 - Council Dentl Educ & Licensure	5.0	-	778	75	20	-	-	(873)
1600050005 - Commission Dentl Accreditation	15.0	4,137	1,835	934	67	-	-	1,302
1600050020 - CERP	3.0	471	354	30	13	-	-	73
1600050601 - International Consultation and Accre	0.0	91	-	-	-	-	-	91
1600050602 - International PACV	0.0	85	-	40	-	-	-	45
1600100100 - Nat?l Board Dental Exam Pt. II	0.0	5,860	-	123	1,651	-	-	4,087
1600100200 - Nat?l Board Dental Exam Hyg	0.0	4,424	-	-	1,513	-	-	2,911
1600150000 - Admission Tests	5.0	7,866	668	20	1,628	-	-	5,550
1600150005 - Outside Client Services	3.0	2,207	307	16	765	-	-	1,119
1600150100 - Advanced Dental Admission Test	0.0	240	-	17	66	-	-	157
1600150200 - ATDH	0.0	304	-	-	148	-	-	156
1600200000 - Library Services	6.0	4	796	18	372	-	-	(1,182)
1600300000 - Research and Dev Fund	3.0	-	(14)	-	-	-	-	14
1600500000 -Dent Licensure OSCE	1.0	394	58	-	619	-	-	(284)
1600600000 - Commission on the Recognition of D	1.0	130	169	27	2	-	-	(68)
1600050100-Coalition For Modernizing Dental Lice	0.0	83	-	58	18	-	-	7
1600100300-Integrated National Board Dental Exa	30.0	3,813	3,756	-	861	-	-	(805)
Educ - Education	**76.0**	**30,108**	**9,508**	**1,364**	**7,746**	**-**	**-**	**11,490**

Department Descriptions	
Level	**Cost Center Description**
1600000000 - Sr. VP Education/Prof Affairs	The Office of the SVP—Education/Professional Affairs oversees the Division of Education/Professional Affairs and provides history, insight and overview on issues that are not or cannot be addressed at the departmental level.
1600050000 - Council Dentl Educ & Licensure	The Council on Dental Education and Licensure (CDEL) develops and implements programs, projects, and policies to support and advance the strategic plan of the Association in the areas of dental education and licensure, such as: consideration and investigation of emerging issues; responding to directives received from the HOD and BOT; proposal of new policies and rescission/amendments to existing policies; and serving as a source of expert information. Other specific duties include: approval of allied dental certifying boards; recognition of categories of allied dental personnel; and monitoring/dissemination of information on continuing education. In addition, CDEL develops guidelines, policy, and continuing education on dental anesthesia and airway management and oversees the Dental Admission Testing Program (DAT and ADAT). These programs primarily benefit the profession, all dentists, and various stakeholder groups, including dental educators, state boards of dentistry, dental students, and the public.
1600050005 - Commission Dentl Accreditation	The Commission on Dental Accreditation offers accreditation services for U.S. based dental and dental related education programs, in accordance with CODA's established accreditation process. Dental and dental related education programs seek accreditation for the purpose of obtaining an independent, external review. This program primarily benefits the profession and various stakeholder groups, including dental educators and programs, state licensing agencies, and the public.
1600050020 - CERP	The Commission on Continuing Education Provider Recognition (CCEPR) evaluates and recognizes providers of continuing dental education within the US and internationally, based on the Continuing Education Recognition Program (CERP) Standards. Its goal is to improve the quality of CE available for the profession, assist dentists in selecting quality CE to meet their CE re-licensure and/or re-certification requirements, and assist stakeholders such as dental regulatory agencies and certifying boards in establishing a sound basis for increasing their uniform acceptance of CE credits. The CCEPR program also provides a mechanism of acceptance of the CE activities offered by international providers. This program primarily benefits the profession, state boards of dentistry, and the public. The AGD Pace provider recognition program provides direct competition to CCEPR.
1600050100-Coalition For Modernizing Dental Licensure	Agency advocating for dental licensure reform.
1600050601 - International Consultation and Accredi	Accreditation services are provided through the Commission on Dental Accreditation, following an international program's successful completion of the international consultative process. The Commission accredits international dental education programs, in accordance with CODA's established accreditation process for programs interested in the United States Commission on Dental Accreditation process for accreditation. International dental education programs may seek accreditation for the purpose of obtaining an independent, external review for benchmarking. This program primarily benefits the profession and various stakeholder groups, including international dental educators and programs, state licensing agencies, and the public.
1600050602 - International PACV	Accreditation consultation services are provided through the Commission on Dental Accreditation's Standing Committee on International Accreditation. This Standing Committee includes joint Commission and ADA membership. The committee reviews survey materials, evaluates self-study documents, and conducts site visits for international predoctoral dental education programs interested in the United States Commission on Dental Accreditation process for accreditation and makes a determination whether the programs have the potential to be successful going through the CODA accreditation process. International dental education programs also seek consultation for the purpose of obtaining an independent, external review for benchmarking. This program primarily benefits the profession and various stakeholder groups, including international dental educators and programs, state licensing agencies, and the public.
1600100100 - Nat'l Board Dental Exam Pt. II	The Joint Commission on National Dental Examinations (Joint Commission) governs the National Boards Dental Examinations (NBDE) Part II. The JCNDE develops and conducts highly reliable, state of the art cognitive examinations that assist regulatory agencies in making valid decisions regarding licensure of oral health care professionals, develops and implements policy for the orderly, secure, and fair administration of its examinations, and is a leader and resource in assessment for the oral health care profession.

1600100200 - Nat'l Board Dental Exam Hyg	The Joint Commission on National Dental Examinations (Joint Commission) governs the National Board Dental Hygiene Examination (NBDHE). The JCNDE develops and conducts highly reliable, state of the art cognitive examinations that assist regulatory agencies in making valid decisions regarding licensure of oral health care professionals, develops and implements policy for the orderly, secure, and fair administration of its examinations, and is a leader and resource in assessment for the oral health care profession.
1600100300-Integrated National Board Dental Examination	the Integrated National Board Dental Examination (INBDE) mirrors that of the NBDE Program: to assist dental boards in determining the qualifications of individuals who seek licensure to practice dentistry.
1600150000 - Admission Tests	The Dental Admission Test (DAT) is governed by the Council on Dental Education and Licensure. The Council establishes the policies of the programs and the Department of Testing Services implements those policies and manages day-to-day operations. This program primarily benefits the profession and various stakeholder groups, including dental education programs, potential dental students and graduate students, and the public. The DAT is designed for use by dental schools in making admissions decisions.
1600150005 - Outside Client Services	Professional examination development, administration, scoring, reporting, and client services for outside clients. This includes activities involving the Optometry Admission Test (OAT) and the Canadian Dental Aptitude Test (CDAT), as well as custom work for outside clients such as AGD and SCDA. This program primarily benefits other dental and health profession agencies, including education programs, potential students, and the public.
1600150100 - Advanced Dental Admission Test	The Advanced Dental Admission Test (ADAT) is governed by the Council on Dental Education and Licensure. The ADAT is designed to provide advanced dental education programs with insight into applicants' potential for success in their program. The ADAT enables programs to quantitatively compare applicants using a nationally standardized and objective test. The ADAT can be used in conjunction with other assessment tools to help inform program admission decisions
1600150200 - ATDH	The ATDH is an admission test designed to provide dental hygiene education programs with a means to assess an applicant's readiness and potential for success in these programs.
1600200000 - Library Services	The ADA Library & Archives is a premier dental research library serving the information needs of the association and its members. Services and resources include expert literature and database searching services in support of research and clinical questions; evidence-based clinical point-of-care tools; thousands of scientific journals and eBooks; and healthcare management resources. The ADA Library & Archives is also the repository of the ADA archives, and provides archival and dental history reference.
1600300000 - Research and Dev Fund	This Cost Centre Covers expenses associated with JCNDE research and development activities. This includes, for example, expenses associated with the development of new Joint Commission examination programs.
1600500000 -Dent Licensure OSCE	The Dental Licensure Objective Structured Clinical Examination (DLOSCE) is envisioned as a high-stakes licensure examination which will require candidates to use their clinical skills to successfully complete one or more dental problem solving tasks.
1600600000 - Commission on the Recognition of Dental Specialties and Certifying Boards	The National Commission is the ADA agency that recognizes dental specialties and dental specialty certifying boards. In addition, the National Commission monitors on an annual basis the adherence of the dental specialty certifying boards to the requirements for recognition, along with conducting the periodic review of dental specialties which occurs every ten years.

FINANCE, OPERATIONS & BUILDINGS

FINANCE, OPERATIONS, & BUILDINGS

Finance, Operations, & Buildings Division Summary by Natural Account In Thousands							
	FY2019	FY2020	FY2021	FY2022	----------2022 Budget----------		
	Actuals	Actuals	Budget	Budget	vs. Act 2019	vs. Act 2020	vs. Budg 2021
Revenue							
Rental Income	6,751	6,884	7,042	7,024	274	140	(18)
Royalties	24	26	15	3,015	2,991	2,989	3,000
Investment Income	2,051	1,060	1,425	1,700	(351)	640	275
Other Income	1,171	1,216	1,326	1,296	125	80	(30)
Total Revenue	9,996	9,186	9,808	13,035	3,039	3,849	3,227
Expense							
Salaries and Temporary Help	3,053	3,255	3,268	3,261	(207)	(6)	8
Fringe Benefits	1,173	1,182	1,298	1,261	(88)	(79)	37
Consulting Fees & Outside Svcs	116	299	238	200	(84)	99	38
Print., Publicat. & Marketing	22	9	21	9	13	0	12
Meeting Expenses	0	0	0	0	0	0	0
Travel Expenses	78	14	73	59	19	(45)	15
Professional Services	463	367	420	394	68	(28)	25
Bank & Credit Card Fees	2	0	5	0	2	0	5
Office Expenses	143	108	140	135	8	(27)	5
Facility and Utility Costs	6,777	6,177	7,094	7,076	(298)	(899)	18
Depreciation and Amortization	1,715	1,756	2,754	3,367	(1,652)	(1,611)	(613)
Other Expenses	107	104	87	92	14	11	(5)
Total Expense	13,650	13,270	15,398	15,854	(2,204)	(2,584)	(456)
Net Income After Taxes	(3,654)	(4,084)	(5,590)	(2,819)	835	1,265	2,771

Operational Changes

1. Royalty revenue starting in 2022 includes $3M in current year royalties on Members' Insurance Plans.

Finance, Operations & Buildings 2022 Budget Department Income Statements Thousands of Dollars								
Department			Expense					
	# of FTE	Revenue	Employee Costs	Travel	Services	Deprec	Income Tax	Net Income
1400000000 - Chief Financial Officer	2.0	1,700	435	-	57	-	-	1,208
1400050000 - Accounting Department	16.8	-	2,282	13	42	-	-	(2,336)
1400150000 - Council on Mbr Ins & Rtrmt Prg	2.0	4,365	251	37	165	-	-	3,913
1400200000 - Central Services	8.0	20	975	0	62	70	-	(1,087)
1400400000 - Financial Planning and Analysis	3.0	-	579	10	26	-	-	(615)
1360300000 - Headquarters Building	-	5,297	-	-	5,760	2,995	-	(3,458)
1361111000 - HQ Building Facility	-	-	-	-	670	-	-	(670)
1370000000 - Washington DC Building	-	1,653	-	-	1,126	302	-	225
FinOpsBld - Finance, Operations & Buildings	**31.8**	**13,035**	**4,522**	**59**	**7,906**	**3,367**	**-**	**(2,819)**

Department Descriptions	
Level	**Cost Center Description**
1360300000 - Headquarters Building	The HQ Building cost center manages rents, finds tenants for open space, handles ADA and tenant requests, manages the building maintenance, repairs, and security. The HQ team manages all day to day aspects of the HQ building.
1361111000 - HQ Building Facility	The HQ Building cost center manages rents, finds tenants for open space, handles ADA and tenant requests, manages the building maintenance, repairs, and security. The HQ team manages all day to day aspects of the HQ building.
1370000000 - Washington DC Building	The Washington Building cost center manages rents, finds tenants for open space, handles ADA and tenant requests, manages the building maintenance, repairs, and security. The Washington team manages all day to day aspects of the Washington building.
1400000000 - Chief Financial Officer	The overall role of The CFO is to provide guidance in managing the financial, business and administrative affairs of the Association. Among the duties of the CFO are oversight of the budget process, financial matters, central services, business planning, CMIRP, and Washington & HQ Buildings.
1400050000 - Accounting Department	The Department of Accounting is responsible for accounting matters for the ADA and subsidiaries, including audited financial statements, tax returns, monthly financial reports, monthly budget status reports, monthly general ledger, reserve investments, listing of cost centers and chart of accounts. It includes the areas of Financial Reporting, Accounts Payable, Accounts Receivable, and Payroll.
1400150000 - Council on Mbr Ins & Rtrmt Prg	The Council on Members Insurance and Retirement Programs is the agency of the American Dental Association whose purpose is to enhance the value of membership by overseeing the ADA member's insurance and retirement programs and by aiding dentists in the management of their personal and professional risks through development of educational programs and resources.
1400200000 - Central Services	The Department of Central Services is an administrative support agency for other departments within the organization. Primary services at the Chicago building include purchasing, duplicating, mailroom services, receiving, building facility services, stocking, distribution of office supplies, delivery of supplies for ADA floor coffee and tea stations, and record archiving.
1400400000 - Financial Planning and Analysis	The Financial Planning & Analysis team leads the Association's operational financial planning, analyzes performance trends, and creates ad-hoc predictive financial models. FP&A helps ADA operating units create departmental budgets and forecasts and provides summaries to executive leadership and volunteer oversight bodies. FP&A also analyzes results and trends to improve forecast accuracy and guide operational improvement strategies. This includes systematic examination of results (such as membership or expense trends) and breaking the data into its component parts to understand interrelationships.

GOVERNMENT AFFAIRS DIVISION

GOVERNMENT AFFAIRS

Government Affairs Division Summary by Natural Account In Thousands	FY2019 Actuals	FY2020 Actuals	FY2021 Budget	FY2022 Budget	----------2022 Budget---------- vs. Act 2019	vs. Act 2020	vs. Budg 2021
Revenue							
Rental Income	17	2	31	31	14	29	0
Meeting & Seminar Income	27	5	17	17	(10)	12	0
Grants, Contributions, Sprship	22	1	0	0	(22)	(1)	0
Other Income	12	5	10	10	(2)	6	0
Total Revenue	78	13	58	58	(20)	45	0
Expense							
Salaries and Temporary Help	3,026	3,156	3,293	3,291	(265)	(135)	2
Fringe Benefits	1,015	992	1,130	1,139	(124)	(146)	(8)
Consulting Fees & Outside Svcs	1,358	1,498	1,127	1,178	180	319	(51)
Print., Publicat. & Marketing	63	40	52	90	(26)	(50)	(37)
Meeting Expenses	305	62	99	499	(194)	(438)	(400)
Travel Expenses	1,158	209	696	890	268	(681)	(194)
Professional Services	30	43	65	32	(2)	11	33
Bank & Credit Card Fees	1	0	1	1	0	(0)	0
Office Expenses	231	182	248	260	(29)	(78)	(12)
Facility and Utility Costs	88	78	113	113	(25)	(35)	0
Grants and Awards	1,935	2,097	2,078	2,323	(387)	(225)	(244)
Depreciation and Amortization	164	164	298	298	(135)	(135)	0
Other Expenses	3	0	0	0	3	0	0
Total Expense	9,378	8,521	9,201	10,113	(735)	(1,592)	(912)
Net Income After Taxes	(9,300)	(8,508)	(9,143)	(10,055)	(755)	(1,547)	(912)

Operational Changes

1. Resumption of In-Person Lobby Day Conference.
2. Addition of Staff Positions frozen in 2021.

Government & Public Affairs 2022 Budget								
Department Income Statements								
Thousands of Dollars								
Department			**Expense**					
	# of FTE	**Revenue**	**Employee Costs**	**Travel**	**Services**	**Deprec**	**Income Tax**	**Net Income**
1200000000 - Sr. VP Government/Public Aff.	4.0	-	640	46	578	-	-	(1,264)
1200050000 - Council on Government Affairs	0.0	-	-	77	3	-	-	(80)
1200100000 - State Government Affairs	5.0	17	728	82	49	-	-	(842)
1200150000 - ADPAC Gov	4.0	-	610	174	124	-	-	(909)
1200150001 - Lobby Day	0.0	-	-	171	506	-	-	(677)
1200250000 - Congressional Affairs	4.0	-	732	31	46	-	-	(809)
1200300000 - Federal Affairs/Policy	5.0	-	661	7	10	-	-	(678)
1200700000 - State Public Affairs Program	0.0	-	-	17	2,906	-	-	(2,923)
1200800000 - ADA House	0.0	29	-	-	52	164	-	(188)
1500300000 - CAAP - Administrative	7.0	-	1,057	157	55	-	-	(1,269)
1500300005 - Fluoridation	0.0	-	-	17	1	-	-	(18)
1500300015 - Access and Community Health	0.0	-	-	75	40	-	-	(115)
1500300033 - Nat?l Children?s Dental Health	0.0	-	-	-	23	-	-	(23)
1500300045 - Preventative Health	0.0	-	-	35	15	-	-	(50)
1200900000 - ADA DC HOUSE II	0.0	13	-	-	88	135	-	(210)
GovPubAffr - Government & Public Affairs	**29.0**	**58**	**4,429**	**890**	**4,495**	**298**	**-**	**(10,055)**

Department Descriptions	
Level	**Cost Center Description**
1200000000 - Sr. VP Government/Public Aff.	Sr. VP over sees all production and administration within the division.
1200050000 - Council on Government Affairs	CGA is the voluntary agency within in the ADA that provides input on legislative and regulatory policy matters for the association.
1200100000 - State Government Affairs	SGA is a resource for state dental assoc. and ADA members in their state-level advocacy efforts. It identifies legislative trends, advises states with sound pub policy advice and develops advocacy materials and research for member needs.
1200150000 - ADPAC Gov	ADPAC is responsible for raising money, distributing political contributions, grassroots advocacy and political education.
1200150001 - Lobby Day	Yearly meeting of dentists and dental students for the purpose of meeting with and lobbying their Representatives/Senators of issues affecting dentistry.
1200250000 - Congressional Affairs	Develops strategy and appropriate arguments for legal action in accordance with ADA policy. We lobby both the Legislative branch and the executive branch with the policy team.
1200300000 - Federal Affairs/Policy	Responsible for legislative and regulatory policy matters that impact the profession, dental practices and federal dental services. This includes legislative analysis, in person meetings and regulatory comments on behalf of the association.
1200700000 - State Public Affairs Program	Grant program offered by the ADA to assist state assoc. in their advocacy efforts. State grantees use SPA funds to deal with issues including: workforce and Medicaid reimbursement rates, then share their learning and results with other state assoc.
1200800000 - ADA House	House Side - 137 C Street, SE, Washington DC, Purchased in 2015.
1200900000 - ADA DC HOUSE II	Senate Side - 400 C St. NE, Washington DC, Purchased in 2018.
1500300000 - CAAP - Administrative	Provides support for the Coordinator for Action for Dental Health to capture metrics, provide educational info. to members and coordinate measure for initiatives with member activities. Also, this program provides support for two Council meetings; doing the business of the Council between those meetings. CAAP Admin contains efforts to implement Action for Dental Health Initiatives (including consultants).
1500300005 - Fluoridation	Fluoridation is the only entity within the ADA that assists members and state assoc. in technical assistance for community water fluoridation issues at the state and local level.
1500300015 - Access and Community Health	Assists members in their practice and community based activities which promote access to dental care and prevention of dental disease.
1500300033 - Nat'l Children's Dental Health	Each year, the ADA sponsors National Children's Dental Health Month to raise awareness about the importance of oral health through messaging and materials to people in communities across the country.
1500300045 - Preventative Health	This is the only program area which assists our members in their efforts to improve health literacy for underserved populations as well as guide member activities with school based health, oral cancer prevention and nutritional guidance.

HEALTH POLICY INSTITUTE

HEALTH POLICY INSTITUTE

Health Policy Institute Division Summary by Natural Account							
In Thousands							
	FY2019	FY2020	FY2021	FY2022	----------2022 Budget----------		
	Actuals	Actuals	Budget	Budget	vs. Act 2019	vs. Act 2020	vs. Budg 2021
Revenue							
Publication and Product Sales	14	10	0	0	(14)	(10)	0
Other Income	64	81	0	0	(64)	(81)	0
Total Revenue	78	91	0	0	(78)	(91)	0
Expense							
Salaries and Temporary Help	1,405	1,435	1,527	1,591	(186)	(156)	(64)
Fringe Benefits	502	479	498	516	(14)	(36)	(17)
Consulting Fees & Outside Svcs	529	405	570	570	(41)	(165)	0
Print., Publicat. & Marketing	1	0	1	1	0	(1)	0
Meeting Expenses	8	3	0	10	(2)	(7)	(10)
Travel Expenses	50	9	31	31	19	(22)	0
Bank & Credit Card Fees	1	0	0	0	1	0	0
Office Expenses	16	26	12	23	(7)	3	(11)
Depreciation and Amortization	3	4	4	1	1	3	3
Total Expense	2,513	2,361	2,643	2,743	(230)	(382)	(99)
Net Income After Taxes	(2,434)	(2,271)	(2,643)	(2,743)	(308)	(472)	(99)

Health Policy Institute 2022 Budget								
Department Income Statements								
Thousands of Dollars								
Department			Expense					
	# of FTE	Revenue	Employee Costs	Travel	Services	Deprec	Income Tax	Net Income
1550000000 - Health Policy Institute	13.0	-	2,106	31	604	1	-	(2,743)
HealthPolResCntr - Health Policy Institute	13.0	-	2,106	31	604	1	-	(2,743)

Department Descriptions	
Level	Cost Center Description
1550000000 - Health Policy Institute	HPI delivers critical policy knowledge related to the U.S. dental care system by generating, synthesizing, and disseminating innovative research on a variety of topics that are relevant to ADA leadership, policy makers, health care advocates and providers. The key issues that HPI focuses on include health policy reform, access to dental care, the dental workforce, dental care utilization and benefits, dental education and oral health outcomes.

HUMAN RESOURCES

HUMAN RESOURCES

Human Resources Division Summary by Natural Account In Thousands							
	FY2019	FY2020	FY2021	FY2022	----------2022 Budget----------		
	Actuals	Actuals	Budget	Budget	vs. Act 2019	vs. Act 2020	vs. Budg 2021
Expense							
Salaries and Temporary Help	941	938	951	1,009	(68)	(71)	(58)
Fringe Benefits	254	276	307	322	(69)	(46)	(15)
Consulting Fees & Outside Svcs	33	46	45	45	(12)	1	0
Print., Publicat. & Marketing	140	57	151	181	(40)	(124)	(29)
Meeting Expenses	1	0	0	0	1	0	0
Travel Expenses	22	1	6	6	16	(5)	0
Office Expenses	19	12	18	19	0	(7)	(0)
Other Expenses	442	427	486	493	(50)	(66)	(7)
Total Expense	1,852	1,756	1,965	2,074	(222)	(318)	(109)
Net Income After Taxes	(1,852)	(1,756)	(1,965)	(2,074)	(222)	(318)	(109)

Human Resources 2022 Budget								
Department Income Statements								
Thousands of Dollars								
Department			Expense					
	# of FTE	Revenue	Employee Costs	Travel	Services	Deprec	Income Tax	Net Income
1050400000 - Human Resources	8.0	-	1,331	6	737	-	-	(2,074)
HumanRes - Human Resources	**8.0**	**-**	**1,331**	**6**	**737**	**-**	**-**	**(2,074)**

Department Descriptions	
Level	**Cost Center Description**
1050400000 - Human Resources	As a shared service functional division, Human Resources is key resource in support of organizational goals and priorities by establishing policies consistent with work life balance/total rewards, employment regulatory guideline compliance and the enhancement of the employee experience. This includes, but is not limited to: identifying, designing, and managing delivery of a broad range of employee benefit plans and offerings; serving as data owner, manager and analyst for the central database of the ADA's electronic employee records; driving the hiring, onboarding and placement strategies of ADA staff; designing and executing learning opportunities in support of staff/talent development, future planning and skill-building; working as a catalyst for organizational design and change strategies; managing ADA's compensation philosophy and salary administration; and serving as staff support for both the Compensation and Pension Committees of the ADA Board of Trustees.

INFORMATION TECHNOLOGY

INFORMATION TECHNOLOGY

Information Technology Division Summary by Natural Account In Thousands	FY2019 Actuals	FY2020 Actuals	FY2021 Budget	FY2022 Budget	----------2022 Budget---------- vs. Act 2019	vs. Act 2020	vs. Budg 2021
Expense							
Salaries and Temporary Help	5,698	4,643	2,225	2,049	3,649	2,594	176
Fringe Benefits	2,113	1,780	645	624	1,489	1,156	20
Consulting Fees & Outside Svcs	2,138	2,860	6,477	8,602	(6,464)	(5,742)	(2,126)
Meeting Expenses	2	0	0	0	2	0	0
Travel Expenses	66	5	56	40	26	(36)	15
Bank & Credit Card Fees	4	4	5	5	(1)	(1)	0
Office Expenses	1,591	1,397	1,521	1,743	(152)	(346)	(222)
Facility and Utility Costs	14	14	14	14	(0)	(0)	(0)
Depreciation and Amortization	1,823	1,615	3,360	2,706	(882)	(1,091)	655
Other Expenses	14	7	24	17	(3)	(10)	7
Total Expense	13,464	12,324	14,325	15,800	(2,336)	(3,476)	(1,475)
Net Income After Taxes	(13,464)	(12,324)	(14,325)	(15,800)	(2,336)	(3,476)	(1,475)

Information Technology 2022 Budget Department Income Statements Thousands of Dollars								
Department			Expense					
	# of FTE	Revenue	Employee Costs	Travel	Services	Deprec	Income Tax	Net Income
1450000000 - Chief Technology Officer	3.0	-	639	8	103	-	-	(750)
1450350000 - Enterprise Services	5.0	-	961	5	5,636	628	-	(7,230)
1450400000 - Data Management	2.0	-	336	4	228	-	-	(569)
1450450000 - Digital Member Experience	4.0	-	736	23	4,414	2,077	-	(7,250)
Tech - Information Technology	**14.0**	**-**	**2,673**	**40**	**10,381**	**2,706**	**-**	**(15,800)**

Department Descriptions	
Level	**Cost Center Description**
1450000000 - Chief Technology Officer	This cost center provides the leadership and guidance for the Association's technology, which includes all core business applications; all web-based applications, all other software applications; network infrastructure and telecommunications services for the Chicago, DC and VRC offices. It also provides day-to-day business and administrative support for the division.
1450350000 - Enterprise Services	This cost center provides the staff resources, systems, software, security, audio visual, network infrastructure, telecommunications and technical support services that support ADA business operations. This includes on premise systems for all ADA locations, as well as off premise private cloud services, public cloud services, Software as a Service (SaaS) and similar technology.
1450400000 - Data Management	This cost center provides the staff resources, software tools and services to manage the operation and maintenance of databases used by applications throughout the ADA. This area also builds and updates the data warehouse, which produces management and strategic reporting to all levels of the Tripartite. Finally, this area collaborates with various divisions to set and maintain policies on how data is acquired, governed and reported.
1450450000 - Digital Member Experience	This cost center provides the integration and maintenance of software tools and services that allows ADA members to connect to relevant digital content, industry experts and each other via the ADA websites. It provides the staff resources to support, maintain, manage and enhance these systems and tools to promote the digital member experience.

INTEGRATED MARKETING & COMMUNICATIONS

INTEGRATED MARGETING & COMMUNICATIONS

Integrated Marketing & Comunications Division Summary by Natural Account In Thousands							
	FY2019	FY2020	FY2021	FY2022	----------2022 Budget----------		
	Actuals	Actuals	Budget	Budget	vs. Act 2019	vs. Act 2020	s. Budg 202
Revenue							
Meeting & Seminar Income	4	0	7	0	(4)	0	(7)
Total Revenue	4	0	7	0	(4)	0	(7)
Expense							
Salaries and Temporary Help	4,055	4,082	3,165	3,391	665	691	(226)
Fringe Benefits	1,257	1,262	1,093	1,182	75	81	(89)
Consulting Fees & Outside Svcs	845	462	505	653	192	(191)	(149)
Print., Publicat. & Marketing	3,191	1,019	1,985	2,040	1,150	(1,021)	(55)
Meeting Expenses	4	3	24	24	(20)	(21)	0
Travel Expenses	154	29	130	132	21	(103)	(3)
Professional Services	0	2	0	0	0	2	0
Office Expenses	87	51	31	29	57	22	1
Facility and Utility Costs	0	1	0	0	0	1	0
Depreciation and Amortization	0	0	1	1	(1)	(1)	(0)
Other Expenses	6	3	0	0	6	3	0
Total Expense	9,599	6,915	6,932	7,453	2,147	(537)	(521)
Net Income After Taxes	(9,595)	(6,915)	(6,925)	(7,453)	2,143	(537)	(528)

Operational Changes

1 Two FTEs have been added to the 2022 Budget under Digital Services & Communications Cost
2 Centers (Social Media Manager and Web Ops Manager).
3 Added support for Growing Segments, specifically Recruitment and Retention Marketing.

Integrated Marketing & Communications 2022 Budget								
Department Income Statements								
Thousands of Dollars								
Department			Expense					
	# of FTE	Revenue	Employee Costs	Travel	Services	Deprec	Income Tax	Net Income
1240000000 - Sr VP Communications	2.0	-	513	13	32	1	-	(559)
1240050000 - Integrated Marketing	7.0	-	1,140	10	1,458	-	-	(2,608)
1240100000 - Digital Services	10.0	-	1,443	8	902	-	-	(2,353)
1240200000 - Communications	6.0	-	899	21	353	-	-	(1,274)
1240250000 - Council on Communication	2.0	-	294	80	2	-	-	(376)
1240400000 - Video Studio - Comm	2.0	-	283	-	-	-	-	(283)
Integrated Marketing & Communications	**29.0**	**-**	**4,573**	**132**	**2,747**	**1**	**-**	**(7,453)**

Department Descriptions	
Level	**Cost Center Description**
1240000000 - Sr VP Communications	The Chief Communications Officer cost center champions paid, earned, shared and owned communications excellence across the ADA, focusing on integrated campaigns, member and stakeholder communications, public affairs, research, digital expertise, social media, content creation, public relations, and creative services and issues management programs that are directly tied to ADA Strategic Goals, Mission and Vision.
1240050000 - Integrated Marketing	The Integrated Marketing and Brand Strategy cost center produces unified growth-marketing strategies, programs, messaging and content across all marketing channels, including paid, earned, shared and owned mediums. It facilitates a marketing and content development process and execution via cross-divisional teams and resources. Specifically, it operates 5 marketing centers of excellence: Member Value Marketing (Recruitment and Retention); State and Local Marketing; Non-Dues Sales Marketing; Industry and Consumer Engagement; and Integrated Content Delivery.
1240100000 - Digital Services	The Digital Services cost center encompasses strategy and execution of the Digital Member Experience initiative, including the redesign of ADA.org, support for users publishing content on ADA sites, SEO, SEM and Social Media strategy. Digital services supports states and locals in launching sites on the Branded Web Templates, providing site planning, content strategy, content management training and client service to member societies. ADA's Visual branding, creative design, photography and video production and animation are also included in the Digital cost center.
1240200000 - Communications	Elevates ADA's visibility and influence as the leading authority on oral health to multiple stakeholders including members and potential members, federal legislators and regulatory agencies, national news media, and think tanks. Leads ADA's reputation management/crisis communications and thought leadership and influencer strategies and outreach. Provides executive communications support for ADA President, President Elect and Executive Director.
1240250000 - Council on Communication	The Council on Communications advises on the reputation and brand of the ADA. It provides strategic oversight on the strategic communications plan that supports the ADA strategic plan (currently Members First 2020) and recommends strategies for significant communications campaigns across the Association.
1240400000 - Video Studio - Comm	The video studio cost center provides funds for the ADA staff salaries and equipment needed to develop ADA videos and maintain the ADA Video Studio and operatory.

LEGAL AFFAIRS DIVISION

LEGAL AFFAIRS

Legal Affairs Division Summary by Natural Account In Thousands	FY2019 Actuals	FY2020 Actuals	FY2021 Budget	FY2022 Budget	----------2022 Budget---------- vs. Act 2019	vs. Act 2020	vs. Budg 2021
Revenue							
Other Income	41	52	57	108	67	56	52
Total Revenue	41	52	57	108	67	56	52
Expense							
Salaries and Temporary Help	2,453	2,593	2,652	2,711	(258)	(118)	(59)
Fringe Benefits	743	720	693	757	(14)	(37)	(64)
Consulting Fees & Outside Svcs	0	0	16	17	(17)	(17)	(1)
Print., Publicat. & Marketing	3	0	4	4	(1)	(4)	0
Meeting Expenses	3	0	4	4	(1)	(4)	0
Travel Expenses	47	14	79	86	(39)	(72)	(8)
Professional Services	990	783	959	903	87	(120)	56
Office Expenses	35	21	32	31	4	(10)	1
Grants and Awards	4	0	4	4	0	(4)	0
Total Expense	4,278	4,132	4,443	4,518	(239)	(385)	(74)
Net Income After Taxes	(4,238)	(4,080)	(4,387)	(4,410)	(172)	(329)	(23)

Legal Affairs 2022 Budget Department Income Statements Thousands of Dollars								
Department			Expense					
	# of FTE	Revenue	Employee Costs	Travel	Services	Deprec	Income Tax	Net Income
1150000000 - Chief Legal Counsel	14.0	108	2,992	20	425	-	-	(3,329)
1150050000 - Council Ethics Bylaws & Judic	2.6	-	477	66	18	-	-	(561)
1150240000 - Internal Audit Services	0.0	-	-	-	256	-	-	(256)
1150250000 - Annual External Audit & Tax Fees	0.0	-	-	-	264	-	-	(264)
LeglAffr - Legal Affairs	**16.6**	**108**	**3,468**	**86**	**963**	**-**	**-**	**(4,410)**

Department Descriptions	
Level	**Cost Center Description**
1150000000 - Chief Legal Counsel	The Division of Legal Affairs provides (1) legal advice and support to the ADA and its subsidiaries and agencies in carrying out their missions in a legally acceptable manner that accords with the Association policies and minimizes risk; 2) drafts of appropriate agreements and other legally binding documents to facilitate the conduct of the activities and business of the ADA and its subsidiaries; (3) effective management of the Association's litigation; (4) policies and advice to promote compliance with antitrust, employment, health care, and privacy laws and regulations; (5) assistance to members in making informed decisions about legal issues relating to their business and employment practices, including guidance on the terms of participating dental provider contracts with insurers and health plans; and (6) advice and guidance to state and local dental societies on governance issues and legal topics as requested.
1150050000 - Council Ethics Bylaws & Judic	The Council on Ethics, Bylaws and Judicial Affairs (CEBJA), (1) contributes to the highly ethical image of the ADA and its members with the public, the media and government decision makers; (2) protects the dentistry's privileges of self-regulation by keeping the ADA Principles of Ethics and Code of Professional Conduct strong and relevant and as the appellate tribunal for members disciplined by component/constituent societies, ensures a fair and uniform disciplinary process; (3) administers the ADA member conduct policy; (4) creates awareness of ethics and professionalism among dental students, including the obligation to participate in organized dentistry; (5) attracts and retains members by fostering pride in the high ethical standards set by the ADA; (6) provides professional ethical guidance to constituent and component societies and members; (7) reviews proposed revisions to the ADA Constitution and Bylaws to maintain Bylaws currency and relevance; and (8) responds to requests from the tripartite and membership for Bylaws interpretations.
1150240000 - Internal Audit Services	Internal auditing is an independent appraisal function to assist management and the Audit Committee of the Board of Trustees in the effective discharge of their responsibilities through the objective review, risk assessment and evaluation of the business processes and internal controls of the Association. Additionally, the services of a certified public accounting firm are utilized to facilitate the preparation of required tax filings for local, state and federal governments. The audit function is housed in the Legal Division.
1150250000 - Annual External Audit & Tax Fees	The external audit of the ADA financial statements is an independent review conducted in accordance with generally accepted standards that results in an independent opinion of the fairness of the presentation of those statements. The external audit of the ADA financial statements is required at least annually by the ADA Bylaws. The audit function is housed in the Legal Division.

MEMBER & CLIENT SERVICES

MEMBER & CLIENT SERVICES

Member and Client Services Division Summary by Natural Account In Thousands	FY2019 Actuals	FY2020 Actuals	FY2021 Budget	FY2022 Budget	----------2022 Budget---------- vs. Act 2019	vs. Act 2020	vs. Budg 2021
Revenue							
Membership Dues	55,822	55,542	57,976	58,184	2,362	2,642	208
Advertising	0	0	0	9	9	9	9
Meeting & Seminar Income	0	-1	81	76	76	77	(5)
Grants, Contributions, Sprship	155	30	135	150	(5)	120	15
Total Revenue	55,977	55,571	58,192	58,419	2,441	2,847	226
Expense							
Salaries and Temporary Help	4,127	4,655	4,777	4,821	(694)	(166)	(44)
Fringe Benefits	1,439	1,493	1,664	1,672	(233)	(179)	(8)
Consulting Fees & Outside Svcs	100	116	175	163	(63)	(46)	12
Print., Publicat. & Marketing	312	407	358	421	(109)	(14)	(63)
Meeting Expenses	75	15	225	188	(114)	(173)	36
Travel Expenses	592	144	661	672	(80)	(528)	(11)
Professional Services	2	4	50	97	(95)	(93)	(47)
Bank & Credit Card Fees	761	909	728	779	(17)	130	(51)
Office Expenses	122	105	113	88	33	17	25
Facility and Utility Costs	2	0	0	33	(31)	(33)	(33)
Grants and Awards	190	100	261	261	(70)	(161)	0
Other Expenses	12	4	16	12	(0)	(8)	4
Total Expense	7,732	7,951	9,027	9,205	(1,473)	(1,254)	(178)
Net Income After Taxes	48,245	47,620	49,165	49,214	969	1,594	49

Operational Changes

1. Transfer of Membership Brochures, ADA-State Co-Branded Applications, and SPI Mailers from the Division of Integrated Marketing and Communications into the Division of Member and Client Services.

Member and Client Services 2022 Budget								
Department Income Statements								
Thousands of Dollars								
Department			**Expense**					
	# of FTE	**Revenue**	**Employee Costs**	**Travel**	**Services**	**Deprec**	**Income Tax**	**Net Income**
1300000000 - Sr. VP Membership & Client Svcs	2.0	-	286	11	7	-	-	(304)
1300100000 - Client Services	9.0	204	1,591	204	536	-	-	(2,126)
1300200050 - Council on Membership Admin.	2.0	-	305	92	252	-	-	(648)
1300250000 - Member Service Center	10.0	-	1,518	1	4	-	-	(1,523)
1300450000 - Department of Membership Info	8.0	58,184	976	32	788	-	-	56,387
1300500000 - Dental School Programs	1.0	30	180	89	20	-	-	(259)
1300550000 - Office of Student Affairs	2.0	-	321	60	232	-	-	(613)
1300600000 - Membership Data Analytics & Repo	4.0	-	835	11	178	-	-	(1,024)
1300700000 - Aptify Support	3.0	-	424	21	1	-	-	(446)
1050500100 - New Dentist Committee	0.0	-	56	151	23	-	-	(230)
MbrTriMktg - Member and Client Services	**41.0**	**58,419**	**6,492**	**672**	**2,040**	**-**	**-**	**49,214**

Department Descriptions	
Level	**Cost Center Description**
1300000000 - Sr. VP Membership & Client Svcs	Provides strategic leadership and guidance to the departments within the division of Member and Client Services in support of the ADA's Membership Recruitment and Retention goals per the ADA Strategic Plan.
1300100000 - Client Services	Client Services is comprised of Dental Society, Dental School, and Diversity and Inclusion Outreach. We are committed to supporting state and local dental societies to foster member growth, deliver services and build community to positively impact membership across the ADA.
1300200050 - Council on Membership Admin.	Supports the ADA's membership recruitment and retention strategic plan goals by facilitating the bylaws responsibilities of the Council in formulating membership policy recommendations, analyzing membership trends, and developing programs to enhance involvement particularly among underrepresented segments.
1300250000 - Member Service Center	The Member Service Center improves the member/customer experience as the first point of contact in support of the ADA's recruitment, retention and non-dues revenue strategies by centralizing transactions such as orders and inquiries.
1300450000 - Department of Membership Info	The Department of Membership Operations implements membership policies and procedures in accordance with the ADA Constitution and bylaws, and maintains the ADA dentist masterfile database of over 300,000 records and annually handles over $55 million in member dues processing.
1300500000 - Dental School Programs	The Dental Student Program is designed to help dental students be successful in the transition to practice, and is often one of their first introductions to the ADA. The purpose of the program is to educate students about life after dental school, which conveys member value. The Success programs reach approximately 8,000 dental students each year, introducing both member and non-member students to the ADA as a lifelong resource and helping them prepare for success in the profession.
1300550000 - Office of Student Affairs	The Office of Student Affairs fosters collaboration between the ADA and ASDA, and keeps students and the ADA informed on important issues while creating more than 5,000 new student records annually, and continually maintains a database of 22,000+ student records; and processes ADA student membership dues.
1300600000 - Membership Data Analytics & Reporting	The Membership Data Analytics and Reporting team provides predictive and advanced analytics, as well as advanced operational reports (i.e. R&R Report, Membership Statement, National Member Dashboard, State & Student Portfolio). The team also maintains and cleanses data on the ADA Masterfile, and also maintains ADA Licensure Data, Dentist Survey Data, Faculty Data, CAQH License Data, Member Data Audits, etc.
1300700000 - Aptify Support	The Aptify Support Team provides ADA, State and Local dental society users with a wide array of technical support and consultative services designed to help them put Aptify to work providing information support to facilitate the goals and mission of their associations.
1050500100 - New Dentist Committee	This budget includes funding for the work of the NDC to advise the Board on needs, interests and concerns from the perspective of new dentists. Provide strategic oversight to the ADA Success program.

PRACTICE INSTITUTE

PRACTICE INSTITUTE

Practice Institute Division Summary by Natural Account In Thousands	FY2019 Actuals	FY2020 Actuals	FY2021 Budget	FY2022 Budget	----------2022 Budget---------- vs. Act 2019	vs. Act 2020	vs. Budg 2021
Revenue							
Publication and Product Sales	7	5	12	11	4	6	(1)
Meeting & Seminar Income	34	0	33	9	(25)	9	(24)
Grants, Contributions, Sprship	76	70	77	20	(56)	(50)	(57)
Royalties	29	11	12	12	(17)	1	0
Other Income	110	85	97	97	(13)	12	0
Total Revenue	256	172	231	149	(107)	(22)	(81)
Expense							
Salaries and Temporary Help	3,394	3,255	2,973	2,973	420	281	(0)
Fringe Benefits	1,193	1,119	985	986	207	133	(1)
Consulting Fees & Outside Svcs	133	571	1,151	1,088	(954)	(517)	64
Print., Publicat. & Marketing	73	64	169	168	(95)	(104)	0
Meeting Expenses	66	19	55	35	31	(17)	19
Travel Expenses	752	142	308	506	246	(364)	(198)
Professional Services	21	8	47	21	0	(14)	26
Bank & Credit Card Fees	2	1	2	1	1	(0)	1
Office Expenses	185	123	173	152	33	(29)	22
Facility and Utility Costs	0	0	0	0	0	0	0
Grants and Awards	2	0	3	3	(2)	(3)	0
Total Expense	5,821	5,300	5,866	5,934	(113)	(634)	(68)
Net Income After Taxes	(5,564)	(5,128)	(5,635)	(5,784)	(220)	(656)	(149)

Practice Institute 2022 Budget Department Income Statements Thousands of Dollars								
Department			**Expense**					
	# of FTE	Revenue	Employee Costs	Travel	Services	Deprec	Income Tax	Net Income
1450500000 - Standards Admin	5.0	22	821	212	171	-	-	(1,182)
1450500005 - U.S. Sub-Tags	0.0	47	-	7	40	-	-	0
1500000000 - VP Practice Institute	2.0	-	530	9	11	-	-	(551)
1500050000 - Center for Dental Practice	7.0	10	1,023	161	66	-	-	(1,240)
1500050300 - PCSS MAT	0.0	20	-	3	6	-	-	11
1500200000 - Ctr for Den Ben, Code & Qlty	10.0	50	1,586	114	1,173	-	-	(2,822)
PracticeInst - Practice Institute	**24.0**	**149**	**3,960**	**506**	**1,468**	**-**	**-**	**(5,784)**

Department Descriptions	
Level	**Cost Center Description**
1450500000 - Ctr for Informatics & Standards	PUBLIC Goal/Trusted Oral Health Info - Directs the development of national and international standards utilizing over 500 volunteers from the dental profession, industry, academia and government. Standards affect all aspects of dentistry - Executive Summaries; Food and Drug Administration (FDA); Standards Committee on Dental Informatics (SCDI); Standards Committee on Dental Products (SCDP); Am. National Standards Institute (ANSI); International Organization for Standardization (ISO). The Center also directs the ADA's Dental Informatics activities; e.g., activities related to electronic data interchange (EDI); electronic health records; health information exchange, structured clinical terminology, national and international standards; provides liaison to government agencies and national organizations responsible for policy that affects the administrative and clinical components of IT use in health care (SNODENT; HL7; HIPPAA; SNOMED AND SNOWOWL.
1450500005 - U.S. Sub-TAGs	PUBLIC Goal/Trusted Oral Health Info - Provides support for the U.S. input and vote on all international dental standards. This cost center is comprised of industry technical reimbursement dues as revenue.
1500000000 - VP Practice Institute	PUBLIC Goal Lead - Provides strategic vision and leadership for the development of ADA policy regarding practice issues and national oral health care quality. Focusing on the needs of patients and members from all modalities of professional practice and promoting the ADA as the pre-eminent, nationally, and internationally trusted resource, the office leads an operating agency committed to growing ADA membership with the policy-development advice and oversight of the Council on Dental Practice and the Council on Dental Benefit Programs. This office is also responsible for the administration of all standards activities for five commission-like agencies, including the Dental Quality Alliance, Standards Committee on Dental Products, Standards Committee on Dental Informatics, Code Maintenance Committee and the SNODENT Maintenance Committee.
1500050000 - CDP Administration	PUBLIC Goal/Elder Care and Emerging Issues - Policy development, oversight and advocacy, and thought leadership in all aspects of dental practice management, including but not limited to emerging issues, practice models, dentist health, wellness and well-being activities, and elder care. The Council on Dental Practice oversees the activities of the Center.
1500050300 - PCSS MAT	PUBLIC Goal/Emerging Issues - PCSS is a program funded by the Substance Abuse and Mental Health Services Administration (SAMHSA) created in response to the opioid overdose epidemic to provide web-based training to dental providers in the evidence-based prevention and treatment of opioid use disorders and treatment of pain. (Hosted webinars; Dentist Health & Wellness Conference).
1500200000 - Ctr for Den Ben, Code & Qlty	PUBLIC Goal/Advocacy and Third Party Payer - Advocates on behalf of members regarding third party payer issues, educates dentists and dental offices on dental benefit plans, supports resolution of claims issues for State dental societies, maintains the CDT Code, provides ADA input into ICD codes and electronic transactions, oversees the Dental Quality Alliance and supports the ADA's Credentialing Service powered by CAQH and the Clinical Data Warehouse/Registry. The Council on Dental Benefit Programs oversees the Center's activities.

13. Summary of Prior Year Results

Delegates are also encouraged the read the quarterly financial reports that are posted on ADA Connect to the House of Delegates each quarter and the audited financial statements posted annually.

ADA Operations
2020 Statement of Activities
Excludes Non-Operating Revenue and Expenses
Millions of Dollars

	2019 Actual	2020 Budget	2020 Actual		2020 v 2019 Fav / (Unfav) $	2020 v 2019 Fav / (Unfav) %	2020 v 2020B Fav / (Unfav) $	2020 v 2020B Fav / (Unfav) %
Revenue								
Membership Dues	$ 55,822	$ 57,814	$ 55,542		$ (280)	-0.5%	$ (2,272)	-3.9%
Education Division	27,839	28,916	25,002		(2,837)	-10.2%	(3,914)	-13.5%
Publishing, Products, Annual Meeting	23,050	21,948	12,087		(10,963)	-47.6%	(9,861)	-44.9%
Other Revenue	24,112	24,642	25,186		1,075	4.5%	544	2.2%
Total	130,823	133,319	117,817		(13,006)	-9.9%	(15,502)	-11.6%
Expenses								
Employee Costs	62,848	65,571	64,106		(1,258)	-2.0%	1,465	2.2%
Outside Services								
Education	7,448	6,905	6,865	-7%	583	7.8%	40	0.6%
Publishing, Products, Annual Meeting	17,613	14,304	8,905	-19%	8,708	49.4%	5,400	37.7%
Information Technology	3,764	3,503	4,281	-7%	(518)	-13.8%	(779)	-22.2%
Buildings	7,327	7,403	6,641	1%	686	9.4%	762	10.3%
Board Contingency	335	721	499	115%	(164)	-49.1%	222	30.8%
Communications & Marketing	4,133	3,870	1,541	-6%	2,592	62.7%	2,328	60.2%
Administrative Services	2,885	2,810	2,206	-3%	680	23.6%	605	21.5%
Member and Client Services	1,575	1,382	1,659	-12%	(85)	-5.4%	(277)	-20.0%
Government Affairs	4,015	4,475	4,000	11%	15	0.4%	475	10.6%
Other Divisions	5,473	6,218	8,887	14%	(3,413)	-62.4%	(2,669)	-42.9%
Total Outside Services	54,568	51,592	45,484	-5%	9,084	16.6%	6,108	11.8%
		-5%						
Travel Expenses	7,288	6,735	1,321	-8%	5,967	81.9%	5,414	80.4%
Payment to ADASRI	2,198	2,200	2,200	0%	(2)	-0.1%	0	0.0%
Depreciation and Amortization	6,429	6,305	5,710	-2%	720	11.2%	595	9.4%
Total Expenses	133,332	132,403	118,821		14,511	10.9%	13,582	10.3%
Taxes	768	950	557		211	27.5%	393	41.4%
Net Income before Reserves	(3,277)	(34)	(1,560)		1,717	-52.4%	(1,527)	4552.8%

The ADA experienced the effects of the pandemic on almost all revenue sources. The shut down of not only dental practices but the overall economy for a period had an effect on Testing Revenue (closure of the testing facilities for 2 months), product sales, Annual Meeting Revenue (cancelling of in person meeting), publishing revenue (adverstising), affinity royalties and membership dues. Rental income was one of the few areas that was not significantly affected by the pandemic.

As with Revenue, the ADA saw the effects of the pandemic on its operating expenses. Accross the board travel expenses were dowm significantly with budget due to the travel restrictions in place for much of 2020. Within employee costs, base salaries and fringe benefits were below budget driven by some restructuring initiatives inacted as a result of the pandemic reforecasting and long term strategic initiatives. Publishing, products and annual meeting cost weere down from budget due to the cancellation of the Annual Meeting and its associated costs. Communication costs were also down as many of the projects budgeted to be completed in 2020 were either delayed or cancelled. The one area with an unfavorable variance was in other divisions and related to the unbudgeted PPE program where the the expenses for PPE (Approx $3.5 million)

Resolutions

(See Resolution 75; Worksheet:2084)
(See Resolution 76; Worksheet:2085)

Resolution No. 75 New

Report: Board Report 2 Date Submitted: August 2021

Submitted By: Board of Trustees

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

Total Net Financial Implication: $143,878,557 (Revenue)
$143,831,487 (Expense & Taxes)
Net Dues Impact: $9

Amount One-time _____ Amount On-going _____

ADA Strategic Plan Objective: None

How does this resolution increase member value: See Background

APPROVAL OF 2022 BUDGET

Background: (See Report 2 of the Board of Trustees to the House of Delegates: 2022 Budget (Worksheet:2010). In accordance with its Bylaws duties, the Board of Trustees is recommending a 2022 operating budget for the Association. The proposed budget reflects $143,878,557 in revenues and $143,831,487 in expenses and income taxes, generating a net income of $47,070. The budget assumes annual membership dues of $582 in 2022, an increase of $9 from 2021 in compliance with the ADA Policy on Long-Term Financial Strategy of Dues Stabilization (*Trans*. 2019:244). If the resolution to establish membership dues of $582 is not adopted, then the final budget revenue will be adjusted accordingly.

Resolution

75. Resolved, that the 2022 Annual Budget of revenue and expenses, including net capital requirements, be approved.

BOARD RECOMMENDATION: Vote Yes

Vote: Resolution 75

ARMSTRONG	Absent	HIMMELBERGER	Yes	MARANGA	Yes	RODRIGUEZ	Yes
DOROSHOW	Yes	KESSLER	Absent	MEDOVIC	Yes	ROSATO	Yes
EDGAR	Yes	LEARY	Yes	MORRISON	Yes	SABATES	Yes
FIDDLER	Yes	LEIGHTY	Yes	OYSTER	Yes	SHEPLEY	Yes
HARRINGTON	Yes	LIDDELL	Absent	RAPINI	Yes	STEPHENS	Yes

Resolution No. 76 New

Report: Board Report 2 Date Submitted: August 2021

Submitted By: Board of Trustees

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

Total Net Financial Implication: 900,000 Net Dues Impact: $9

Amount One-time _____ Amount On-going _____

ADA Strategic Plan Objective: None

How does this resolution increase member value: See Background

ESTABLISHMENT OF THE DUES EFFECTIVE JANUARY 1, 2022

Background: The Board of Trustees at its August 2021 meeting approved a preliminary 2022 budget with a net income of $47,070. The 2022 budget as proposed includes a 1.6 % membership dues increase based on inflation, in compliance with the ADA Policy on Long-Term Financial Strategy of Dues Stabilization (*Trans*. 2019:244). The increase would raise full dues by $9, bringing the 2022 full dues rate to $582.

Resolution

76. Resolved, that the dues of the ADA active members shall be $582.00, effective January 1, 2022.

BOARD RECOMMENDATION: Vote Yes

Vote: Resolution 76

ARMSTRONG	Absent	HIMMELBERGER	Yes	MARANGA	Yes	RODRIGUEZ	Yes
DOROSHOW	Yes	KESSLER	Absent	MEDOVIC	Yes	ROSATO	Yes
EDGAR	Yes	LEARY	Yes	MORRISON	Yes	SABATES	Yes
FIDDLER	Yes	LEIGHTY	Yes	OYSTER	Yes	SHEPLEY	Yes
HARRINGTON	Yes	LIDDELL	Absent	RAPINI	Yes	STEPHENS	Yes

Resolution No. N/A N/A

Report: Council on Membership Report 1 Date Submitted: August 2021

Submitted By: Council on Membership

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

Total Net Financial Implication: None Net Dues Impact:

Amount One-time Amount On-going

ADA Strategic Plan Objective: Membership Obj-1: Increase membership market share of lagging demographics by 2% per year.

How does this resolution increase member value: See Background

COUNCIL ON MEMBERSHIP REPORT 1 TO THE HOUSE OF DELEGATES: RESPONSE TO RESOLUTION 40-2020: REQUEST THAT ADA EXPLORE NEW DUES STRUCTURE REFLECTING EVOLVING DENTAL PRACTICE MODELS

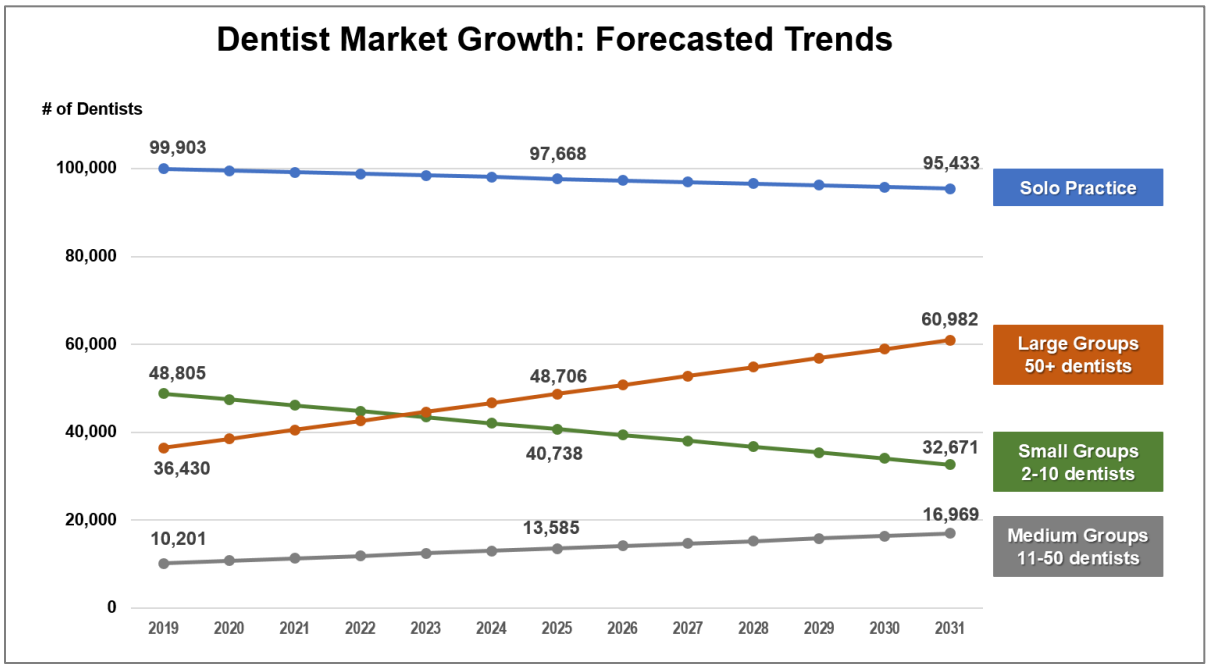
Background: In accordance with Resolution 97H-2020, Special Order of Referral Consent Calendar, which directed the appropriate ADA agencies to report back on each referred resolution, Resolution 40-2020, Request That ADA Explore New Dues Structure Reflecting Evolving Dental Practice Models, was referred to the Council on Membership. In response to this request, the Council undertook a study of the evolving dental practice landscape and reports as follows. Resolution 40-2020 is appended to this report.

Multi-state large group practices (LGPs), inclusive of dental support organizations (DSOs), are growing as the dental industry experiences consolidation. According to the ADA Health Policy Institute research published in 2020, 10.4% of all U.S. dentists were affiliated with a DSO (up from 7.4% in 2015), including about one in five dentists under the age of 35 (20.4%, up from 16.3% in 2015).[1] ADA Health Policy Institute (HPI) research also shows that dental practice ownership is declining, especially among younger dentists. Dentists under the age of 35 saw a drop in practice ownership from 49% in 2005 to 30.7% in 2019, as shown in Exhibit A:[2]

Exhibit A[2]

Exhibit B[3] highlights the ADA's forecast of the growth and decline of dentists by practice size over the next 10 years. Within these current trends of consolidation, solo practices are projected to continue a gradual decline, small group practices (2-10 dentists) are projected to decline more quickly, medium group practices (11-50 dentists) are projected to grow gradually, and large group practices (50+ dentists) are projected to grow more rapidly.

Exhibit B[3]



Over this past year, the Council on Membership took initial steps to address tripartite membership dues structures that could more accurately reflect evolving practice models, including:

- A mini environmental scan of other national associations that revealed many other associations are experiencing consolidation in their respective industries and are also challenged with maintaining member market share among professionals working in consolidated business models. National associations in the scan included the American Medical Association, American Optometric Association, National Funeral Directors Association, American Veterinary Medical Association, American College of Emergency Physicians, and American Pharmacist Association.
- Consideration of dues discounts to large groups (which is currently only being implemented by one other large national organization included in the environmental scan.) The Council determined that a discount would negatively affect the Tripartite's long-term financial viability, as well as their ability to deliver the critically important resources and information on which members and nonmembers rely, and did not move forward with the concept.
- Exploration of a Flat Rate Dues Strategy Pilot Program that allows the ADA to quickly quote a real-time flat dues amount to LGPs during acquisition conversations. The Council advanced a flat dues rate pilot proposal to the ADA Board of Trustees in July 2021 and it was approved (B-70-2021). This flat-rate dues structure pilot is not a discount on ADA dues offered to LGPs. It simply allows the ADA to annually calculate a flat dues amount by averaging national, state, and local full dues, weighted by the number of dentists in each state, and use this number to quickly and consistently provide a dues quote for an LGP wishing to provide ADA membership for its affiliated/employed dentists, by multiplying the flat dues rate by the number of dentists in the LGP. This will allow the ADA to conduct discussions with LGPs in a more agile format and avoid losing momentum during the time required to provide a quote of actual dues based on rosters that span multiple states. As part of this pilot program the ADA will work with interested state and local dental societies to a) coordinate the processes for collecting tripartite dues from large group practices on behalf of the dentists in said practices, b) distribute the actual dues owed to the state and local societies choosing to participate in the pilot program, and c) coordinate the processes for tripartite member value, engagement, and retention, including the use of half-year dues (HYD) and quarter-year dues (QYD) offers to add value to negotiations with LGPs.

Ongoing Consideration of New Tripartite Membership Dues Structures: The initial considerations and flat rate dues pilot program are first steps in the Council on Membership's broader work to study the complex landscape of ADA's dues membership structure.. The Council continues to look at opportunities to enhance the ADA's membership model—how membership and membership dues are structured within the Association, who pays what and how much, and what level of value they receive for the price. Early explorations reveal that variable options offer a host of advantages and disadvantages. Thus, careful consideration and analysis is necessary to determine and implement an effective structure. As the Council continues its exploration, consideration of the members' and potential members' preferences and the level of revenue risk that the Association (national, state and local) can manage will be key considerations. The Council also recognizes that modernizing the membership structure is not the sole answer to member growth with dentists choosing to practice in evolving practice models. Early findings reveal that value and experience must be explored in tandem with a review of an enhanced dues structure. Accordingly, the Council on Membership, in collaboration with other key volunteer stakeholder agencies, has formed an ADA Joint Action Team to ensure broad collaboration on the evolution of structure, value and experience

Collectively, these combined efforts will set a path forward to ensure the most comprehensive response to Resolution 40-2020Given the complexity of the request, the Council on Membership anticipates a multi-year study with incremental changes leading up to a final solution The Council will provide an update on its progress at the 2022 ADA House of Delegates.

Resolution

This report is informational and no resolution is presented.

[1] ADA Health Policy Institute, How Big are Dental Service Organizations? (PDF) (July 2020)
https://www.ada.org/~/media/ADA/Science%20and%20Research/HPI/Files/HPIGraphic_0720_1.pdf?la=en

[2] ADA Health Policy Institute, Dentists' Practice Ownership is Declining (PDF) (January 2021)
https://www.ada.org/~/media/ADA/Science%20and%20Research/HPI/Files/HPIgraphic_0121_2.pdf?la=en

[3] Forecast based on Forecasting and Analyst staff's analysis of historical data and projected growth trends.

BOARD RECOMMENDATION: Vote Yes to Transmit.

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

WORKSHEET ADDENDUM
2020 Resolution 40—Wisconsin Dental Association—Request that ADA Explore New Dues Structure Reflecting Evolving Dental Practice Models

40. Resolved, that the American Dental Association direct its appropriate agency to explore a new tripartite membership dues structure that more accurately reflects evolving practice models, and be it further

Resolved, that their findings be reported to the 2021 ADA House of Delegates

Resolution No. N/A New

Report: Council on Membership Report 2 Date Submitted: August 2021

Submitted By: Council on Membership

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

Total Net Financial Implication: None Net Dues Impact:

Amount One-time Amount On-going

ADA Strategic Plan Objective: Membership Obj-3: Maintain an overall retention rate of 94%.

How does this resolution increase member value: See Background

COUNCIL ON MEMBERSHIP REPORT 2 TO THE HOUSE OF DELEGATES: REPORT ON PILOT FOR ENHANCING RETENTION IMPACT OF THE QUARTER YEAR DUES CAMPAIGN

Background: Based on Chapter V., Section 70.M. of the ADA *Bylaws*, the Board of Trustees may authorize pilot programs of limited duration subject to the provisions in the *Governance and Organizational Manual* of the American Dental Association (ADA *Governance Manual*). Accordingly, at the August 2020 Board meeting, the Council on Membership recommended that the Board approve a pilot program, beginning in 2020, to test join and renewal enhancements for the Quarter-Year Dues Campaign. The Board approved the pilot beginning in 2020, with the expansion of the pilot to continue into 2021.

The Quarter Year Dues Campaign, which provides free membership to potential members at the end of the year, has been a long-standing promotion to aid in recruitment at the end of the calendar year. This campaign, while resulting in positive end-of-year numbers, has also resulted in low retention the following year. The average retention rate over the last three years for dentists joining at the $0 Quarter Year Dues rate is 34%, while the average retention rate over three years for other promotional campaigns is 61%. It is anticipated that this lag may stem from the short time periods that a member has to experience and enjoy the value of ADA membership before being billed (2 months) and/or notified of membership cut-off (6 months). In an effort to create a positive joining experience and improve retention of new members acquired through the Quarter Year Dues Campaign, a new 15 months of value for the price of 12 months acquisition model required auto renewal upon joining was recommended.

This report provides an update to the enhancements made through the Quarter-Year Dues Pilot Program:

Key Highlights: The overarching goal of the pilot is to enhance joining and renewing through the Quarter-Year Dues Campaign. To help ensure promotion of the campaign was measured equally to the standard Quarter Year Dues campaign, a complete parallel campaign was created and implemented.

State Participation: The parameters of the initial pilot allowed participation of up to seven states. A total of five states participated: Florida, Minnesota, Missouri, North Carolina and Oregon. States were primarily selected on their ability, willingness and capacity to engage in the pilot. With approval of the expansion, the plan is to grow the pilot to 20 states participating.

***Enhanced Application Process*:** A new application was created for the pilot which consisted of new features to enhance both the member experience, streamline dues processing for state societies and minimize capacity impacts across the tripartite. Collaborative efforts across national ADA and state

societies resulted in the ability to offer a one-time interaction for the joiner with a one-step approval process on the back end for the state societies. In addition, five key new features aided in the enhancement of the application process:

1. Real time on demand tripartite dues quote that allowed joiners to immediately know what their full dues amount would be at across all levels.
2. Ability to quote a dues amount to be paid that allowed for immediate processing of the member application.
3. The immediate option of a 12 month installment payment or one-time payment.
4. Ability to use a secured credit card payment feature at the time of application.
5. An auto renew stipulation that requires pilot joiners to accept and agree in enrollment of auto-renew processing.

Results and State Feedback: Ultimately, the pilot program rendered a 98.5% retention rate with 132 out of the 134 members retaining membership in the subsequent year. This retention percentage is considerably higher than retention rates across the standard Quarter Year Dues campaign, which, in 2019, averaged approximately 35% retention across all states and 72% retention across the current pilot states.

The campaign targeted approximately 6,000 prospective dentists across the five participating states with 134 members taking advantage of the offer and joining the ADA. This initial 2.2% join percentage compares to a 3.8% join percentage across the non-pilot states with 35,000 prospective dentists targeted. For comparison, the average return on national campaigns (not quarter year dues) is about 2-3%. For example, results from the strategic promotional incentive campaign (which offers a discount of 50%) rendered a 2.1% join percentage in 2020 (914 new members from 43,000 prospective dentists targeted). il should be noted that the join percentage for this pilot was anticipated to be lower than the other campaigns given the additional commitment related to the auto renew requirement. While state societies' 4th quarter "joined" numbers during the pilot campaign may have been lower in comparison to the standard campaign, pilot participants agreed that having subsequent higher retention rates rendered greater economic value than initial high acquisition. Ultimately, participating states reported to the ADA that they were very pleased with the pilot campaign results and would like to continue with the new approach.

Additionally, out of the 134 dentist who joined, 80 (61%) were nonmembers and 52 (39%) were nonrenews who during the 4th quarter would have been identified as nonmembers. While the pilot was essentially focused on nonmembers, having nonrenews rejoin through this campaign is positive. The Board approved continuing to target recent nonrenews through the pilot version of the Quarter Year Dues Campaign as nonrenew recapture through this campaign offers several key benefits:

1. Encourages a shorter separation period from membership,
2. Reinstates nonrenews at nearly full dues versus a discounted nonmember promotional incentive rate that dentists would have potentially been eligible for in the subsequent year (based on nonmember status), and
3. Ensures a higher likelihood of renewal through the auto-renew process.

Financial Risk/Benefits: The auto-renew feature integrated into the pilot is projected to help create positive revenue impact given that external research suggests a member is likely to renew at a higher rate when participating in auto renewals. The ADA is now conducting an internal data analysis to validate this determination (or not) for its members. Also, while operational advantages gained through the auto renew process may render retention gains, the ultimate goal is to secure new acquisitions over the long-term through relevant value, increased engagement and enhanced member experiences. Nevertheless, through the auto-renew process, $74,580 ($565 multiplied by 132) of membership dues revenue will potentially be automatically collected in 2021 as compared to $54,805 ($565 multiplied by 97) solicited and collected in 2020 for the five same states. This additional $19,775 may not have been collected

through the standard Quarter Years Dues campaign based on past retention rates and would require additional national, state and local staff time dedicated to invoicing.

Given the start of the pilot campaign occurs prior to the close of the House of Delegates and determination of future dues amounts, real time dues quotes provided through this pilot are applied pricing for the current year and not the subsequent auto-renewal membership year. As a result, members who joined at Quarter Year Dues and auto renewed for 2021 paid 2020 dues in 2021. This real time quote ability resulted in unrealized revenue of $1,056 ($8 multiplied by 132 new members). The Council on Membership believes this monetary impact to be minimal compared to the potential economic value of the newly acquired member over the long-term.

Moving forward the dues quoted during the Quarter Year Dues Pilot Program, again given the timing of the close of the HOD, would remain the difference between the subsequent year full dues amount determined at the HOD and the current year membership dues amount.

Resolution

This report is informational and no resolution is presented.

DRAFT BOARD RECOMMENDATION: Vote Yes to Transmit.

PLEASE NOTE YOUR COMMENTS/CHANGES TO THIS DRAFT BOARD RECOMMENDATION BELOW.

Resolution No. None New

Report: Board Report 6 Date Submitted: August 2021

Submitted By: Board of Trustees

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

Total Net Financial Implication: None Net Dues Impact:

Amount One-time Amount On-going

ADA Strategic Plan Objective: Organizational Obj-7: Improve overall organizational effectiveness at the national and state levels.

How does this resolution increase member value: See Background

REPORT 6 OF THE BOARD OF TRUSTEES TO THE HOUSE OF DELEGATES: COMPENSATION AND CONTRACT RELATING TO THE EXECUTIVE DIRECTOR

The following report has been prepared by the Compensation Committee for the full Board's consideration and transmittal to the 2021 House of Delegates as a Report from the Board.

Background: This report is provided for informational purposes and does not include any resolutions. In order to facilitate the transition to a new Executive Director, the Executive Director's last day of employment will be November 15, 2021. The Executive Director will receive full pay and benefits through December 31, 2021 (the original term of the Executive Employment Agreement ("Agreement"), as extended by the parties in June 2020), and as memorialized in a Memorandum of Understanding between the parties. The Executive Director is the only member of the ADA staff with a written employment agreement.

Compensation and Benefits: The Executive Director's current annual base salary is $575,250 and is paid in accordance with the Association's standard payroll schedule and policies. The Agreement provides that the Board of Trustees shall review the Executive Director's salary on an approximately annual basis and may in its sole discretion, increase her compensation by up to four percent based on a performance review by the Board. The current salary level was set in March 2018 based on the contracted increase of 3% over the prior annual base salary of $558,502.

The Memorandum of Understanding, consistent with the Executive Director's original Agreement, provides that the Executive Director may be eligible to receive an annual bonus ranging up to twenty (20%) of her base pay as determined by the Board of Trustees, based on the performance criteria jointly approved by the Executive Director and the Board of Trustees through November 15, 2021. The bonus is subject to available funds. The Executive Director relinquished the opportunity for a bonus to be paid in 2021 for work performance in the 2020 calendar year due to COVID-19 and in solidarity with many dentists who experienced financial hardship during that time. In February 2020 before COVID-19 issues, the Board of Trustees agreed to approve a bonus for the Executive Director for her 2019 performance in the amount of $74,898, representing 13.02% of her base salary.

The Executive Director shall be entitled to fringe benefits during the term of the Agreement that are offered to all other similarly situated Association employees having her length of service; provided, however, that such benefits shall 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 Agreement.

The Agreement provides 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 travel to the Association's annual meeting and any other required spousal travel consistent with the ADA Board's spousal travel policy in effect at the time; membership dues in professional associations up to an annual amount of $6,000 (except for the dues of the American Dental Association and its constituent and component dental societies) and a total term life insurance plan with benefit amounts exceeding group term life policy subject to evidence of insurability (year 2021 - $1,000,000).

This report is informational and no resolutions are presented.

BOARD RECOMMENDATION: Vote Yes to Transmit.

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

Resolution No. None N/A

Report: Board Report 7 Date Submitted: August 2021

Submitted By: Board of Trustees

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

Total Net Financial Implication: None Net Dues Impact:

Amount One-time Amount On-going

ADA Strategic Plan Objective: Organizational Obj-7: Improve overall organizational effectiveness at the national and state levels.

How does this resolution increase member value: Not Applicable

REPORT 7 OF THE BOARD OF TRUSTEES TO THE HOUSE OF DELEGATES: ADA PENSION PLANS

Background: This report is in response to House of Delegates Resolution 77H-2011 (*Trans.*2011:444).

Resolution 77H-2011 reads as follows:

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

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

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

- The new terms of the pension plan reduce future costs and risks by more than 60% compared to the old plan terms.
- Supplemental pension funding is not optional and represents payment of prior service costs under the old pension plan. This funding is the majority of the ADA's annual budget cost and is required even if the plan is terminated.
- If the pension plan were terminated completely, the ADA would not have access to plan assets to reduce costs in future periods.
- A "hard freeze" plan termination would come at a high price because conservative accounting rules lock in the value of the liability based on an assumed liquidation of pension benefits as of the termination date using current, historic low interest rates. This liability can only be reduced by the future payment of those plan 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 12/31/20 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 1/1/21 Adjusted Funding Target Attainment Percentage ["AFTAP"] Certification Report (based on government ERISA calculation rules).

Although these two liability calculation methods differ, in general terms the net Pension liability represents the amount of projected total pension contributions that would be 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, which actually happened in 2020 (for balance sheet purposes), the amount needed to reach 100% funded status goes up. Conversely, if interest rates go up or longevity estimates decrease, then the calculated amount to reach fully funded status goes down.

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 12/31/20 audited balance sheet): The following roll-forward analysis of the ADA's 12/31/20 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 pension liability; and

3. The decrease in the net pension liability due to the increase in the value of the plan's 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.

Finally, studies of mortality experience for participants in pension plans have been published by the Society of Actuaries in recent years. While these studies have often indicated that pension plan participants are generally living longer, sometimes revised mortality tables adjust life expectancy estimates downward. As such, updated mortality assumptions have been published to reflect the results of these studies. The ADA has made changes to its mortality assumptions as a result of these studies, and the impact on results due to these changes is included in the following chart.

The following historical roll-forward analysis chart shows a ten year history of the pension plan since 2011, the year before the plan benefit reduction. The results for fiscal year 2011 show normal service costs under the old plan while years 2012 through 2020 present the actual results after plan changes. Beyond normal service costs and interest on the 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. For year-end 2015, the liability decreased due to an increase in discount rates from 4.55% to 4.86%, but was offset by unfavorable investment performance and updated mortality assumptions. For year-end 2016, the liability increased due to a decrease in discount rates from 4.86% to 4.68%, but was offset by favorable investment performance. For year-end 2017, the liability increased due to a decrease in discount rate from 4.68% to 4.03%, which was offset by favorable investment performance and revised mortality improvement expectations. For year-end 2018, the liability decreased due to an increase in discount rate from 4.03% to 4.72% and revised mortality improvement expectations, which was offset by unfavorable investment performance. For year-end 2019, the liability increased due to a decrease in discount rate from 4.72% to 3.55%, which was partially offset by favorable investment performance, revised mortality assumptions and the execution of a one-time temporary lump sum window option for certain inactive participants (which additionally reduced the size and overall risk profile of the plan). For year-end 2020, the liability increased due to a decrease in the discount rates from 3.55% to 2.97%, but was offset by favorable investment performance and revised mortality assumptions.

So far in 2021, interest rates have been increasing while asset performance has been trending upward but has been volatile as a result of the COVID-19 pandemic and its impact on the economy. The impact of increasing “spot” interest rates has an 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 this chart for each year.

ADA Consolidated

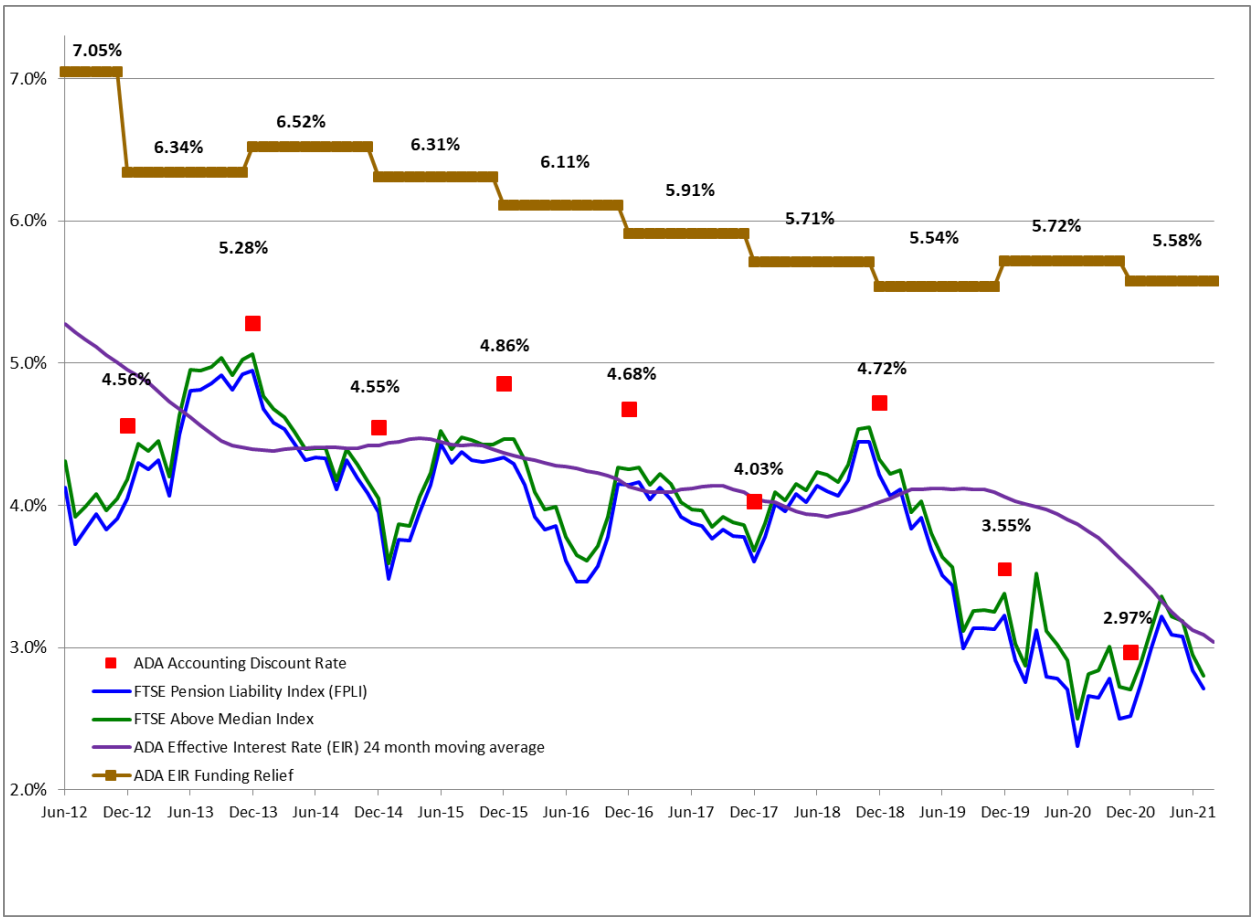
Net Pension Liability Analysis - Historical

Millions of Dollars; Increase/(Decrease) in Liability

	Fiscal Year Ending										
	2011	**2012**	**2013**	**2014**	**2015**	**2016**	**2017**	**2018**	**2019**	**2020**	**Notes**
Beginning Balance, December 31 of prior year	48.8	51.1	56.8	29.0	50.4	54.1	56.4	53.0	49.7	54.7	Net Liability, based on discount rate in effect at start of year less plan assets
Contributions (Cash Funding):											Actual cash cost to ADA in each plan year:
Normal Service Cost - Current Employees	(5.2)	(1.7)	(1.8)	(2.0)	(2.1)	(2.1)	(2.2)	(2.7)	(2.4)	(3.1)	Based on Old Plan formula in 2011; New Plan formula for 2012 to 2020
Supplemental/Catch-up - Prior Service	(7.6)	(4.6)	(4.4)	(5.1)	(3.0)	(3.5)	(4.1)	(4.7)	(4.3)	(4.5)	Required contributions of prior service costs on path to 100% status
Expected Obligation Increase	13.4	10.0	10.0	10.5	11.1	11.5	11.8	11.7	12.2	11.4	Service Cost (benefit accrual) and Interest Cost (interest on prior obligation)
Net Investment (Gains)/Losses	(2.0)	(16.7)	(15.5)	(13.0)	3.1	(10.5)	(27.6)	9.3	(32.4)	(30.6)	Actual plan investment results based on market values at each year end
Actuarial (Gain)/Loss	2.1	4.5	0.4	0.6	1.5	2.1	1.9	2.7	1.9	2.6	Impact of updated participant population, salaries and mortality experience
Reduction in Benefits	(8.9)	-	-	-	-	-	-	-	-	-	2011 reflects impact of change in Plan formula
Impact due to temporary Lump Sum Window	-	-	-	-	-	-	-	-	(0.9)	-	2019 reflects impact of temporary Lump Sum Window offered to certain inactive participants
Annual FAS 158 Actuarial Valuation Adjustment											
Discount Rate	10.0	14.1	(16.4)	18.2	(7.9)	4.7	18.1	(18.9)	32.8	18.2	Estimated non-cash impact of changing discount rate per accounting rules
Mortality Assumption Change	N/A	N/A	N/A	9.0	1.1	0.1	(1.4)	(0.6)	(2.0)	(1.1)	Estimated non-cash impact of updating mortality assumption per actuarial studies
Impact due to adjustment for IRS Reg. 415	-	-	-	3.1	-	-	-	-	-	-	
Supplemental Benefit Trust	0.5	0.1	(0.1)	0.1	(0.1)	-	0.1	(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**	**54.1**	**56.4**	**53.0**	**49.7**	**54.7**	**47.7**	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%	4.55%	4.86%	4.68%	4.03%	4.72%	3.55%	
End of Year	5.16%	4.56%	5.28%	4.55%	4.86%	4.68%	4.03%	4.72%	3.55%	2.97%	
Rate change impact: (increase)/decrease liability	**-0.49%**	**-0.60%**	**0.72%**	**-0.73%**	**0.31%**	**-0.18%**	**-0.65%**	**0.69%**	**-1.17%**	**-0.58%**	
Projected Benefit Obligation - End of Year	162.3	183.9	170.7	204.6	197.9	206.9	226.8	211.1	236.8	256.0	
Fair Value of Plan Assets - End of Year	111.1	127.1	141.7	154.3	143.7	150.5	173.8	161.4	182.2	208.3	
Net Unfunded / (Overfunded) Liability	**51.1**	**56.8**	**29.0**	**50.4**	**54.1**	**56.4**	**53.0**	**49.7**	**54.7**	**47.7**	
Accrual Basis Funded Status	68.5%	69.1%	83.0%	75.4%	72.6%	72.7%	76.6%	76.4%	76.9%	81.4%	

Low interest rates, more than any other factor, typically 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 2020, but have increased slightly to date in 2021.

The funded status calculated based on accrual basis liability and fair value of plan assets included in the ADA's 12/31/20 balance sheet was 81.4% which compares to 76.9% funded status as of 12/31/19.



The "ADA Accounting Discount Rate" shown in the graph above reflects the rates used for the year-end financial statements. The "ADA Effective Interest Rate (EIR)" is a 24 month moving average of rates published by the IRS which would typically apply to funding requirements. However, the "MAP-21 Rates", further modified by "HATFA", "BBA 2015" and "ARPA 2021" relief as discussed further below, reflect higher "ADA EIR Funding Relief" rates based on a 25 year average to provide pension relief which reduced the Plan's funding requirements for 2012 through 2021.

The FTSE (Financial Times Stock Exchange Group) Indexes are also included as an indicator of current interest rate trends. These rates moved downward in 2020 resulting in a lower accounting rate at 12/31/20 than at 12/31/19. So far during 2021, these rates have slightly increased.

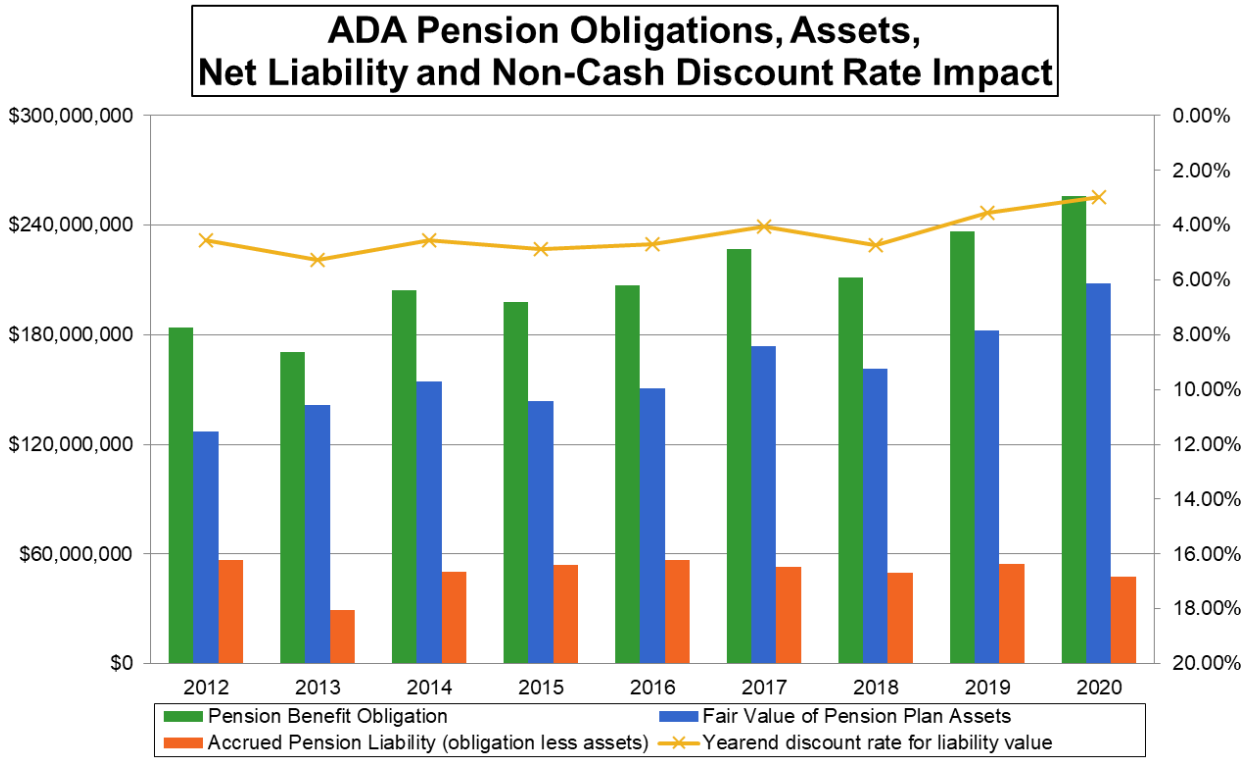
The inverse relationship between interest rates and the valuation of the year-end pension liability can also be seen in the following multi-year graph that includes:

a) the gross pension obligation,

b) the pension plan asset balance,

c) the net ADA pension liability balance, and

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 indicated by the yellow line and the liability balance represented by the green bar. 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 provide investment recommendation updates. 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 $30.8M on the liability with an offsetting impact on the plan assets estimated at $14.1M which combine to a total "net impact" of $16.7M. So far in 2021, U.S. Treasury interest rates moved upward from historic lows. This increase in interest rates reflects inflationary pressures and the stabilization of economic conditions from the COVID-19 pandemic. However, the additional interest rate required by investors to hold corporate bonds rather than Treasuries (i.e., credit spreads) has decreased. The plan's liabilities are calculated using corporate interest rates, so this decline in credit spreads has limited the decline in value of plan liabilities. Interest rates continue to remain low on a historical basis. Based on the profile of the Plan's assets and liabilities, increases in longer-term interest rates would result in favorable adjustments to the Plan's funded status.

It is important to note that although the use of year end "spot rates" determines the value of the liabilities for accounting purposes at year end, and while lower rates can also drive higher contribution rates to plan

assets, it is the actual cash payout of the retirement benefits that will only happen over many decades that represents the true economic cost of the plan. Cash contributed to the plan to fund future benefits stays in the plan until those benefits are paid. And the actual payout of the 12/31/20 pension plan liability through monthly benefits to retirees will only happen over the next 30 to 40 years with the final payments expected into the next century. The following graph shows these expected annual payments to plan participants from plan assets:

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

Pension Relief: Because so many actuaries for large pension plans questioned the use of "spot rates" to value pension liabilities and lobbied legislators to use a longer 25 year average interest rate to calculate the requirements for cash contributions to pension plans, "pension relief" was passed under MAP-21 in 2012 to reduce the short-term funding burden on pension plan sponsors caused by the current, low interest rate environment. This "pension relief" was further modified and extended by HATFA in 2014, the Bipartisan Budget Act (BBA) of 2015 and the American Rescue Plan Act (ARPA) of 2021.

Additionally, ARPA adjusted the funding rules to extend the period for amortizing changes in the liability of the plan. This is expected to result in greater flexibility for the ADA and, in conjunction with ADA's funding policy for the plan, is anticipated to provide a cushion to absorb year-over-year changes and stabilize future contributions to the plan.

Cash Basis Pension Liability (included in the annual actuarial certification of the pension plan funding status): The other pension liability recalculated by our actuary each year is the Cash Basis Pension Liability which is published in the ADA's annual Adjusted Funding Target Attainment Percentage

["AFTAP"] Certification Report (based on ERISA calculation rules). This report is significant because it includes the annual funded status of the plan. In addition, as this "cash basis" liability fluctuates, the amount of annual cash contributions required from the next year's Operating Budget will also fluctuate.

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

American Dental Association **Employees' Retirement Trust** **Adjusted Funding Target Attainment Percentage ("AFTAP") Funding Status as of January 1 (valuation date)** **($000s)**	Year End 2016		Year End 2017		Year End 2018		Year End 2019		Year End 2020	
	amount	%	amount	%	amount	%	amount	%	amount	%
AFTAP Net Effective Interest Rate	**5.91%**		**5.71%**		**5.54%**		**5.72%**		**5.58%**	
Cash Basis Target Liability (= 100% status)	$ 170,791	100.0%	$ 178,074	100.0%	$ 189,771	100.0%	$ 183,451	100.0%	$ 186,751	100.0%
Less: Plan Assets	(150,126)	87.9%	(178,530)	100.3%	(170,666)	89.9%	(171,533)	93.5%	(187,477)	100.4%
Net AFTAP Report Unfunded Plan Liability	$ 20,665	12.1%	$ (456)	-0.3%	$ 19,105	10.1%	$ 11,918	6.5%	$ (726)	-0.4%

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

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

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

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

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

In addition, the significant cut in pension plan benefits reduced "normal" pension costs, for 1 year of service, from $5.2 million in 2011 to $1.7 million in 2012 to $1.8 million in 2013 to $2.0 million in 2014 to $2.1 million in 2015 to $2.1 million in 2016 to $2.2 million in 2017 to $2.7 million in 2018 to $2.4 million in 2019 and to $3.1 million in 2020.

Although the historic low "point in time" interest rates at year end have resulted in higher pension liability valuations, expected long term higher interest rates will turn this liability into an asset in the future. Pension relief intended to reduce the funding burdens on pension plan sponsors caused by the current, low interest rate environment was signed into law in 2012 as part of the MAP-21 Act and further modified by HATFA in 2014, BBA in 2015 and ARPA in 2021. These laws provide relief from the low interest rate environment and reduce the impact of year-over-year changes by extending the required period for funding unexpected events.

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

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

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

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

Resolutions

This report is informational and no resolutions are presented.

BOARD RECOMMENDATION: Vote Yes to Transmit.

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

Resolution No. None N/A

Report: Board Report 9 Date Submitted: August 2021

Submitted By: Board of Trustees

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

Total Net Financial Implication: None Net Dues Impact:

Amount One-time Amount On-going

ADA Strategic Plan Objective: Finance Obj-6: Total unrestricted reserves will be targeted at no less than 50% of annual operating expenses.

How does this resolution increase member value: See Background

REPORT 9 OF THE BOARD OF TRUSTEES TO THE HOUSE OF DELEGATES: TECHNOLOGY INITIATIVES, EXPENDITURES AND ESTIMATED FUTURE PROJECTS

Background: This report to the House of Delegates on the ADA's 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.

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

- *Enterprise Reporting & Analytics.* The first phase of the Data Platform Modernization project was completed. This phase included reviewing the current data architecture to identify pain points and recommend design changes; define future state reference data architecture and prove feasibility of recommended future state tools and define a roadmap to implement future state data platform. In 2022, work will continue to implement the solutions identified in Phase I, which will include moving to the Cloud and transitioning to the business intelligence tool, Power BI for reporting. A project is underway to redesign the load process for the Office Database. This project will automate the loading and integration of a number of external data sources to allow improved tracking of Dental Service Organizations. It will also standardize the process used for any external data that needs to be matched to dentist data
- *Websites*. The Coveo Search software used on ADA.org and other ADA website properties was moved to the Cloud. This move was necessary because the vendor discontinued support of the current software. In addition, this upgrade offers Artificial-Intelligence (AI)-powered site search solutions. Coveo's AI capabilities will be expanded as site visitor viewing preferences are accumulated to further move the strategy of delivering more personalized experiences. Work continues on moving website properties into the Microsoft Azure Cloud to take advantage of more modern technology including DevOps processes as well as automated quality assurance review. The new ADA.org launching later this year will include the Coveo AI capabilities and the Microsoft Azure Cloud DevOps as well as automated quality assurance review. A new Member Directory web application was developed and released that is built as a single page application. This migration allows us to take advantage of the capabilities offered through the Microsoft Azure Cloud such as, system DevOps, which makes source control more efficient and allows new code to be continuously released. These capabilities are essential for the technology strategy to develop Release Control Plans for core systems. An Urchin Tracking Module (UTM) was implemented, which will build user journey tracking capability across ADA's websites. Once

implemented, UTM parameters will provide ADA insight into the specific use of a URL and the marketing campaign that refers traffic to an ADA website. The checkout functionality in eCatalog was updated to facilitate tracking of sales data in Google Analytics. Multiple updates have been implemented to the website analytics functionality such as Google Tag Manager, Google Studio expansion and a script control process. Site Improve Analytics has also been implemented as a secondary analytics system.

- As part of the Power of 3 initiative, the ADA developed Branded Web Templates (BWT) to deploy to the states and local societies that are on Aptify. BWT offers the states and locals a similar "look and feel" web presence, which gives visitors a similar web experience at the local, state and national level. As of this report, 145 sites (37 states and 108 components) are using BWT with another 9 sites (1 state and 8 components) scheduled to be deployed this year. Sitefinity, the Web content management system (CMS) software used on these sites was upgraded to the latest version. This version provides new features and functionality as well as helps ensure compliance with the software maintenance agreement. A project is underway to move the website hosting services from a third-party vendor to Microsoft Azure Cloud environment. This move is in line with the overall hosting strategy and will allow website enhancements to be implemented in a timely manner and allow more immediate control and access to the hosting environment to resolve issues and reduce downtime.
- *Digital Member Experience.* This project provides an improved online experience offering tailored experiences based on individual interests as determined through purchases, online interactions, demographic data and geo location. Industry experts are helping develop the User Experience strategy that balances current technology investments with innovation. Since 2020, work has been underway for a new Sitecore infrastructure in Microsoft Azure Cloud. The new website experience offers a new membership directory, a new myADA experience, which will be accessible across multiple devices (i.e. desktop, laptop, tablet and mobile phone). Development is underway on the non-dues revenue areas of ADA.org, including a new Catalog and member loyalty program, meetings and events registration and ADA Seal. The new ADA.org site will launch in November. Implementation and launch of a new Learning Management System for continuing education will launch early next year. Development and migration of ADA affiliated commission sites, MouthHealthy.org and ADA Member Advantage will follow in 2022. Additional technology improvements that are currently ongoing include technology-enabled process automation to simplify complex business processes, artificial intelligence powered content searching on web properties, and modernized development operations to improve collaboration on code development of web properties.
- *Mobility*. Existing mobile applications continue to be upgraded annually to the current iOS and Android platforms. The existing Chairside Instructor mobile application is being upgraded to compliment the new 12th edition of the *Chairside Instructor* book. A required dark mode compatibility design was implemented on all existing ADA mobile applications. This design mode reduces the light emitted by device screens while maintaining the minimum color contrast ratios required for readability. It enhances visual ergonomics by reducing eye strain, facilitating screens to adjust according to current light conditions and providing comfort of use at night or in dark environments. Additionally, it conserves battery power, thereby enabling device usage for longer periods without charging. A mobile version of the Member Directory was released. It was developed as a hybrid web application that utilizes both native phone capabilities as well as online web capabilities. The application utilizes the new site design direction and offers multiple capabilities to ADA members including the ability to look up other members' contact information across the United States; access to their own digital membership card as well as view information from their Find-a-Dentist profile. The new Member Directory mobile application was architected to allow future expansion as it is built on the same technology as single page applications. This architecture allows website features to be ported onto mobile application thus transitioning from a single-purpose mobile application into an enhanced personalized mobile experience for ADA members.
- *Finance/HR/Payroll*. Since the initial implementation of NetSuite in 2018, system enhancements and updates continue to be identified and developed with the business users. A report was

developed that allows accounting to see monthly expense trends for a cost center by account and drill down to the details. A Journal Entry Reversal feature was implemented that allows accounting to efficiently reverse the financial impact of a journal entry. A button at the top of the purchase order entry form was created that opens another window to show additional information on the vendor contract. A custom CSV data file import page was developed to streamline the process and reduce the number of clicks. A new pop-up warning message feature was implemented to show when a vendor bill (invoice) amount is between $99 and $10,000 more than the associated purchase order's remaining amount. A new custom allocation feature was implemented to help streamline the process of re-classifying financial activity from the retained earnings account to multiple net asset equity accounts (by program). As part of the Amazon Business launch, a scheduled report was developed to help Purchasing maintain the system users' access.

- *Infrastructure, Hardware and Software Licenses*. The Association maintains hardware and software licenses necessary for the Association's network infrastructure as well as end-user equipment such as desktops, laptops and printers. In addition, funding is budgeted annually for a manufacturer-certified on-site technician to fix hardware under warranty instead of depending on “depot warranty service” thus minimizing downtime for users. A required Exchange server upgrade was completed to keep the environment current and in compliance for support. Various compliance and network security requirements continue to be monitored with network security improvements implemented as needed. The ADA’s telephone system replacement was completed in January 2021. The implementation experienced significant delays from the telephone service carrier and from the equipment installation vendor due to the COVID-19 pandemic. The replacement system offers features and functionality to support staff that are working remotely. Extensive network infrastructure upgrades were completed in 2020 and 2021 to facilitate the VoIP (Voice over Internet Protocol) telephone functionality and to improve internet service. Microsoft has discontinued its Skype for Business communication tool and replaced it with MS Teams. This new tool offers users similar functionality such as chat and video conferencing. The MS Teams solution was implemented and deployed in July. Work is underway at the new Stanton Park office location in DC to provide technology services (network, storage, phone connectivity, and AV) to support staff working at this location. Work is being done at the DC office to facilitate consolidation from two floors to one floor. An evaluation of the MS SharePoint environment is slated for 2021 in preparation for a required upgrade. In 2022, we will continue to examine the ADA’s infrastructure to identify products that can be upgraded to Cloud solutions based on industry standards and best practices.
- *Aptify*. As of this report, 47 states, Washington DC and Puerto Rico are on Aptify. The ADA currently has three (3) Aptify environments – Enterprise (will include CERP), DTS and CODA. Each environment requires a separate upgrade due to the customization of each environment. The CODA environment was upgraded in 2020, DTS environment will be upgraded in 2021, and the Enterprise instance in 2022. These upgrades move the environments to a current software version offering new features and functionalities and to ensure software compliance. The Aptify eBusiness 6.0 module was implemented to introduce a new front end framework that will integrate more seamlessly with Sitecore 9.3 and allow better utilization of new front-end frameworks that will make the website more modern and responsive. This module enables interaction with the Aptify database from the browser and not require user’s submitting after each on screen action. A new universal online membership application is being developed, which will provide a standardized form for all states to use for the member application process.

A multi-year project is underway to evaluate, select and implement a replacement for Aptify. The Aptify system has been in place since 2011. At that time, only a few association-management systems (AMS) were available and Aptify was the best option to meet the ADA’s and the tripartite’s needs. Since 2011, the AMS market offers new and improved systems that can potentially replace what Aptify currently offers. In addition, Aptify was bought by Community Brands in 2017. This merger has resulted in less focus on the Aptify product thus leaving the ADA with many unknowns on the future of Aptify in regards to system support and new, more current functionality. This project will require a multi-year investment. The exact costs to

purchase and implement a new system are unknown at this time. This information will become available once vendor proposals have been received. The Board of Trustees will be kept apprised and the appropriate funding will be requested.

- *Aptify/Education*. An upgrade to the latest Aptify Web version for the CODA environment was completed in 2020. This back office upgrade provided additional features and functionality for the users. The new Admissions Test for Dental Hygiene (ATDH) was developed and implemented. This test allows for assessing applicants and making admissions decisions to dental hygiene programs. A project is underway to move the existing CERP database from MS Access as well as implement a new CERP eRecognition system to Aptify. These new solutions will replace the antiquated solution with a more modern system that provides web-based self-service functionality for staff and users. This project is slated for completion by year end. A project is underway to replace the CODA instance of Aptify with a system that meets the needs much more effectively than the current custom solution. The goal is to have the solution selected in 2021 and the implementation completed in 2022.

The table below outlines actual project implementation expenditures in the core areas in 2020, projected spending in 2021 and planned spending in 2022. Also disclosed is spending related to infrastructure hardware and major projects.

IT Core Area	2020 Actual Spending	2021 Projected Spending	2022 Planned Spending
Enterprise Reporting & Analytics	0	75,000	0
Websites	14,719	65,500	25,000
Mobile Applications	60,480	34,800	20,000
Digital Member Experience	16,575	535,750	1,175,750
Digital Member Experience (Reserves)	3,417,998	3,877,523	1,442,564
Finance/HR/Payroll	4,174	2,500	10,000
Finance/HR/Payroll (Reserves/Capital/Special Projects)	4,069	51,000	47,556
Infrastructure, Hardware & Software Licenses	539,859	729,086	1,437,750
Infrastructure, Hardware & Software Licenses (Reserves/Capital/Special Projects)	542,768	0	0
Aptify	303,851	846,000	590,000
Aptify (Reserves)	0	275,000	210,000
Total Project Spending	4,904,493	6,492,159	4,958,620
Balance of IT Operating Budget	12,590,392	12,036,642	12,607,228
Total IT Spending	17,494,885	18,528,801	17,565,848

Resolution

This report is informational and no resolutions are presented.

BOARD RECOMMENDATION: Vote Yes to Transmit.

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

Resolution No. N/A N/A

Report: Board Report 10 Date Submitted: August 2021

Submitted By: Board of Trustees

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

Total Net Financial Implication: None Net Dues Impact:

Amount One-time Amount On-going

ADA Strategic Plan Objective: Membership Obj-1: Increase membership market share of lagging demographics by 2% per year.

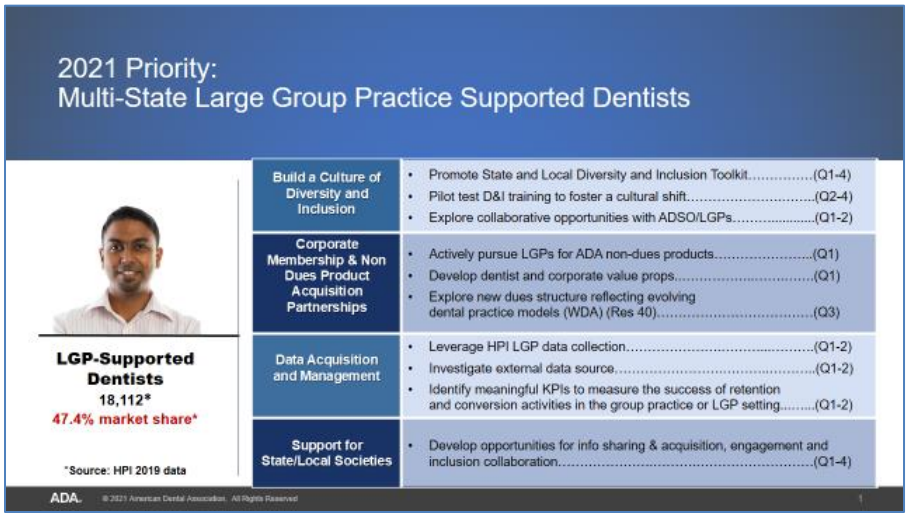
How does this resolution increase member value: Not Applicable

REPORT 10 OF THE BOARD OF TRUSTEES TO THE HOUSE OF DELEGATES: BOARD AUTHORIZED PILOT PROGRAM-LARGE GROUP PRACTICE MEMBERSHIP DUES STRATEGY

Background: An objective in the ADA Strategic Plan: Common Ground 2020-2025 is to increase membership in lagging demographics. The ADA has identified one such lagging demographic as dentists who practice in multi-state large group practice (LGP) settings. (Dental support organizations, or DSOs, are a type of LGP.) In addition, the ADA includes professional practice choice as a dimension of diversity. As such, the ADA must increase its engagement of dentists in LGP settings as part of its membership and diversity efforts.

To support the development of a cohesive LGP strategy, in 2020 the ADA Board of Trustees, at the recommendation of its New Dentist Committee (February 2020), adopted a resolution urging the Council on Membership to develop an overarching strategy to increase engagement for dentists practicing in LGP settings. The overarching strategy, consisting of four key pillars, was shared with the Board of Trustees in August 2020 and was also discussed with the Board of Trustees in February 2021, the outcomes from which discussion are presented in Exhibit 1:

Exhibit 1



Dues Structure Exploration:

The request for authorization of this pilot came to the Board of Trustees from the Council on Membership. In its request, the Council acknowledged that dentists working in multi-state large group practice (LGP) settings are an emerging market within in the field of dentistry and a lagging demographic within the ADA membership. (LGPs are inclusive of DSOs.) According to the ADA Health Policy Institute research on DSOs published in 2020, 47.4% of dentists working in DSOs were ADA members, which significantly lagged overall market share of 62.4%. Of all U.S. dentists, 10.4% were affiliated with a DSO (up from 7.4% in 2015), including one in five (20.4%) dentists under the age of 35 (up from 16.3% in 2015)[1]. This growth trend is expected to continue.

The Council considered a wide range of dues models that could more effectively attract LGP-supported dentists and decision makers within LGPs. They determined that offering membership dues discounts is not a sufficient strategy, nor is offering direct (national only) membership for dentists working in LGPs. They also considered the Great Expressions Dental Centers (GEDC) pilot program that was approved in 2018 and through which $1,141,433.25 in dues revenue has been collected from 2019 through 2021 to date. This model is not scalable in its current format due to the operational capacity demands required by ADA and multiple states and local societies to determine hundreds or thousands of dues totals. The Council determined that a flat-rate dues strategy had the greatest potential to eliminate this burden at the beginning of the acquisition process. In addition, the Council recognized the value of the ability to quote a real-time flat rate dues amount to LGPs during acquisition conversations and negotiations.

In the resulting proposed flat-rate dues model pilot, the ADA would annually calculate a flat dues amount by averaging national, state, and local full dues, weighted by the number of dentists in each state. This flat rate would be used by ADA representatives to quickly and consistently provide a dues quote for an LGP wishing to provide ADA membership for its affiliated/employed dentists, by multiplying the flat dues rate by the number of dentists in the LGP. The ADA could then conduct discussions with LGPs in a more agile format and avoid losing momentum during the time required to provide a quote of actual dues based on rosters that span multiple states. To accommodate greater transparency needs on the behalf of a LGP, the opportunity to wait for a more detailed quote would remain an option.

Pilot Flat-Rate Dues Structure Process:

- If an LGP agrees to the flat dues rate, the LGP would make a payment to the ADA (flat dues rate multiplied by X number of dentists in the LGP).

- Following payment by the LGP, the ADA would calculate and distribute the actual state and local dues owed for each member, to the states. Each state and local dental society would receive the dues rate at the appropriate rate code for that member. Payments would be reconciled on a determined schedule based on updated rosters as dentists join and leave the LGP. As the number of LGP acquisitions grows, this could require additional ADA staff capacity. (Distributing a flat dues rate to the states and locals for each member would be administratively simpler, but it is not feasible due to states' rights.)
- Any losses resulting from the flat dues rate quote would be absorbed by the ADA (losses are anticipated to be negligible (up to 1%) based on: the distribution of dentists in low/high dues states, the collection of full dues for all dentists – even those who qualify for early career discounts, the collection of dues from new members who are difficult to acquire – currently 53% of the LGP market, and the reliability of the practice data used for the model).
- Any dollars gained, which are anticipated to be negligible (up to 1%), would be absorbed by the ADA and revealed to the large group practice with value add offerings (not money) made available to them to offset the money gained by the ADA.

The Council also discussed that the ADA may, as part of the pilot, use the half-year dues (HYD) and quarter-year dues (QYD) offers to add value to negotiations with LGPs. For example, the ADA could offer free membership to the LGP's nonmember dentists through QYD along with a goal of direct payment for its members from the LGP or assistance from the LGP to influence payment from its individual doctors for the following year. The ADA would then use this 4Q period to activate member value strategies. This approach compliments the recently revamped QYD auto renewal program piloted by the Council on Membership and approved by the ADA Board of Trustees for adoption into operations in August 2020 (B-108-2020). To accommodate offering this option for bulk membership, and in the spirit of efficiency, the pilot would not enforce the one-time use limitation on these QYD and HYD offers. The ADA will also explore collaborations with key states that have interest in exploring member acquisition opportunities with LGPs.

An LGP's engagement with the ADA during the 4th Quarter will allow the ADA to thoughtfully build relationships with both the LGPs and its participating doctors through additional value adds and collaborations for the benefit of the profession. The ADA will also have additional opportunities to build non-dues revenue opportunities through these relationships.

Financial Risk/Benefits:

In 2019 the member market share among dentists in LGP settings was 47.4%, indicating that member revenues have the potential to be doubled among dentists within each participating LGP. The flat-rate dues model is projected to provide a positive impact on revenue. This is based on a variety of scenarios modeled by ADA membership analysis team using data from the ADA Health Policy Institute Office Database. The following chart in Exhibit 2 illustrates the potential gross and net revenue gains to the ADA and states/locals for each 100 dentists that are acquired through the pilot.

Exhibit 2

	# Dentists	Sample Flat Dues Rate	Total Dues Revenue	National Revenue	State and Local Revenue
Large Group Practice	**100**	**$1,500**	**$150,000**	**$57,400**	**$92,600**
Net Gain for each 100 dentists: (based on 47% current market share)				**$30,422**	**$49,076**

Staff will continue to validate this research using scenarios constructed during the pilot program. The ultimate goal is to build a parallel path for membership and revenue growth by optimizing ADA membership within each participating LGP, especially among dentists whom it would otherwise be very difficult for the ADA to acquire. This will also allow the ADA to increase engagement and enhance member experiences in order to build long-term growth.

After consideration, this pilot was approved by the ADA Board of Trustees at its July 2021 meeting by adoption of the following resolution:

> **B-70-2021. Resolved**, that the Board of Trustees authorizes the development and implementation of a pilot program of up to three years duration to explore efficiencies and interest in a dues collection process which allows the ADA to offer multi-state large group practices the option to pay an average flat-rate dues amount for its employed and affiliated dentists, which amount will be calculated by the ADA annually, and be it further
>
> **Resolved**, that as part of this pilot program the ADA work with interested state and local dental societies to:
>
> - coordinate the processes for collecting tripartite dues from large group practices on behalf of the dentists in said practices,
> - distribute the actual dues owed to the state and local societies choosing to participate in the pilot program, and
> - coordinate the processes for tripartite member value, engagement, and retention,
>
> and be it further
>
> **Resolved**, that that pilot program be assessed by the Council on Membership and reports be provided to the Board of Trustees and the House of Delegates annually after it has been implemented.

Discussions are underway with several large group practices to begin exploring their interest in participating in the pilot program.

Ongoing Consideration of Tripartite Membership Dues Structures:

The initial considerations and flat rate dues pilot program are a first step in the Council on Membership's response to Resolution 40-2020, Request that ADA Explore New Dues Structure Reflecting Evolving Dental Practice Models, and broader work to study the complex landscape of ADA membership structure and value propositions. The Council continues to look at opportunities to enhance the ADA's membership models—how membership and membership dues are structured within the Association, who pays what and how much, and what level of value they receive for the price. Early explorations reveal that variable options offer a host of advantages and disadvantages. Thus, careful consideration and analysis is

necessary to determine and implement an effective structure. As the Council conducts its exploration, consideration of the members' and potential members' preferences and the level of revenue risk that the Association can manage will be key considerations. The Council also recognizes that modernizing membership categories is not the sole answer and that value must be explored in tandem with a review of an enhanced membership structure.

Resolution

This report is informational and no resolution is presented.

[1] How Big are Dental Service Organizations?, ADA Health Policy Institute, 2020. Source: HPI analysis of the ADA masterfile and the Association of Dental Support Organizations (ADSO) membership list. Based on data from 2019. Notes: Dentists are considered to be affiliated with a dental service organization (DSO) if at least one location they practice in is a member of the ADSO or part of American Dental Partners, Western Dental Services Inc., Kool Smiles or Gentle Dental/Interdent.

BOARD RECOMMENDATION: Vote Yes to Transmit.

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

Resolution No. 78 New

Report: N/A Date Submitted: July 2021

Submitted By: Council on Membership

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

Total Net Financial Implication: None Net Dues Impact:

Amount One-time Amount On-going

ADA Strategic Plan Objective: Organizational Obj-7: Improve overall organizational effectiveness at the national and state levels.

How does this resolution increase member value: See Background

AMENDMENT OF THE POLICY, FOUR-YEAR RECENT GRADUATE REDUCED DUES PROGRAM

Background: In accordance with Resolution 170H-2012 (*Trans*.2012:370), Regular Comprehensive Policy Review, the Council conducted a review of ADA policies related to membership. Every ADA agency conducting policy reviews is advised to consider the following concepts during the process and when offering recommendations to the House of Delegates:

- Relevance to current situation
- Continued need
- Consistency with other Association policies
- Appropriateness of language and terminology

During its July 2021 meeting, the Council reviewed the ADA Policy, Four-Year Recent Graduate Reduced Dues Program *(Trans.*2008:482) and noted that the current recent graduate reduced dues program set forth in the *Governance and Organizational Manual of the American Dental Association* is a two-year program (CHAPTER I. Section B.1.a.i-iii). The House of Delegates approved the change from a four-year program to a two-year program by adoption of Resolution 15H-2019 (*Trans*.2019:242). To update the policy, the Council proposes the following resolution:

PROPOSED RESOLUTION

78. Resolved, that the ADA policy, Four-Year Recent Graduate Reduced Dues Program (*Trans*.2008:482), be amended as follows (additions underscored; deletions ~~stricken~~):

Two ~~Four~~-Year Recent Graduate Reduced Dues Program

Resolved, that the ADA urges constituent and component societies to adopt the ADA two ~~four~~-year reduced dues structure for recent dental school graduates.

BOARD RECOMMENDATION: Vote Yes.

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

Resolution No. 84 New

Report: N/A Date Submitted: August 2021

Submitted By: Council on Membership

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

Total Net Financial Implication: None Net Dues Impact:

Amount One-time Amount On-going

ADA Strategic Plan Objective: Organizational Obj-7: Improve overall organizational effectiveness at the national and state levels.

How does this resolution increase member value: See Background

RESCISSION OF THE POLICY, QUALIFICATIONS FOR MEMBERSHIP

Background: In accordance with Resolution 170H-2012 (*Trans*.2012:370), Regular Comprehensive Policy Review, the Council conducted a review of ADA policies related to membership. Every ADA agency conducting policy reviews is advised to consider the following concepts during the process and when offering recommendations to the House of Delegates:

- Relevance to current situation
- Continued need
- Consistency with other Association policies
- Appropriateness of language and terminology

At its July 2021 meeting, the Council reviewed the policy titled, Qualifications for Membership (*Trans*.1959:210,1996:672, 2013:365). Background related to the policy included a 2016 informational report that recapped the changes approved by the House of Delegates to Chapter I of the ADA *Bylaws (*Resolution 79H-2016), and which took effect following the following year, at adjournment of the 2017 House of Delegates *sine die*. At that time, one significant change was that dental licensure is no longer a requirement for membership. Due to this change in the *Bylaws* for the dental licensure requirement, the Council recommends rescission of the policy.

RESOLUTION

84. Resolved, that the ADA policy, Qualifications for Membership (*Trans*.1959:219; 1996:672; 2013:365), be rescinded.

BOARD RECOMMENDATION: Vote Yes.

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

WORKHSEET ADDENDUM
BOARD OF TRUSTEES
ADA POLICY TO BE RESCINDED

Qualifications for Membership (*Trans.*1959:219; 1996:672; 2013:365)

Resolved, that the constituent societies be requested to examine their bylaws and consider making any changes in the qualifications for an appropriate membership category to permit a dentist licensed in another state to become a member with other than resident active membership category.

Resolution No. 90 New

Report: N/A Date Submitted: August 2021

Submitted By: Eleventh Trustee District

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

Total Net Financial Implication: None Net Dues Impact:

Amount One-time Amount On-going

ADA Strategic Plan Objective: None

How does this resolution increase member value: Not Applicable

ELIMINATING BARRIERS FOR UNDERREPRESENTED MINORITIES INTO THE DENTAL PROFESSION

The following was submitted by the Eleventh Trustee District and transmitted on August 24, 2021, by Kainoa Trotter, Assistant Executive Director, Washington State Dental Association.

Background: *"Talent is equally distributed but opportunity is not" - Leila Janah*

A substantial body of literature has highlighted the many benefits that come from fostering a diverse and inclusive workforce. Increasing access to care and improving the quality of care received, especially among those who are underserved, are among the many benefits the literature has demonstrated. Improvements in patient communication, preventive care and patient satisfaction have also been demonstrated when there is concordance between providers and patients. Additionally, a more diverse healthcare workforce possesses a broader scope of lived experiences that will hold promise for shaping research and policy agendas that are more inclusive and equitable. (1)

This "diversity benefit" extends to students in professional schools as well. Increased student diversity has been associated with them being better prepared to care for treating diverse populations and also improves equitable access to care. A recent report by the ADA's Health Policy Institute confirms that the diversity of those enrolled in predoctoral dental education programs continues to lag far behind anything resembling parity, especially for those who identify as Black, Hispanic, American Indian and Alaska Native. (2) While there have been many local and national initiatives, (e.g., dental pipeline programs) to increase racial and ethnic diversity within dental education over the last 20+ years, enrollment data from U.S. dental schools in general shows minimal, if any, success. (3, 4)

Many factors have been cited as contributing to this enrollment disparity. The list includes, the cost of dental education, lack of academic preparation, the role of biases (e.g., anchor bias, performance bias) in admission requirements and candidate acceptance, lack of mentors, limited exposure to health careers and the use of high stakes examinations that are used in admissions decisions (e.g., Dental Admissions Test [DAT]). (5, 6, 7, 8, 9)

Looking through the lens of diversity and inclusion, the ADA has an opportunity to research and develop a strategic plan that will move the profession of dentistry's workforce toward racial and ethnic parity with the general population.

1. *My View: Why diversity in dentistry matters and how you can help". Laila Hishaw, D.D.S. ADA News April 09, 2021.*

2. *"The Dentist Workforce – Key Facts". The ADA's Health Policy Institute. February 2021.*

3. *First Year Dental Student Enrollment by Race/Ethnicity: Percent of Total Yearly Enrollment (1985-2016). Prepared by: Douglass L. Jackson, DMD, MS, PhD, Associate Dean - Equity, Diversity and Inclusion, University of Washington School of Dentistry.*

4. *"Estimation and Comparison of Current and Future Racial/Ethnic Representation in the US Health Care Workforce". Edward Salsberg, MPA; Chelsea Richwine, PhD; Sara Westergaard, MD, MPH; Maria Portela Martinez, MD, MPH; Toyese Oyeyemi, MPH, CHES; Anushree Vichare, MBBS, PhD; Candice P. Chen, MD, MPH. AMA Network Open. 2021;4(3):e213789, March 31, 2021.*

5. *"Growing Diversity in Dentistry Requires More Than a Diverse Pipeline". Steven Pollock president and CEO of DentaQuest. May 27, 2021. Todays Dental News*

6. *"Assessing the pipeline: Perceived barriers to applying to dental school among pipeline program alumni". Lorel E. Burns DDS, MS, Cheryline Pezzullo DDS, Rose J. Amable DDS, Lenny Mayorga DDS, Eugenia E. Mejia PhD. J Dent Educ. 2021 Feb;85 (2):157-165.*

7. *"Breaking Barriers for Underrepresented Minorities in the Health Professions". Christopher Toretsky, Sunita Mutha, and Janet Coffman. Healthforce Center at UCSF. July 2018*

8. *"The Impact of Dental School Admissions Processes on the Racial and Ethnic Composition of the Student Body". Pollene Speed-McIntyre, Douglass L. Jackson, Carol C. Brown Kathleen Craig Susan E. Coldwell. OHDM- Vol. 15- No.1-February, 2016.*

9. *"Diversity, equity, and inclusion interventions to support admissions have had little benefit to Black students over past 20 years". Romesh P. Nalliah BDS, MHCM, Peggy Timothé DDS, MPH, Michael S. Reddy DMD, DMSc. J Dent Educ. 2021;85:448–455.*

Therefore, the following resolution is presented for House consideration:

Resolution

90. Resolved, that an ADA Task Force be convened by the ADA President that will explore the current barriers for entry into the dental profession by underrepresented minorities, and be it further

Resolved, the ADA will develop policies and a broad-reaching strategy that will strengthen and support a workforce that is more representative of the population, and be it further

Resolved, that the task force shall report its findings and recommendations to the 2022 ADA House of Delegates.

BOARD COMMENT: Delivered to the House of Delegates absent Board of Trustees evaluation, recommendation or comment due to inadequate process time of resolution.

Resolution No. 90S-1 Substitute

Report: N/A Date Submitted: September 2021

Submitted By: Eleventh Trustee District

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

Total Net Financial Implication: None Net Dues Impact:

Amount One-time Amount On-going

ADA Strategic Plan Objective: None

How does this resolution increase member value: Not Applicable

ELIMINATING BARRIERS FOR UNDERREPRESENTED MINORITIES INTO THE DENTAL PROFESSION

The following was submitted by the Eleventh Trustee District and transmitted on August 24, 2021, by Kainoa Trotter, Assistant Executive Director, Washington State Dental Association.

Background: *"Talent is equally distributed but opportunity is not" - Leila Janah*

A substantial body of literature has highlighted the many benefits that come from fostering a diverse and inclusive workforce. Increasing access to care and improving the quality of care received, especially among those who are underserved, are among the many benefits the literature has demonstrated. Improvements in patient communication, preventive care and patient satisfaction have also been demonstrated when there is concordance between providers and patients. Additionally, a more diverse healthcare workforce possesses a broader scope of lived experiences that will hold promise for shaping research and policy agendas that are more inclusive and equitable. (1)

This "diversity benefit" extends to students in professional schools as well. Increased student diversity has been associated with them being better prepared to care for treating diverse populations and also improves equitable access to care. A recent report by the ADA's Health Policy Institute confirms that the diversity of those enrolled in predoctoral dental education programs continues to lag far behind anything resembling parity, especially for those who identify as Black, Hispanic, American Indian and Alaska Native. (2) While there have been many local and national initiatives, (e.g., dental pipeline programs) to increase racial and ethnic diversity within dental education over the last 20+ years, enrollment data from U.S. dental schools in general shows minimal, if any, success. (3, 4)

Many factors have been cited as contributing to this enrollment disparity. The list includes, the cost of dental education, lack of academic preparation, the role of biases (e.g., anchor bias, performance bias) in admission requirements and candidate acceptance, lack of mentors, limited exposure to health careers and the use of high stakes examinations that are used in admissions decisions (e.g., Dental Admissions Test [DAT]). (5, 6, 7, 8, 9)

Looking through the lens of diversity and inclusion, the ADA has an opportunity to research and develop a strategic plan that will move the profession of dentistry's workforce toward racial and ethnic parity with the general population.

This substitute for Resolution 90 provides examples of impactful organizations that should be members of the task force as well as clarifying that the task force, not the ADA, will be responsible for developing strategies and actions plans rather than policies for the organization to consider. The substitute resolution also recognizes that the ADA president has no control over whether third party organizations will provide members for the task force. Thus, the first resolve has been divided into two separate clauses that better defines these two separate and distinct actions.

1. *My View: Why diversity in dentistry matters and how you can help". Laila Hishaw, D.D.S. ADA News April 09, 2021.*

2. *"The Dentist Workforce – Key Facts". The ADA's Health Policy Institute. February 2021.*

3. *First Year Dental Student Enrollment by Race/Ethnicity: Percent of Total Yearly Enrollment (1985-2016). Prepared by: Douglass L. Jackson, DMD, MS, PhD, Associate Dean - Equity, Diversity and Inclusion, University of Washington School of Dentistry.*

4. *"Estimation and Comparison of Current and Future Racial/Ethnic Representation in the US Health Care Workforce". Edward Salsberg, MPA; Chelsea Richwine, PhD; Sara Westergaard, MD, MPH; Maria Portela Martinez, MD, MPH; Toyese Oyeyemi, MPH, CHES; Anushree Vichare, MBBS, PhD; Candice P. Chen, MD, MPH. AMA Network Open. 2021;4(3):e213789, March 31, 2021.*

5. *"Growing Diversity in Dentistry Requires More Than a Diverse Pipeline". Steven Pollock president and CEO of DentaQuest. May 27, 2021. Todays Dental News*

6. *"Assessing the pipeline: Perceived barriers to applying to dental school among pipeline program alumni". Lorel E. Burns DDS, MS, Cheryline Pezzullo DDS, Rose J. Amable DDS, Lenny Mayorga DDS, Eugenia E. Mejia PhD. J Dent Educ. 2021 Feb;85 (2):157-165.*

7. *"Breaking Barriers for Underrepresented Minorities in the Health Professions". Christopher Toretsky, Sunita Mutha, and Janet Coffman. Healthforce Center at UCSF. July 2018*

8. *"The Impact of Dental School Admissions Processes on the Racial and Ethnic Composition of the Student Body". Pollene Speed-McIntyre, Douglass L. Jackson, Carol C. Brown Kathleen Craig Susan E. Coldwell. OHDM- Vol. 15- No.1-February, 2016.*

9. *"Diversity, equity, and inclusion interventions to support admissions have had little benefit to Black students over past 20 years". Romesh P. Nalliah BDS, MHCM, Peggy Timothé DDS, MPH, Michael S. Reddy DMD, DMSc. J Dent Educ. 2021;85:448–455.*

Therefore, the following substitute to Resolution 90 is presented for House consideration (additions are underlined; deletions are ~~stricken~~):

Resolution

90S-1. Resolved, that an ADA Task Force be convened by the ADA President ~~that will~~ to explore the current barriers for entry into the dental profession by underrepresented minorities, and be it further

Resolved, that invitations be extended to at least the American Dental Education Association, American Student Dental Association, National Dental Association, Hispanic Dental Association and Society of American Indian Dentists to nominate members of their respective organizations to participate in the Task Force, and be it further

Resolved, the ~~ADA~~ Task Force will develop ~~policies and a~~ broad-reaching ~~strategy~~ strategies and action plans that will strengthen and support a workforce that is more representative of the population, and be it further

Resolved, that the Task Force shall report its findings and recommendations to the 2022 ADA House of Delegates.

BOARD COMMENT: Received after the September 2021 Board of Trustees Meeting.

Resolution No. 102 New

Report: N/A Date Submitted: September 2021

Submitted By: Third Trustee District

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

Total Net Financial Implication: None Net Dues Impact:

Amount One-time Amount On-going

ADA Strategic Plan Objective: Membership Obj-4: Increase overall average rates of conversion across membership categories by 1% per year.

How does this resolution increase member value: See Background

STRATEGY FOR ENGAGING DENTAL RESIDENTS

The following resolution was submitted by the Third Trustee District and transmitted on September 24, 2021 by Mr. Ward Blackwell, executive director, Pennsylvania Dental Association.

Background: The current ADA Strategic Plan specifically identifies lagging demographic segments targeted for recruitment. While National Signing Day is an effective vehicle for the initial engagement of graduating dental students, factors such as re-location, effective mentoring and local networking can lead to lost opportunities.

A significant portion of newly graduated dentists opt to attend post-graduate programs and general practice residencies. This cohort of practitioners very clearly reflects dentistry's new demographic and in turn creates the ideal opportunity at cementing a lifelong connection during their time in that insular environment. In fact, one of the primary motivations to attend a graduate practice residency is mentorship. And, a 2016 study in the *American Sociological Review* found that mentoring, in comparison to other tactics (such as mandatory diversity training), increased minority representation in the workplace anywhere from 9 to 24%.

Accordingly, a strong outreach to engage and mentor post-graduate dental students should significantly bolster ADA's member recruitment.

Resolution

102. Resolved, that the appropriate ADA agencies work collaboratively to formulate a specific strategy that is designed to engage, connect, recruit and develop long-term commitments with dental students in post-graduate programs, including general practice residencies, and be it further

Resolved, that said strategy be implemented as a new initiative no later than the 2022 House of Delegates, and starting with the 2023 House of Delegates the metrics for assessing the initiative's impact shall be reported as regular part of the business before the House of Delegates.

BOARD COMMENT: Received after the September 2021 Board of Trustees Meeting.

Resolution No. 103 New

Report: N/A Date Submitted: September 2021

Submitted By: Third Trustee District

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

Total Net Financial Implication: None Net Dues Impact:

Amount One-time Amount On-going

ADA Strategic Plan Objective: Membership Obj-3: Maintain an overall retention rate of 94%.

How does this resolution increase member value: See Background

RESOURCES FOR ADA DENTIST MEMBERS TRANSITIONING INTO RETIREMENT

The following resolution was submitted by the Third Trustee District and transmitted on September 24, 2021 by Mr. Ward Blackwell, executive director, Pennsylvania Dental Association.

Background: According to the ADA Health Policy Institute's *The Dentist Workforce – Key Facts* (published in February 2021), 37.4 percent of members are Baby Boomers, generally defined as those born between 1946 -1964. This is currently the largest segment of the ADA membership, and the vast majority of them either recently retired or will likely be doing so in a few years. Yet, our Association has very few resources to assist guiding into retirement, other than financial.

Questions such as, "How can I ease my transitioning into retirement?" or "How can I make retirement satisfying?" or "How can I prepare for retirement?" become real and extremely relevant to the seasoned dentist. Other professional associations, such as the Pennsylvania Psychological Association, for example, have such resources for their members, but we are lacking.

The proposed resolution addresses the ADA Mission Statement: to help dentists succeed, as well as its Core Values: Commitment to Members, and Inclusion.

Resolution

103. Resolved, that the appropriate agencies evaluate and develop a program that could possibly include a full-time counselor/advisor, and continuing education, both live face-to-face and virtual, to guide its members who are or will be transitioning into retirement, with resources to include, but not be limited to:

- basics of retirement living
- mental and emotional needs
- social needs
- current health needs
- long-term healthcare needs
- retirement budget
- personal or spiritual growth, and of course
- fun

and be it further

Resolved, that the appropriate agencies report back to the 2022 House of Delegates regarding said program and the financial implication of implementing it.

BOARD COMMENT: Received after the September 2021 Board of Trustees Meeting.

Resolution No. 105 New

Report: N/A Date Submitted: September 2021

Submitted By: Eleventh Trustee District

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

Total Net Financial Implication: None Net Dues Impact:

Amount One-time Amount On-going

ADA Strategic Plan Objective: Organizational Obj-7: Improve overall organizational effectiveness at the national and state levels.

How does this resolution increase member value: See Background

INCREASING TRANSPARENCY AND IMPROVING MEMBER ENGAGEMENT THROUGH VIRTUAL TESTIMONY AT THE HOUSE OF DELEGATES REFERENCE COMMITTEES

The following resolution was submitted by the Eleventh Trustee District and transmitted on September 22, 2021 by Mr. Kainoa Trotter, assistant executive director, Washington State Dental Association.

Background: In 2020, due to the COVID-19 Pandemic, all reference committee hearings were held virtually which provided ADA members the opportunity to participate in and provide testimony as has historically been afforded to ADA members in a live setting at the House of Delegates. The entire parliamentary community learned new methods in conducting virtual testimony at various meetings throughout the country during the past fifteen months. At this year's American Institute of Parliamentarians three-day West Coast Practicum in January 2021, parliamentarians from around the country concluded that virtual meetings will offer new possibilities in communications for associations going forward.

For many, observing reference committees showcases the breadth and depth of work that the ADA regularly performs in maintaining its position as America's leading oral health advocate. Furthermore, new voices were heard in 2020 because the virtual format provided the opportunity for an individual to engage on an issue of personal importance without being required to physically travel to a hotel ballroom in a pre-determined city. Requiring physical presence at a reference committee hearing restricts access primarily to those who can either afford to pay their own way or to those whose travel and lodging expenses are covered by a sponsoring organization.

Increasingly, members are demanding to know what benefits their membership in the ADA provides as well as more direct access to their association's governance processes. As technology dramatically reduces barriers to engagement, members (and potential members) are seeking out venues where their voices are both heard and are effecting change.

Unfortunately, the ADA unnecessarily restricts access to the materials related to its House of Delegates. Only members of a state dental association's House of Delegates delegation have access to the reports, resolutions, and other information pertinent to the business of the House of Delegates. Dues-paying members have limited ability to learn about the matters before the House of Delegates. Furthermore, the ADA does not disclose the names of the delegates and alternate delegates which further impedes access to members not in positions of leadership or influence who do not personally know these elected individuals.

The tripartite spends extensively to help our members voices be heard in external advocacy each year; the same commitment should be extended to ensuring our members can more easily contribute to sharing their experiences, knowledge, and beliefs on matters related to the dental profession that come before the House of Delegates each year. Ultimately, ADA policy will be stronger if all members impacted are provided an opportunity to provide input into the process.

While the COVID-19 Pandemic compelled the ADA to run the 2020 House of Delegates virtually, there were many lessons learned that can be applied to future meetings. The 2020 House of Delegates was executed successfully due in large part to tireless efforts by ADA Speaker of the House, leadership and staff. The lessons of the 2020 House of Delegates should offer opportunities from which we improve our member communications and shape future member engagement on the business before the House of Delegates.

To maintain its relevance, ADA must continually assess how decisions with sweeping impacts on the profession and patients are made. For decades, the ADA has utilized the same analog format from a time when synchronously connecting hundreds of people from several times zones could only be accomplished with in-person meetings. A fresh look at fostering new channels of communication for generating testimony for Reference Committees on various ADA policies has the potential to demonstrate value to the profession.

Resolution

105. Resolved, that the House of Delegates form an ADA task force to present a two-year pilot proposal to the 2022 House of Delegates for expanding reference committee testimony to members in a virtual format and making House of Delegates resolutions, reports, and other, non-privileged information accessible to all members virtually.

BOARD COMMENT: Received after the September 2021 Board of Trustees Meeting.

Dental Benefits, Practice and Related Matters

Resolution No. 42 New

Report: N/A Date Submitted: June 2021

Submitted By: Council on Dental Practice

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

Total Net Financial Implication: None Net Dues Impact:

Amount One-time Amount On-going

ADA Strategic Plan Objective: Public Goal Obj-9: The ADA will be the preeminent driver of trusted oral health information for the public and profession.

How does this resolution increase member value: See Background

AMENDMENT TO THE POLICY STATEMENT ON THE ROLE OF DENTISTRY IN THE TREATMENT OF SLEEP RELATED BREATHING DISORDERS

Background: The American Academy of Dental Sleep Medicine (AADSM) issued a position statement in 2020 on the Scope of Practice for Dentists Ordering or Administering Home Sleep Apnea Tests. The position statement advocates that a dentist "with appropriate training and education should not be prohibited from ordering or administering a home sleep apnea test (HSAT). HSAT results should be interpreted by a licensed physician for diagnosis and verification of treatment efficacy." Dr. Chad Gehani, then-ADA president, forwarded the position statement to the Council on Dental Practice (CDP/the Council) for its consideration.

The Council proposed an amendment to the American Dental Association's (ADA) current statement on the Role of Dentistry in the Treatment of Sleep Related Breathing Disorders to be more descriptive regarding dentists ordering or administering home sleep apnea tests. The amended policy statement will align with AADSM's position and be relevant to the current situation with appropriate language and terminology.

Resolution

42. Resolved, that the Statement on the Role of Dentistry in the Treatment of Sleep Related Breathing Disorders (*Trans.2017:269; 2019:270*) be amended as follows (additions are | underscored, deletions are ~~stricken~~).

Policy Statement on the Role of Dentistry in the Treatment of Sleep Related Breathing Disorders

Sleep related breathing disorders (SRBD) are disorders characterized by disruptions in normal breathing patterns. SRBD are potentially serious medical conditions caused by anatomical airway collapse and altered respiratory control mechanisms. Common SRBD include snoring, upper airway resistance syndrome (UARS) and obstructive sleep apnea (OSA). OSA has been associated with metabolic, cardiovascular, respiratory, dental and other diseases. In children, undiagnosed and/or untreated OSA can be associated with cardiovascular problems, impaired growth as well as learning and behavioral problems.

Dentists can and do play an essential role in the multidisciplinary care of patients with certain sleep related breathing disorders and are well positioned to identify patients at greater risk of

SRBD. SRBD can be caused by a number of multifactorial medical issues and are therefore best treated through a collaborative model. Working in conjunction with our colleagues in medicine, dentists have various methods of mitigating these disorders. In children, the dentist's recognition of suboptimal early craniofacial growth and development or other risk factors may lead to medical referral or orthodontic/orthopedic intervention to treat and/or prevent SRBD. Various surgical modalities exist to treat SRBD. Oral appliances, specifically custom-made, titratable devices can improve SRBD in adult patients. ~~compared to no therapy or placebo devices~~. Oral appliance therapy (OAT) can improve or effectively treat OSA in adult patients, especially those who are intolerant of continuous positive airway pressure (CPAP). Dentists are the only health care provider with the knowledge and expertise to provide OAT.

The dentist's role in the treatment of SRBD includes the following:

- Dentists are encouraged to screen patients for SRBD as part of a comprehensive medical and dental history to recognize symptoms such as daytime sleepiness, choking, snoring or witnessed apneas and an evaluation for risk factors such as obesity, retrognathia, or hypertension. If patients are at risk and appropriate candidates for home sleep apnea tests (HSAT) the dentist may order or administer the HSAT directly. If risk for SRBD is determined, ~~these~~ patients and pertinent patient information and HSAT data should be referred, ~~as needed,~~ to the appropriate physicians for ~~proper~~ diagnosis.

- In children, screening through history and clinical examination may identify signs and symptoms of deficient growth and development, or other risk factors that may lead to airway issues. If risk for SRBD is determined, intervention through medical/dental referral or evidenced based treatment may be appropriate to help treat the SRBD and/or develop an optimal physiologic airway and breathing pattern.

- Oral appliance therapy is an appropriate treatment for mild and moderate obstructive sleep apnea, and for severe obstructive sleep apnea when a CPAP cannot or will not be ~~is not~~ tolerated by the patient.

- When a physician diagnoses obstructive sleep apnea in a patient and the treatment with oral appliance therapy is recommended through written or electronic referral, a dentist should evaluate the patient for the appropriateness of fabricating a suitable oral appliance. If deemed appropriate, a dentist should fabricate an oral appliance, monitor its effectiveness and titrate the appliance as necessary.

- Dentists should obtain appropriate patient consent for treatment that reviews the proposed treatment plan, all available options and any potential side effects of using OAT and expected appliance longevity.

- Dentists treating SRBD with OAT should be capable of recognizing and managing the potential side effects through treatment or proper referral.

- Dentists who provide OAT to patients should monitor and adjust the Oral Appliance (OA) for treatment efficacy as needed, or at least annually. As titration of OAs has been shown to affect the final treatment outcome and overall OA success, ~~the use~~ of ~~unattended cardiorespiratory (Type 3) or (Type 4) portable monitors~~ HSAT may be used by the dentist to help define the optimal target position of the mandible. A dentist trained in the use of ~~these portable monitoring devices~~ HSAT'S may assess the objective interim results for the purposes of OA titration.

- Surgical procedures may be considered as a secondary treatment for OSA when CPAP or OAT is inadequate or not tolerated. In selected cases, such as patients with concomitant dentofacial deformities, surgical intervention may be considered as a primary treatment.

- Dentists treating SRBD should continually update their knowledge and training of dental sleep medicine with related continuing education.

- Dentists should maintain regular communications with the patient's referring physician and other healthcare providers to the patient's treatment progress and any recommended follow-up treatment.

- Follow-up sleep testing ~~by a physician~~ should be conducted so the physician ~~to~~ is able to evaluate the improvement or confirm treatment efficacy for the OSA, especially if the patient develops recurring OSA relevant symptoms or comorbidities.

BOARD RECOMMENDATION: Vote Yes.

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

Resolution No. 42S-1 Citation for Original Resolution: 3000

Submitted By: Sixteenth Trustee District Date Submitted: October 15, 2021

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

Financial Implications (if different from original resolution): $ None

AMENDMENT TO THE POLICY STATEMENT ON THE ROLE OF DENTISTRY IN THE TREATMENT OF SLEEP RELATED BREATHNG DISORDERS

The following substitute was submitted by the Sixteenth Trustee District and transmitted on October 15, 2021 by Dr. John Comisi, Alternate Delegate.

42S-1. Resolved, that the *Statement on the Role of Dentistry in the Treatment of Sleep Related Breathing Disorders (Trans.2017:269; 2019:270) be amended as follows (*additions are double underscored, deletions are ~~double stricken~~).

Policy Statement on the Role of Dentistry in the Treatment of Sleep Related Breathing Disorders

Sleep related breathing disorders (SRBD) are disorders characterized by disruptions in normal breathing patterns. SRBD are potentially serious medical conditions caused by anatomical airway collapse and altered respiratory control mechanisms. Common SRBD include snoring, upper airway resistance syndrome (UARS) and obstructive sleep apnea (OSA). OSA has been associated with metabolic, cardiovascular, respiratory, dental and other diseases. In children, undiagnosed and/or untreated OSA can be associated with cardiovascular problems, impaired growth as well as learning and behavioral problems.

Dentists can and do play an essential role in the multidisciplinary care of patients with certain sleep related breathing disorders and are well positioned to identify patients at greater risk of SRBD. SRBD can be caused by a number of multifactorial medical issues and are therefore best treated through a collaborative model. Working in conjunction with our colleagues in medicine, dentists have various methods of mitigating these disorders. In children, the dentist's recognition of suboptimal early craniofacial growth and development or other risk factors may lead to medical referral or orthodontic/orthopedic intervention to treat and/or prevent SRBD. Various ~~surgical~~ modalities exist to treat SRBD. Oral appliances, specifically custom-made, titratable devices can improve SRBD in adult patients. ~~compared to no therapy or placebo devices~~. Oral appliance therapy (OAT) can improve or effectively treat OSA in adult patients, especially those who are intolerant of continuous positive airway pressure (CPAP). Dentists are the only health care provider with the knowledge and expertise to provide OAT.

The dentist's role in the treatment of SRBD includes the following:

- Dentists are encouraged to screen patients for SRBD as part of a comprehensive medical and dental history to recognize symptoms such as daytime sleepiness, choking, snoring or witnessed apneas and an evaluation for risk factors such as obesity, retrognathia, or hypertension. If patients are at risk and appropriate candidates for home sleep apnea tests (HSAT) the dentist may order or administer the HSAT directly. If risk for SRBD is determined, ~~these~~ patients and pertinent patient information and HSAT data should be referred, ~~as needed,~~ to the appropriate sleep physicians for ~~proper~~ diagnosis.

- In children, screening through history and clinical examination may identify signs and symptoms of deficient growth and development, or other risk factors that may lead to airway issues. If risk for SRBD is determined, intervention through medical/dental referral or evidenced based treatment may be appropriate to help treat the SRBD and/or develop an optimal physiologic airway and breathing pattern.

- Oral appliance therapy is an appropriate treatment for mild and moderate obstructive sleep apnea, and for severe obstructive sleep apnea when a CPAP cannot or will not be ~~is not~~ tolerated by the patient.

- When a sleep physician diagnoses obstructive sleep apnea in a patient and the treatment with oral appliance therapy is recommended through written or electronic referral, a dentist should evaluate the patient for the appropriateness of fabricating a suitable oral appliance. If deemed appropriate, a dentist should fabricate an oral appliance, monitor its effectiveness and titrate the appliance as necessary.

- Dentists should obtain appropriate patient consent for treatment that reviews the proposed treatment plan, all available options and any potential side effects of using OAT and expected appliance longevity.

- Dentists treating SRBD with OAT should be capable of recognizing and managing the potential side effects through treatment or proper referral.

- Dentists who provide OAT to patients should monitor and adjust the Oral Appliance (OA) for treatment efficacy as needed, or at least annually. As titration of OAs has been shown to affect the final treatment outcome and overall OA success, ~~the use~~ of ~~unattended cardiorespiratory (Type 3) or (Type 4) portable monitors~~ HSAT may be used by the dentist to help define the optimal target position of the mandible. A dentist trained in the use of ~~these portable monitoring devices~~ HSAT'S may assess the objective interim results for the purposes of OA titration.

- Surgical procedures may be considered as a secondary treatment for OSA when CPAP or OAT is inadequate or not tolerated. In selected cases, such as patients with concomitant dentofacial deformities, surgical intervention may be considered as a primary treatment.

- Dentists treating SRBD should continually update their knowledge and training of dental sleep medicine with related continuing education.

- Dentists should maintain regular communications with the patient's referring physician and other healthcare providers to the patient's treatment progress and any recommended follow-up treatment.

- Follow-up sleep testing ~~by a physician~~ should be conducted so a sleep ~~the~~ physician ~~to~~ is able to evaluate the improvement or confirm treatment efficacy for the OSA, especially if the patient develops recurring OSA relevant symptoms or comorbidities.

Resolution No. 43 New

Report: N/A Date Submitted: June 2021

Submitted By: Council on Dental Practice

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

Total Net Financial Implication: None Net Dues Impact:

Amount One-time Amount On-going

ADA Strategic Plan Objective: Public Goal Obj-9: The ADA will be the preeminent driver of trusted oral health information for the public and profession.

How does this resolution increase member value: See Background

PROPOSED ADA POLICY STATEMENT ON THE USE OF AUGMENTED INTELLIGENCE IN DENTISTRY

Background: Healthcare augmented intelligence (AI) concepts are being increasingly applied to the practice of dentistry and have had a significant impact on the delivery of patient care. AI algorithms have been developed for use in visual perception, speech recognition, decision-making, and forecasting future outcomes, behaviors, and trends.

As a healthcare policy leader, the American Dental Association has a unique opportunity to ensure that the integration of AI in dentistry is beneficial to patients, dentists and the dental workforce. It must be utilized in ways that will promote quality of care, minimize adverse consequences, support the clinical skills training and development of dentists, dental students, and dental team members or have the potential to reduce barriers to equitable access to oral health care.

Resolution

43. Resolved, that the ADA Policy Statement on the Use of Augmented Intelligence in Dentistry be adopted.

ADA Policy Statement on the Use of Augmented Intelligence in Dentistry

Augmented intelligence (AI) is the theory and development of computer systems that can perform tasks that would otherwise require human intelligence, such as visual perception, speech recognition, decision-making and translation between languages. The term may also be applied to any software that performs intelligent behavior and acts intelligently.

The ADA supports using AI as a tool to supplement the dentist's clinical judgment rather than a technology to replace or override it, while taking into account a patient's clinical presentation, including history, examination, and relevant tests.

- The ADA encourages the development of thoughtfully designed, high-quality, clinically validated dental AI.
- The ADA urges dental professionals to become fully informed about AI technology and how it might support the delivery of patient care.

- The ADA encourages training and education for dental students to ensure that all clinicians in the United States can incorporate AI into clinical practice.

Dental AI Developers: The ADA urges entities to incorporate the following principles when developing AI systems for dental care applications:

- Integrate, when possible, the perspective of practicing dentists in the development, design, validation, and implementation of dental care AI;
- Design and evaluate AI systems following the best practices in dentistry;
- Ensure that the development process of such systems is transparent and conforms to leading standards for reproducibility;
- Address bias and avoid introducing or exacerbating health care disparities when testing on vulnerable populations or deploying new AI tools;
- Demonstrate the efficacy and accuracy of AI systems with reliable data obtained from the relevant clinical domains;
- Safeguard the privacy of patients and other individuals and securing their personal and medical information.

Clinical Practitioners: The ADA supports the following principles for the introduction of AI systems into clinical dental practice:

- Produce outcomes that match or exceed the currently accepted standard of care;
- Prioritize patient safety when using an AI system;
- Encourage dental educators to introduce clinical AI systems in practice and to foster digital literacy in the current and future dental workforce;
- An AI system in clinical dental practice should be supervised by a dentist;
- Identify and acknowledge the limitations of an AI system in clinical decision-making, and continue to collaborate or consult with clinical colleagues as appropriate;
- Demonstrate the efficacy of AI systems with reliable data obtained from the relevant clinical domains;
- Interpret data from dental AI to allow for clinical observation and judgment input from dentists, with an ongoing emphasis on risk management, accountability, and bias;
- Obtain the appropriate informed consent, permission, privacy controls, checks for accuracy and relevance of any patient data used in original development or ongoing refinement of AI algorithms;
- Use patient data only for the stated purpose and storing such data securely.

Third-Party Payers: The ADA supports the following principles for the introduction of AI systems into the claims adjudication processes by third-party payers:

- All decisions on treatment are appropriately the result of a joint discussion between the patient and the dentist;

- If AI is used by dental benefit plans as a tool to assist with claims processing or adjudication, that tool should not be used to diagnose or dictate a treatment plan that interferes with the doctor-patient decision process or deny any benefits that the patient is entitled to under their plan;

- Any AI tool used by third party payers should not be used to direct patients to specified preferred providers;

- AI systems should not allow for denial of claims without consultant review.

BOARD RECOMMENDATION: Vote Yes.

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

Resolution No. 54 New

Report: N/A Date Submitted: June 2021

Submitted By: Council on Dental Practice

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

Total Net Financial Implication: None Net Dues Impact:

Amount One-time Amount On-going

ADA Strategic Plan Objective: Public Goal Obj-9: The ADA will be the preeminent driver of trusted oral health information for the public and profession.

How does this resolution increase member value: See Background

RESCISSION OF POLICY, INDIVIDUAL PRACTICE ASSOCIATION

Background: In accordance with Resolution 170H-2012 (*Trans.* 2012:370) Regular Comprehensive Policy Review, the Council on Dental Practice reviewed the policy titled Individual Practice Association (*Trans*.1990:540).

The current dynamics of Individual Practice Associations have changed significantly in the 30 years since it was adopted. The Council found no added value in maintaining a definition that is no longer relevant to current situation.

Resolution

54. Resolved, that the ADA policy Individual Practice Association (*Trans*.1990:540) be rescinded.

BOARD RECOMMENDATION: Vote Yes.

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

WORKSHEET ADDENDUM
COUNCIL ON DENTAL PRACTICE
POLICY TO BE RESCINDED

Individual Practice Association (*Trans*.1990:540)

Resolved, that the following definition of Individual Practice Association be adopted:
A legal entity organized and governed by individual participating dentists for the primary purpose of collectively entering into contracts to provide dental services to enrolled populations.

Resolution No. 55 New

Report: N/A Date Submitted: June 2021

Submitted By: Council on Dental Practice

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

Total Net Financial Implication: None Net Dues Impact:

Amount One-time Amount On-going

ADA Strategic Plan Objective: Public Goal Obj-9: The ADA will be the preeminent driver of trusted oral health information for the public and profession.

How does this resolution increase member value: See Background

RESCISSION OF POLICY, SUPPORT FOR INDIVIDUAL PRACTICE ASSOCIATIONS

Background: In accordance with Resolution 170H-2012 *Regular Comprehensive Policy Review* (*Trans.* 2012:370), the Council on Dental Practice reviewed the policy Support for Individual Practice Associations (IPAs) (*Trans.*1988:475; 1994:655; 2000:458; 2013:305)

The Individual Practice Associations have changed significantly in the 30 years since this policy was adopted. The Council determined that Support for Individual Practice Associations was no longer relevant to the current situation.

Resolution

55. Resolved, that the policy titled Support for Individual Practice Associations (IPAs) (*Trans.*1988:475; 1994:655; 2000:458; 2013:305) be rescinded.

BOARD RECOMMENDATION: Vote Yes.

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

WORKSHEET ADDENDUM
COUNCIL ON DENTAL PRACTICE
POLICY TO BE RESCINDED

Support for Individual Practice Associations (*Trans.*1988:475; 1994:655; 2000:458; 2013:305)

Resolved, that the American Dental Association provide information to members and plan purchasers about dental individual practice associations (IPAs) that includes legal and regulatory limitations on the uses of IPAs.

Resolution No. 63 New

Report: N/A Date Submitted: June 2021

Submitted By: Council on Dental Benefit Programs

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

Total Net Financial Implication: None Net Dues Impact:

Amount One-time Amount On-going

ADA Strategic Plan Objective: Public Goal Obj-10: Dental benefit programs will be sufficiently funded and efficiently administered.

How does this resolution increase member value: See Background

PROPOSED POLICY FOR THE ELIMINATION OF WAIT PERIODS FOR CHILDREN IN DENTAL BENEFIT PLANS

Background: Many dental plans have imposed wait periods before coverage for certain procedures begins and these waiting periods may delay necessary dental treatment especially for children. This policy seeks to eliminate wait periods in dental benefit policies especially for children.

In accordance with Resolution 97H-2020, Special Order of Referral Consent Calendar, which directed the appropriate ADA agencies to report back to the 2021 House of Delegates on each Referred Resolution, Resolution 83-2020 and Resolution 83B-2020 were reviewed by the Council. Resolutions 83-2020 and 83B-2020 are appended to this report.

The Council supports Resolution 83B. In addition, the Council wishes to specifically call out wait periods for orthodontic care.

Resolution

63. Resolved, that the American Dental Association supports the elimination of wait periods for treatment, <u>including orthodontic treatment,</u> for children from dental benefit plans.

BOARD RECOMMENDATION: Vote Yes.

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

2020 Resolution 83—First Trustee District—Policy for the Elimination of Wait Periods for Children in Dental Benefit Plans and 2020 Resolution 83B—Board Substitute

83-2020. Resolved, that the American Dental Association supports the elimination of wait periods for treatment for children from dental benefit plans, and be it further

Resolved, that the American Dental Association shall support legislative efforts to eliminate treatment wait periods for children in the United States on the state and federal levels.

83B-2020. Resolved, that the American Dental Association supports the elimination of wait periods for treatment for children from dental benefit plans~~, and be it further~~

~~**Resolved,** that the American Dental Association shall support legislative efforts to eliminate treatment wait periods for children in the United States on the state and federal levels~~.

Resolution No. 71 Amendment

Report: N/A Date Submitted: June 2021

Submitted By: Council on Dental Benefit Programs

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

Total Net Financial Implication: None Net Dues Impact:

Amount One-time Amount On-going

ADA Strategic Plan Objective: Public Goal Obj-10: Dental benefit programs will be sufficiently funded and efficiently administered.

How does this resolution increase member value: See Background

AMENDMENT OF THE POLICY, THIRD-PARTY PAYERS OVERPAYMENT RECOVERY PRACTICES

Background: In accordance with Resolution 97H-2020, Special Order of Referral Consent Calendar, which directed the appropriate ADA agencies to report back to the 2021 House of Delegates on each Referred Resolution, Resolution 105-2020 was reviewed by the Council.

Dental offices have reported receiving requests for alleged overpayments by dental insurance companies sometimes up to 3-4 years after a claim has been paid. This puts the dental office in an awkward collections position as these patients may no longer be patients of record with the treating dentist. Resolution 105-2020 directed the Council to review ADA policies regarding recoupment practices. Resolution 105-2020 is appended to this report.

The Council reviewed the policies cited in Resolution 105-2020 and would like to address the issue of recoupment practices by amending existing policy, Third-Party Payers Overpayment Recovery Practices (*Trans*.1999:930; 2013:312) with the proposed revisions for consideration by the 2021 House of Delegates.

Resolution

71. Resolved, that the policy titled Third-Party Payers Overpayment Recovery Practices (*Trans*.1999:930; 2013:312) be amended as follows (additions are underscored; deletions are stricken):

Resolved, that the American Dental Association shall and its constituent societies are urged to seek or support legislation to prevent third-party payers from withholding assigned benefits or recouping payment when a payment made in error has been made on behalf of a different patient covered by the same third-party payer or because of an alleged overpayment to a different dentist, and be it further

Resolved, that dental plans should not retroactively deny, adjust, or seek recoupment or refund of a paid claim for dental care expenses submitted by a provider for any reason, other than fraud or for duplicate payments on claims received from the same plan for the same service from a provider, after the expiration of six months from the date that the initial claim was paid. The plan must provide information about why a refund is due, including the name of the patient, date of service and service provided along with the reason for the overpayment and allow the provider six

months before the refund must be paid. The provider should be allowed 30 days to contest the refund request, and be it further

Resolved, that dental plans, representing self-funded and fully-insured plans, be urged to adopt these guidelines as an industry-wide standard for alleged overpayment of benefits to dentists.

BOARD RECOMMENDATION: Vote Yes.

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

WORKSHEET ADDENDUM

2020 RESOLUTION 105—FOURTEENTH TRUSTEE DISTRICT—INAPPROPRIATE RECOUPMENT PRACTICES OF DENTAL BENEFIT COMPANIES

105. Resolved, that the ADA Council on Dental Benefits Plans (CDBP) review ADA policies regarding recoupment practices including Bulk Benefit Payment Statements (*Trans.*1990: 536, 2013:308, 2015:243); Third-Party Payers Overpayment Recovery Practices (*Trans.*1999:930, 2013:312) and Third Party Payment Choices (*Trans*.2017:265) and, be it further

Resolved, that the Council recommend a policy to encourage fair recoupment practices including reasonable time limitations and regular oversight by regulating agencies.

Resolution No. N/A New

Report: Council on Dental Practice Report 1 Date Submitted: June 2021

Submitted By: Council on Dental Practice

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

Total Net Financial Implication: None Net Dues Impact:

Amount One-time Amount On-going

ADA Strategic Plan Objective: Public Goal Obj-9: The ADA will be the preeminent driver of trusted oral health information for the public and profession.

How does this resolution increase member value: See Background

COUNCIL ON DENTAL PRACTICE REPORT 1 TO THE HOUSE OF DELEGATES: RESPONSE TO RESOLUTION 28H-2019, PEDIATRIC SCREENING FOR SLEEP-RELATED BREATHING DISORDERS

Background: The 2019 House of Delegates adopted the following resolution:

Resolution 28H-2019 Pediatric Screening for Sleep-Related Breathing Disorders

Resolved, that the American Dental Association, through its appropriate agency or agencies, develop and promote a screening tool/protocol for pediatric airway issues for use by dentists.

The proposal for this resolution was to collaborate with other specialty groups and stakeholders to produce a protocol or screener that will serve as the consensus tool for the profession to identify children at risk of breathing disorders.

The Council on Dental Practice (The Council/CDP) convened an advisory group of experts to discuss various existing tools and to assess the work done to date by the Children's Airway Screener Taskforce (CAST) on a screening tool and to gain an understanding of their future validation intentions. The CDP advisory group held its first meeting virtually in April 2021.

The CDP discussed the work of CAST at the Council's May 2021 meeting. The Council elected to continue to engage with and monitor the work of CAST in the creation and validation of a screening tool. The validation process will be based on a variety of program evaluation criteria measuring specificity, sensitivity and spectrum bias. The intent of the validation process will be to generate statistically relevant data that will ultimately support a screening tool/protocol. The findings will be reported at a future meeting of the House of Delegates.

Resolution

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. 74 New

Report: N/A Date Submitted: August 2021

Submitted By: Council of Dental Benefit Programs

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

Total Net Financial Implication: None Net Dues Impact:

Amount One-time Amount On-going

ADA Strategic Plan Objective: Public Goal Obj-10: Dental benefit programs will be sufficiently funded and efficiently administered.

How does this resolution increase member value: See Background

PROPOSED POLICY, DENTAL BENEFITS WITHIN AFFORDABLE CARE ACT MARKETPLACE AND A PUBLIC OPTION

Background: The emerging issue of federal "public option" legislation began in earnest in the previous 116th Congress when several bills were introduced that would expand the role of public programs in health care[1] and it continues be addressed in healthcare reform bills in the 117th Congress. A "public option" could refer to several different policy proposals including but not limited to:

- A Medicare buy-in option for older individuals not yet eligible for the current Medicare program.
- A Medicaid buy-in option that states can elect to offer to individuals through the ACA Marketplace.
- A new public plan option that would be offered to individuals through the ACA Marketplace.

The ADA's position on plans offered though the Affordable Care Act Marketplaces including any government-administered plan remains unclear.

The dental industry has not seen very large impacts since the ACA was enacted in 2012. Over 90% of enrollees are between ages of 18--64 years of age.[2] Of the approximately 11.4 million consumers enrolled in a Marketplace plan during the 2020, only 1.76 million purchased a Stand Alone Dental Plan (SADP) within the Marketplace in 2020.[3] Pediatric dental benefits are considered "Essential Health Benefits" and are available to the limited number of children enrolled in Marketplace plans either through SADP's or within medical plans (Qualified Health Plans). Seventy percent of current Marketplace enrollees are under 250% of the Federal Poverty Level (FPL), with over 90% of enrollees below 400% FPL.

Under a public option introduced within the ACA Marketplaces, the government could create a public financing system potentially administered by the Centers for Medicare & Medicaid Services (CMS). That system would likely be available to all consumers as a choice to purchase through the ACA Marketplaces. Private plans being sold in the Marketplaces would compete with a government plan to attract enrollees.

[1] Kaiser Family Foundation, Compare Medicare-for-all and Public Plan Proposals, May 15, 2019. Accessed March 17, 2021. https://www.kff.org/interactive/compare-medicare-for-all-public-plan-proposals/

[2] Centers for Medicare and Medicaid Services, Health Insurance Exchanges 2020 Open Enrollment Report, April 1, 2020. Accessed March 17, 2021 https://www.cms.gov/files/document/4120-health-insurance-exchanges-2020-open-enrollment-report-final.pdf

Resolution

74. Resolved, that within the Marketplaces established by the Affordable Care Act:

- Dental coverage should be available to consumers through Stand Alone Dental Plans.
- Diagnostic and preventive dental services embedded within Qualified Health Plans should be covered without any additional co-payment, co-insurance or deductibles.
- Dental care is essential across the individual's life span. Individuals seeking to purchase benefits in the Marketplaces must be able to purchase dental benefits without having to first purchase a medical plan.
- Plan designs should remain flexible and offer consumers adequate choices balancing cost and benefit value.
- Dental Plans offered in the Marketplaces must be required to transparently report Dental Loss Ratios (DLR).
- Cost sharing assistance or premium tax credits should be available to consumers purchasing dental plans.

and be it further

Resolved, that if a public option plan that includes pediatric or adult dental benefit plans were introduced within the Marketplaces established by the Affordable Care Act, then such plans should:

- Allow freedom of choice for patients to seek care from any dentist while continuing to receive the full program benefit.
- Not force any providers, including those already participating in existing public programs, to join a Marketplace plan network and instead should support fair market competition, including meaningful negotiation of contracts and annual adjustment of fee schedules.
- Only include minimal and reasonable administrative requirements to promote participation and provide meaningful access.

BOARD RECOMMENDATION: Vote Yes.

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

Resolution No. 79 New

Report: N/A Date Submitted: August 2021

Submitted By: New York State Dental Association

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

Total Net Financial Implication: $40,000 Net Dues Impact: .40

Amount One-time _____ Amount On-going _____

ADA Strategic Plan Objective: Public Goal Obj-9: The ADA will be the preeminent driver of trusted oral health information for the public and profession.

How does this resolution increase member value: See Background

NATIONAL DENTAL ENDOSSEOUS IMPLANT REGISTRY

The following resolution was submitted by the New York State Dental Association and transmitted on August 24, 2021, by Dr. Mark Feldman, executive director, New York State Dental Association.

Background: There are many instances when knowing the manufacturer of a previously placed endosseous implant (including type and size) would provide valuable information for a subsequent-treating dentist. New patients can present to dental practices with loose, failed, or failing implant prostheses where good integration of the implant exists. In addition, there are times when an existing fixed partial denture (FPD) needs to be modified or expanded by the placement of additional fixtures. Attempting to identify a particular implant can be a daunting (and, perhaps, embarrassing) undertaking, especially with the vast assortment of implants that historically have been made available to dentists (some of which may no longer be available). Relying solely on a radiograph or fixture mount is often insufficient. However, being able to access details about an existing implant(s) would, undoubtedly, facilitate treatment.

A national registry of all implant placements would benefit dentists and patients alike. The registry can track patients, implant manufacturer, type, size, and location and be a valuable resource for the profession. In addition, establishing potential trends, such as implant failure associated with a given manufacturer or implant type, would provide useful data for analysis. Such a database would improve care well into the future. Accordingly, the following resolution is submitted for consideration.

Resolution

79. Resolved, that the American Dental Association investigate the establishment of a dental endosseous implant registry, and be it further

Resolved, that the registry maintain data on placed implants by patient, date of placement, implant manufacturer, type, size and intraoral location, and be it further

Resolved, that the database be accessible by dentists only and for the express purpose of providing information that can be of assistance in improving patient care, and be it further

Resolved, that a report with any recommendations be presented to the 2022 American Dental Association House of Delegates meeting.

BOARD COMMENT: The Board appreciates the intent of Resolution 79 submitted by New York State Dental Association. However, the Board believes that establishing a new endosseous implant registry at this time is duplicative, costly and poses significant cybersecurity risks for the Association to manage.

Per House Resolution 25H-2018, the ADA is in the process of developing a comprehensive oral health clinical data warehouse through the newly launched (July 2021) ADA Dental Experience and Research Exchange (DERE) program. This is a multi-year, multi-million dollar effort. DERE aims to connect with practice management software systems to automatically extract clinical data from participating dental practices into a centralized data warehouse.

Part of the clinical data that could potentially be extracted is information regarding implants available within the patient record. However, most practice management software systems do not capture the Unique Device Identifiers (UDI) on implant product labels as structured data within the patient chart. Feasibility of acquiring UDI information in common formats under these circumstances needs to be explored. The ADA Technical Report No. 1081 on UDI's developed through the Standards Committee on Dental Informatics provides more information on technological challenges associated with UDI implementation at the point of care. Without a means of acquiring this data automatically from patient management software or the FDA, dentists would need to voluntarily enter data into a registry with each surgical placement, separately from all other data entry into their own system. Indications to date are that dentists resist separate data entry in addition to their current workflow.

In establishing DERE, the ADA has already gained much of the experiential knowledge this investigation would produce. Significant challenges include cybersecurity risks associated with extracting and storing identifiable patient data and the need for every participating dental office to seek consent from each patient before the data could be transmitted to the ADA. Note that the DERE program is specifically designed around a limited data set (as defined by HIPAA), meaning the data is de-identified. Housing identifiable patient data is a risk the ADA determined it did not want to take when establishing DERE.

While the resolution only seeks an investigation into the establishment of an endosseous registry, we believe that the knowledge gained through the establishment of DERE already exposes known concerns. Therefore, we cannot support additional time and financial resources to assess feasibility of the proposed project.

BOARD RECOMMENDATION: Vote No.

Vote: Resolution 79

ARMSTRONG	Yes	HIMMELBERGER	No	MARANGA	Yes	RODRIGUEZ	No
DOROSHOW	No	KESSLER	Yes	MEDOVIC	Yes	ROSATO	Yes
EDGAR	No	LEARY	Yes	MORRISON	No	SABATES	No
FIDDLER	Yes	LEIGHTY	Yes	OYSTER	No	SHEPLEY	Yes
HARRINGTON	No	LIDDELL	No	RAPINI	No	STEPHENS	No

Resolution No. 85 New

Report: N/A Date Submitted: August 2021

Submitted By: Indiana Dental Association

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

Total Net Financial Implication: $150,000 Net Dues Impact: $1.50

Amount One-time _____ Amount On-going $150,000

ADA Strategic Plan Objective: Membership Obj-1: Increase membership market share of lagging demographics by 2% per year.

How does this resolution increase member value: See Background

ADDRESSING THE DENTAL TEAM WORKFORCE SHORTAGE

The following amendment was submitted by Mr. Doug Bush, executive director, Indiana Dental Association and transmitted on August 26, 2021.

Background: Dentistry is facing a workforce crisis. A shortage of dental hygienists, dental assistants and dental office administrative staff that existed prior to COVID-19 appears to have been exacerbated by the pandemic, as some staff members did not return to the profession after COVID-related dental office shutdowns.

According to a May 17, 2021 study by the ADA Health Policy Institute, 35.8% of owner dentists were recruiting assistants; 28.8% were seeking hygienists and 26.5% were seeking administrative support staff. The same study reported hiring struggles: 86% of dentists reported hygiene recruitment efforts as "extremely" or "very" challenging; and 83% reported assistant recruitment efforts as "extremely" or "very" challenging.

While COVID is partially to blame, the American Dental Education Association (ADEA) *Snapshot of Dental Education 2019-20 (page 4*) data indicates that the problem has been developing for many years. According to ADEA, from 2007 through 2017, the average number of dentists graduating from CODA-accredited educational programs each year increased from 4,714 to 6,238 (32.3%). During the same 10-year period, the average number of hygienist graduates from CODA-accredited programs increased modestly from 6,652 to 7,294 (9.7%), and the average number of assistants from CODA accredited programs actually decreased from 6,097 to 4,852 (-20.4%), partially the result of the increase in unaccredited assisting programs. Clearly the number of graduating dental team members is not keeping pace with the number of graduating dentists.

There is no single solution to this growing workforce shortage. A kneejerk reaction may be to increase class sizes, but some schools report declining applications and enrollment. The problem is not just a need for larger classrooms, but a need for a larger applicant pool. Dentistry needs to be more aggressive in attracting young people to dentistry, hygiene and assisting careers.

The ADA Mission is to "help dentists succeed and support the advancement of the health of the public." It is imperative that dentists be supported by an adequate, well-trained dental team workforce. This is a critical element in access to care and the financial viability and sustainability of dental practices. This can

Resolution No. 85S-1 Amendment

Report: N/A Date Submitted: September 2021

Submitted By: Third Trustee District

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

Total Net Financial Implication: $150,000 Net Dues Impact: $1.50

Amount One-time _____ Amount On-going _____

ADA Strategic Plan Objective: Membership Obj-1: Increase membership market share of lagging demographics by 2% per year.

How does this resolution increase member value: See Background

ADDRESSING THE DENTAL TEAM WORKFORCE SHORTAGE

The following amendment to Resolution 85 (worksheet: 3021) was submitted by the Third Trustee District and transmitted on September 23, 2021 by Mr. Ward Blackwell, executive director, Pennsylvania Dental Association.

Background: The Third District supports the objectives of Resolution 85. This is a critical issue that is having among the most profound impacts of all the challenges for the profession in the course of the pandemic. Any reasonable possibility for improvement that is both significant and reasonably expeditious would seem worth exploring. And, existing dental education institutions would seem to be best positioned in terms of experience and resources to effect meaningful improvement in a reasonable time frame (even though we acknowledge that a "reasonable" time is a fairly subjective metric). Accordingly, the Third District would offer an amendment to Resolution 85 that supplements the original language with additional strategies for evaluation. (Additions are underscored; deletions are ~~stricken~~.)

Resolution

85S-1. Resolved, that the appropriate ADA agency publicize the availability of existing print and social media communications materials that members and state and local dental societies can use to promote and encourage high school students to consider careers in dentistry, dental hygiene and dental assisting, and be it further

Resolved, that the appropriate ADA agency study the issue of dental hygienist and dental assistant employment tenure to determine variables that lead to burnout and high employee turnover, as well as variables that encourage long term employees. The research will be used to develop a toolkit that dentists can use to help increase the tenure of dental team members, and be it further

Resolved, that the appropriate ADA agency conduct a study of accredited dental hygiene and assisting programs and formulate ideal enrollment recommendations by state and or region and make this information available to state and local dental societies, as well as dentistry, hygiene and assisting education administrators~~.~~, and be it further

best be achieved by recruiting and training an adequate workforce, while also taking steps to increase employee tenure by helping establish a safe and nurturing workplace environment.

Resolution

85. Resolved, that the appropriate ADA agency publicize the availability of existing print and social media communications materials that members and state and local dental societies can use to promote and encourage high school students to consider careers in dentistry, dental hygiene and dental assisting, and be it further

Resolved, that the appropriate ADA agency study the issue of dental hygienist and dental assistant employment tenure to determine variables that lead to burnout and high employee turnover, as well as variables that encourage long term employees. The research will be used to develop a toolkit that dentists can use to help increase the tenure of dental team members, and be it further

Resolved, that the appropriate ADA agency conduct a study of accredited dental hygiene and assisting programs and formulate ideal enrollment recommendations by state and or region and make this information available to state and local dental societies, as well as dentistry, hygiene and assisting education administrators.

BOARD COMMENT: The Board completely understands the workforce concerns that are shared across our Association. This issue would appear to be in the purview of ADEA and their constituents in education. Additionally, the lack of impact measures influenced the Board's decision.

BOARD RECOMMENDATION: Vote No.

Vote: Resolution 85

ARMSTRONG	Yes	HIMMELBERGER	Yes	MARANGA	Yes	RODRIGUEZ	Yes
DOROSHOW	No	KESSLER	Yes	MEDOVIC	Yes	ROSATO	Yes
EDGAR	Yes	LEARY	No	MORRISON	No	SABATES	No
FIDDLER	Yes	LEIGHTY	Yes	OYSTER	No	SHEPLEY	No
HARRINGTON	No	LIDDELL	No	RAPINI	No	STEPHENS	No

Resolved, that the appropriate ADA agency(ies) investigate financial incentives, such as possible tax abatements and grants, to motivate existing dental educational institutions to create, or expand existing, dental hygiene and dental assisting programs in order to expedite the resolution of the workforce issue.

BOARD COMMENT: Received after the September 2021 Board of Trustees Meeting.

Resolution No. 85S-2 Substitute

Report: N/A Date Submitted: September 2021

Submitted By: Indiana Dental Association

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

Total Net Financial Implication: $75,000 Net Dues Impact: $.75

Amount One-time _____ Amount On-going _____

ADA Strategic Plan Objective: Membership Obj-1: Increase membership market share of lagging demographics by 2% per year.

How does this resolution increase member value: See Background

ADDRESSING THE DENTAL TEAM WORKFORCE SHORTAGE

The following substitution was submitted by Mr. Doug Bush, executive director, Indiana Dental Association and transmitted on September 28, 2021.

Background: Dentistry is facing a workforce crisis. A shortage of dental hygienists, dental assistants and dental office administrative staff that existed prior to COVID-19 appears to have been exacerbated by the pandemic, as some staff members did not return to the profession after COVID-related dental office shutdowns.

According to a May 17, 2021, study by the ADA Health Policy Institute, 35.8% of owner dentists were recruiting assistants; 28.8% were seeking hygienists and 26.5% were seeking administrative support staff. The same study reported hiring struggles: 86% of dentists reported hygiene recruitment efforts as "extremely" or "very" challenging; and 83% reported assistant recruitment efforts as "extremely" or "very" challenging.

While COVID is partially to blame, American Dental Education Association (ADEA) *Snapshot of Dental Education 2019-20 (page 4*) data indicates that the problem has been developing for many years. According to ADEA, from 2007 through 2017, the average number of dentists graduating from CODA-accredited educational programs each year increased from 4,714 to 6,238 (32.3%). During the same 10-year period, the average number of hygienist graduates from CODA-accredited programs increased modestly from 6,652 to 7,294 (9.7%), and the average number of assistants from CODA accredited programs actually decreased from 6,097 to 4,852 (-20.4%), partially the result of the increase in unaccredited assisting programs. Clearly the number of graduating dental team members is not keeping pace with the number of graduating dentists.

There is no single solution to this growing workforce shortage. A kneejerk reaction may be to increase class sizes, but some schools report declining applications and enrollment. The problem is not just a need for larger classrooms, but a need for a larger applicant pool. Dentistry needs to be more aggressive in attracting young people to dentistry, hygiene and assisting careers.

The ADA Mission is to "help dentists succeed and support the advancement of the health of the public." It is imperative that dentists be supported by an adequate, well-trained dental team workforce. This is a critical element in access to care and the financial viability and sustainability of dental practices. This can best be achieved by recruiting and training an adequate workforce, while also taking steps to increase employee tenure by helping establish a safe and nurturing workplace environment.

The author of the resolution offers the following substitute resolution to clarify several aspects of the proposal, including the collaboration of ADEA in studying optimal hygiene and assisting program enrollment recommendations. (Additions are underscored; deletions are ~~stricken~~.)

Resolution

85S-2. Resolved, that the appropriate ADA agency ~~publicize the availability of~~ distribute existing print and social media communications materials ~~that members and~~ to state and local dental societies ~~can~~ to use to promote and encourage middle and high school students to consider careers in dentistry, dental hygiene and dental assisting, and be it further

Resolved, that the appropriate ADA agency study the issue of dental hygienist and dental assistant employment tenure to determine variables that lead to ~~burnout~~ attrition and high employee turnover, as well as variables that encourage long term employees. The research will be used to develop a toolkit that dentists can use to help increase the tenure of dental team members, and be it further

Resolved, that the appropriate ADA agency request ADEA to collaborate in conducting a study of accredited dental hygiene and assisting programs and formulate ideal enrollment recommendations by state and or region and make this information available to state and local dental societies, as well as dentistry, hygiene and assisting education administrators.

BOARD COMMENT: Received after the September 2021 Board of Trustees Meeting

Resolution No. 88 New

Report: N/A Date Submitted: August 2021

Submitted By: Fourteenth Trustee District

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

Total Net Financial Implication: $1,000,000 Net Dues Impact: $2.00 per year for five years

Amount One-time Amount On-going $200,000 per year for five years

ADA Strategic Plan Objective: Membership Obj-1: Increase membership market share of lagging demographics by 2% per year.

How does this resolution increase member value: See Background

REINSTATEMENT OF ADA THIRD PARTY PAYER CONCIERGE SERVICE

The following resolution was submitted by the Fourteenth Trustee District and transmitted on August 30 by Dr. Julius N. Manz, Director, Dental Hygiene Program, San Juan College.

Background: In 2020, the American Dental Association (ADA) decided to end its third-party dental insurance concierge service. The service assisted ADA members who used it with insurance disputes they had with third-party insurance companies. Numerous state dental associations have stated that the members using the service found it to be of significant benefit and value. The ADA explained that its decision to terminate the service was based on the costs for the service, which the ADA indicated only had about 5,000 calls from ADA members per year. To that end, numerous supporters of the service responded that it was not heavily promoted by the ADA (perhaps explaining its low usage) and yet, even at 5,000 calls per year, that far exceeded the usage of other services that the ADA has invested in and continues to invest in.

Moving forward, the ADA suggested that third-party insurance issues be handled by the individual states, but if the ADA's centralized service had low turnout (5,000 calls per year), then spreading those services out over 50 states would only seem to result in even higher overhead for less usage (in just spreading out 5,000 calls over 50 states, each state would need someone (so 50 people compared to the ADA's 5 people) to handle on average 100 calls per year). Given the significant member value that this service provided for those who used it and the efficiencies and cost-savings that can be achieved by providing it at the ADA level rather than the state level, are reasons enough to reinstate this program. Moreover, any issues of underuse hopefully could be resolved by increasing the promotional efforts for the service to all ADA members.

Resolution

88. Resolved, that the ADA restart and significantly promote its third-party dental insurance concierge service for a five-year period, at which time this service can be re-evaluated as an ADA member benefit.

BOARD COMMENT: Delivered to the House of Delegates absent Board of Trustees evaluation, recommendation or comment due to inadequate process time of resolution.

Resolution No. 89 New

Report: N/A Date Submitted: August 2021

Submitted By: Indiana Dental Association

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

Total Net Financial Implication: None Net Dues Impact:

Amount One-time Amount On-going

ADA Strategic Plan Objective: Membership Obj-1: Increase membership market share of lagging demographics by 2% per year.

How does this resolution increase member value: See Background

ADDRESSING THIRD PARTY DENTAL REIMBURSEMENT RATES

The following amendment was submitted by Mr. Doug Bush, executive director, Indiana Dental Association and transmitted on August 26, 2021.

Background: Dentistry is facing a workforce crisis. A shortage of dental hygienists, dental assistants and dental office administrative staff that existed prior to COVID-19 appears to have been exacerbated by the pandemic, as some staff members did not return to the profession after COVID-related dental office shutdowns.

According to a May 17, 2021, study by the ADA Health Policy Institute, 35.8% of owner dentists were recruiting assistants; 28.8% were seeking hygienists and 26.5% were seeking administrative support staff. The same study reported hiring struggles: 86% of dentists reported hygiene recruitment efforts as "extremely" or "very" challenging; and 83% reported assistant recruitment efforts as "extremely" or "very" challenging.

This workforce shortage is leading to substantial increases in staffing costs for dentists. This inflation is further exacerbated by increasing personal protection equipment (PPE) and other infection control costs created by the COVID pandemic. Rising costs will ultimately be reflected in rising dental fees.

Third party payers should recognize these increases in dental office overhead and make appropriate adjustments to dental reimbursement rates.

Resolution

89. Resolved, that the ADA communicate to dental insurance industry leaders that COVID-related increases in dental staffing costs and enhanced infection control expenses have increased the cost of dental care and third party payer reimbursement rates should be adjusted accordingly.

BOARD COMMENT: Delivered to the House of Delegates absent Board of Trustees evaluation, recommendation or comment due to inadequate process time of resolution.

Resolution No. 93 New

Report: N/A Date Submitted: August 2021

Submitted By: Fourteenth 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

ADA Strategic Plan Objective: Public Goal Obj-9: The ADA will be the preeminent driver of trusted oral health information for the public and profession.

How does this resolution increase member value: See Background

DEVELOPING SAFEGUARDS TO PROTECT EMPOYEE DENTISTS

The following was submitted by the Fourteenth Trustee District and transmitted on August 31, 2021, by Dr. Julius N. Manz.

Background: As dental practice models evolve, concerns arise with regard to the role of dentists working as employees. One area of particular concern is the issue of billing claims made to third party payers done under the employee dentist's NPI number and signature on file but without the employee dentist's approval. Use of the employee dentist's NPI and signature on file directly indicates that the employee dentist has authorized the claim and accepts liability for the accuracy of that claim.

When such claims are inaccurately or inappropriate submitted without the employee dentist's approval, it exposes the employee dentist to allegations of fraud.

This is less of an issue with third party payers, and more of an issue pertaining to employment. There is growing evidence that this type of misappropriation of employee dentist's information is occurring in a wide variety of different practice settings where a dentist is employed.

Dentists should therefore be made aware of the risks that they accept when entering into business relationships. In order to help facilitate this, the ADA should develop guidelines to protect its member dentists who are employee dentists. Such guidelines will help employee dentists in safeguarding their personal information and will help minimize the risk of a fraudulent claims being submitted under the employee dentist's name.

Although the ADA currently has policy (Statement Regarding Employment of a Dentist (Trans.2013:353; 2018:357; 2019:251)) which states that employers should make certain that proper business practices, including billing, are followed, no guidelines currently exist which would assist the employee dentist in either avoiding these pitfalls or addressing them with their employer should they occur.

Resolution

93. Resolved, that the appropriate ADA agency develop guidelines off of the existing policy which would be aimed at assisting the employee dentists to assure the accuracy of claims and communications to other parties on their behalf.

BOARD COMMENT: Delivered to the House of Delegates absent Board of Trustees evaluation, recommendation or comment due to inadequate process time of resolution.

NEW BUSINESS-MAJORITY VOTE RECEIVED FOR CONSIDERATION

Resolution No. 107 New

Report: N/A Date Submitted: October 2021

Submitted By: Sixteenth 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

ADA Strategic Plan Objective: Public Goal Obj-10: Dental benefit programs will be sufficiently funded and efficiently administered.

How does this resolution increase member value: See Background

STANDARD FORM FOR CONSOLIDATING DENTAL IMPLANT AND IMPLANT RESTORATION DATA

The following resolution was submitted by the Sixteenth Trustee District and transmitted on October 6, 2021 by Mr. Phil Latham, executive director, South Carolina Dental Association.

Background: Replacing and repairing existing implant restorations is becoming increasingly difficult and complicated due to lost data regarding implant and abutment details. This resolution offers a simple and non-intrusive way to establish a standard form to assist dentists and patients affected by failing implant restorations. The following resolution addresses both of these.

Resolution

107. Resolved, that the appropriate ADA agency create a form for patients and dental records that consolidates the data on placed implants and implant restorations to include the date of placement, implant manufacturer, type, size and intraoral location as well as abutment manufacturer, type, size and dental laboratory, and be it further

Resolved, that the ADA urge dentists to use the form for patient records and provide a copy to the patient.

BOARD COMMENT: Received after the deadline for New Business submission of September 28.

Dental Education, Science and Related Matters

Resolution No. 31 New

Report: N/A Date Submitted: June 2021

Submitted By: Commission for Continuing Education Provider Recognition

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

Total Net Financial Implication: None Net Dues Impact:

Amount One-time Amount On-going

ADA Strategic Plan Objective: Public Goal Obj-9: The ADA will be the preeminent driver of trusted oral health information for the public and profession.

How does this resolution increase member value: See Background

AMENDMENT OF CHAPTER IX, SECTION A OF THE GOVERNANCE AND ORGANIZATIONAL MANUAL OF THE AMERICAN DENTAL ASSOCIATION

Background: The American Association of Dental Boards (AADB), an organization which selects a member to serve on the Commission for Continuing Education Provider Recognition (CCEPR), pursuant to Chapter IX, Section A.3 of the *Governance and Organizational Manual of the American Dental Association* (the *Governance Manual),* has introduced a new program for accrediting continuing dental education activities, the Accredited Continuing Education (ACE) program.

The ACE program presents a competing business interest with the ADA Continuing Education Recognition Program (ADA CERP). As AADB is one of the organizations that appoints a member to CCEPR, the agency with oversight and administrative responsibility for ADA CERP, this has created a new potential for conflicts of interest.

To mitigate any real or perceived conflicts of interest that could arise from the appointment of a CCEPR member by an organization with a competing business interest, the Commission recommends that Chapter IX. Section A.3 of the *Governance Manual* be amended to eliminate the requirement that AADB appoint a member to CCEPR.

Chapter IX. Section A.3 of the *Governance Manual* states that, except for the six appointments mandated in that document, the Commission may establish the number and method of selecting and appointing its remaining members. The CCEPR *Rules* currently specify the selection and appointment of an additional 14 members, including one member appointed by each of the sponsoring organizations of the dental specialties recognized by the National Commission on Recognition of Dental Specialties and Certifying Boards, one member appointed by the American Society of Constituent Dental Executives, and one public member appointed by the Commission.

To help ensure that the Commission continues to receive input from individuals with insights and experience in the regulatory community, the Commission proposes to amend its *Rules* and *Policies and Procedures*, to stipulate that the Commission shall appoint a member who is a member of a state dental board or jurisdictional dental agency. Draft revisions to the CCEPR *Rules* and *Policies and Procedures* conforming with the proposed amendment to the *Governance Manual,* and outlining the criteria for the appointment by the Commission of a dental board or jurisdictional dental agency member, are attached in Appendix 1. In the event that the proposed amendment to the *Governance Manual* is adopted, the Commission intends to make these conforming changes to the CCEPR *Rules* and *Policies and Procedures.*

Taking steps to minimize potential conflicts of interest that may arise by the appointment of a Commissioner by an organization with a competing business interest will help ensure that the Commission conducts its business in an unbiased manner, and will help minimize reputational risk to the ADA and CCEPR.

Accordingly, CCEPR recommends adoption of the following resolution to amend the *Governance Manual* by deleting the requirement that the American Association of Dental Boards select a member to serve on CCEPR.

Resolution

31. Resolved, that Chapter IX. Section A.3 of the *Governance and Organizational Manual of the American Dental Association* be amended as shown below (additions underscored*;* deletions ~~stricken~~):

Commission for Continuing Education Provider Recognition. The number of and the method of selection of members of the Commission for Continuing Education Provider Recognition shall be governed by the Rules of the Commission for Continuing Education Provider Recognition, except that ~~six~~ five (~~6~~5) members shall be selected as follows:

a. Four (4) members who shall be appointed by the Board of Trustees from the names of active, life or retired members of this Association. None of the appointees shall be a faculty member of any dental education program working more than one day per week or a member of a state board of dental examiners or jurisdictional dental licensing agency. At least two (2) of the members appointed shall be general dentists.

~~b. One (1) member who is an active member of the American Association of Dental Boards and also, if eligible, an active, life or retired member of this Association shall be selected by the American Association of Dental Boards.~~

~~c~~b. One (1) member who is an active member of the American Dental Education Association and also, if eligible, an active, life or retired member of this Association shall be selected by the American Dental Education Association.

BOARD RECOMMENDATION: Vote Yes.

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

Appendix 1

RULES OF THE COMMISSION FOR CONTINUING EDUCATION PROVIDER RECOGNITION, *excerpt*

(additions underscored; deletions ~~stricken~~)

Article II. BOARD OF COMMISSIONERS

Section 2. COMPOSITION: The Board of Commissioners shall consist of:

Four (4) members who shall be appointed by the Board of Trustees from the names of active, life or retired members of this Association. None of the appointees shall be a faculty member of any dental education program working more than one day per week or a member of a state board of dental examiners or jurisdictional dental licensing agency. At least two (2) of members appointed shall be general dentists.

~~One (1) member who is an active member of the American Association of Dental Boards and also, if eligible, an active, life or retired member of this Association shall be selected by the American Association of Dental Boards.~~

One (1) member who is an active member of the American Dental Education Association and also, if eligible, an active, life or retired member of this Association shall be selected by the American Dental Education Association.

The remaining Commissioners shall be selected as follows: one (1) dentist who is board certified in the respective discipline-specific area of practice and is selected by each of the following organizations: American Academy of Oral and Maxillofacial Pathology, American Academy of Oral and Maxillofacial Radiology, American Academy of Oral Medicine, American Academy of Orofacial Pain, American Academy of Pediatric Dentistry, American Academy of Periodontology, American Association of Endodontists, American Association of Oral and Maxillofacial Surgeons, American Association of Orthodontists, American Association of Public Health Dentistry, American College of Prosthodontists; the American Society of Dentist Anesthesiologists; and one (1) member appointed by the American Society of Constituent Dental Executives. In addition, the Commission shall select and appoint (i) one (1) member who is also a member of a state dental board or jurisdictional dental licensing agency, and (ii) one (1) member of the public who is neither a dentist nor an allied dental personnel nor teaching in a dental or allied dental education institution, 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. The Director of the Commission shall be an ex-officio member of the Board without the right to vote.

CCEPR POLICIES AND PROCEDURES, *excerpt*

(additions underscored; deletions ~~stricken~~)

APPOINTMENT OF PUBLIC MEMBER AND JURISDICTIONAL LICENSING AGENCY MEMBER

The composition of the Commission for Continuing Education Provider Recognition, as established by the ADA *Governance and Organizational Manual* and the Commission's *Rules*, includes one public member to be selected by the Commission~~,~~ and one member who is a member of a state dental board or jurisdictional dental licensing agency to be selected by the Commission.

The public member may not be a dentist, an allied dental personnel, nor teaching in a dental or allied

dental education institution, and must meet the Criteria for Appointment to the Commission. The public member shall be appointed to one (1) four (4) year term.

The jurisdictional licensing agency member may not (i) hold a leadership position for an entity that has a certification or accreditation program for continuing dental education providers or courses, (ii) be involved in the administration of a certification or accreditation program for continuing dental education providers or courses, or (iii) work more than one day a week as a faculty member of any dental education program. The jurisdictional licensing agency member shall be appointed to one (1) four (4) year term.

The Commission shall publicize ~~an~~ open positions for a public member and jurisdictional licensing agency member by posting notices on the CCEPR website and and/or emailing notices to professional organizations, state boards, and other interested parties and groups. Notices shall be sent at least 60 days before the deadline for applications. Applications will be submitted to CCEPR staff. Applications will be reviewed by an ad hoc committee comprised of three members of the Board of Commissioners to be appointed by the Chair. The Committee shall review applications and make recommendations to the Board of Commissioners.

The Board of Commissioners will select and appoint the public member and jurisdictional licensing agency member at a regularly scheduled meeting of the Commission, by conference call or by electronic ballot.

CRITERIA FOR APPOINTMENT TO THE COMMISSION

All appointees to the Commission must meet the following criteria:

- Ability to commit to one (1) four (4) year term;
- Willingness to commit to ten (10) to twenty (20) days per year to Commission activities, including but not limited to training, comprehensive review of print and electronic materials, and participation in and travel to Commission meetings;
- Ability to evaluate a continuing dental education program objectively in terms defined by recognition standards;
- Stated willingness to comply with all Commission policies and procedures;
- Ability to conduct business through electronic means (email, Commission web sites);
- Active, life or retired member of the American Dental Association, where eligible.

Additional criteria for public member appointees:

- A commitment to bring the public/consumer perspective to the Commission's deliberations. The candidate should not have any formal or informal connection to the profession of dentistry; also, the candidate should have an interest in, or knowledge of, health-related or accreditation issues. In order to serve, the candidate must not be a:
    a. Dentist or member of an allied dental discipline;
    b. Instructor in a dental or allied dental education institution;
    c. Employee, member of the governing board, owner, or shareholder of, or independent consultant to a continuing dental education provider or a company that produces dental products or services;
    d. Member or employee of any professional trade association, licensing/regulatory agency

or membership organization related to, affiliated with or associated with the Commission, dental education, or dentistry; or

e. Spouse, parent, child or sibling of an individual identified in a-d above.

POLICY ON CHANGES TO THE COMPOSITION OF THE BOARD OF COMMISSIONERS

The Commission is composed of representatives and subject area experts from the dental education, dental licensure, organized dentistry, specialty and general dentistry practice communities, and the public at large. As the practice of dentistry and dental education continue to evolve, the Commission may considers a change in its composition, consistent with the Commission's *Rules* and the American Dental Association's *Bylaws* and *Governance and Organizational Manual.*

Resolution No. 32 New

Report: N/A Date Submitted: June 2021

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

ADA Strategic Plan Objective: Public Goal Obj-9: The ADA will be the preeminent driver of trusted oral health information for the public and profession.

How does this resolution increase member value: See Background

AMENDMENT OF THE POLICY: REVIEW OF ADA DEFINITION: CONTINUING COMPETENCY

Background: In accord with Resolution 170H-2012, Regular Comprehensive Policy Review (*Trans.* 2012:370), the Council on Dental Education and Licensure (CDEL) has reviewed the definition Continuing Competency *(Trans.*1999:939) for accuracy and currency.

CURRENT DEFINITION:

Continuing Competency (*Trans.*1999:939)

Resolved, that the following definition of continuing competency be adopted.

> **Continuing Competency:** The continuance of the appropriate knowledge and skills by the dentist in order to maintain and improve the oral health care of his or her patients in accordance with the ethical principles of dentistry.

The Council believes that an amendment should be considered to strengthen the definition and reflect language consistent with Standard 5-3 of the CODA Accreditation Standards for Dental Education Programs which states:

> "The dental school must conduct a formal system of continuous quality improvement for the patient care program that demonstrates evidence of:
>
> c. an ongoing review of a representative sample of patients and patient records to assess the appropriateness, necessity and quality of the care provided;"

Accordingly, the Council on Dental Education and Licensure has concluded that the current definition should be updated and recommends adoption of the following resolution:

Resolution

32. Resolved, that the ADA definition of Continuing Competency (*Trans.*1999:939) be amended as follows (additions underscored; deletions ~~stricken~~):

> Continuing Competency: The continuance of the ~~appropriate knowledge and skills~~ appropriateness, necessity and quality of the care provided by the dentist in order to

maintain and improve the oral health care of his or her patients in accordance with the ethical principles of dentistry.

BOARD RECOMMENDATION: Vote Yes.

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

Resolution No. 46-49 New

Report: CDEL Report 1 Date Submitted: June 2021

Submitted By: Council on Dental Education and Licensure

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

Total Net Financial Implication: $42,500 Net Dues Impact: $0.43

Amount One-time $42,500 Amount On-going

ADA Strategic Plan Objective: Public Goal Obj-9: The ADA will be the preeminent driver of trusted oral health information for the public and profession.

How does this resolution increase member value: See Background

COUNCIL ON DENTAL EDUCATION AND LICENSURE REPORT 1 TO THE HOUSE OF DELEGATES: RESPONSE TO RESOLUTION 100H-2020: SPECIAL NEEDS DENTISTRY

Background: The Council on Dental Education and Licensure has considered Resolution 100H-2020:

> **100H-2020. Resolved,** that the ADA Council on Dental Education and Licensure (CDEL) explore through a survey with other appropriate communities of interest, the feasibility of requesting the development of an accreditation process and accreditation standards for advanced education programs in special needs dentistry by the Commission on Dental Accreditation (CODA), and be it further
>
> **Resolved,** that CDEL address actionable strategies to:
>
> 1. Enhance and expand pre-doctoral training;
> 2. Develop and promote continuing education programs for existing practitioners; and
> 3. Investigate advanced educational opportunities, and be it further
>
> **Resolved,** that the feasibility study with any recommendations be provided to the 2021 ADA House of Delegates.

The Council took the following measures to address Resolution 100H-2020:

- Conducted a survey of the appropriate communities of interest to gather data on the current state of special needs dentistry education.

- In regard to strategies for enhancing and expanding pre-doctoral training, considered the results of the survey, reviewed the current Accreditation Standards for Dental Education Programs as they relate to special needs dentistry, and considered the scope and depth of didactic and clinical instruction provided to students in treating special needs patients.

- In regard to strategies for developing and promoting continuing education programs for existing practitioners, considered the survey results, conducted an environmental scan of current CE offerings on this topic and determined whether additional CE activities should be recommended for development, including financial implications.

- In regard to investigating advanced educational opportunities, reviewed the current accreditation standards for advanced dental education programs in the relevant disciplines as they relate to special needs dentistry and determined whether the standards should be strengthened and/or the development of fellowship programs should be encouraged.

The Survey: The State of Special Needs Dentistry Education Survey was conducted from February 19 – March 26 to gather information from the special needs dentistry communities of interest, e.g., representatives/leaders of the Special Care Dentistry Association, representatives of the American Academy of Developmental Medicine & Dentistry, ADA Council on Advocacy for Access and Prevention, ADA Council on Dental Practice, leadership of the American Dental Education Association, directors of advanced dental education programs, directors of special needs dentistry programs and dental school deans. The survey instrument was designed to gather information and clarify the interest and understanding of the special needs dentistry practice and education communities in 1) developing an accreditation process and accreditation standards for advanced education programs in special needs dentistry in accord with the CODA Criteria (Policies and Procedures For Accreditation of Programs in a New Dental Education Area or Discipline) and 2) assessing whether current education offerings at the predoctoral, advanced dental and continuing education levels are adequate to support the needs of dentists and this patient population. The overall survey response rate was 29.25%. A summary of the results is provided in Appendix 1.

Research and Resources: In addition to the survey results, the following pertinent data was gathered and studied:

- Journal articles and curriculum resources available for dental and advanced dental education programs related to special needs dentistry/patients;

- CODA's Accreditation Standards for Dental Education Programs and background information identifying when the standards were last revised in regards to the management and treatment of special needs patients

- CODA's Accreditation Standards for Advanced Dental Education Programs and background information identifying when the standards were last revised in regards to the management and treatment of special needs patients

- CODA Frequency of Citings Reports identifying the number of dental education programs cited for noncompliance with standards pertaining to special needs dentistry/patients;

- CODA Frequency of Citings Reports identifying the number of advanced dental education programs cited for noncompliance with standards pertaining to special needs dentistry/patients;

- The 2018-19 Curriculum Survey of Dental Education Programs data related to special needs dentistry/patients

- The 2019-20 Survey of Advanced Dental Education Report identifying advanced dental education programs not accredited by CODA that offer special care dentistry programs

- Results of an environmental scan on current continuing education offerings related to special needs dentistry/patients

- 2020 ADEA Senior Survey regarding seniors' preparedness to treat patients with special needs

Predoctoral Dental Education: The Accreditation Standards for Dental Education Programs was strengthened by CODA in August 2019 as a result of a request received by CODA in January 2018 from the National Council on Disability (NCD). The current Standard states:

> **2-25** Graduates **must** [emphasis in original] be competent in assessing and managing the treatment of patients with special needs.
>
> **Intent:**
> *An appropriate patient pool should be available to provide experiences that may include patients whose medical, physical, psychological, or social situations make it necessary to consider a wide range of assessment and care options. As defined by the school, these individuals may include, but are not limited to, people with developmental disabilities, cognitive impairment, complex medical problems, significant physical limitations, and the vulnerable elderly. Clinical instruction and experience with the patients with special needs should include instruction in proper communication techniques including the use of respectful nomenclature, assessing the treatment needs compatible with the special need, and providing services or referral as appropriate.*

Based on all of the information studied, the Council concluded that Standard 2-25 adequately addresses the scope and depth of predoctoral dental education related to special needs dentistry. Dental education programs are required to adhere to the Accreditation Standards which define *Patients with Special Needs* as "Those patients whose medical, physical, psychological, cognitive or social situations make it necessary to consider a wide range of assessment and care options in order to provide dental treatment. These individuals include, but are not limited to, people with developmental disabilities, cognitive impairment, complex medical problems, significant physical limitations, and the vulnerable elderly." Further, Standard 2-25 requires that "Graduates **must** [emphasis in original] be competent in assessing and managing the treatment of patients with special needs." The Council will continue to monitor programs' compliance with the standard via CODA's annual Frequency of Citings Report for Predoctoral Dental Education. However, the Council believed that the intent statement which complements Standard 2-25 could be strengthened to ensure consistent interpretation and application of the standard by programs and accreditation site visitors. Accordingly, the Council transmitted written comment to CODA urging that that revision of the Standard 2-25 intent statement be considered to provide further clarification and additional guidance to programs and accreditation site visitors.

Advanced Dental Education: The Council reviewed the following information about the current scope and depth of special needs dentistry education provided to residents in the relevant advanced dental education programs: current definitions per CODA's Accreditation Standards for Advanced Dental Education Programs; CODA accreditation standards for advanced education programs (general dentistry, general practice residency, dental anesthesiology, pediatric dentistry, periodontics dentistry, orthodontics and dentofacial orthopedics, orofacial pain, and clinical fellowship training programs in craniofacial and special care orthodontics) calling for students to receive training in managing and/or treating patients with special needs; and the 2019-20 Survey of Advanced Dental Education Report and State of Special Needs Dentistry Education survey results identifying advanced education providing instruction/experience in special needs dentistry. These definitions and standards also were reviewed and revised by CODA in 2019 as a result of a request from the Special Care Dentistry Association (SCDA) urging the Commission to consider the standardization of a definition for "Special Needs" across the various Accreditation Standards under the Commission's purview. Some variation among the documents still exists. Depending on the document, residents may be required to achieve competency in assessing, diagnosing, and planning and/or managing and/or providing, and/or examining and/or treating patients with special needs and/or disabilities.

The Council believed that although the CODA Accreditation Standards for Advanced Dental Education Programs address special needs dentistry education, the Commission should consider further strengthening the standards to require all graduates to be competent in *treating* patients with special needs. Further, the Council believed that the Commission should consider strengthening the standards in

other areas such as curriculum, resident evaluation, facilities and patient care to better support the special needs patient population. Accordingly, the Council transmitted written comment to CODA urging further revision of the Accreditation Standards for Advanced Dental Education Programs to require graduates to be competent in treating patients with special needs and to strengthen the standards in other areas such as curriculum, resident evaluation, facilities and patient care to better support the special needs patient population. The Council will continue to monitor advanced dental education programs' compliance with the standards via CODA's annual Frequency of Citings Report for Advanced Dental Education Programs.

Special Care Dentistry: Fifty-three respondents to the State of Special Needs Dentistry Education survey indicated awareness of an association/organization/entity that may be interested in leading the pursuit of CODA-accreditation for special needs dentistry programs, most often citing the Special Care Dentistry Association as the organization that may be interested in taking the lead. As presented in (Resolution 46), the Council recommends that the findings of this feasibility study be provided to the Special Care Dentistry Association for its consideration in pursuing an accreditation process and accreditation standards for advanced education programs in special needs dentistry by CODA and that the Special Care Dentistry Association be urged to collaborate with advanced dental education programs and their sponsoring institutions to enhance the current scope and depth of instruction related to special needs dentistry and to encourage the establishment of more training programs in special needs dentistry.

Continuing Education: In regard to continuing education offerings in this subject area, survey respondents indicated that general dentists and dental specialists need more continuing dental education related to managing and treating special needs patients, e.g., people with developmental disabilities, cognitive impairment, complex medical problems, significant physical limitations, and the vulnerable elderly. Many suggested topics that could be presented via CE activity were noted. An environmental scan of current CE offerings related to special needs dentistry/patients also was reviewed. Given the survey results and the current CE offerings on this subject, the Council concluded that market research should be conducted to learn more about the continuing education interests of practicing dentists related to special needs dentistry (Resolution 47) and that ADA should offer more continuing education programs to increase knowledge and awareness of managing and providing oral health care to patients with special needs. Such CE activities could include annual meeting courses, video-based on demand courses, and/or a multi-modular online course. To begin, it is suggested that two webinars be conducted in 2022 and that asynchronous on-demand online CE courses be produced using the content of the webinars. (Resolution 48).

Proposed Policy: The ADA has several policies addressing the special needs population and supporting continuing education in general, but none specifically urging dentists to pursue continuing education in this subject. The Council recommends that the House of Delegates adopt policy encouraging dentists and dental specialists to pursue continuing education opportunities in this area and submits (Resolution 49).

Resolutions

46. Resolved, that the findings of the feasibility study conducted by the Council on Dental Education and Licensure be provided to the Special Care Dentistry Association for its consideration in pursuing an accreditation process and accreditation standards for advanced education programs in special needs dentistry by the Commission on Dental Accreditation, and be if further

Resolved, that the Special Care Dentistry Association be urged to collaborate with advanced dental education programs and their sponsoring institutions to enhance the current scope and depth of instruction related to special needs dentistry and to encourage the establishment of more training programs in special needs dentistry.

47. Resolved, that market research be conducted to learn more about the continuing education interests of practicing dentists related to managing and treating patients with special needs, i.e., people with developmental disabilities, cognitive impairment, complex medical problems, significant physical limitations, and the vulnerable elderly.

48. Resolved that a variety of continuing education activities related to special needs dentistry be developed by the appropriate ADA agency.

49. Resolved, that the following policy be adopted:

Patients with Special Needs

The dental profession's continued ability to effectively provide dental care for America's special needs population is dependent on sustaining a strong educational foundation in this area. The ADA encourages efforts to maintain and expand the availability of courses and programs at the predoctoral, advanced and continuing educational levels that support practitioners in providing dental treatment to patients whose medical, physical, psychological, cognitive or social situations make it necessary to consider a wide range of assessment and care options. These individuals include, but are not limited to, people with developmental disabilities, cognitive impairment, complex medical problems, significant physical limitations, and the vulnerable elderly. The ADA encourages dental practitioners to regularly participate in continuing education in this area.

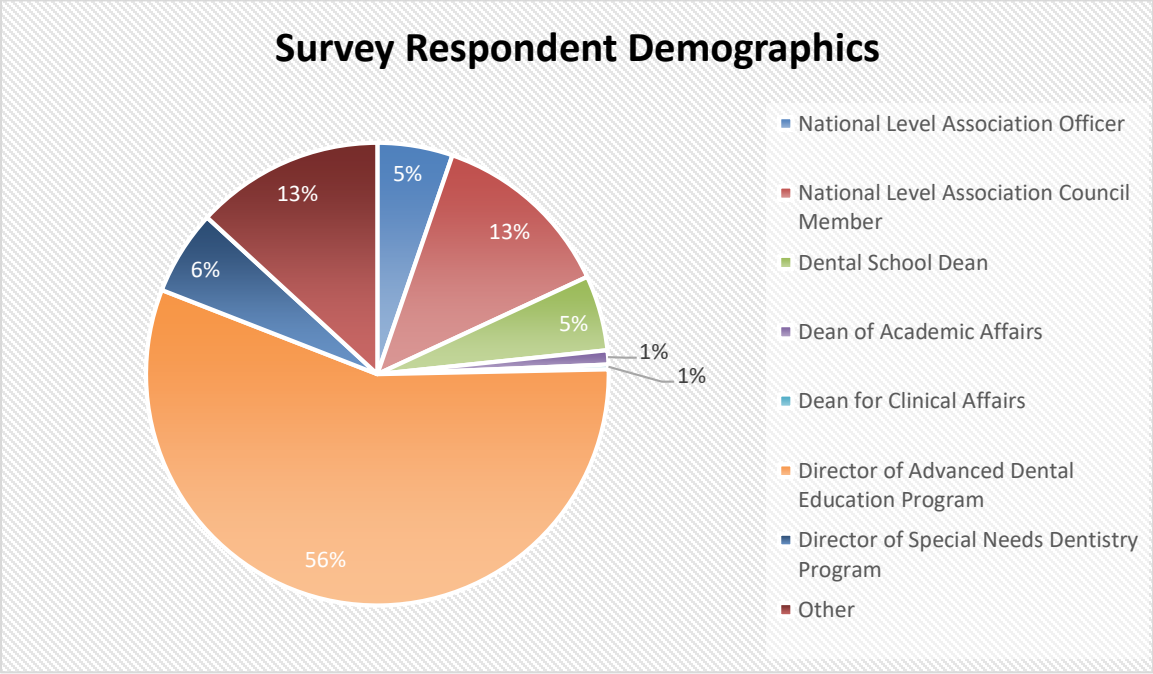
(Resolution 46:Worksheet:4057)
(Resolution 47:Worksheet:4058)
(Resolution 48:Worksheet:4059)
(Resolution 49:Worksheet:4060)

BOARD RECOMMENDATION: Vote Yes to Transmit.

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

ADA Council on Dental Education and Licensure State of Special Needs Dentistry Education Survey Results April 2021

Q1 - Please indicate which of the following best describes you (select all that apply).



Q1 - Director of CODA Accredited Advanced Dental Education Program - Discipline:

Director of CODA Accredited Advanced Dental Education Program Discipline:
Pediatric Dentistry (26)
GPR (43)
Orthodontics (4)
AEGD (19)
Prosthodontics (6)
DPH (2)
Orofacial Pain Program (1)
Endodontics (11)
Periodontics (3)
Craniofacial and Special Care Orthodontics (1)

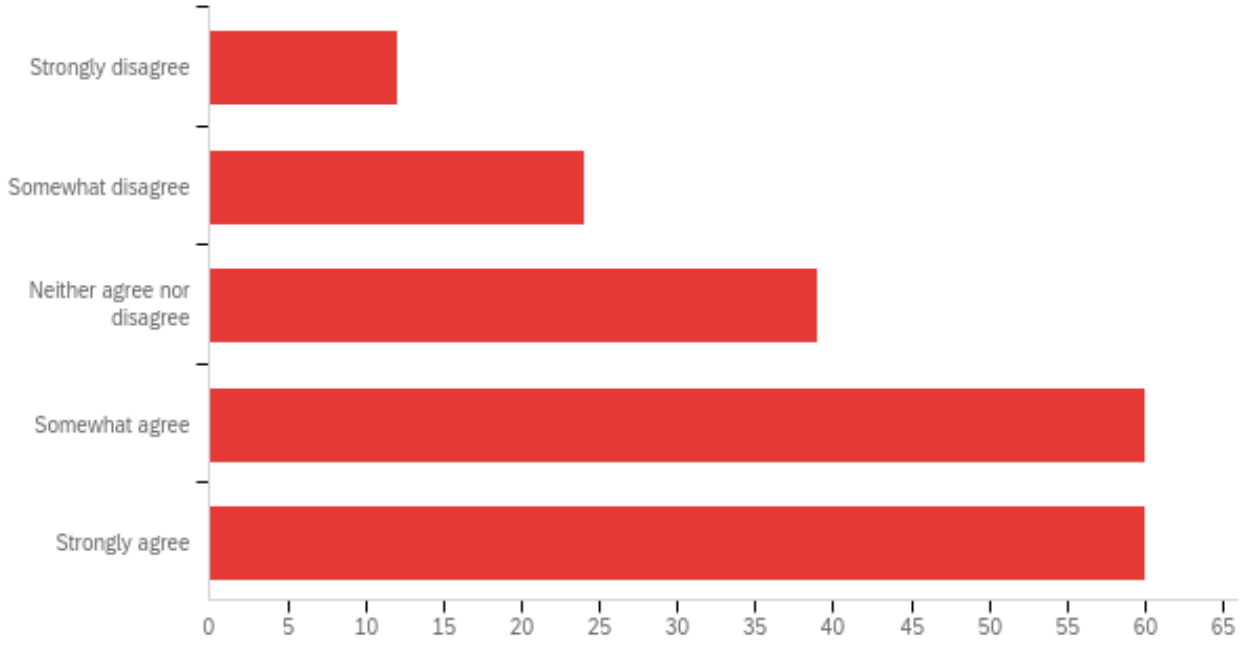
Orthodontics and Dentofacial Orthopedics (3)
Oral and Maxillofacial Surgery (10)
Dental Anesthesiology (5)
Oral Maxillofacial Radiology (1)

Q1 - Other; please describe:

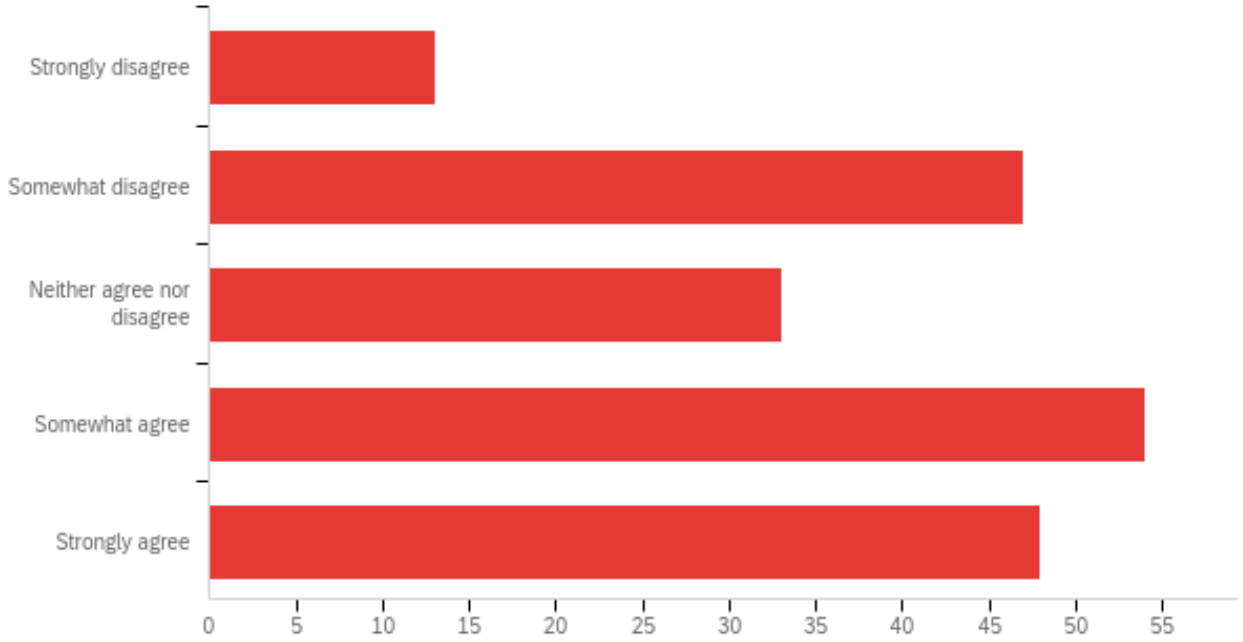
Other:
Academic Program Coordinator
Section Chair of Geriatric and Special Patients. Chair of Dental Public Health and Pediatrics
Program Director Oral & Maxillofacial Surgery
Senior Attending Dentist, CODA accredited GPR AND PEDO training program.
Clinical Faculty for Special Patient Care Clinic
CDEL Member
Former Director of Special Needs and current Director of Geriatric Dentistry Masters and Certificate Program
Director of OMR Graduate Program
Director of a Graduate Periodontics Residency Program
Program Director
Division Director of Orthodontics
Chairman Department of Dental Medicine with CODA residency programs in General Practice, Pediatrics and Oral Surgery.
Faculty in special needs clinic
pediatric dentist
General dentist FOCUSING on pediatrics and special needs for 24+ years
Co-Director GPR program
Assistant Professor, Director of Community Dentistry (includes coursework and clinical experiences within special needs dentistry)
Former Dean
Private practice dentist whose practice focuses on treatment of Special Needs populations
Member local oral health coalition CSHCN workgroup
Director of CODA Accredited GPR
Hospital base GPR with a high focus on treating special needs populations.

Faculty teaching special care to predoctoral students
Pediatric Dentistry Mentor for US Army's Advanced Education in General Dentistry 2-Year Program
full time faculty dentist anesthesiologist
Council on Advocacy for Access and Prevention
course director Geriatrics/Special needs
Special Needs Dentistry Program Faculty/Attending Dentist
Dental School Faculty
Dentist who focuses on patients who have special needs
Program Director, OMFS
Associate Program Director and Immediate past-President of state dental organization.
Past Director of Special Needs Program for 18 years.
Dental Dean for Student Affairs
Residency Program Director
Department Chair, Pediatric Dentistry

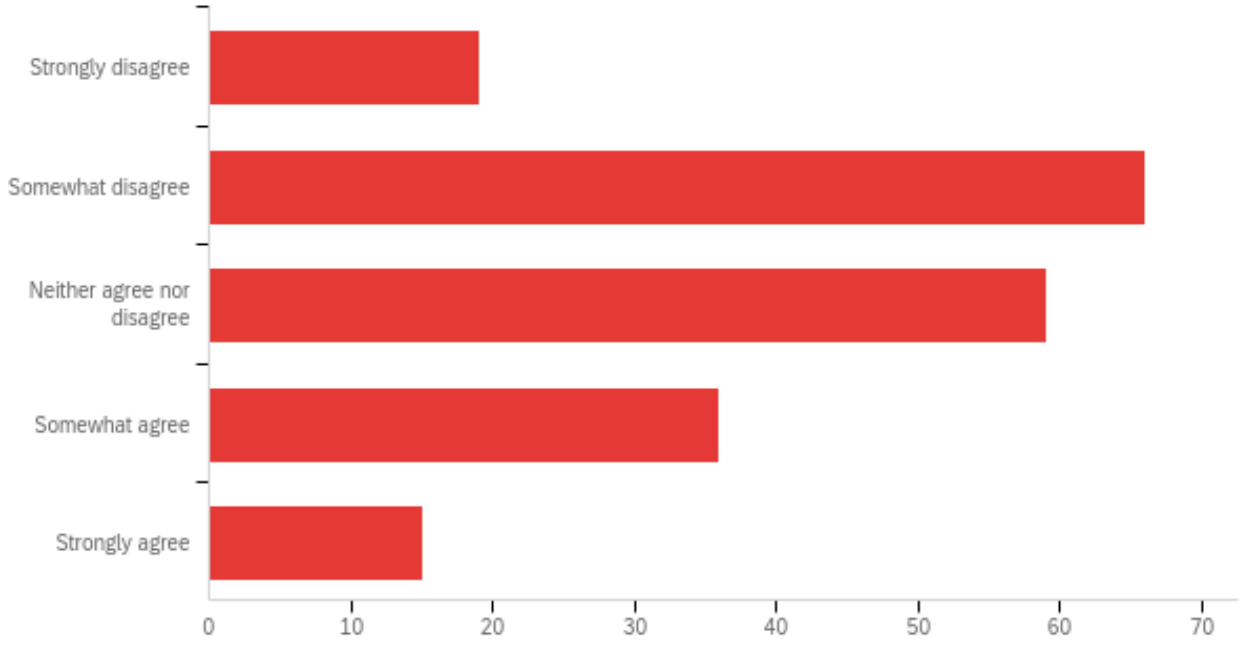
Q2 - There is a body of established, evidence-based, substantive, scientific dental knowledge related to special needs dentistry to educate individuals in advanced education programs for a minimum of one 12-month full-time academic year in length.



Q3 - This knowledge in large part is distinct from, or more detailed than, special needs dentistry training taught in other advanced education programs already accredited by CODA (including, but not limited to, general practice residencies, advanced education in general dentistry programs, pediatric dentistry programs).



Q4 - There is a sufficient number of established programs with structured curriculum, qualified faculty and enrolled students to establish a peer-reviewed accreditation process for these programs.



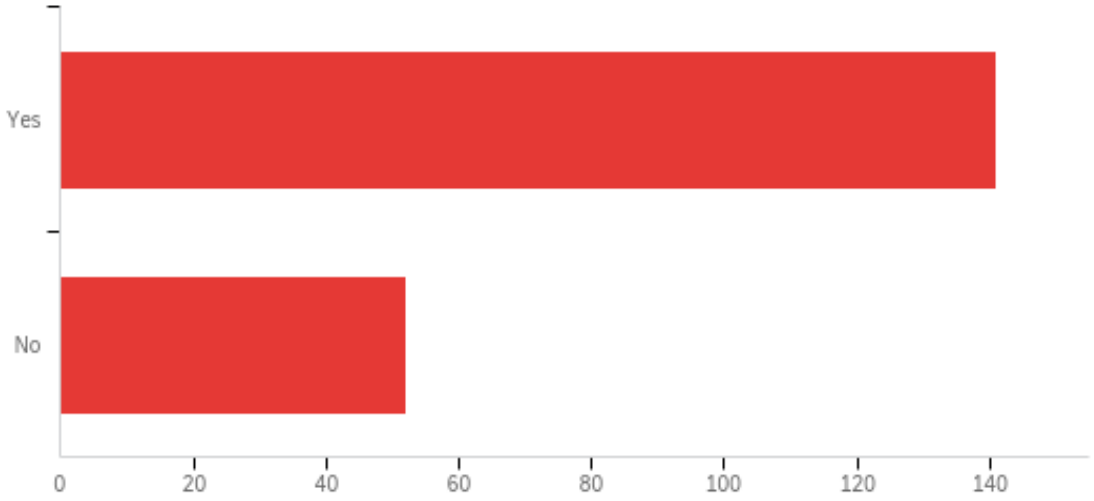
Q5 - List the advanced education programs that are one 12 month full academic year in length in special needs dentistry that currently exist. Please include their sponsoring university or hospital.

List the advanced education programs that are one 12 month full academic year in length in special needs dentistry that currently exist. Please include their sponsoring university or hospital.
LSUSD University of the Pacific
Not sure I know of any that has a core curriculum devoted to 12 month training. Most programs focus on people with disabilities rather than complex medical conditions. Both NYU College of Dentistry's Oral Health Center for People with Disabilities and the University of Washington Department of Pediatric Dentistry and Seattle Childrens Hospital received special HRSA funding for expanding teaching to dental students last year. Many dental schools provide education through their hospital dentistry programs / clinics
North Carolina Dental Program Targets Special Needs sponsored by: North Carolina Dental Society (NCDS)
University of Washington DECOD program
Craniofacial and Special Care Orthodontics 12-month fellowships are the only special need programs that I know of; UCLA, Univ. Mich., Case Western, UCSF
Stony Brook
University of Iowa Special Care and Geriatrics University of Washington Special Care Dentistry - 2nd year GPR USC Geriatric Dentistry Masters Program
OSF Saint Francis Medical Center General Practice Residency Illinois Masonic Dental Residency
University College London
Special needs dentistry is largely the prevue of GPR programs and this should be enhanced rather than separated out
Rancho Los Amigos National Rehabilitation Center +More complete list can be found on the Special Care Dentistry website
UOP AEGD, SF Lee Specialty Clinic, KY Rancho Los Amigos
Montefiore Medical Center, Dept. of Dentistry, Albert Einstein Medical College, Bronx, NY
Special Care GPR Programs self-identified and published on the SCDA website: https://www.scdaonline.org/page/GPRPrograms DECOD Program, University of Washington (option of second year) GPR in Dentistry at Wake Forest School of Medicine (option of 2 years)
Rose Fitzgerald Kennedy Center, Jacobi Medical Center, Bronx Oral Health Center for Patients with Disability, NYUCD

I think there is one at Stony Brook and one at Helen Hays, in NY. I don't understand this question. Why do you care if I know about these programs??
Rose F. Kennedy Stony Brook Pacific Dental Services (PDS) Foundation Dentists for Special Needs clinic at NYUCD
Advanced Education-Special Needs Dentistry Fellowship - LSU
Yeshiva University, Rose. F. Kennedy Center fellowship in Special care Dentistry (Montefiore Medical Center) Special Care Fellowship Stonybrook University School of Dentistry Fellowship in Special Care Dentistry LSU School of Dentistry University of Tennessee Graduate School of Medicine Fellowship NYU AEGD ASDOH Site PGY2 year dedicated to Special Care The University of Iowa Fellowship In Geriatrics and Special Care
Rose F Kennedy Center - Albert Einstein College of Medicine/Montefiore Stonybrook university (I believe Helen Hayes just closed, which is a shame.) NYU school of dentistry has a special care center but I am not sure if they have a residency
Medical University of South Carolina, College of Dental Medicine 1 year AEGD and related Graduate/Post-Doctoral Programs. I serve as the Periodontics Residency Director and this population is served by us in both our outpatient and OR setting.
AEGD Texas A&M University College of Dentistry
ASDOH ATSU U of Pacific NYU Harvard U of Penn - I do not know of all the programs.
NYU Dentistry University of Washington School of Dentistry
University of Iowa LSU Washington UCSF Stonybrook
LSU
Stony Brook Dental School, NY Eastman Dental, Rochester, NY AT Still Dental School, Arizona Wake Forest Dental School, North Carolina University of Michigan Dental School, Michigan University Washington School of Dentistry, Washington
Rose F. Kennedy Program, UW DEOCOD program, Swedish Medical Center
Stony Brook University
Arizona- AEGD Tufts- GPR Washington- AEGD
NYU School of Dentistry UW School of Dentistry
OMFS AEGD GPR Pediatric Dentistry
SUNY Stony Brook - Special Care Dentistry fellowship program LSU - Special Care Fellowship Albert Einstein Medical Center (NY) - Special Care fellowship Texas A&M - Special Care fellowship program (relatively new) University of Tennessee- Operating Room fellowship (focus on special needs) Ohio State Univ - Community Based fellowship (with focus on special needs) Univ of WA - 2nd year GPR dedicated to special needs (linked with Leadership Education in Neurodevelopmental and related disabilities fellowship); Univ. of WA also offers short-term special care fellowships
GPR, University of Oklahoma, Childrens Hospital of Oklahoma
GPR Carilion Medical Center
St. Elizabeth's Hospital/ GPR Washington, DC

GPR
I am only aware of a program at Rutgers Dental School/and it may only be a part of the dental school curriculum
New York City is the only one I know of
AEGD and GPR programs really help with this for the adult population and Peds Dent covers both adult and peds dent.
Texas A&M University College of Dentistry, New York University, Univ. of PA School of Dental Medicine
Columbia College of Dental Medicine LSU Special Needs Fellowship
University of Washington DCODE program
Tufts University School of Dental Medicine GPR Program
Rutgers University Univ of Washington DECOD SUNY-Stony Brook University
Helen Hayes Hospital Rose F. Kennedy University of Tennessee
Advanced General and Special Needs Dentistry (Nova-) 1 yr Dental Operating Room Fellowship (U Tenn)- 1 yr Advanced Education- Special Needs Dentistry Fellowship (LSU)- 1 yr Special Care Dentistry GPR2 slot at Univ Washington GPR with DECOD – 1 yr Dental Care for the Developmentally Disabled (Stony Brook)- 1 yr Special Care Dentistry Fellowship Program at Rose F Kennedy Center (Albert Einstein Col of Med)- 1 yr Geriatric Dentistry (Harvard)- 2 yrs, 3 yrs with MMSc, 4 yr with DMS Interdisciplinary Geriatric Fellowship Program (U Rochester- Eastman)- 2yrs Geriatric Dental Medicine Residency (Boston U)- 1 yr Geriatric Dentistry (U Southern Calif_ - 2 yr MS degree
UCLA University of Iowa
SUNY Stony Brook School of Dental Medicine
Stony Brook University School of Dental Medicine
The Lee Specialty Clinic- Louisville, KY - Dr. Henry Hood AT Still University- Dr. Maureen Perry I think one in New York? I also think one in Oregon? I also think one in San Francisco
Advanced Education in General Dentistry, Pacific Dugoni School of Dentistry
Iowa
Helen Hayes Rose F Kennedy Center pending: NYU Dentistry (HRSA Grant with Dr. Courtney Chinn as PI)
Kentucky, Lexington Tennessee: UT Washington State: UW New York/NYU
Rose F Kennedy Special Care Dentistry Fellowship Program Stony Brook School of Dental Medicine Dental Care for the Developmentally Disabled University of Washington School of Dentistry - 2nd year general practice residency track with emphasis in special care dentistry (in coordination with UW Dental Education in the Care of Persons with Disabilities DECOD Program) UMDNJ General Practice Residency with Second Year Concentration in Special Care Dentistry

Q6 - Do you believe established special needs dentistry programs and their sponsoring institutions would be interested in pursuing accreditation by the Commission on Dental Accreditation?



Q6.a - Please explain why.

Please explain why.
I think there is desperate need for this niche to be established.
CODA-accreditation would provide a mechanism for federal Graduate Medical Education (GME) funding that would provide the financial resources needed to fund residents, attending staff, and the infrastructure needed to provide sufficient care for the full spectrum of patients with intellectual and developmental disabilities.
Because there is a need for this type of training. The more they are recognized the more people will know about them and they will get recognition among other dental groups and the public in general.
It will make it easier for programs to go after HRSA grants
all programs wish to be CODA accredited whether it's justified or not
There is a training need. Is there a demand by the young dentists? If you build it, will they come?
Recognition of status
By being an accredited program, Hospitals would be much more receptive and cognizant of the program needs. They would be more committed to financial support.
Accreditation lends value to a specialty and standardizes the programs to an extent that you can have an expectation of the level the graduates achieve.
There is such a critical need for special needs adult populations and the margin of error is small with treating that population. It warrants a program dedicated to special needs training for an entire year. It is difficult for programs that are already doing other advanced dental concepts to adequately train residents in one year the extensive skills required to treat special needs patients.
I think this would increase the level of interest of graduating students and would offer GME funding that would help support these programs.
This is an area that could easily be expanded to promote more understanding in this so in need population.
Why wouldn’t they. STATUS
Once it becomes a program offered by many institutions, those participating will seek accreditation and validation of their time and effort
Potentially yes. I think that would be an important step to fully recognize these programs and expand the knowledge and recognition to a greater level.
There is a specific niche of population that would benefit from specialty treatment regarding special needs. Some of these patients are being seen by Dental Anesthesiologists. With the same logic, the Special Needs advanced trained dentist, would seek establishing their own specialty.
I am not familiar with special needs dental programs but would assume they want to fulfill the highest standards of accreditation for their patients and education for their trainees.

More and more Special Needs individuals are living into advancing ages and seeking dental care. This area of care needs a broader educational platform than can currently be provided in the pre-doctoral curriculum.
Accreditation of a special needs dentistry program might entice more dentists to pursue this specialty.
Accreditation will solidify credentials for eventual specialty status.
Having a specialty in Special Care improves the training and knowledge for all providers and training programs.
Yes. To allow for CODA / ADA recognized certification
I've mixed feelings on this. Let them tell you. Accreditation is a strong indicator of quality. The more programs are accredited, the more likely they would seek specialty status. However, the attending and staff time needed to devote to accreditation is daunting and continuous, and might dissuade programs from seeking accreditation.
See my previous comments
It will provide standardization and guidelines to be followed.
Yes, either as a standalone residency or an advanced aspect of their curriculum portfolio
Accreditation provides legitimacy to programs. However, I believe that special needs training should be focused on existing GPR programs as they are best equipped to meet the needs of this population with the hospital based services currently offered
To maintain the educational standard
Interested candidates will have a more focused experience; will hopefully expand access to care for this highly underserved population. Will also help structure and establish a SPHCN curriculum - that can potentially cross-over to pre-doctoral education.
Accreditation will help drive growing the programs and curriculum
At the behest of the requesters
The need!!
There is a need for programs which embody such patients' needs, but will the dental community encourage new graduates to regard this as a legitimate and necessary area of specialization.
Brings a certain degree of credibility to the program and encourages potential applicants to seriously consider an accredited program.
It would establish the discipline as well as provide resources for the support of these training programs.
Yes due to the increased number of special needs patients
Great unmet need public demand validation
If a program exists, having an accreditation would provide support to that program.
Good for programs to have an oversight and also gives credibility.
self-evident
If education in special needs was a specialty that included an education from an accredited program, I believe more students would pursue it.

Having CODA accreditation would strengthen a programs reputation. However, it would also require specific program features, such as adequate patients to achieve competence. This may not be possible for all programs.
Because there is a great need
There was a needs assessment completed and published in the Journal of Special Care Dentistry by Hicks et al. that includes this information.
accreditation gives programs structure and a framework to gear resident education, I dont see why any program would not want to be accredited, also accreditation for some institutions can open the door for GME funding and with so few special needs programs, I wonder if the lack of accreditation and GME funding is preventing more programs from arising and serving both patients with special needs and helping train providers who are motivated to do so
I suspect they want to be acknowledged some day as a specialty.
Would improve standing of the program
I believe the proponents of these programs would welcome the legitimacy that accreditation would bring.
Accreditation does give the program since of respect and accountability
It would be a starting point for more programs.
Many would probably pursue a career in education or a hospital.
Creating a credential in Special Needs Dentistry would attract candidates who would like to become skilled in SND and have a program certificate or credential that would verify their education.
To create more uniformity in training and guidelines across programs
By having CODA approval, sponsoring institutions could apply for Graduate Medical Education funding. This would create another funding mechanism for some existing programs and a pathway to create additional programs.
I believe accreditation will help lead to GME funding which will make the programs more attractive to applicants.
it is an area that works better to be concentrated on and not diluted in order to give the learner better understanding and skills
The treatment of patients with special needs has become much more complex than the traditional pediatric dental residency can manage. A new specialty dedicated to these patients would greatly enhance the care they receive. There is a tremendous need for more programs with a dedicated faculty providing a specific knowledge base. A specialty brings recognition. Who wouldn't want that?
I believe that the established special needs dentistry programs associated with dental schools may be interested in pursuing accreditation by CODA because it could conceivably cause the programs to receive more grants and would give their programs increased respect in the academic world. This and possible increased enrollment would increase the income of these institutions.
This is critical to the future of dentistry and these patients are not getting adequate care.
I think that these specialists would need to work in the hospital and that Accreditation would be integral to the practice. Accredited programs would absolutely need to have a must statement regarding hospital training and cases.

Our GPR curriculum and patient care experience is sufficient. Additional accreditation would be duplicative for this program and thus easier to obtain.
It would mean a different potential path to licensure.
The Commission on Dental Accreditation implements accreditation standards that promote quality and improvement of dental programs. Therefore, I assume special needs dentistry programs would be interested in pursuing the accreditation.
Accreditation leads to credibility as well as some standardization across programs.
To be recognized by their peers
Peer validation of the educational process
It is necessary and uncommon
These programs are run by individuals who incorporate a sensitivity to special populations and view their challenges to higher levels of oral health as a necessity not a burden
So that they are recognized with more skill for working with these special needs patients which require more time and effort to treat properly. This should also help in the reimbursement for insurance and billing purposes. Treating a regular patient and a special needs patient is not the same and should be compensated appropriately.
Every effort should be made to have the treatment of special needs in the DMD/DDS curriculum and in the residency programs for AEGD, GPR, and Pediatrics.
I think it would serve a purpose of achieving the same standards at all programs
Accreditation is, in my mind, always desirable and allows for standardization of outcomes expectations for the educational process as well as providing a standard of care for the providers and students.
It would help standardize the programs and raise their visibility.
Gives them more credibility
The demand for SN Dentistry is high and the access is low.
Program reputation GME funding of hospital-based programs
This will improve the quality of care and quantity of patients in the community that they could see due to promotion of these clinics
There should be reasonable standards set up that hold a Program to be accountable
There seems to be a lack of special needs care provided in the elderly population.
Because accreditation status is important in seeking hospital based positions.
the program needs standard and needs to meet standard
I think it would be helpful to have as a recognized specialty.
CODA accreditation provides universities/hospitals, faculty, residents, and the benefiting patients the assurance that a curriculum has been established in a systematic fashion. It establishes a set of goals and standards through which providers are held accountable for ensuring they provide the highest quality of care. In this scenario, patients with special health care needs require particular care and accommodations that otherwise healthy patients or patients with mild systemic disease may not require.

Graduating from an accredited institution would be more substantial than obtaining a certificate from a non-accredited institution.
To make sure that all Special Needs programs are following the same guidelines (methods may differ)
There is a demand on the local and state levels for creation of programs to provide care for individuals with intellectual and developmental disabilities. Access for this population is limited, and creation of these programs will increase access and train providers to care for this population. In addition these training programs are needed to increase faculty at dental schools to meet the CODA standards.
establishing a structured agreed upon body of knowledge to pass on to others will help with recruiting additional individuals interested in working with the patient population
Would be recognized by GME funding
Gives them academic credibility.
there is a tremendous unmet need
There is not enough training on special needs dental care.
There is an overwhelming need that has long been ignored. Providers would jump at the chance for accreditation
Almost every body of dentistry wants recognition for the work they do.... the easiest method for recognition for accreditation.
Due to the unique set of skills necessary to provide care to special needs in both out-patient and hospital-based settings. Advance knowledge in oral medicine, anesthesiology, and behavioral management is necessary as the ability to provide dental care in compromised settings.
CODA accreditation would raise the profile of these programs helping them to attract greater numbers of qualified applicants. I have seen this happen in my 35 years of involvement with dental resident education in Dental Anesthesiology.
From what I gather in classes and meetings, people who are involved in the special needs industry, whether in a volunteer or career capacity, are ALWAYS saying they need more dentists to see and feel comfortable seeing special needs patients. Their institutions should be happy to have the accreditation, I'm my opinion.
For many, ability to compete for graduate medical education support (Medicare IMD/DME) from their local partner hospital.
So many persons with special needs cannot find well trained professionals to provide the care they need. I believe it's the desire of many of us in the field to promote the field to Specialty status. The recognition of the body of knowledge and specialized skills by CODA would promote greater interest in the field and help to increase the number of professionals serving this vastly underserved population. It also would make clear that serving this group requires specialized training and consequently better reimbursement for services. Better reimbursement would also attract more professionals to treat this vastly underserved population.
Programs that already established should be recognized. However in the Stony Brook program all the dental students and residents have interactions with our established program
This is an area that requires training in proper patient management, use of sedation methods, knowledge of appropriate diagnosis and treatment planning and should be regulated.
Perhaps with accreditation they can establish GME funding and increase enrollment rates

Increases the availability of GME funding
Funding - I think this would also increase the number of programs that exist which is what is desperately needed.
Population is aging and changing making it more critical that oral health care providers of appropriately educated
Professional recognition
This would allow better standardization and sharing of resources.
it would be better for them
This is an area that is lacking care providers and they follow to pediatric dentists to take care of, but once they have adult needs it becomes difficult.
Credibility Funding
Residents attending CODA accredited programs know with more certainty what didactic and clinical educational experiences to expect. CODA Accredited programs must comply with the standards developed for the program.
If given the opportunity, I would believe any high quality educational institution would appreciate accreditation to show it maintains high standards.
I do not feel I can speak on behalf of these programs. I do not know their situations in detail to know what the pros and cons of this would be for them and their staff. This is a yes/ no question, I would select n/a.
Because advanced training is needed in this field to meet the needs of our most vulnerable populations. While many people with disabilities and other special health care needs can access dental care in traditional dental office, many need access to providers with advanced skills. These are not traditionally obtained in GPR/AEGD residency programs and the work-around of having a yearlong fellowship or 2nd year AEGD/GPR track is not sufficient to have a standardized education in this field. We need our own standards.
there is a great need to establish such programs with credible educational standards
Because of the huge unmet need out in the community, the need for more trainees to complete this type of program, and the fact that accreditation could help programs attract the best residents into their programs.
They feel it is unique enough to be a specialty.

Q6.b - Please explain why not.

Please explain why not.
The amount of training is not sufficient to support a 12 month program.
Should already be covered in existing programs
I'm not familiar with any Advanced Education programs that are centered on treating special-needs patients.
Most GPR and AEGD programs already include didactic and clinical education on the treatment of Patients with Special Needs.
Most special needs individuals can be treated by generalists IF dental curriculum includes such education. CODA standards have moved in that direction. Having a Specialty will dis-incentivize generalists from "taking care" of those they should.
There is a lack of foundational knowledge to assist in establishing criteria for accreditation
Pediatric dentist and Hospital Dentistry cover this topic with OMS very well
Patient population , in terms of numbers, does not merit dental subspecialty recognition
Accreditation by CODA then facilitates the ability to apply for Graduate Medical Education funding to support the training of residents and advanced post-doctoral trainees. This is essential in designing a successful and sustainable program.
Sadly, no market for it...meaning not enough funding to sustain a business model. Our Pedodontists and GPR get special needs training as part of their programs so they can incorporate it into their own practices to fill that need the best they can.
Because we already have more paperwork than we need to be accredited as it is. I believe this is part of pediatric dentistry.
Reimbursement is often challenging with insurances and there is a routine loss of time due to coordination of travel especially during COVID. The Special needs community needs support financially, this is only one area of concern. Even designated areas are often back-logged with numbers.
It is intensive with a lot of faculty needed to cover all aspects of the program. You would in addition to regular faculty but also faculty in dental anesthesiology which is currently in a shortage.
Not immediately...need to have multiple programs that exhibit a standard that can be emulated by others...then seek accreditation
It is part of our care already.
Training is already an integral part of the CODA accredited programs
"I don't know" is a more appropriate response.
Economically challenging in the private practice setting
We have too many specialties
Accreditation is laborious

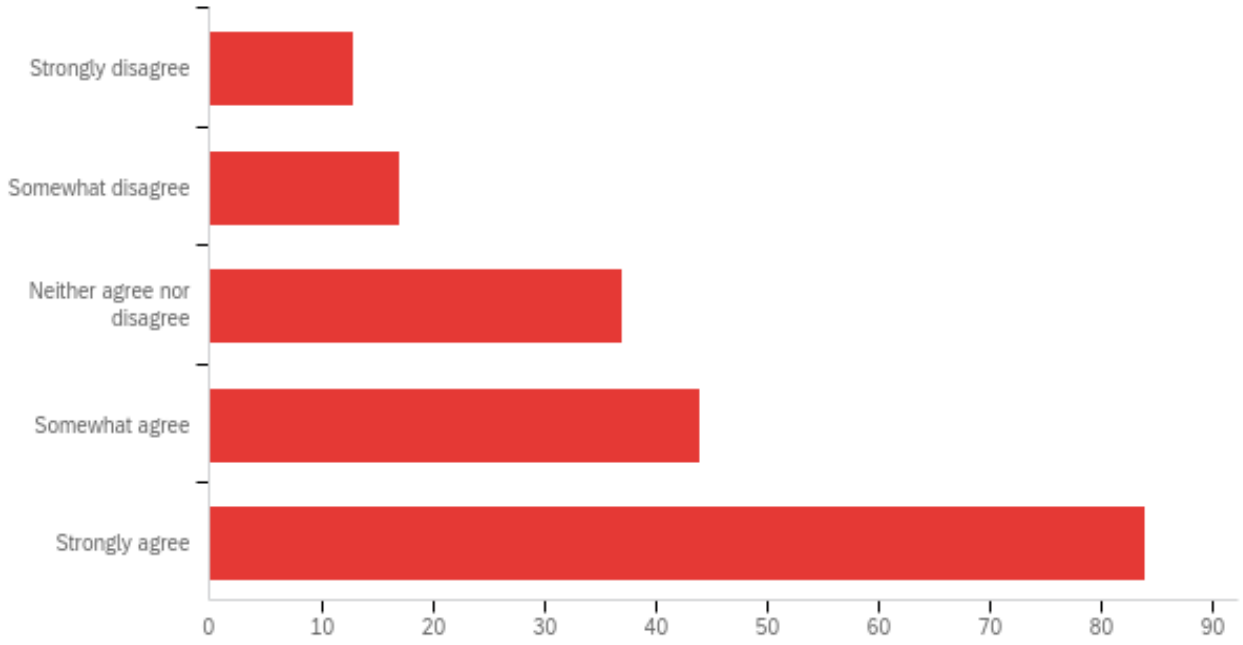
The patient population is too limited and would only be of interest to academic practitioners. Nearly impossible to make a living in our state based on the poor reimbursement for services. Well-staffed GPR programs generally provide services for this population as a result.
It’s going to be a lot of work.
I don't know of any so I can’t comment on it
Many of the special care dentistry training programs are closely aligned with general dentistry and pediatric dentistry programs and may not have the resources to be accredited independent of the other programs.
Administrative burden
Possibly, but I think it is better to have rotating GPRs than a standalone program
It is a headache to do the special needs in the OR prior doing the case (H&P, consent, conservator paperwork). Spend a lot of time and resources blocking out time to do the case in the OR for a very small amount of money. Major institutions get dumped on with these cases, because no one else wants to do them. Need to incentivize offices to do these cases
I believe this can be taken care of in most GPR or AEGD programs.
I'm unsure of the benefit.
Lack of interest in the bureaucracy that accompanies the CODA accreditation process.
We need to educate dentists and specialists to manage children and adults with special needs and FUND them to provide care of individuals with special needs. Even if you establish a specialty without funding it will not work.
Needs already being met by Pediatric and OMS
Too small of a focus for establishment of a specialty
The terminology of special care is too broad.
Too much bureaucracy would be created. Burdensome levels of paperwork would not benefit people with special needs. I think it only serve to dissuade dentists from becoming more involved.
This is a component of several GPR programs that allow exposure and some expertise in the area. I believe it could detract from programs and remove a resource some program residents would find helpful and educational without it being a devoted special needs program.
Not a specialty or certificate program
Extra cost
There would be no advantage to the individuals who finish. The accreditation process is not worth the effort for them.
In our case, we already have an established GPR program and having accreditation in this area would not change the types of patients we see as our work already centers around this.
There is no need for a subspecialty. This population of patients is well cared for by those trained in pediatric, AEGD/GPR programs, and oral and maxillofacial surgery programs. Any lack of access is generally due to poor reimbursement or aging out of Medicaid, not a lack of provider experience.
It depends on the obstacles that would be involved in the process. Most of these clinics and programs are encumbered with limitations of effort, money, resources and community support. More paperwork, expense and administrative needs would be a serious deterrent.

It is too onerous of a process.
Current GPR and AEGD programs provide training and clinical experience in special care dentistry
The same happens for all of the unanswered short response questions

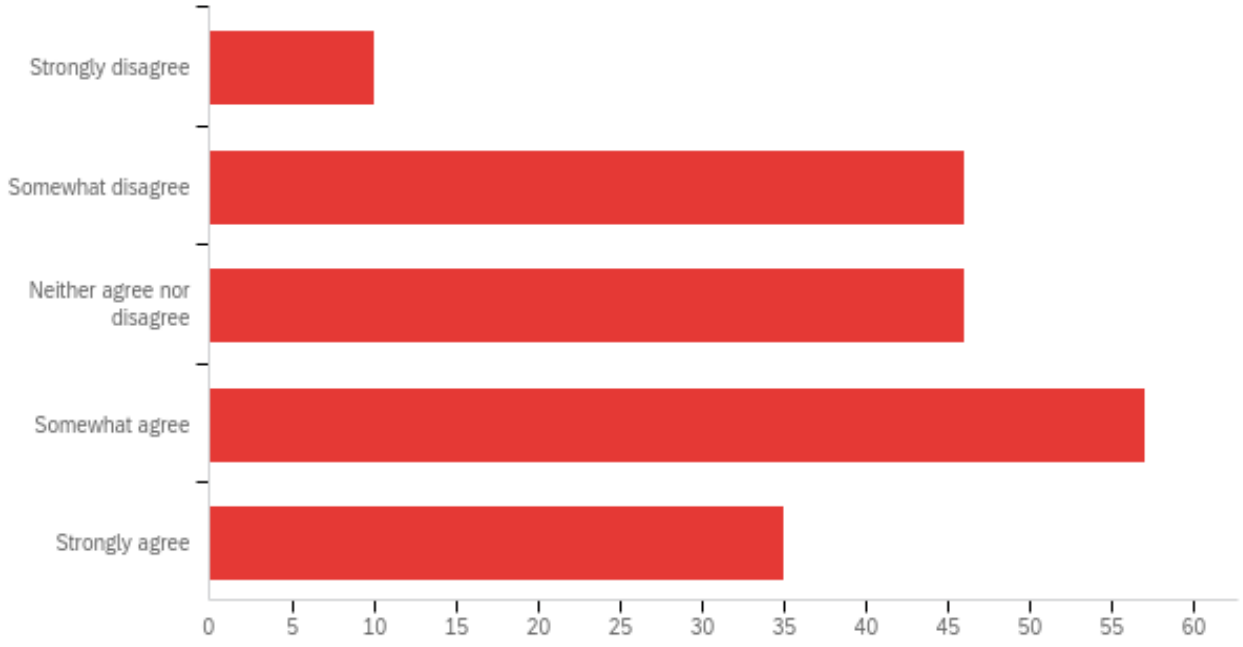
Q7 - An association/organization/entity that may be interested in leading the pursuit of CODA-accreditation for special needs dentistry programs is:

An association/organization/entity that may be interested in leading the pursuit of CODA-accreditation for special needs dentistry programs is:
Special Care Dentistry Association (53)
American Academy of Pediatric Dentistry (5)
American Dental Association (3)
Academy of General Dentistry (2)
Hospital Based Dentistry (2)
American Society of Hospital Dentists and the Organization of Special Care in Dentistry
GPR programs
General Practice Residency Cleveland Dental Institute St. Vincent's Charity Medical Center Suite 136 11201 Shaker Blvd. Cleveland, Ohio 44104
Rancho Los Amigos National Rehabilitation Center
American Association of Orthodontists
American Academy of Developmental Medicine and Dentistry (possible interest)
ACLU, AAPH , Special Olympics
Dental School.
American Dental Education Association
ATSU Missouri School of Dentistry and Oprah Health ATSU Arizona School of Dentistry and Oral Health
I assume the hospital dentistry group would, but it is important to distinguish between adult and pediatric care.
Herman Ostrow School of Dentistry
American Association of Public Health Dentistry
UConn in Farmington, CT or St. Francis Hospital in Hartford, CT
CODA should lead this
Pediatric Dentistry and Oral Maxillofacial Surgery likely receive the most comprehensive training in management of patients with special health care needs. The difficulty that specialists in these fields face is that, as patients with special health care needs age, their dental needs also change. These dental needs cannot always be satisfied in a comprehensive manner due to lack of skill set on the part of the pediatric dentist or oral surgeon. For example, pediatric dentists are not typically proficient in performing root canal therapies on permanent teeth, or managing complex prosthodontic needs for these patients.
Almost all pediatric residency programs as well as most geriatric programs.
The Ohio State University, Arkansas Children's Hospital, Wake Forest University
Tufts University School of Dental Medicine / Tufts Dental Facilities Program for Individuals with Special Needs
American College of Prosthodontists (ACP)
American Academy of Developmental medicine and dentistry
SPCA
Autism Speaks/ Autism Society of Minnesota (AuSM MN) Special Olympics United Cerebral Palsy ARC
American Board of Special Care Dentistry

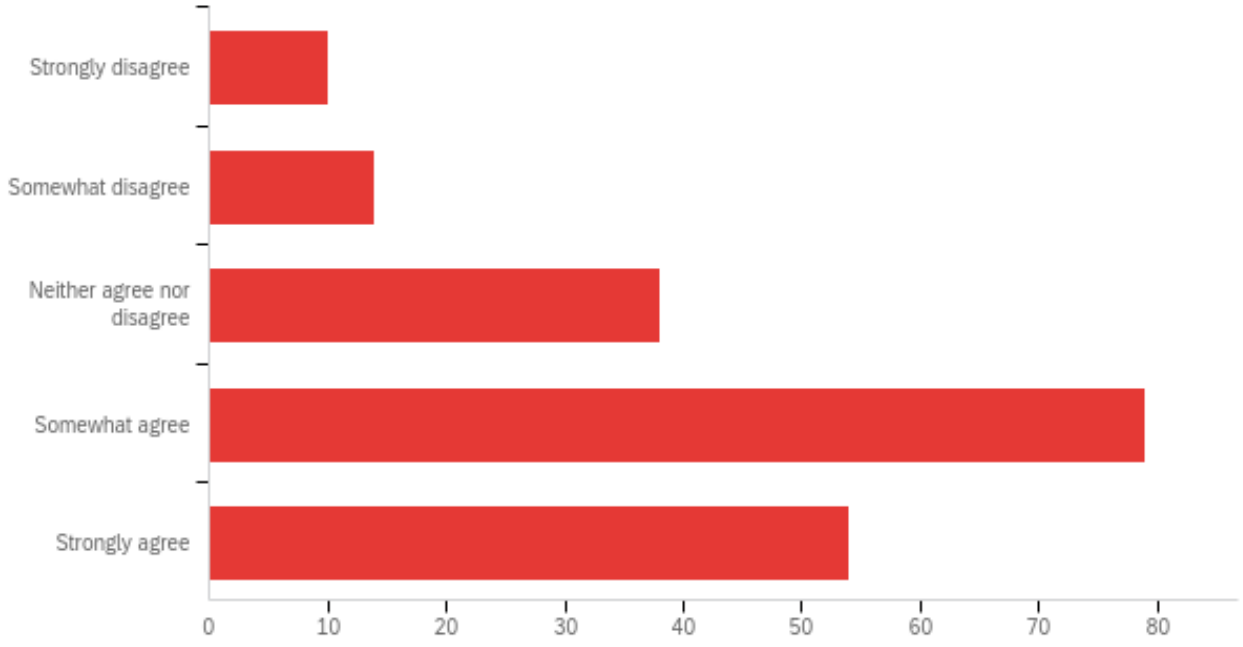
Q8 - Accredited advanced education programs in special needs dentistry will increase access to care for this patient population.



Q9 - There is evidence of need and support from the public and professional communities to sustain advanced education programs in special needs dentistry, e.g., there is evidence that program graduates will obtain employment and practice the discipline.



Q10 - There is evidence that undergraduates trained more specifically in special needs dentistry would expand their treatment options to include special needs patients into their general practice.



Q11 - Please add a list of special needs conditions which are currently not addressed by students in your program and which are routinely referred to external facilities for treatment. This information will enable the Council to better assess the needs and the focus for an advanced dental education program.

Please add a list of special needs conditions which are currently not addressed by students in your program and which are routinely referred to external facilities for treatment. This information will enable the Council to better assess the needs and the focus for an advanced dental education program.
my program is able to treat IDD patients
Severe developmental conditions Some Cerebral Palsy cases Moderate to Severe Intellectual Disabilities Epidermolysis Bullosa Severe Down Syndrome Severe Autism Uncontrolled epilepsy/seizures
Special needs children go to the pediatric dentist; along with some special needs adults. TBI impacted patients often go to GPR along with complicated medical patients. PTSD patients may wind up in the GPR or AEGD clinic depending on comfort of patients.
Any syndrome or condition that causes a cognitive disability where conventional treatment is not possible: Down Syndrome Various Trisomies Cerebral Palsy Autism TBI Asperger's Syndrome Stroke Dementia Alzheimer's Sensory Processing Disorders
We have a large and diverse special needs population. We address most needs but need to refer for more complex surgical procedures. Also, because of the limited number of programs available with access to sedation we are overwhelmed with patient volumes and need to refer many patients out of our service area.
We treat special needs patients
Oncology patient, hematologic patient, patient with pain control issues
Down Syndrome CB
Severely medical compromised patients. Patients with behavior problems Patients with severe physical limitations
Autism (pediatric)
We have a Special Needs Clinic that has been in existence for over 30 years. We treat all people with Special Needs including those requiring sedation. Those who have unstable medical conditions are referred to hospital settings.
Comprehensive care under IV sedation
Our Special Care and Geriatrics Program treats all patients with special health care needs. The only referral to outside providers is related to the limited availability of a dental anesthesiologist.
Home-bound Many institutionalized large gurneys/chairs motion disorders (flailing, severe Parkinson's, etc) severe cognitive disability
Care in long-term care facilities

We are fortunate to be able to offer a wide range of procedures within the scope of our dental service, including special needs patient's, however it would be beneficial for there to be a standard accreditation minimum that would support the program and legitimize our offerings while further providing the resident with a governing body sanctioning that training and documentation for their portfolio.
Our program offers comprehensive care to all special needs individuals. The limitation is not in training but rather in financial resources available to these individuals and their families. Current undergraduate training is at best insufficient and at worst harmful to these populations as it promotes dentistry that is lower than the standard of care.
We manage most Pts with Special Needs within our AEGD Residency. Our school also has a Special Care Clinic, and a small hospital-based GPR Residency, which is able to manage most Pts with Special Needs that we are not able to treat in a traditional dental clinic setting; they have the ability to take Pts with Special Needs to the OR when indicated.
Patients with complex medical problems. Patients with history of stem cells transplant and organ transplant etc.
For many years, Rancho has only treated individuals with physical and/or neurodevelopmental disabilities within LA County Dept of Health Services and private practice dental clinics in Southern California. We refer out very few cases each year (1-2/yr) - all of them general anesthesia cases. While Rancho performs dental treatment in the OR quite frequently, every once in a while, we refer out patients who are very fragile medically. For those cases, we refer them to our level 1 trauma hospitals as they have more robust emergency services compared to our hospital.
the transitioning adult population of IDD/ DD as well as physically and medically compromised... The paradigm of screening out patients due to "we don't have faculty to oversee" needs to be relooked.. We should have faculty help train younger, less experienced faculty to be able to teach and oversee care... We should not seek the lowest common denominator...but prepare the clinicians for moderately challenging cases... Studies suggests that with minor modification, a special needs patient can be seen in over 80% of offices. That is not to say there is not a significant population that can benefit from true "advanced cases".... but a lot of that is behavioral management, occupational therapy techniques and understanding the pathophysiology of the disease or syndrome.
The hospital-based GPR program with an affiliated dental school site provide the majority of care for complex patients with special healthcare needs. Patients with multiple diagnoses who experience functional challenges with mobility, cooperation and medical co-morbidities that require a higher level of management and/or modification are seen outside of a dental school/trainee, pre-doctoral dental or dental hygiene setting. This website provides a generic reference for multiple conditions that are often included in the scope of special needs: **https://dental.washington.edu/dept-oral-med/special-needs/patients-with-special-needs/**
This program does extend and accept special needs patients but there are limitations in terms of space, equipment and training.
None - we take special needs patients of all kinds up to the OR for dentistry.
Firstly doctors won't treat if they are uncomfortable. But more importantly, they won't treat if they cannot make a living doing it. Make it profitable, and doctors will pursue the education that they need. We are a capitalist society. Doctors won't see special needs patients if it takes twice as long to earn less money. I feel that this is a wasted effort. Get insurance companies to pay for autistic kids to be seen in the OR. Start with the basics. We only refer endo, we will see any special needs patient. There are trained doctors, they just need to financial incentives.

Our patients vary- we have a few that are deaf, many are Autistic, a couple that are developmentally slow, some born with syndromes- i.e. fetal alcohol, or Downs. The institution has a hard time with capture of reimbursable codes, follow-up care, and points of contact especially when it comes to foster care, group home or adult home facilities.
Wheel chair bound patients, adults with intellectual challenges, institutionalized adults, homeless populations, refugee populations, older adults with complex medical conditions, disabled veterans who cannot access VA care.
Understanding the medical complexities of patients with IDD is challenging and can be elusive. The is impacted by the many layers of people and entities involved with the support of this patient population particularly if they reside in a group setting with caregivers, house managers, fiduciaries, etc. Access to medical care is similarly limited particularly influenced by the cooperation of the patient which can limit the medical history obtained. Regardless of the primary diagnosis (Down Syndrome, ASD, CP, etc.), the level of mental function is what is most impacting. The more severe this presentation is for a patient, the more limited is the ability to obtain appropriate medical and dental information. This type of assessment and evaluation is beyond the capacity of dental students. This involves intensive and specialized education and training that is best achieved through residency training. Even in the AEGD or GPR settings, this is not typically addressed at the appropriate level. Working for the past several years (20+) with AEGD residents at several institutions, I find there is limited capacity for these residents to properly and appropriately treat this patient population. It requires more focused training and education that would be best accomplished in a directed and specific residency training program.
In our Institution we do have a specialty care facility and all special needs patients are seen there
Autism, Developmental disability.
children and adults with cognitive/behavioral issues currently require Operating Room sedation in order to accomplish lengthy/involved endodontic procedures
Patients that test high on the autism spectrum Special needs patients that require extensive dental treatment and need to be sedated.
We attempt to manage all we can for all patients of need, especially in the realm of emergencies through creative approaches as needed
We do not refer patients from our Center. We have a well-trained faculty many of whom are fellows in Special Care as well as Diplomates. We have D3, D4, and PGY1 and PGY2 residents who treat our patients.
we are fortunate to collaborate with the Rose F Kennedy Center for special care dentistry. we send patients with a whole range of physical and psychological/developmental/neurological conditions such as cerebral palsy, autism, developmental delay, ADHD, epilepsy and a variety of genetic conditions for care at RFK
Patients who need sedation or General Anesthesia are currently not treated by our students, but we are developing programs to address these issues.
We provide comprehensive oral health care for all infants, children, and adolescents, including those with special healthcare needs. No family is referred away because of their special healthcare need.
We are able to take care of all our needs related to special needs patients Multi specialty approach drive by GPs
Almost all are referred to the residency program. Before we had a program students learned to work on special needs patients in the school.

as we are a military based practice, many special needs are not seen within our program, for medically complex and patients with dental anxiety...we are able to see in our program
We are that eternal facility. We are 3 community hospitals. Our catchment area has 1.1 million people. We receive many referrals for: 1. special needs patients with complex medical conditions requiring dental treatment 2. Special needs patients that require moderate, deep and general anesthesia 3. Special needs patients that have to be admitted to the hospital to manage their medical conditions in order to provide dental treatment 4. Special needs patients that require multidiscipline care coordination. If CODA approved such programs, our sponsoring organization would definitely seek to establish a CODA approved Advanced Education Program in Special Needs Thank you.
Patients presenting with advanced airway complications, patients requiring sedation/general anesthesia, patients with severe cognitive conditions (including Alzheimer's and dementia), medically frail patients presenting with long lists of medications and/or medical conditions
As the Director of a GPR program that services the special needs patients in our area, we feel that well trained Doctors who graduate will continue to treat these patients in their private practices and will have the training to take these patients into the OR.
OR cases are handled by the resident
We do not refer any patients to any other facility. Advocate Aurora Illinois Masonic Medical Center has a 9-resident GPR and 2-resident Dental Anesthesia residency. We have an established Special Patient Care program, but there is not a dedicated 12-months of education in only special needs dentistry. The combination of the GPR with the DA residency means we can treat anybody without referring them. We routinely receive referrals from the University of Illinois College of Dentistry for patients they cannot or will not treat.
I am not associated with a special needs program; however, my wife and I had a special needs child for 14 years with severe disabilities. She was nonverbal, could not walk and could not feed herself. It was during that time and since that time I have come to realize that there is a critical deficit of private practitioners willing to learn how to care for special needs patients of all ages. Practitioners being uncomfortable around those with special needs is a major roadblock to treating them. I was self-taught and my compassion for this sector of our population overcame my fear and intimidation. Treating special needs patients carries with it elevated risks to the patient and dentist. I am unsure if many will want to accept the challenge. Special needs conditions that must be addressed are autism, cerebral palsy, severe cognitive disorders, metabolic disorders, and multiple disorders in the same patient.
patients who cannot safely or appropriately be treated by predoctoral (DMD) students are not referred externally, but rather are referred internally to residents in the general dentistry training programs there are many existing general dentistry (AEGD and GPR) and pediatric dentistry residency programs that provide significant training and experience in the management of patients with special needs
None - we see all persons with any degree of special needs.
Any condition requiring sedation/operating room treatment.
Adults with special healthcare needs; we treat individuals who are aged 20 years and below. The state of Tennessee does not extend Medicaid dental benefits to individuals who "age out" of the system at 20. Adults with special healthcare needs are woefully underserved; however, I am not sure that a specialty program will be able to improve access to care for these individuals without additional insurance coverage policies. Thus, all adults with these special healthcare needs: Cardiac (particularly individuals with congenital heart defects who have extended lifespans like Tetrology of Fallot) Cancer patients (xerostomia and radiation to the head and neck) Down syndrome Autistic/Developmental Delay Cerebral Palsy Spina Bifida Liver disease/failure Kidney disease/failure Epilepsy Osteoporosis/Bone disease Respiratory (cystic fibrosis, persistent asthma) GERD Celiac/Crohns Craniofacial anomalies/syndromes (Crouzon, Apert, Goldenhar, etc).

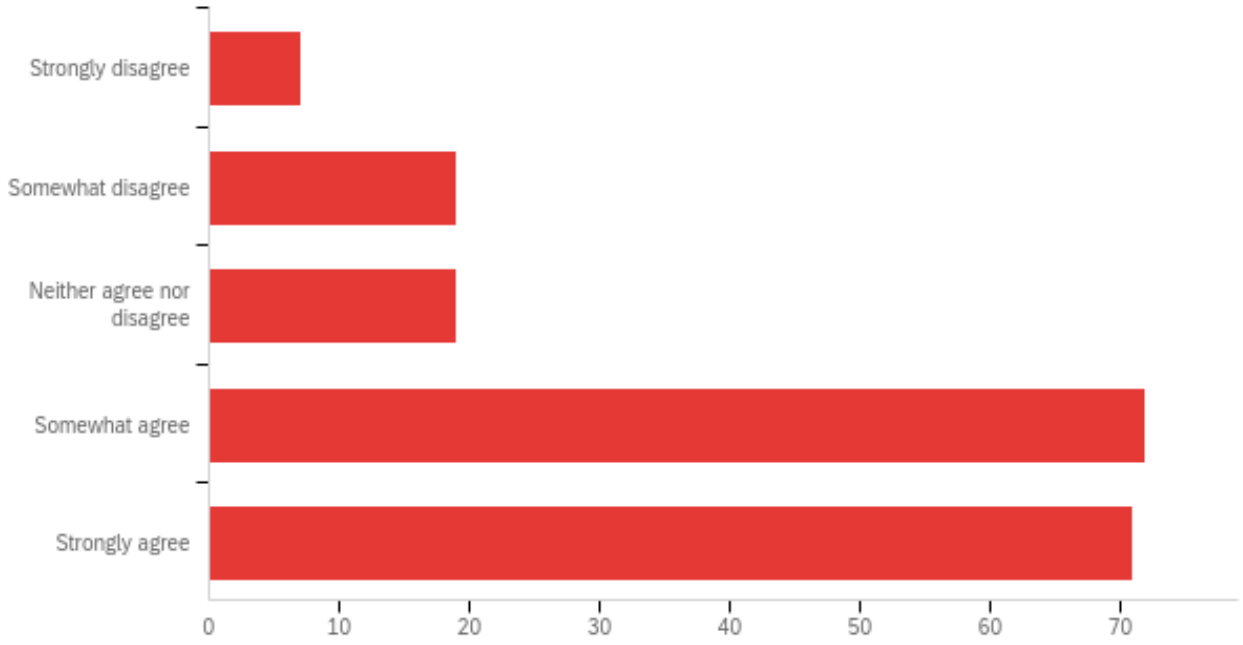
We are a VA program so we do not get an opportunity to treat many children with special needs, only adults whose special needs were a result of their military service.
Autism Multiple sclerosis Trisomy 21
I am a private practitioner. A GPR I teach at only addresses challenging patients whom require general anesthesia for care due to combative behavior, with basic dental care covered by Medicaid and not reconstructive care prosthetic etc.
Autism Developmental Delays
The main problem is treating the special needs patient that requires general anesthesia in an operating room setting. Often there is no funding / insurance.
My program is a Veterans hospital so there is exposure to special needs patients
We provide most dental services to our special needs patients including or care but due to the small number of attending staff that feel comfortable overseeing the care there are very long wait lists to be seen. Also pediatric dentists, who are most comfortable with patient management, are often not comfortable with adult and geriatric special needs patients. We are unable to provide any prosthodontic services to this patient population.
It is impossible to list them all here. In general, dental students do not have much meaningful education, either didactic or clinical, related to the treatment of this patient population.
Downs syndrome Mental disabilities
Our program is the final stopping point for SN people is our city and surrounding states. We receive referrals from GP's. Pedo, Endo, OS and Perio doctors to take care of these type of patients. Students are NOT taught how to handle SN populations. Many local dentists do not even try to see these people in their offices, they just tell them to go to the University. We need to educate the dentist (both older and new practitioners) on how to provide care in their offices. Students do not learn: patient management, how to access if they need to go to the OR, how to examine a patient with SN and get as much info as possible, sedation techniques, restraint techniques, etc. Health history reviews and pre-operative evaluations are not addressed in schools. Post-operative follow up and care is also not taught.
Patients with behaviors necessitating general anesthesia
Patient with severe disabilities Patients that require special equipment to be treated Patients with behavior disorders
We are basically "Black or White" in our Program. If a patient cannot be treated here in the clinic (mentally, medically, physically or behaviorally), then we treat them in the O.R.
N/A- we take on the special needs cases that everyone else does not want to do.
Special needs dentistry should be part of primary care dentistry, just as special needs populations are part of primary care medicine and pediatrics. Can you imagine having to take you child to a "special" pediatrician just because he/she had a developmental disorder? To remove special needs dentistry and classify it as its own specialty is just giving general dentists a pass to only see uncomplicated, easy, short visit, high reimbursement patients, and pushing off more complicated patients that end up with less reimbursement for their time to other (and fewer) dental professionals - and would result in an overall decrease in access to care in this already disenfranchised population. The ADA should follow the lead of the AMA, and make caring for all populations as part of a primary general practice.
There is a shortage of information for how to treat patients with autism.
My program affords me the opportunity to collaborate with all dental specialists to provide comprehensive dental care for patients with special health care needs. My limitations occur in the

setting of this dental care in an outpatient facility. If the patient requires sedation or general anesthesia, my hospital (which is not a level 1 facility) is not equipped to support patients with some ASA III and ASA IV status, and I am forced to find them a dental home somewhere else that can support their medical and dental treatment needs. This is not always an easy task, particularly in a military setting, where families may be limited by finances or transportation to a military treatment facility that can support them.
Cerebral Palsy Autism Down Syndrome Severe mental health issues
Medically complex Autistic adults Anxious adults
Autism Patients with behavior issues, students and residents are not currently getting the training in behavior management to successfully treat these patients in traditional clinical settings. The patients get referred automatically and are treated under anesthesia. There is a continuum of care that is missing from the student and resident curriculum.
Severely medically compromised individuals. Due to Covid and budget cuts, we no longer offer general anesthesia. Due to Covid and budget cuts, we no longer have the services of an oral surgeon.
This is about a concept, the list needs to be developed by those that embark on this road, which is very much needed
Cerebral palsy Paralysis
developmental disabilities cognitive impairment complex medical problems significant physical limitations vulnerable elderly
Cognitive disorders, seizure disorders
I am program director of a hospital based Dental Anesthesiology residency program - NYU Langone Brooklyn. My residents get extensive experience in the Main Operating Room Suite. Special Needs dental patients are reserved Block Time in the OR schedule one full day every week. Special Needs cases that cannot be treated elsewhere are routinely referred to this facility. Conditions requiring these referrals include: combative adults, involved medical histories, extensive treatment needs requiring general anesthesia.
Psychological
From DDS education "student" perspective, there is limited interaction with geriatric and intellectually/developmentally disabled patients and those with complex health needs. Even before COVID, the faculty in the dental school did not feel "comfortable" treating the special needs patients in student clinics. There is no nitrous oxide available for analgesia use in clinics. Sedation techniques only exist in pediatric dentistry, OMFS and Periodontics at graduate student levels. There is a 1 week "rotation" of DDS3-4 to our "special care/geriatric clinic" that has been hampered by COVID. This has been the "special needs" clinical experience. Some students have taken an "elective" with one of our now retired pediatric dentists on managing the developmentally disabled in a clinic setting. Our DDS3-4 extramural rotations to community sites and to hospitals were dramatically reduced in the past 5-10 years so our historical 4 week hospital dentistry rotation is no longer required of students and few opportunities exist for learning how to work in this setting and with these more complicated patients treated in an interprofessional care setting. This past summer, with retirement of our Public Health focused director of extramural programs, administration folded this experience into clinical education services as a mode of obtaining more routine dental experiences off site from the school as a few focused community health collaborators. Thus the "special needs" experience of the extramural rotation program was essentially eliminated. In defense of the school, the hospital extramural rotation partners administrators also over this time period became increasingly worried about their clinic's financial bottom line, removing as much time/focus on education as possible to focus on faster care provision by their hired dentists.

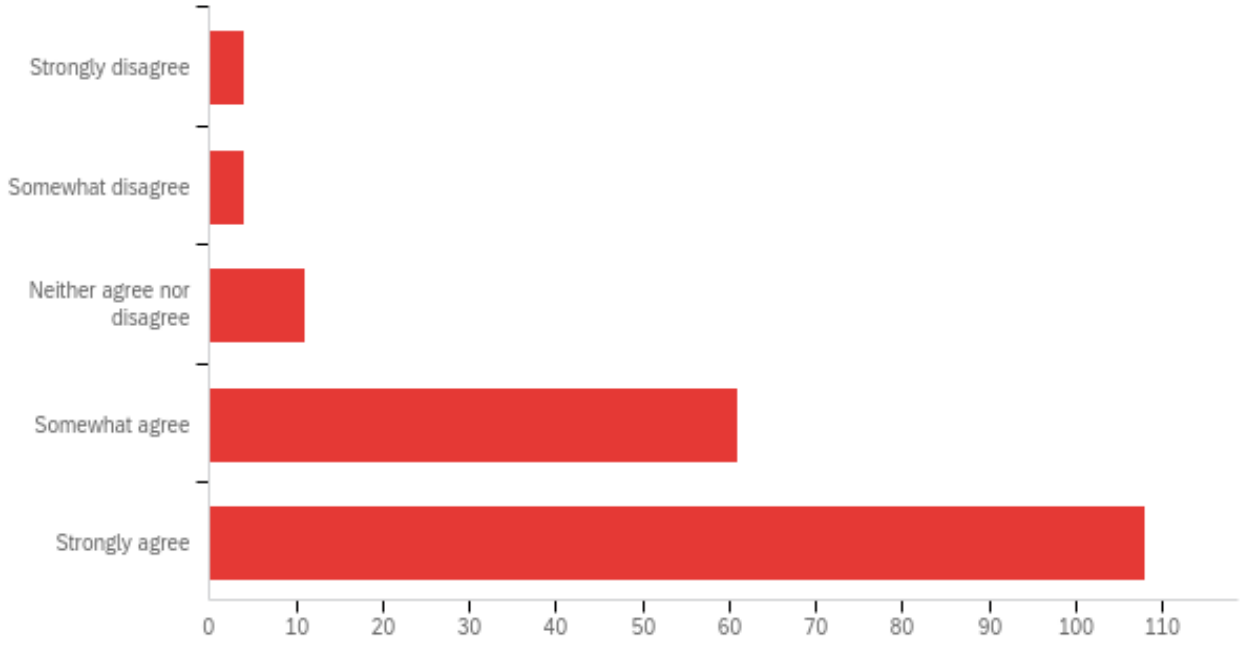
Any patient that requires IV sedation or general anesthesia is referred to external facilities. This tends to include many moderate to severely uncooperative patients.
There needs to be better reimbursement if we are to expect a group of students would specialize in this field. Having a designated SN specialty would just allow dentists to punt their moral responsibility to treat patients to a group that still would be unable to meet the demand both due to time and money.
We treat all patients in our program. There is no one else to refer to.
Cases that require hospital procedures and OR treatment are routinely referred to the Special Needs Program at the School of Dental Medicine
Adult dentistry Treatment of older adults with special needs
We are the place that takes everyone - But I feel people need more education in Aspiration risks and respiratory problems Conditions that effect swallowing Treating people in wheelchairs Treating people in hospital beds Interdisciplinary collaboration with MDs Consent issues for dependent adults Behavior management adults Behavior management dementia Protective Medical stabilization Movement disorders Sensory stimulation and creating a low sensory environment Hospital dentistry Sedation Seizure disorders
Cerebral palsy Severe autism
Those that require General Anesthesia and post op monitoring
When adult special needs patient have endodontic needs. We are also booked out for patients that need treatment in the OR.
None. The special needs program sponsored by the GPR that I am affiliated with as Program Director receives referrals from a multi-state region.
We do not have a craniofacial/cleft palate focused team here at Hennepin Healthcare so any young children are referred to the University of Minnesota for the early intervention. We do see these patients as adolescents/adults in our clinic. The pediatric dental residency here performs some orthodontic care, but refers the complex cases that would affect some of these populations to the University of Minnesota or to practitioners in the community who are willing to care for them, when appropriate. All other populations defined by this survey can be cared for here.
My program is not a GPR, but I would think that a GPR covers more in depth these special need patients. I wonder how much overlap there would be between these two programs; however, I'm not in a position to determine that.
In our Pediatric Dentistry program we treat many patients with SHCNs and do not need to refer out fortunately. We are able to provide treatment with non-pharmacologic and pharmacologic (sedation and general anesthesia) behavior guidance for our patients. We address all conditions in clinic and/or in our didactic courses.
We have a GPR, oral surgery residency, pediatric dentistry residency and all special needs patient are cared for within this group without need for external referrals.
Our teaching will address all aspects of treating persons with disabilities providing appropriate accommodations needed to successfully treat persons with disabilities.

We are the program that people refer to. Our patients with Down syndrome, autism, intellectual disability, cerebral palsy, and traumatic brain injury have particular difficulties with access and often report be sent away from multiple dental offices before finding us; however, it is not always correlated with diagnosis or even the severity of the diagnosis but how that individual is affected in their ability to tolerate dental care, follow instructions for dental care, their medical complexity, behavioral complexity, etc.
Cerebral palsy patients, severe autism patients, patients with chronic advanced stage disabling diseases (Parkinson, ALS, MS etc.)vulnerable elderly with dementia
All special needs population patients are treated at the hospital which serves as a referral base for the region.
1. Adults with developmental disabilities being treated in the operating room or outpatient environment- our dental students could not possibly be competent at the time of graduation- advanced training would be necessary 2. Those on the severe end of the autism spectrum 3. Vulnerable elderly in nursing homes 4. Some medically complex/medically unstable patients best treated in a hospital setting, or whose dental treatment must be completed very efficiently, for example pre-transplant, pre-cardiac surgery, pre radiation therapy for head and neck cancer 5. Those with dental fear requiring medication and/or behavioral interventions

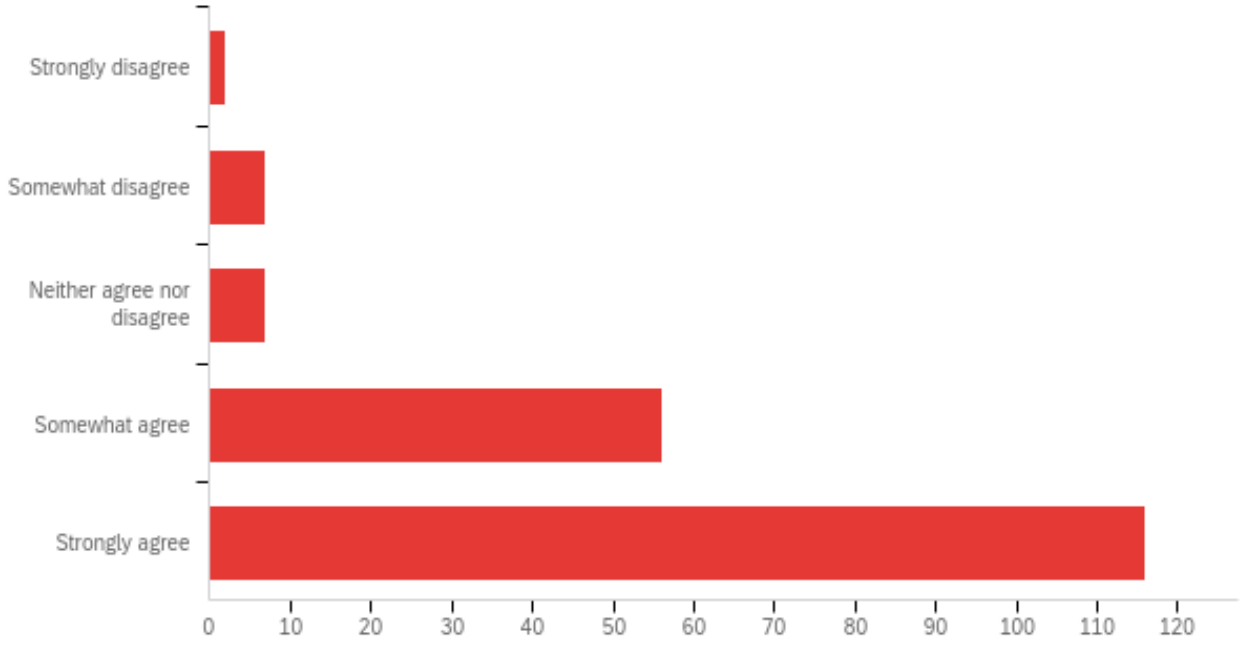
Q12 - Graduates of DDS/DMD programs must be competent in assessing and managing the treatment of patients with special needs.



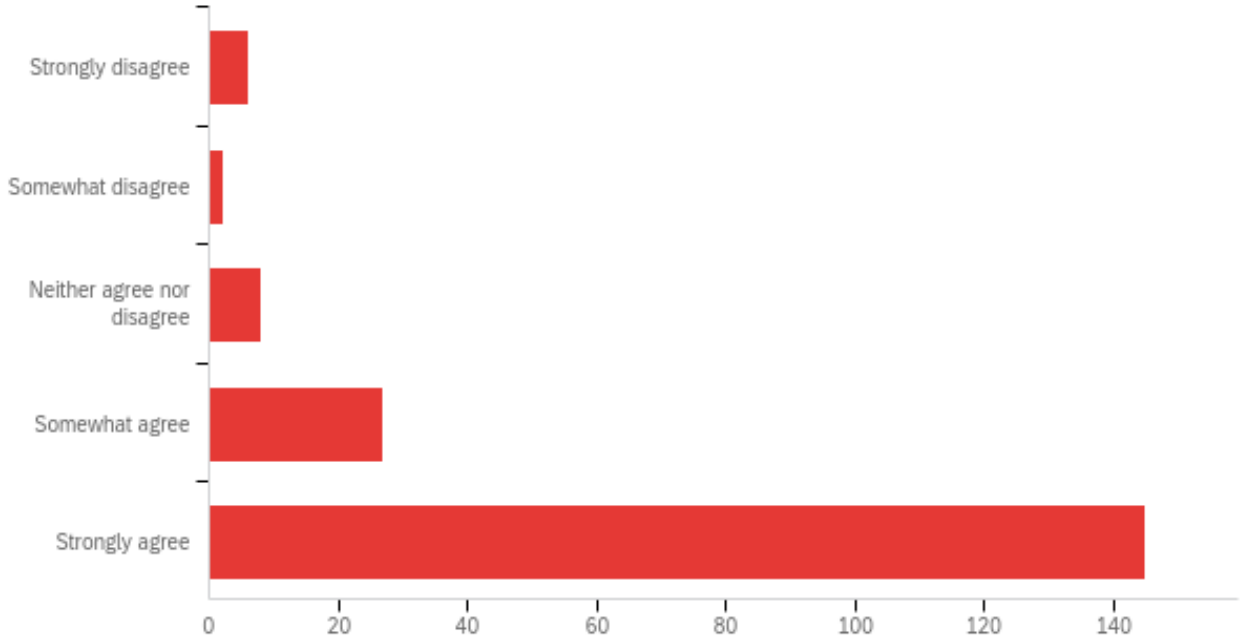
Q13 - Graduates of Advanced Education in General Dentistry Programs must be able to assess, diagnose and plan for the provision of multidisciplinary oral health care for a wide variety of patients including patients with special needs.



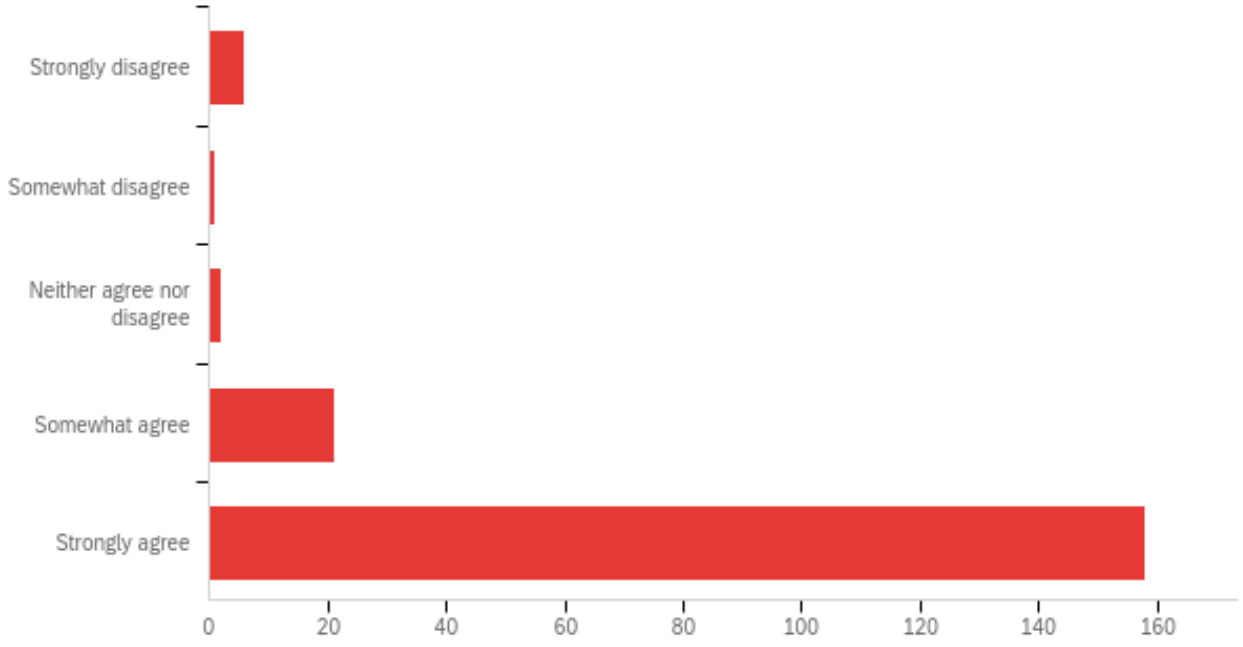
Q14 - Graduates of General Practice Residency Programs must be able to assess, diagnose, and plan for the provision of multidisciplinary oral health care for a wide variety of patients including patients with special needs.



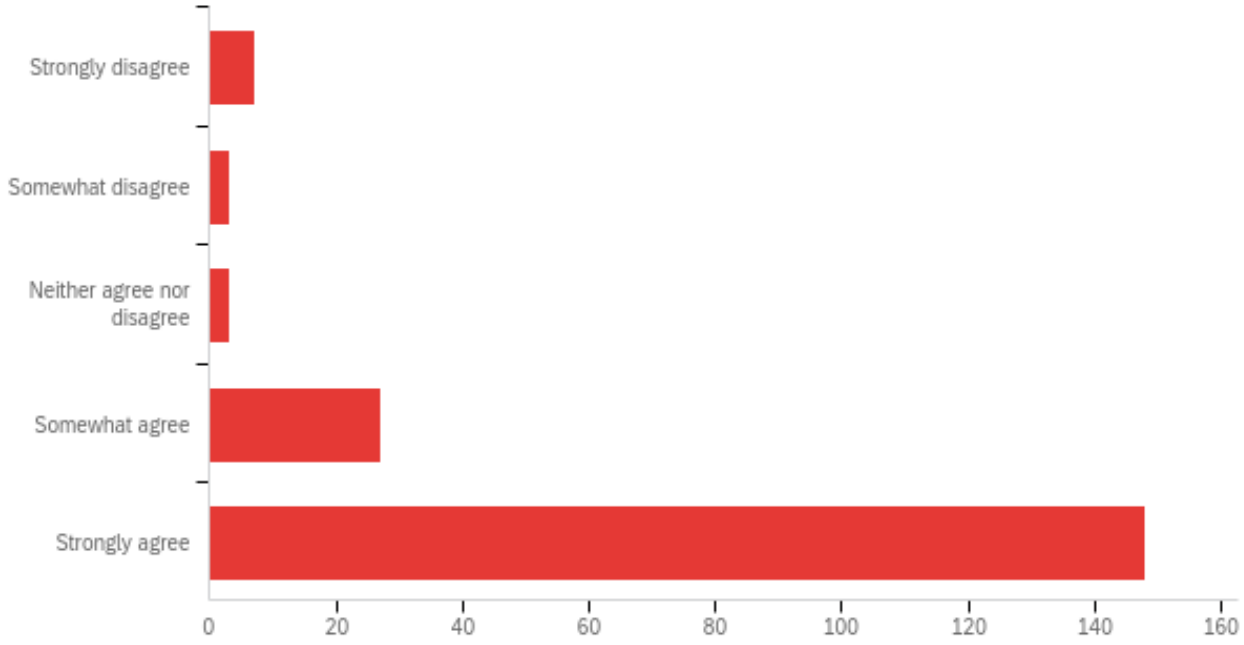
Q15 - Graduates of Dental Anesthesiology Residencies must be competent in providing comprehensive anesthesia care using pharmacologic and non-pharmacologic methods to manage anxiety and pain in adult and child dental patients, including patients with special needs.



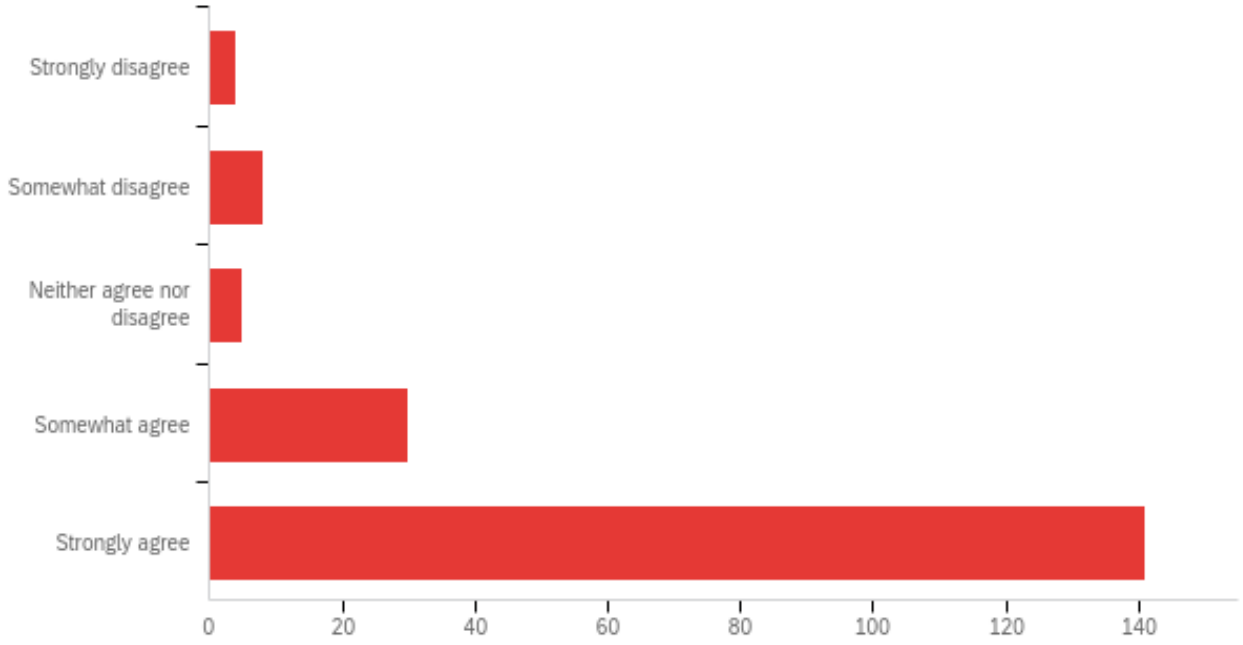
Q16 - Graduates of Pediatric Dentistry Residencies must be competent in providing both primary and comprehensive preventive and therapeutic oral health care for infants and children through adolescence, including those with special health care needs.



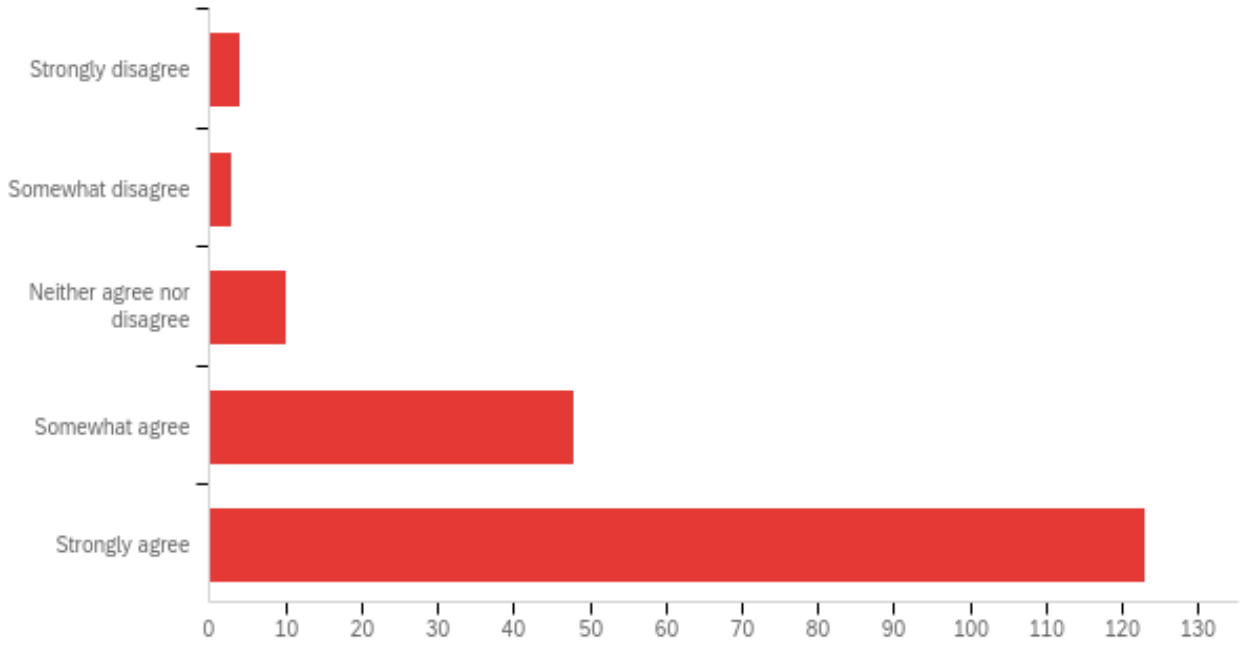
Q17 - Graduates of Pediatric Dentistry Residencies must be competent in diagnosis and treatment planning for infants, children, adolescents and those with special health care needs.



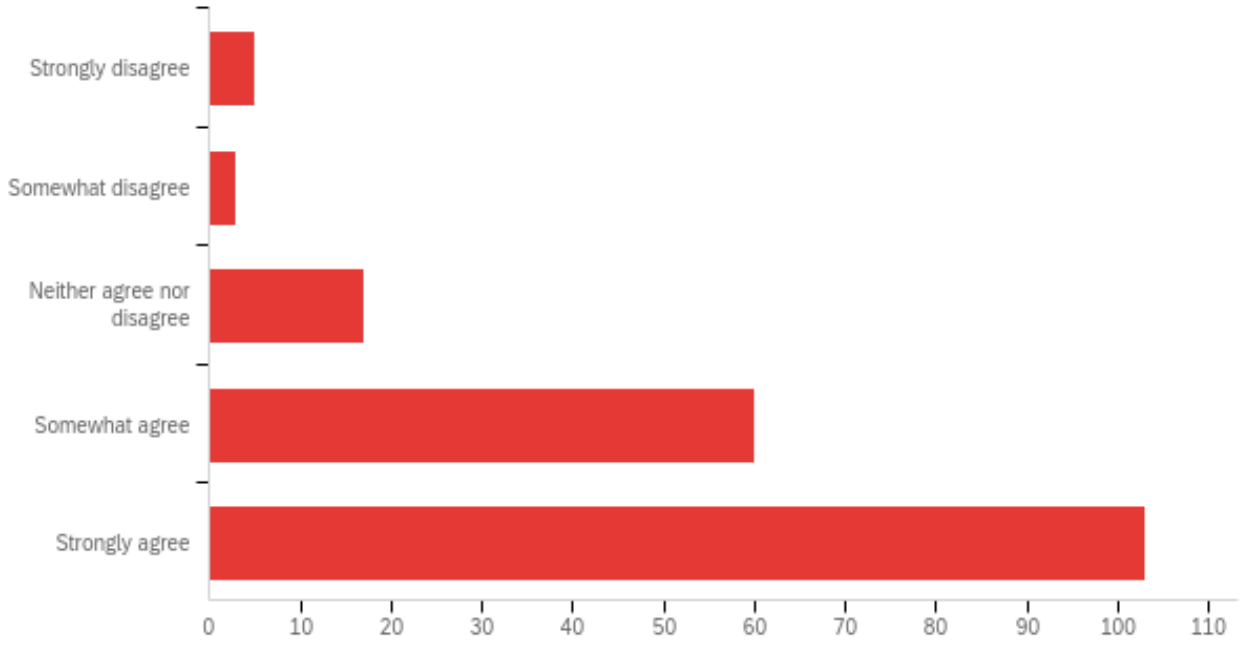
Q18 - Graduates of Pediatric Dentistry Residencies must be competent in the provision of comprehensive dental care to infants, children, adolescents and those with special health care needs in a manner consistent with the dental home.



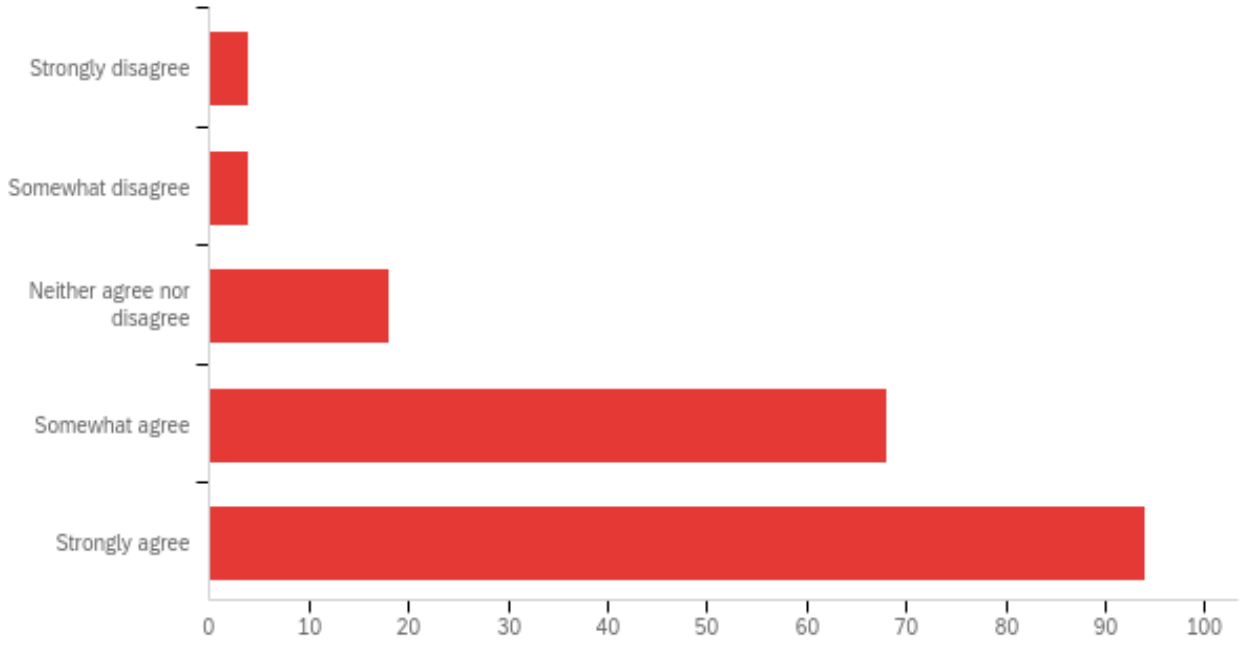
Q19 - Graduates of Clinical Fellowship Training Programs in Craniofacial and Special Care Orthodontics must be competent to treat patients with congenital and acquired deformities of the integument and its underlying musculoskeletal system within the maxillofacial area and associated structures and patients with special needs including disabilities and medically compromised patients who require comprehensive treatment.



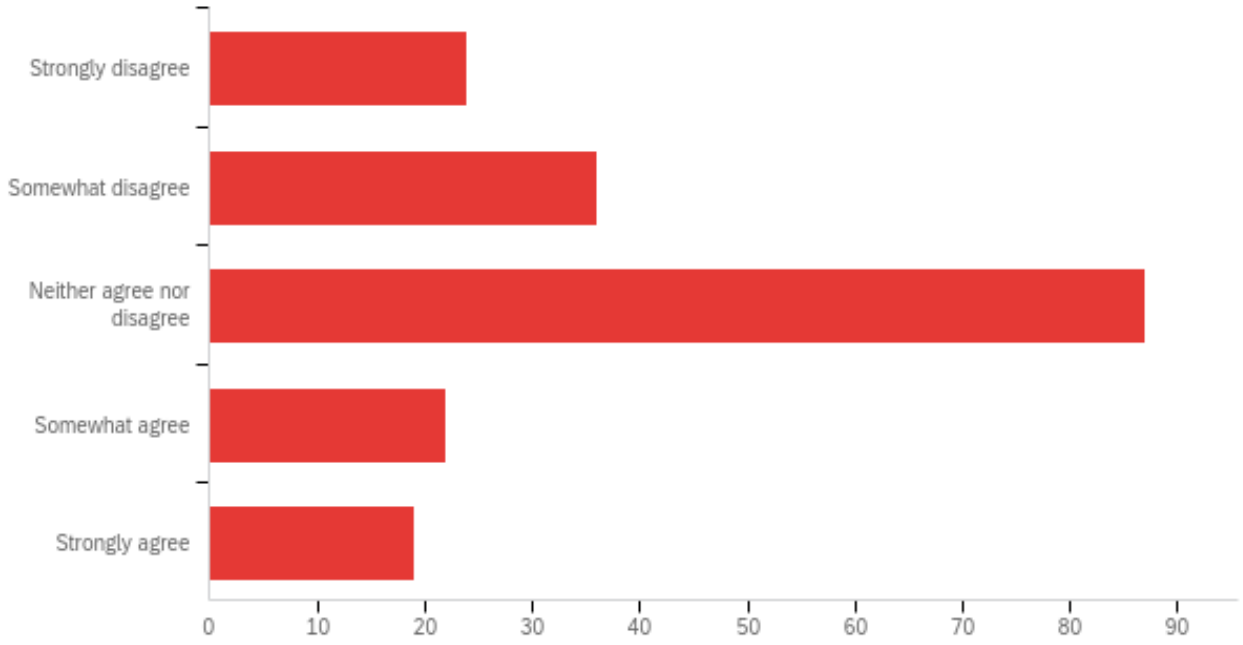
Q20 - General dentists need more continuing dental education offerings on the subject of managing and treating special needs patients.



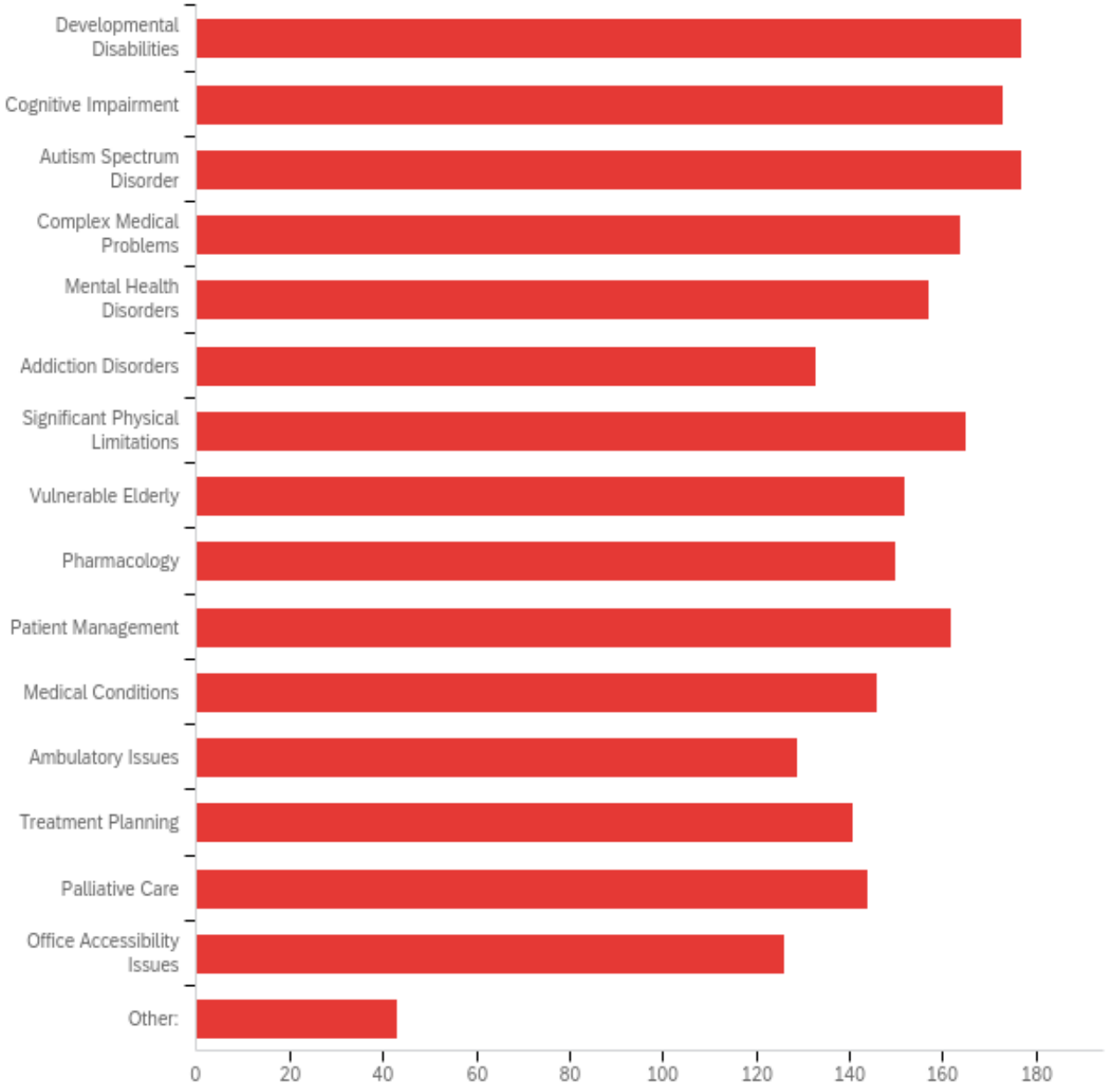
Q21 - Dental specialists need more continuing dental education offerings on the subject of managing and treating special needs patients.



Q22 - My dental colleagues plan to take a continuing dental education course on managing and treating special needs patients in the next 12 months.



Q23 - Please indicate which topics you believe should be covered in a continuing dental education course on managing and treating special needs patients (select all that apply).



Q23 Other:

Other: - Text
All these topics are really important and I consider that we need to be updating them on a regular basis.
Emphasis should be placed in providing dental care for intellectually challenged or patients with complex medical histories at the same level as provided for all patients. Most patients in this category are often relegated to merely urgent care with minimal consideration of aesthetics and function. Physically and intellectually challenged patients should have the same opportunities for the best dental care as our patients.
Business Plan
Teledentistry is new but I feel should become part of the curriculum. We are starting to utilize for nursing home patients and find it very effective.
family approach toward management and treatment for special needs member
Cognitive impairment; rare developmental diseases, the unique qualities of older adults and those with physical and cognitive impairments. (The word elderly is out of favor).
Proper Informed Consent and Legal Guardianship Analysis for this sub group population
Sedation and General Anesthesia
Caries Risk Assessment and prevention program
Ergonomics
PTSD
Of course. There is never too much training. You might want to add behavior management
Empathy
Medicaid billing, CDT coding, third party payer issues, medical billing codes
Health care disparities endured by patients with special needs Social aspects of care, working with families and caregivers Understand the system of care, group homes, assisted living Medicare, Medicaid, social service agencies.
Understanding Medicaid, advocating for special needs patients with Medicaid, and understanding how to make positives changes in Medicaid that directly impact patient care and a dental practice.
Cancer patients undergoing RT and/or chemo or post-RT/chemo patients.
Compassion exploration and development
Please note the previous questions regarding pediatric dentistry did not specify whether the special needs component is limited to infancy through adolescence, or adults. I responded as if adults were excluded. I would have responded differently if adults were included. I do not know what was intended or what other respondents assumed the question was asking.
behavior management techniques
Triage for various modalities of restraint Medical Ethics Intricacies of consent legally and assent when applicable

All of these are critical for proper training.
If the patient needs sedation, the practitioner should be able to have this option available and know how to refer or provide this service.
Alzheimer and geriatric patients
Treatment planning based on reality of the patient's ability
Interfacing with Special Needs Caregivers - especially in managing the communication divide between family members and daily institutional caregivers of SN Patients.
Financial issues- barriers to care
reimbursement issues consent/healthcare proxy issues legal issues
Recognition of Patients that cannot be treated in a conventional Dental Setting and the ability to refer these patient to a special care facility that can accommodate these patients and give them care
Traumatic brain injuries
Private practice colleagues generally want to know about billing/ reimbursement/ compensation.
Assessing capacity to consent; differentiating between capacity and competency to consent; resolving ethical/legal challenges when capacity and competency do not align, especially for adults with cognitive and intellectual disabilities Communication disorders Autonomy and the role of caregivers and guardians Oral manifestations associated with specific disabilities/conditions Social determinants of health for people requiring special care dentistry The emotional experience of people living with disabilities, understanding patient perspectives Interdisciplinary care Spinal cord injury Disability language Cultural humility related to disability Legal issues related to disabilities Advocacy The Americans with Disabilities Act Institutionalized care and deinstitutionalization Other living settings, such as group homes Facilitation techniques in special care dentistry
How to get paid for the care. This is a major barrier to dentists participating in this type of care. How to get hospital privileges. Advocacy at the local and state level.

Resolution No. 46 New

Report: CDEL Report 1 Date Submitted: June 2021

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

ADA Strategic Plan Objective: Public Goal Obj-9: The ADA will be the preeminent driver of trusted oral health information for the public and profession.

How does this resolution increase member value: See Background

SPECIAL CARE DENTISTRY ASSOCIATION

Background: In its report to the 2021 House of Delegates, the Council on Dental Education and Licensure has offered several actions in response to Resolution 100H-2020 (Worksheet:4013). The Council has recommended that the Special Care Dentistry Association be provided with the Council's feasibility study for consideration on the development of an accreditation process and accreditation standards for advanced education programs in special needs dentistry by the Commission on Dental Accreditation. Further, the Council recommends that the House of Delegates urge the Special Care Dentistry Association to collaborate with advanced dental education programs and their sponsoring institutions to enhance the current scope and depth of instruction related to special needs dentistry and encourage the establishment of more training programs in special needs dentistry.

Therefore, the Council on Dental Education and Licensure presents Resolution 46:

Resolution

46. Resolved, that the findings of the feasibility study conducted by the Council on Dental Education and Licensure be provided to the Special Care Dentistry Association for its consideration in pursuing an accreditation process and accreditation standards for advanced education programs in special needs dentistry by the Commission on Dental Accreditation, and be if further

Resolved, that the Special Care Dentistry Association be urged to collaborate with advanced dental education programs and their sponsoring institutions to enhance the current scope and depth of instruction related to special needs dentistry and to encourage the establishment of more training programs in special needs dentistry.

BOARD RECOMMENDATION: Vote Yes.

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

Resolution No. 47 New

Report: CDEL Report 1 Date Submitted: June 2021

Submitted By: Council on Dental Education and Licensure

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

Total Net Financial Implication: $35,000 Net Dues Impact: $0.35

Amount One-time $35,000 Amount On-going

ADA Strategic Plan Objective: Public Goal Obj-9: The ADA will be the preeminent driver of trusted oral health information for the public and profession.

How does this resolution increase member value: See Background

CONTINUING EDUCATION MARKET RESEARCH

Background: In its report to the 2021 House of Delegates, the Council on Dental Education and Licensure has offered several actions in response to Resolution 100H-2020 (Worksheet:4014). Respondents to the State of Special Needs Dentistry Education Survey conducted by the Council indicated that general dentists and dental specialists need more continuing dental education related to managing and treating special needs patients, e.g., people with developmental disabilities, cognitive impairment, complex medical problems, significant physical limitations, and the vulnerable elderly. Many suggested topics that could be presented via CE activity were noted. An environmental scan of current CE offerings related to special needs dentistry/patients also was reviewed. Given the survey results and the current CE offerings on this subject, the Council concluded that market research should be conducted by the appropriate ADA agency to learn more about the continuing education interests of practicing dentists related to the general and specific subject areas of special needs dentistry.

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

Resolution

47. Resolved, that market research be conducted to learn more about the continuing education interests of practicing dentists related to managing and treating patients with special needs, i.e., people with developmental disabilities, cognitive impairment, complex medical problems, significant physical limitations, and the vulnerable elderly.

BOARD RECOMMENDATION: Vote Yes.

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

Resolution No. 48 New

Report: CDEL Report 1 Date Submitted: June 2021

Submitted By: Council on Dental Education and Licensure

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

Total Net Financial Implication: $7,500 Net Dues Impact: $0.08

Amount One-time $7,500 Amount On-going

ADA Strategic Plan Objective: Public Goal Obj-9: The ADA will be the preeminent driver of trusted oral health information for the public and profession.

How does this resolution increase member value: See Background

DEVELOPING CONTINUING EDUCATION ACTIVITIES

Background: In its report to the 2021 House of Delegates, the Council on Dental Education and Licensure has offered several actions in response to Resolution 100H-2020 (Worksheet:4014). Respondents to the State of Special Needs Dentistry Education Survey conducted by the Council indicated that general dentists and dental specialists need more continuing dental education related to managing and treating special needs patients, e.g., people with developmental disabilities, cognitive impairment, complex medical problems, significant physical limitations, and the vulnerable elderly. Many suggested topics that could be presented via CE activity were noted. An environmental scan of current CE offerings related to special needs dentistry/patients also was reviewed. Given the survey results and the current CE offerings on this subject, the Council concluded that the ADA should offer more continuing education programs to increase knowledge and awareness of managing and providing oral health care to patients with special needs. Over time, such CE activities could include annual meeting courses, video-based on demand courses, and/or a multi-modular online course. To begin, it is suggested that two webinars be conducted in 2022 and that asynchronous on-demand online CE courses be produced using the content of the webinars.

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

Resolution

48. Resolved that a variety of continuing education activities related to special needs dentistry be developed by the appropriate ADA agency.

BOARD RECOMMENDATION: Vote Yes.

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

Resolution No. 49 New

Report: CDEL Report 1 Date Submitted: June 2021

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

ADA Strategic Plan Objective: Public Goal Obj-9: The ADA will be the preeminent driver of trusted oral health information for the public and profession.

How does this resolution increase member value: See Background

PROPOSED POLICY: PATIENTS WITH SPECIAL NEEDS

Background: In its report to the 2021 House of Delegates, the Council on Dental Education and Licensure has offered several actions in response to Resolution 100H-2020 Special Needs Dentistry (Worksheet:4014).

In regard to ADA policy, the Council noted several policies addressing the special needs population and supporting continuing education in general. However, there is no policy specifically urging dentists to pursue continuing education in this subject. Accordingly, the Council recommends that the 2021 House of Delegates adopt the following resolution:

Resolution

49. Resolved, that the following policy be adopted:

Patients with Special Needs

The dental profession's continued ability to effectively provide dental care for America's special needs population is dependent on sustaining a strong educational foundation in this area. The ADA encourages efforts to maintain and expand the availability of courses and programs at the predoctoral, advanced and continuing educational levels that support practitioners in providing dental treatment to patients whose medical, physical, psychological, cognitive or social situations make it necessary to consider a wide range of assessment and care options. These individuals include, but are not limited to, people with developmental disabilities, cognitive impairment, complex medical problems, significant physical limitations, and the vulnerable elderly. The ADA encourages dental practitioners to regularly participate in continuing education in this area.

BOARD RECOMMENDATION: Vote Yes.

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

Resolution No. N/A New

Report: CDEL Report 2 Date Submitted: June 2021

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

ADA Strategic Plan Objective: Public Goal Obj-9: The ADA will be the preeminent driver of trusted oral health information for the public and profession.

How does this resolution increase member value: See Background

COUNCIL ON DENTAL EDUCATION AND LICENSURE REPORT 2 TO THE HOUSE OF DELEGATES: RESPONSE TO RESOLUTION 76-2020 – ELDER CARE STRATEGIES ON INCREASED PREPAREDNESS OF EDUCATIONAL INSTITUTIONS

Background: In accordance with Resolution 97H-2020, Special Order of Referral Consent Calendar, which directed the appropriate ADA agencies to report back to the 2021 House of Delegates on each Referred Resolution, Resolution 76-2020 was reviewed by the Council on Dental Education and Licensure (CDEL). Resolution 76-2020 is appended to this report.

The Council has considered Resolution 76-2020 and elected not to re-offer it to the 2021 House of Delegates for the following reasons.

In regard to advocating for geriatric fellowship programs, the Council has taken action by requesting that the Council on Government Affairs (CGA) and Council on Advocacy for Access and Prevention (CAAP) increase advocacy for the HRSA Geriatrics Workforce Enhancement Program and in conjunction with the Council on Dental Practice (CDP), enhance communications with ADA members regarding current funding opportunities for geriatric programs and fellowships. In addition, per the House directive, the Council has transmitted its 2019 report, Council on Dental Education and Licensure Response to Resolution 83-2018: Geriatric Dentistry (*Trans.*2019:281), to the Special Care Dentistry Association for its consideration in pursuing an accreditation process and accreditation standards for advanced education programs in geriatric dentistry by the Commission on Dental Accreditation.

In regard to geriatric curriculum for dental and advanced dental education programs, the Council reviewed numerous reports and documents (examples below) and concluded that curriculum and resources exist:

- White Paper on Dental Care Needs of Aging U.S. Populations, 2004 Supplement to Annual Reports and Resolutions Excerpt, Volume 1, Report 4101
- Report of the Task Force on Elder Care to the House of Delegates: Vision for the Future and Recommendations, 2006 Supplement to Annual Reports and Resolutions Excerpt, Volume 1, Report 4000
- Oral Health for Independent Older Adults: ADEA/GSK Predoctoral Curriculum Resource Guide
- 2018-2019 Curriculum Survey of Dental Education Programs (DDS/DMD), Excerpts
- CDEL Response to Resolution 83-2018: Geriatric Dentistry
- Report of the Elder Care Workgroup in Response to Resolution 33H-2018: Presidentially-

appointed Elder Care Workgroup
- Excerpt of 2020 Unofficial Actions of the House of Delegates
- Literature Search related to Elder Care/Geriatric Dentistry Curriculum

While the Council appreciates the strategies suggested in Resolution 76-2020, the Council believes matters related specifically to elder care/geriatric dentistry education have been and are being addressed. A number of non-accredited geriatric/elder care fellowship-level programs currently offered by universities and the Department of Veterans Affairs have been identified. Increasing advocacy in collaboration with CGA, CAAP and CDP for these programs via the HRSA Geriatrics Workforce Enhancement Program also may provide incentive for the development of more training programs. Further, the Special Care Dentistry Association has been urged to consider pursuing an accreditation process and accreditation standards for advanced education programs in geriatric dentistry by the Commission on Dental Accreditation. Finally, the curriculum presented in accredited dental and advanced dental education programs currently includes competencies in the management and treatment of geriatric patients.

BOARD RECOMMENDATION: Vote Yes to Transmit.

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

WORKSHEET ADDENDUM

2020 RESOLUTION 76—ELDER CARE WORKGROUP—ELDER CARE STRATEGIES ON INCREASED PREPAREDNESS OF EDUCATIONAL INSTITUTIONS

76-2020. Resolved, that in order to prepare the profession for the increased demographic shift to an older population, the appropriate ADA agencies should consider integrating the following elder care strategies on increased preparedness of Educational Institutions as priority projects, and be it further

Resolved, increase preparedness of educational institutions to train dentists and specialists in elder care by:

1. advocating for geriatric fellowship programs; and encourage universities, the Department of Veterans' Affairs (VA), and hospitals to develop these; the fellows will play an important role in both the delivery of care, and the education of dental students.
2. advocating for the inclusion of treating the elderly population, including complex cases, for pre-doctoral and relevant specialties in school curriculum.
3. working with other relevant associations to develop curriculum guidelines for inter-professional education on both the oral-systemic connection and the dental management of the medically complex older adult.

Resolution No. 64 New

Report: N/A Date Submitted: June 2021

Submitted By: Council on Scientific Affairs

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

Total Net Financial Implication: None Net Dues Impact:

Amount One-time Amount On-going

ADA Strategic Plan Objective: Public Goal Obj-9: The ADA will be the preeminent driver of trusted oral health information for the public and profession.

How does this resolution increase member value: See Background

AMENDMENT OF THE POLICY STATEMENT ON INTRAORAL/PERIORAL PIERCING AND TONGUE SPLITTING

Background: In accordance with House Resolution 170H-2012, Regular Comprehensive Policy Review (*Trans.*2012:370), the Council on Scientific Affairs (Council) reviews Association policies on a broad range of scientific issues every five years, and proposes policy revisions or other recommendations as appropriate.

This report provides an update on the regular review of Policy Statement on Intraoral/Perioral Piercing and Tongue Splitting (*Trans*.1996:743; 2000:481; 2004;309; 2012:469: 2016:300), which was last reviewed in 2016.

Policy Statement on Intraoral/Perioral Piercing and Tongue Splitting

Resolved, that the American Dental Association advises against the practices of cosmetic intraoral/perioral piercing and tongue splitting, and views these as invasive procedures with negative health sequelae that outweigh any potential benefit.

The Council considered this policy review alongside Resolution 109-2020, which was assigned to the Council following the 2020 House of Delegates (HOD) meeting.

The Council reviewed existing resources on this subject, which included a recently-updated Oral Health Topics (OHT) page on Oral Piercing/Jewelry. This OHT page also presented information on the use of tooth gems and oral jewelry, which corresponded with the charge given to the CSA under Resolution 109-2020.

Following review, the Council determined that considerations regarding tooth gems and oral jewelry have a fair degree of overlap with the current ADA Policy on Intraoral/Perioral Piercing and Tongue Splitting. Wearing oral piercings or tooth gems/jewelry (as well as tongue splitting) can be associated with various adverse effects (e.g., plaque accumulation, enamel damage, erosion, or potential aspiration of jewels, labrets or gems). However, it also noted a lack of data in this area, and that the use of tooth gems and jewelry has both historical and current cultural applications that should be considered alongside potential clinical concerns.

In January 2021, after further review of the ADA Policy Statement on Intraoral/Perioral Piercing and Tongue Splitting, the Council approved an amended policy statement addressing both the standard review of existing policy, and the request to develop additional policy around the use of tooth gems.

The Council has proposed that the ADA Policy Statement on Intraoral/Perioral Piercing and Tongue Splitting be amended in response to both regular review of existing policy, and the concerns addressed in Resolution 109-2020.

The Council presents the following resolution for consideration.

Resolution

64. Resolved, that the Policy Statement on Intraoral/Perioral Piercing and Tongue Splitting (*Trans*.1998:743; 2000:481; 2004:309; 2012:469; 2016:300) be amended as follows (additions underscored; deletions ~~stricken~~):

ADA Policy Statement on Intraoral/Perioral Piercing, Tooth Gems/Jewelry and Tongue Splitting

Resolved, that the American Dental Association advises against the practices of cosmetic intraoral/perioral piercing, tooth gems/jewelry, and tongue splitting, ~~and views these as invasive procedures~~ due to the increased risk of negative health outcomes. ~~sequelae that outweigh any potential benefit.~~

BOARD RECOMMENDATION: Vote Yes.

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

Resolution No. 65 New

Report: N/A Date Submitted: June 2021

Submitted By: Council on Scientific Affairs

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

Total Net Financial Implication: None Net Dues Impact:

Amount One-time Amount On-going

ADA Strategic Plan Objective: Public Goal Obj-9: The ADA will be the preeminent driver of trusted oral health information for the public and profession.

How does this resolution increase member value: See Background

AMENDEMENT OF THE POLICY, RESEARCH FUNDS

Background: In accordance with Resolution 170H-2012 (*Trans*.2012:370), Regular Comprehensive Policy Review, the Council on Scientific Affairs (Council) reviewed the ADA Policy titled Research Funds (*Trans*.1984:519; 1999:974; 2016:302). The ADA policy statement reads as follows:

Research Funds

Resolved, that the ADA urges appropriate external agencies and organizations to provide funding for basic and clinical research that advances the scientific basis of dentistry and the oral and craniofacial health sciences.

The Council reviewed the Current Policy on Research Funds in June 2021 and recommended that the policy be amended to focus more directly on research funding advocacy, a role the ADA has pursued for many years on behalf of member dentists and the entire profession.

In addition to revisions made to the existing resolved clause, a second resolve clause was added to reflect the need for—and importance of—ADA advocacy to support the diversification efforts in the oral health sciences. The recommended revisions are intended to articulate the urgent need for sustained, robust funding support from appropriate external agencies and organizations in oral health research. The Council believes that the proposed revisions to this policy statement are timely, appropriate, and present a clear public stance for the ADA on diversity and equity in the research workforce.

The Council recommends the following resolution be adopted:

Resolution

65. Resolved, that the ADA Policy Statement on Research Funds (*Trans.*1984:519; 1999:974; 2016:302) be amended as follows (additions underscored; deletions ~~stricken~~):

Policy Statement on Research Fundings~~~~ Advocacy

Resolved, that the ADA ~~urges appropriate external agencies and organizations to provide~~ advocate for sustained, robust funding ~~for~~ in basic, translational and clinical oral and craniofacial health research for the improvement of health outcomes in diverse populations across the lifespan ~~advances the scientific basis of dentistry and the oral and craniofacial health sciences~~, and be it further

Resolved, that the ADA advocate for research funding to enhance gender, racial and ethnic diversity and equity across the research workforce in the oral and craniofacial health sciences.

BOARD RECOMMENDATION: Vote Yes.

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

Resolution No. 66 New

Report: N/A Date Submitted: June 2021

Submitted By: Council on Scientific Affairs

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

Total Net Financial Implication: None Net Dues Impact:

Amount One-time Amount On-going

ADA Strategic Plan Objective: Public Goal Obj-9: The ADA will be the preeminent driver of trusted oral health information for the public and profession.

How does this resolution increase member value: See Background

RESCISSION OF THE POLICY, COMPARATIVE EFFECTIVENESS RESEARCH AND PATIENT-CENTERED OUTCOMES RESEARCH

Background: The ADA Policy Statement on Comparative Effectiveness Research and Patient-Centered Outcomes Research (*Trans*.2011:457; 2016:302) was adopted in 2011 and last reviewed by the Council on Scientific Affairs (Council) in 2016 as part of its regular review process. This policy urges the Patient-Centered Outcomes Research Institute (PCORI) or other comparative effectiveness research and patient-centered outcomes research (CER and PCOR) entities to consider several key principles when evaluating diagnostic or treatment modalities pertaining to the provision of oral health care.

The full text of the policy is provided in the worksheet addendum.

The Council's review of the 2016 policy noted the following considerations:

- The policy statement is outdated and of limited utility. The PCORI was established in 2010 as a non-profit institute created through the 2010 Patient Protection and Affordable Care Act. Feedback from ADA Government Affairs division confirmed that the 2016 ADA policy statement has not been directly referenced or cited in ADA research advocacy efforts for some time (the last known advocacy-related correspondence presenting this policy statement is from March 2012).

- The policy statement is redundant. The ADA Policy Statement on Evidence-Based Dentistry (*Trans*.2001:462; 2012:469; 2017:275) provides a mechanism and framework for ADA advocacy for patient-centered outcome research and comparative effectiveness research. This is underscored by the current ADA Strategic Plan, Common Ground 2025, which indicates that being "science/evidence-based" is a core value for the Association.

- The policy has limited impact. The policy statement presents a general overview of recommendations or characteristics of CER supported by the ADA, as originally developed by the CSA (e.g., research on dental and oral conditions, diseases and therapies; participation of organized dentistry in the scientific and clinical aspects of comparative effectiveness studies). However, these recommendations and statements of principle have had relatively little impact on CER studies related to dental interventions.

- The policy is imprecise. The policy includes some imprecise phrasings regarding CER and PCOR. As an example, the policy does not clearly delineate between the concepts of CER and PCOR, which are partially overlapping but distinct fields of study (the terms are also not fully synonymous). CER studies typically evaluate the comparative effectiveness of medications, devices, or other treatment interventions, but a CER study does not necessarily need to include an evaluation of patient-centered outcomes. Additionally, a PCOR study may not include a head-to-head comparative clinical evaluation of treatments and/or their impact on patient-important outcomes.

The Council determined that the 2016 ADA policy has fulfilled its intent of outlining desired components/attributes within CER studies on clinical issues related to dentistry, and that its currency and utility as ADA policy is no longer particularly strong (e.g., since PCORI's establishment in 2010, dental CER studies have received relatively little research funding).

The Council also noted that its recommendation to amend the 2016 ADA Research Funds policy (see *Resolution 65*), which proposes amendments that focus more directly on research funding advocacy, would sufficiently provide for ADA advocacy for translational research, CER and PCOR. The Subcommittee considered this to be sufficient to address any future dental research considerations regarding these areas of study.

The Council recommends the following resolution be adopted:

Resolution

66. Resolved, that the policy titled Comparative Effectiveness Research and Patient-Centered Outcomes Research (*Trans*.2011:457; 2016:302) be rescinded.

BOARD RECOMMENDATION: Vote Yes.

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

WORKSHEET ADDENDUM
POLICY TO BE RESCINDED

Policy Statement on Comparative Effectiveness Research and Patient-Centered Outcomes Research (*Trans*.2011:457; 2016:302)

The American Dental Association (ADA) has a long history of identifying and supporting scientific advances in dentistry. Through rigorous scientific inquiry and knowledge sharing, the ADA supports advancements in dental research that improve the health of all Americans.

As an organization with a strong commitment to evidence-based dentistry and improving patient outcomes, the ADA supports comparative effectiveness research and patient-centered outcomes research (CER and PCOR) as methodologies that can lead to improved clinical outcomes, more cost-effective and personalized treatments, and increased patient satisfaction. Concurrently, such research should be designed to address important variables that may impact outcomes, such as patient subgroups to help address biological variability and individual patient needs.

Through the 2010 Patient Protection and Affordable Care Act, Congress has established an independent, non-profit organization to conduct comparative effectiveness research and patient-centered outcomes research. This organization, the Patient-Centered Outcomes Research Institute (PCORI), seeks public input and feedback prior to adoption of priorities, agendas, methodological standards, peer review processes and dissemination strategies.

Therefore, the ADA urges PCORI or other CER/PCOR entities to incorporate the following principles when evaluating diagnostic or treatment modalities pertaining to the provision of oral health care.

1. CER/PCOR Must Be Well Designed.

Objective, independent researchers should conduct thorough, rigorous and scientifically valid research with specific outcome measures. The researchers' and sponsors' actual potential and perceived conflicts of interest must be disclosed.

Protocols must be developed to ensure sound, reliable and reproducible research. Additionally, all efforts must be made to reduce bias in research protocols, literature reviews and clinical summaries.

Patient safety, confidentiality of personal health information and data security must be assured. Institutional review boards (IRBs) must be used to consider whether any risk to patients is balanced by potential research gains. Informed consent must be obtained from patients participating in CER and PCOR studies.

CER and PCOR must adequately consider specific populations by race, gender, ethnicity, age, economic status, geography or any other relevant variable to assure the applicability of the study. Long-term and short-term studies should be performed and adequately funded. Periodic reevaluation must be done to determine the efficacy of oral health related to CER/PCOR.

2. CER PCOR Process Must Be Open and Transparent.

Setting research priorities, developing research techniques and selecting investigators must be accomplished following an equitable, transparent process that emphasizes engagement with patients and openness to ideas from individuals across the health care community.

3. CER/PCOR Should Not Limit Innovative Treatments or Diagnostics.

CER/PCOR should not act to limit the continued development of innovative therapeutic or diagnostic modalities.

4. The Doctor/Patient Relationship Must Be Maintained.

The unique dentist/patient relationship and patient autonomy are overriding principles that must be included when assessing CER/PCOR information. Results from CER/PCOR studies should not be used to mandate or predetermine a course of treatment for an individual patient, nor should it be used to determine a standard of care.

5. CER/PCOR Should Be Widely Disseminated.

Balanced, clear, accurate, effective and timely communication of results, written with the audience in mind, should be made. PCORI or other CER/PCOR research entities should work with the ADA to disseminate results that are relevant to oral health care providers.

6. CER/PCOR Should Not Be Payment Driven.

PCORI or other CER/PCOR entities should not make recommendations on payment or coverage decisions. The primary focus of research designed and/or supported by PCORI or other CER and PCOR entities should be to improve patient outcomes, quality of care and/or quality of life.

7. CER/PCOR Should Address Dental Treatment Outcomes.

The dental profession needs PCOR and CER for improved evaluation of health outcomes in clinical practice. This includes independent evaluation of the effectiveness of specific treatments in dental practice.

Resolution No. N/A N/A

Report: Council on Scientific Affairs Report 1 Date Submitted: June 2021

Submitted By: Council on Scientific Affairs

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

Total Net Financial Implication: None Net Dues Impact:

Amount One-time Amount On-going

ADA Strategic Plan Objective: Public Goal Obj-9: The ADA will be the preeminent driver of trusted oral health information for the public and profession.

How does this resolution increase member value: See Background

COUNCIL ON SCIENTIFIC AFFAIRS REPORT 1 TO THE HOUSE OF DELEGATES: RESPONSE TO RESOLUTION 21H-2020—FEASIBILITY OF ASSESSING THE ROLE OF DENTAL HEALTH IN THE MANAGEMENT OF DISEASES AND MEDICAL CONDITIONS

Background: In October 2020, the Council on Scientific Affairs (Council) introduced proposed policy under Resolution 86H-2016, Proposal to Convene Three Expert Panels to Address Optimizing Dental Health Prior to Surgical/Medical Procedures and Treatment. The proposed policy was amended and ultimately adopted by the ADA House of Delegates (HOD) as Resolution 21H-2020, Proposed ADA Statement on Optimizing Dental Health Prior to Surgical/Medical Procedures and Treatments. The final adopted policy statement, as amended by the House of Delegates, reads as follows:

ADA Statement on Optimizing Dental Health Prior to Surgical/Medical Procedures and Treatments

> The ADA believes that optimizing dental health prior to the performance of complex medical and surgical procedures can be an important component of clinical care. Inter-professional communication and collaboration are crucial to identifying pre-existing or underlying oral health concerns that may impact post-medical/surgical complications or healing time, particularly for patients who are immunocompromised or otherwise at greater risk of adverse medical outcomes because of underlying health problems. Direct communication with patients and their medical teams regarding the need for, and ability to obtain, a dental examination, as well as a consultation and treatment, when appropriate, prior to initiation of complex surgical and medical treatments is especially recommended.
>
> and be it further,
>
> **Resolved,** that the appropriate ADA agency consider the feasibility of assessing the role of dental health in the management of diseases and medical conditions and report back to the 2021 House of Delegates.

With the adoption of Resolution 21H-2020, the House of Delegates established new Association policy on Optimizing Dental Health Prior to Surgical/Medical Procedures and Treatments, and requested a report on the feasibility of assessing the role of dental health in the management of diseases and medical conditions. Following the 2020 HOD meeting, the policy was assigned to the Council as lead agency.

The Council considered the request within the context of work completed to date pertaining to Resolution 86H-2016, which included evidence-based reviews on optimizing oral health prior to the performance of complex medical and surgical procedures. To date, the Council has overseen work with respect to a previous House Resolution, 86H-2016, including evaluations of the effect of dental treatment before: (a) cardiac valve surgery (published in September 2019) and (b) radiotherapy for head and neck cancer (pending completion in Q4 2021).

During its research efforts addressing Resolution 86H-2016, the Council determined that there is very limited evidence supporting oral health strategies, interventions, or treatments in the management of diseases and medical conditions. Similarly, it determined that there are few (if any) randomized clinical trials and observational studies addressing this very broad topic, and the evidence base is insufficient for conducting meta-analyses or systematic reviews, or drawing evidence-based statements and recommendations.

At its January 2021 meeting, the Council determined that there currently is insufficient evidence to support the development of an evidence-based deliverable addressing the role of dental health in the management of diseases and medical conditions.

Conclusion

Given these findings, the Council determined that at this time, while an important and clinically valuable area of study, there is insufficient high-quality research evidence to produce a viable evidence-based document or deliverable, including any type of review to support policy and inform practice.

Resolution

This report is informational and no resolutions are presented.

BOARD RECOMMENDATION: Vote Yes to Transmit.

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

Resolution No. N/A N/A

Report: Council on Scientific Affairs Report 2 Date Submitted: June 2021

Submitted By: Council on Scientific Affairs

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

Total Net Financial Implication: None Net Dues Impact:

Amount One-time Amount On-going

ADA Strategic Plan Objective: Public Goal Obj-9: The ADA will be the preeminent driver of trusted oral health information for the public and profession.

How does this resolution increase member value: See Background

COUNCIL ON SCIENTIFIC AFFAIRS REPORT 2 TO THE HOUSE OF DELEGATES: RESPONSE TO RESOLUTION 72H-2020—MODIFYING THE EXISTING MEDICARE DENTAL COVERAGE: STATUTORY DENTAL EXCLUSION

Background: In October 2020, the ADA House of Delegates adopted Resolution 72H-2020 "Modifying the Existing Medicare Dental Coverage: Statutory Dental Exclusion" as part of a series of proposed resolutions introduced by the Eldercare Workgroup. This resolution was referred to the Council on Scientific Affairs (Council) in November 2020. The resolution reads as follows:

> **Resolved**, that the appropriate ADA agencies should consider conducting a review of the current scientific evidence that would support expanding the oral health services provided to medically frail recipients prior to major medical or surgical treatments available through Medicare in order to determine next steps for modifying the Medicare statutory exclusion, with the recommendation that the review include but not be limited to the following:
>
> - head and neck radiation therapies
> - osteoclast inhibitor therapy
> - organ transplants
> - cancer chemotherapy including hematopoietic cell transplantation
> - joint replacement
> - cardiac valve replacement

Following a review of the resolution, and based on recent efforts and existing resources developed under Resolution 86H-2016, including investigations into dental treatment prior to cardiac valve surgery (*JADA*, Sept. 2019) and head and neck cancer treatments (publication forthcoming), the Council has concluded that the supporting research evidence on the above topic areas is sparse, and thus evidence-based reviews on the topic areas cited in the resolution would very likely lack the scientific basis to support any significant clinical conclusion or recommendation.

Additionally, the Council expressed concerns about the significant staff resources required to support such a request, as those resources have already been dedicated to existing projects and priorities.

While it concedes that Eldercare is an important topic, and that the areas put forth by the resolution are of clinical importance, based on the above considerations, the Council recommends against conducting a review of the current scientific evidence to support expanding the oral health services provided to medically frail recipients prior to major medical or surgical treatments available through Medicare.

Resolution

This report is informational and no resolutions are presented.

BOARD RECOMMENDATION: Vote Yes to Transmit.

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

Resolution No. N/A N/A

Report: Council on Scientific Affairs Report 3 Date Submitted: June 2021

Submitted By: Council on Scientific Affairs

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

Total Net Financial Implication: None Net Dues Impact:

Amount One-time Amount On-going

ADA Strategic Plan Objective: Public Goal Obj-9: The ADA will be the preeminent driver of trusted oral health information for the public and profession.

How does this resolution increase member value: See Background

COUNCIL ON SCIENTIFIC AFFAIRS REPORT 3 TO THE HOUSE OF DELEGATES: RESPONSE TO RESOLUTION 75-2020—ELDER CARE STRATEGIES ON RESEARCH

Background: Resolution 75-2020, "Elder Care Strategies on Research," was introduced to the ADA House of Delegates in October 2020 as part of a series of proposed resolutions introduced by the Eldercare Workgroup. In accordance with Resolution 97H-2020, Special Order of Referral Consent Calendar, which directed the appropriate ADA agencies to report back to the 2021 House of Delegates on each Referred Resolution, Resolution 75-2020 was reviewed by the Council on Scientific Affairs (Council), with support from the Council on Dental Practice (CDP), in November 2020. Resolution 75-2020 is appended to this report.

In response to this request, the Council considered the current research landscape with regard to integrating the five elder care strategies on research as priority projects, and reviewed a summary of current or forthcoming ADA resources targeting elder oral health care (Appendix 1), and elder care considerations in past and current systematic reviews and clinical practice guideline projects (e.g., development of guidelines on caries management and the management of acute dental pain).

The Council also considered its Intramural Research Priorities, which have been established through 2022 (with committed resources), but specifically note that the priority area of "Oral Diseases/Conditions" include the consideration of "specific patient sub-populations (e.g., pediatric, geriatric, pregnant patients) where relevant and appropriate" (Appendix 2). Furthermore, the Council's Extramural Research Priorities (also established through 2022), which identify priority areas for external organizations to consider when conducting or funding research, similarly identify the need for extramural research addressing prevention, assessment and management of oral diseases and conditions "across a patient's lifespan within diverse population groups" (Appendix 3).

The Council also noted that, in its consideration of a separate House resolution (21H-2020), relatively little research was identified that addressed oral health treatments/interventions on "optimizing oral health prior to the performance of complex medical and surgical procedures." And noted that while data in this area are limited, the Council, in accordance with its stated priorities and initiatives, remains committed to consideration of older patient populations in its clinical resources, where feasible and appropriate.

At this time, given the above considerations, the Council recommends against pursuing development of any specific translatable research study on the oral health treatment of geriatric populations, including medically, functionally or cognitively impaired complex patients, to assist in establishing the linkage

between oral health care and overall health. Accordingly, the council has decided not to re-offer the resolution for consideration.

Resolution

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)

WORKSHEET ADDENDUM

2020 RESOLUTION 75—COUNCIL ON SCIENTIFIC AFFAIRS—ELDER CARE STRATEGIES ON RESEARCH

Resolution

75-2020. Resolved, that in order to prepare the profession for the increased demographic shift to an older population, the appropriate ADA agencies should consider integrating the following elder care strategies on research as priority projects, and be it further

Resolved, focus research by:

1. pursuing translatable research on the oral health treatment of geriatric populations including medically, functionally or cognitively impaired complex patients to establish the linkage between oral health care and overall health
2. leading in the collection and dissemination of evidence-based recommendations on the oral systemic health connection
3. studying states with dual eligible Medicare and Medicaid beneficiaries to determine the financial savings, health outcomes and costs of the programs
4. studying cost savings and health outcomes from dental benefit plans
5. promoting the implementation of new treatment approaches, such as Silver Diamine Fluoride or other minimally invasive interventions, and determining the beneficial effects of the treatments on older adult patients in terms of quality of life and cost effectiveness

Appendix 1

Overview of ADA Resources Related to Resolution 75-2020--Elder Care Strategies on Research for Oral-Systemic Health and Translatable Research on the Oral Health Treatment of Older Individuals

Oral Diseases in the Growing Elderly Population: The Council recognizes that the burden of oral disease commonly increases with age, and that poor oral health can have a significant impact on overall health and quality of life. Caries and periodontal disease are the most prevalent oral diseases, particularly among older populations. Research from the National Center for Health Statistics has found that 20 percent of adults over age 65 have untreated tooth decay, and 25 percent of adults over 75 are edentulous. Epidemiologic studies, using data from the SEER database, have also shown that life-threatening conditions such as oral cancer affect older adults more commonly.

The ADA and CSA have developed a number of resources in the last few years to address this growing need. The following is an overview of recent CSA systematic reviews, guidelines and resources with information pertaining to elder oral health care and translatable research on the oral health treatment of older individuals (publication dates included parenthetically).

- Non-restorative Caries Management Meta-analysis; Systematic Review and Meta-analysis (*Journal of Dental Research*, January 2019), and Clinical Practice Guideline on Non-restorative Treatments for Carious Lesions (October 2018 JADA) [both articles present recommendations for older adults with root caries, including use of silver diamine fluoride];
- Systematic review on the effect of dental treatment before cardiac valve surgery: systematic review and meta-analysis (published in September 2019 issue of *JADA*);
- Forthcoming new draft guidelines on caries prevention and restorative caries treatment (both to include recommendations for adults 18-65 years of age and the elderly);
- Forthcoming new systematic review addressing the effect of dental intervention on subsequent development of osteoradionecrosis in people undergoing radiotherapy for head and neck cancer (to be submitted for publication in 2021).

Additional guideline projects that will be conducted over next two years (e.g., dental radiographic exams, sedation and general anesthesia) will also include clinical recommendations specific to older patients.

*Enhancing the Relevance of ADA Evidence-based Clinical Practice Guidelines for Specific Subpopulations***:** The Council's clinical practice guideline projects have consistently integrated considerations pertaining to specific patient subpopulations (e.g., children, adolescents, pregnant women, cancer patients under active treatment, the elderly, and patients with multiple comorbidities). The Council's development of evidence-based guidelines has also presented opportunities for identifying future research needs and priorities on key clinical topics, such as oral cancer screening. The Council also works with the ADA Government and Public Affairs Division to advocate for support of oral health across the lifespan.

Additional Resources Addressing Elder Oral Health Care and Age-Related Oral-Systemic Health Considerations: The ADA publishes scientific information on a variety of topics via its Oral Health Topics (OHT) pages on ADA.org, for some of which the Council's Clinical Excellence Subcommittee provides advisory oversight. The OHT pages address a range of elder oral health care and oral-systemic health considerations, including:

(a) Aging and Dental Health
(b) Oral-Systemic Health
(c) Hypertension (High Blood Pressure)
(d) Xerostomia (Dry Mouth)
(e) Diabetes
(f) Sjögren disease

(g) Cardiac Implanted Devices and Electronic Dental Instruments
(h) Osteoporosis Medications and Medication-Related Osteonecrosis of the Jaw
(i) Oral Anticoagulant and Antiplatelet Medications and Dental Procedures
(j) Denture Care and Maintenance
(k) Sleep Apnea (Obstructive)

Additional OHT pages address oral disease considerations for older individuals (e.g., a new OHT on silver diamine fluoride (SDF) presents evidence on the use of SDF for treating root caries).

The ADA also has several resources on dental therapeutics for various patient populations, including older individuals and the elderly, through the CSA's guideline projects (e.g., caries management); and publications, including the *ADA Dental Drug Handbook: A Quick Reference*. An updated version of the ADA Dental Drug Handbook will be issued later in 2021, and will include a new chapter titled "The Elderly and Medication Considerations."

The ADA has also developed a resource titled "Dentistry in Long-Term Care: Why It's Important," which addresses the importance of oral health care for the elderly in long-term facilities (e.g., to reduce risk for aspiration pneumonia).

"For the Patient" Pages Addressing Elder Oral Health Care: The ADA also publishes "For the Patient" pages in *JADA* to help dentists communicate with patients regarding oral health care and treatment. Recent "For the Patient" pages addressing elder oral health care considerations include the following: Oral Care During Cancer Treatment (January 2019); Oral and Throat Cancer (April 2019); and Oral Health Tips for Caregivers (May 2019); The Changing Oral Health Care Needs of Older Adults (June 2020); Preventing Tooth Loss (September 2020); Is Your Mouth Always Dry? (October 2020). Another JADA "For the Patient" page (scheduled for publication in spring 2021) will address "Replacing Missing Teeth" (e.g., bridges, implants).

ADA Council on Scientific Affairs
Recommended Intramural Scientific Research Priorities (2020-2022)

Background/Purpose

As America's premier voice for oral health, the ADA advocates for strong investment in scientific research for the advancement of dental care and improvement of patient and population health outcomes. Beginning in 2020, and every three years thereafter, the ADA Council on Scientific Affairs (CSA) has a responsibility (in accordance with the ADA *Governance and Organizational Manual*) to identify intramural and extramural research priorities for the organization.

In 2018, the CSA chair created the Research Priorities Subcommittee to identify and propose intramural and extramural research priorities for CSA consideration. Priorities identified by CSA are intended to be practical and clinically relevant to practicing dentists and aimed at improving the safety and effectiveness of existing dental procedures, techniques, treatments, and products; as well as promoting the development and evaluation of novel treatments, techniques, and products that are most likely to impact dental practice in the near future. More specifically, these priorities provide recommendations to ADA Science and Research Institute (ADASRI) staff in their efforts to (1) synthesize, translate, and disseminate scientific content to inform clinical decisions; and (2) evaluate/test dental products and technologies relevant to practicing dentists.

The Council emphasizes that these priorities are not exhaustive, but rather address important scientific issues and research needs that are directly related to patient care, are actionable, and are most likely to significantly impact the practice of dentistry. The identified priorities reflect interests of ADA members reflected in environmental scans, as well as input from CSA members and ADA staff. Periodic review of these priorities will help ensure that the identified priorities accurately reflect the immediate interests and needs of practicing dentists. Once approved, these priorities will be submitted to ADA senior leadership, the ADA House of Delegates, and to the ADASRI Board to help coordinate the ADA and ADASRI scientific research portfolios.

CSA Recommended Intramural Research Priorities (2020-2022)

The CSA recommends that the ADA support scientific research in the following categories for 2020-2022 (listed in alphabetical order):

- **Dental Equipment and Instruments**
  - CAD/CAM
  - Curing units
  - Dental radiographs and computed tomography
  - Handpieces and instruments

- **Dental Pharmacology**
  - Antibiotic stewardship
  - Guidelines for the use of sedation and general anesthesia by dentists (*Trans.*2007:282; 2012:468; 2016:277)
  - Management of acute dental pain (including patient expectations of pain)

- **Innovations and Assessment of Biomaterials/Dental Materials**
  Note: Where relevant and appropriate, the characteristics of the materials as they interact with the oral environment and tissues should be addressed.

- Bonding agents
- Ceramics
- Composites
- Corrosion of dental materials

- **Oral Diseases/Conditions**
  Note: Where relevant and appropriate, the needs of specific patient sub-populations (e.g., pediatric, geriatric, pregnant patients) should be addressed.
  - Caries
  - Dental acid erosion
  - Dental considerations for medically-complex patients (Resolution 86H-2016)
  - Oral and oropharyngeal cancer
  - Periodontal disease
  - Xerostomia/hyposalivation

- **Oral Hygiene Products**
  - OTC products
  - Professionally-applied products
  - Professionally-dispensed products

- **Orthodontic aligners**

- **Tobacco, Nicotine, and Marijuana Products**
  - Cannabis and cannabidiol products (Resolution 79H-2019)
  - Vaping and electronic cigarettes (Resolution 84H-2019)

ADA Council on Scientific Affairs
Recommended Extramural Research Priorities for Oral Health: Addressing the Needs of Practicing Dentists in the United States (2020-2022)

Background/Purpose

As America's premier voice for oral health, the ADA advocates for strong investment in scientific research for the advancement of dental care and improvement of patient and population health outcomes. Beginning in 2020, and every three years thereafter, the ADA Council on Scientific Affairs (CSA) has a duty to define intramural and extramural research priorities that are practical and clinically relevant to practicing dentists. Priorities are aimed at improving the safety and effectiveness of existing dental procedures, techniques, treatments, and products; as well as promoting the development and evaluation of novel treatments, techniques, and products that are most likely to impact dental practice in the near future.

In 2018, the CSA chair created the Research Priorities Subcommittee to identify and propose intramural and extramural research priorities for CSA consideration. Extramural priorities are intended to provide list of key research priorities for the Association. The ADA Extramural Research Priorities are shared with external organizations, dental schools and funding agencies to promote further study and external financial support for these priorities. Triennial updates help ensure that the document addresses existing and emerging research needs and priorities in dentistry, with input from ADA members and other critical stakeholders.

As America's leading advocate for oral health, the ADA strongly supports the dental research enterprise, and takes a leading role in promoting, conducting and critically reviewing research on topics related to dentistry and its relationship to the overall health of individuals and populations. The ADA will continue to serve as a facilitator of the national dental research effort, identify priority topics for research, and help ensure the timely dissemination of information to the profession.

CSA Recommended Extramural Research Priorities (2020-2022)

Priority 1: Strengthen the Nation's Investment in the Oral Health Research Infrastructure

1. Expand the oral health research infrastructure across the research continuum to facilitate research conduct and scholarly activity.

2. Invest in training to improve diversity and inclusivity within the oral health research workforce.

3. Support "big data" and health services research, including use of the dental practice-based research network and/or large clinical databases, to improve oral health surveillance and oral disease monitoring.

Priority 2: Integrate Dental and Medical Aspects of Dental and Craniofacial Research to Improve Patient Care

1. Examine the relevance of oral health to the overall well-being and health of individuals and populations, and promote resulting evidence of these relationships.

2. Promote the integration of oral diseases and oral health quality-of-life outcomes into health studies and initiatives.

3. Explore the impact of environmental, behavioral, and social determinants on oral health outcomes across a patient's lifespan within diverse* population groups.

4. Examine the complexity of the human oral microbiome and its interactions with other human ecosystems.

5. Promote the integration of principles and practices of evidence-based dentistry within the rapidly changing scientific foundation of precision health care, and seek inclusion of dentistry in this scientific foundation, such as within the auspices of the Precision Medicine Initiative.

6. Expand funding to support integration of dental electronic health record systems with medical systems, with the goal of promoting the integration of oral health care within the overall health care system.

7. Support oral health research funding opportunities to enable more multidisciplinary and inter-professional longitudinal studies.

Priority 3: Improve Prevention of Oral Diseases and Conditions across a Patient's Lifespan within Diverse* Population Groups

1. Support studies on the etiology and prevention of oral diseases and conditions. Diseases and conditions of interest include (in alphabetical order):

    - Caries
    - Dental acid erosion
    - Oral and oropharyngeal cancer
    - Peri-implant conditions
    - Periodontal disease
    - Xerostomia/hyposalivation

2. Support the development of evidence-based clinical practice guidelines for the prevention of oral diseases and conditions. Diseases and conditions of interest include (in alphabetical order):

    - Caries
    - Oral and oropharyngeal cancer
    - Periodontal disease

3. Support research on the role of tobacco, nicotine, and marijuana products in oral disease (including vaping and e-cigarettes).

Priority 4: Improve the Assessment and Management of Oral Diseases and Conditions Across a Patient's Lifespan within Diverse* Population Groups

1. Support studies on the pathogenesis and pathophysiology of oral diseases and conditions, including diagnostic, prognostic and risk assessment tools to advance precision dentistry and establish foundational knowledge for improved therapies. Diseases and conditions of interest include (in alphabetical order):

* Diverse population groups include, but are not limited to: geriatric individuals (e.g., focus on root caries and patients with hyposalivation), children and adolescents; pregnant and medically-complex patients; and vulnerable populations (e.g., disabilities, etc.). Diversity considerations also include research into gender-specific responses to preventive and therapeutic strategies used to address oral diseases and conditions.

- Caries
- Dental acid erosion
- Oral and oropharyngeal cancer
- Peri-implant conditions
- Periodontal disease
- Pulpal pathology
- Xerostomia/hyposalivation

2. Support the development of evidence-based clinical practice guidelines to address the management of (in alphabetical order):

    - Acute dental pain
    - Caries
    - Oral and oropharyngeal cancer
    - Periodontal disease

3. Explore the mechanisms of pain and management of acute and chronic dental pain (including patient expectations and perceptions of pain).

4. Expand the understanding of the underpinnings of inflammatory responses associated with oral diseases and conditions to include the innate immune response, neuro-inflammatory pathways and epithelial barrier functions, with the goal of developing applications for individual and population health.

5. Support and promote research for the development, testing, and use of safe, novel restorative materials and biomimetic materials for oral and craniofacial health care, including the restoration and regeneration of hard and soft tissues affected by trauma, disease and developmental defects.

Priority 5: Encourage the Dissemination and Implementation of New Evidence-Based Technologies, Tools, and Strategies to Improve Oral Health Outcomes

1. Support research on the adoption and use of evidence-based strategies, including clinical practice guidelines, risk assessment protocols, and other clinical decision support tools, to enhance the prevention and management of common oral diseases and conditions, including acute dental pain, caries, periodontal disease, and oral cancer.

2. Support research on the effectiveness of tele-dentistry and other virtual consultation applications to improve patient health outcomes.

3. Identify barriers to the:

    - diffusion of new knowledge in oral health;
    - implementation of effective oral health treatments; and
    - identification and de-implementation of ineffective oral health treatments.

Priority 6: Encourage Effective and Holistic Infectious Disease Response Research

Note: This priority is derived from, but not limited to, response items related to COVID-19, and is intended to address the needs of dentists and patients stemming from similar public health emergencies.

1. Support research to develop patient treatment protocols and decision support tools to enhance dental response to pandemics and other public health emergencies. This includes:

- Research into the risks of disease transmission in the dental clinic, with emphasis on aerosolized and airborne infectious agents;
- Development of new practice paradigms;
- Triage of care;
- Emergency treatment needs and criteria;
- Occupational health and safety of dental teams; and
- Protection and safety of patients during treatment.

2. Advance the understanding of anxiety and other mental health conditions that impact dental treatment during a public health emergency; this includes mental health research aimed at both dental teams and patients.

3. Support studies for the development of safe and effective infection control procedures and protocols for use in dental treatment environments; this includes research to address:
    - Risk of disease transmission within dental settings;
    - Personal protective equipment; and
    - Disease monitoring to protect the health of patients and the dental team.

Resolution No. N/A N/A

Report: Council on Scientific Affairs Report 4 Date Submitted: June 2021

Submitted By: Council on Scientific Affairs

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

Total Net Financial Implication: None Net Dues Impact:

Amount One-time Amount On-going

ADA Strategic Plan Objective: Public Goal Obj-9: The ADA will be the preeminent driver of trusted oral health information for the public and profession.

How does this resolution increase member value: See Background

COUNCIL ON SCIENTIFIC AFFAIRS REPORT 4 TO THE HOUSE OF DELEGATES: RESPONSE TO RESOLUTION 109-2020: ADA POLICY ON TOOTH GEMS AND JEWELRY

Background: Resolution 109-2020, "ADA Policy on Tooth Gems and Jewelry," was submitted by the Fourteenth District for consideration by the 2020 House of Delegates (HOD). This resolution was included on the 2020 HOD referral consent calendar.

In accordance with Resolution 97H-2020, Special Order of Referral Consent Calendar, which directed the appropriate ADA agencies to report back to the 2021 House of Delegates on each Referred Resolution, Resolution 109-2020 was reviewed by the Council on Scientific Affairs (Council). In October 2020, the Council chair assigned Resolution 109-2020 to its Clinical Excellence Subcommittee (Subcommittee). Resolution 109-2020 is appended to this report.

Update: In an audit of existing resources on this subject, the Subcommittee noted that a recently-updated Oral Health Topics (OHT) page on Oral Piercing/Jewelry presented information on the use of tooth gems and oral jewelry.

Tooth gems are a type of tooth jewelry, and practices of oral ornamentation (decoration with jewels, crystals, gold, rhinestone or other gems/stones) are associated with various cultures worldwide. In contemporary society, tooth gems using diamonds or precious stones have become used as forms of oral body art and self-expression. Other forms of oral jewelry are also available to consumers, including dental grills (also called "grillz" or "fronts"), or ornamental gold crowns worn on anterior teeth (usually an incisor). The Council notes that research articles on tooth gems and jewelry are relatively scarce, and no systematic reviews on the topic are available at present.

In addition to the OHT page, an existing ADA policy was identified as a potentially appropriate vehicle for efficiently addressing the request of a new ADA policy on tooth gems. The existing ADA Policy Statement on Intraoral/Perioral Piercing and Tongue Splitting is as follows:

Policy Statement on Intraoral/Perioral Piercing and Tongue Splitting (*Trans*.1998:743; 2000:481; 2004:309; 2012:469; 2016:300)

Resolved, that the American Dental Association advises against the practices of cosmetic intraoral/perioral piercing and tongue splitting, and views these as invasive procedures with negative health sequelae that outweigh any potential benefit.

This policy was identified for regular review by the Council in 2021 pursuant to Resolution 170H-2012, Regular Comprehensive Policy Review (*Trans*.2012:370), which requires review of ADA policies on a five-year cycle. At its January 2021 meeting, the Council, following the recommendation of the Subcommittee, concluded that considerations regarding tooth gems and oral jewelry have a fair degree of overlap with the current ADA Policy on Intraoral/Perioral Piercing and Tongue Splitting and that a revision of existing policy may be a more appropriate vehicle to address Resolution 109-2020.

Given these findings, the Council does not recommend creation of new policy on tooth gems. In response to Resolution 109-2020, a proposed revision of existing ADA policy on oral piercings and tongue splitting is recommended in a separate report.

Resolution

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)

WORKSHEET ADDENDUM

2020 RESOLUTION 109—FOURTEENTH TRUSTEE DISTRICT—ADA POLICY ON TOOTH GEMS AND JEWELRY

Resolution

109-2020. Resolved, that the appropriate ADA agencies recommend a policy on tooth gems and jewelry to the 2021 House of Delegates.

Resolution No. None N/A

Report: Board Report 5 Date Submitted: August 2021

Submitted By: Board of Trustees

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

Total Net Financial Implication: None Net Dues Impact:

Amount One-time Amount On-going

ADA Strategic Plan Objective: Membership Obj-3: Maintain an overall retention rate of 94%.

How does this resolution increase member value: See Background

REPORT 5 OF THE BOARD OF TRUSTEES TO THE HOUSE OF DELEGATES: ADA LIBRARY AND ARCHIVES ADVISORY BOARD ANNUAL REPORT

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

At its September 2021 meeting, the Board of Trustees approved the appended Annual Report of the ADA Library Archives Advisory Board for transmittal to the 2021 House of Delegates.

Resolutions

This report is informational and no resolutions are presented.

BOARD RECOMMENDATION: Vote Yes to Transmit.

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

Appendix 1

ADA Library & Archives Advisory Board

Harrington, Jr., John F., 2021, Board of Trustees, 5th District (chair)
Liddell, Rudolph, 2021, Board of Trustees, 17th District
Dionne, Raymond, 2021, North Carolina, Council on Scientific Affairs
Lefebvre, Carol A., 2021, Georgia, Council on Scientific Affairs
Niessen, Linda, 2021, Texas, Council on Dental Education and Licensure
Lim, Jun, 2021, Illinois, Council on Dental Education and Licensure
Masters, Antonette, 2021, California, at-large member
Jhaveri, Viren, 2021, New York, at-large member
Nevius, Amanda, 2021, public member, special/dental librarian

Nickisch Duggan, Heidi, director, ADA Library & Archives
Fleming, Anna, electronic resources & research services librarian, ADA Library & Archives
Matlak, Andrea, archivist & metadata librarian, ADA Library & Archives
O'Brien, Kelly, informationist, ADA Library & Archives
Pontillo, Laura, coordinator, ADA Library & Archives
Strayhorn, Nicole, data informationist, ADA Library & Archives

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

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

Objective 1: Grow Active, Full Dues Paying Membership

Initiative/Program: Scientific Support/Utilization of Library Content

Success Measure: Achieve a 10% variance in the number of user searches via electronic resources from prior year by December 2020.

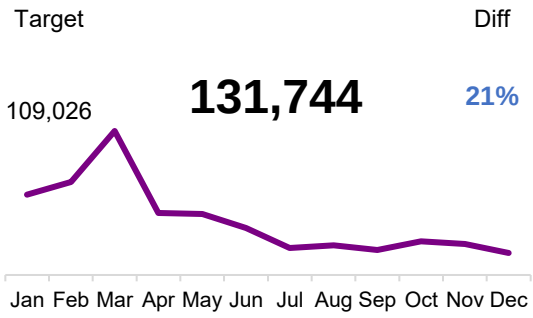
Target: 109,026 (Regular and automated searches)

Range: 98,123 – 119,929

Outcome: Exceeded, 131,744

Usage statistics show continued increased use of the Library's electronic resources (journals, databases, e-books, clinical resources). ADA members and staff conducted approximately 21% more regular and automated searches in 2020 over 2019's 79,142 regular and automated searches.

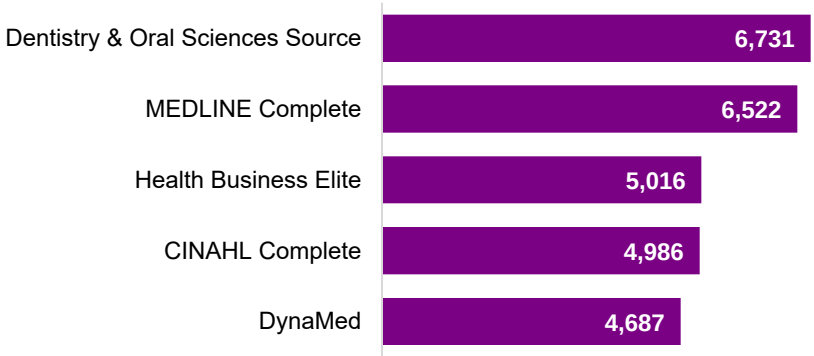
Table 1: Database Searches, Regular* and Automated, 2020**



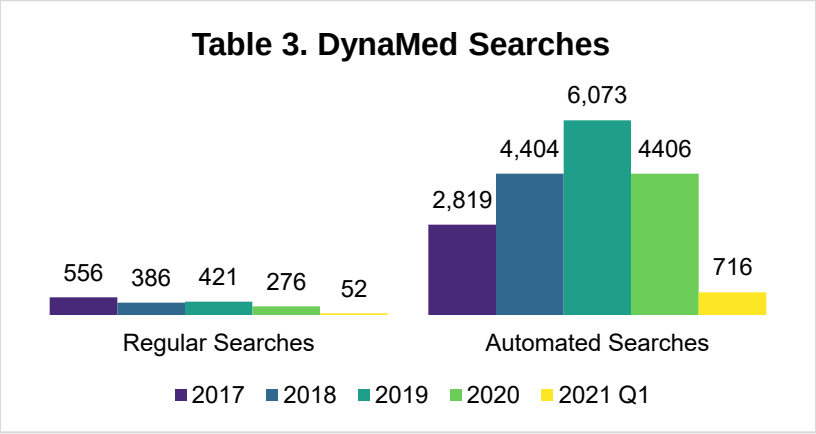
*Regular Searches refers to the number of times a user searches a database, where they have actively chosen that database from a list of options OR there is only one database available to search.

** Automated Searches refers to the number of times a user searches a database, where they have not actively chosen that database from a list of options. That is, Searches Automated is recorded when the platform offers a search across multiple databases by default, and the user has not elected to limit their search to a subset of those databases.

Table 2: Top 5 Subscribed Databases by Regular & Automated Searches, 2020



DynaMed, an evidence-based resource of drug information and clinical summaries intended to reduce time-to-answer, is available through the ADA Library & Archives website. DynaMed incorporated enhancements such as CE in 2020. The library does not yet have data on how many ADA members are claiming CE for their learning. There is no additional cost to ADA members to access this valuable resource.



*Regular Searches refers to the number of times a user searches a database, where they have actively chosen that database from a list of options OR there is only one database available to search.

** Automated Searches refers to the number of times a user searches a database, where they have not actively chosen that database from a list of options. That is, Searches Automated is recorded when the platform offers a search across multiple databases by default, and the user has not elected to limit their search to a subset of those databases

Objective 2: Grow Active, Full Dues Paying Membership

Initiative/Program: Scientific Support/Utilization of Library Content

Success Measure: Achieve a 10% variance in the number of unique item investigations and full-text downloads via electronic resources from prior year by December 2020.

Target: 22,111

Range: 19,900 – 24,322

Outcome: Exceeded, 25,229

Downloads and unique item investigations (the number of unique content items (e.g. chapters) investigated by a user) are more difficult to predict because ADA staff and members tend to search for known items and ask for staff assistance when conducting more open research, for instance, to answer a clinical question. As a result, ADA Library & Archives staff search more broadly, thus increasing the total search numbers but selecting fewer and more focused full-text downloads than the typical user might. ADA Library & Archives service goals influence sending only the most relevant full-text downloads combined with abstracts and citations to prompt user evaluation.

Table 4: Downloads & Unique Item Investigations, 2020

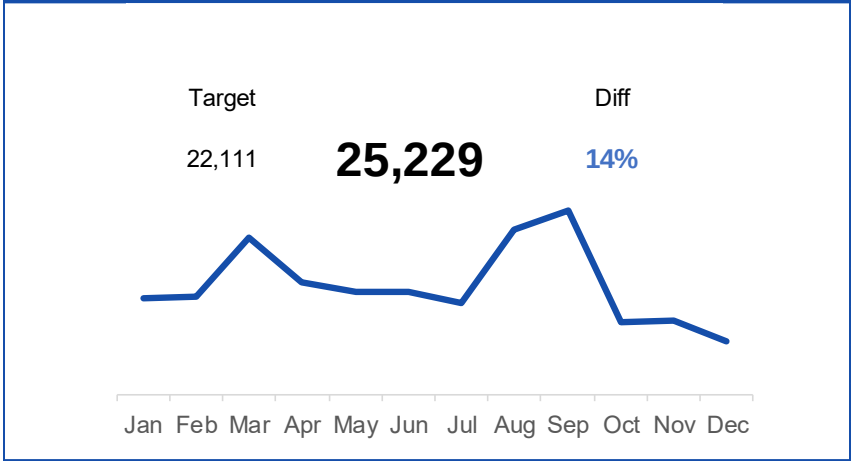


Table 5: Top 10 Journals by Article Dowloads, 2020

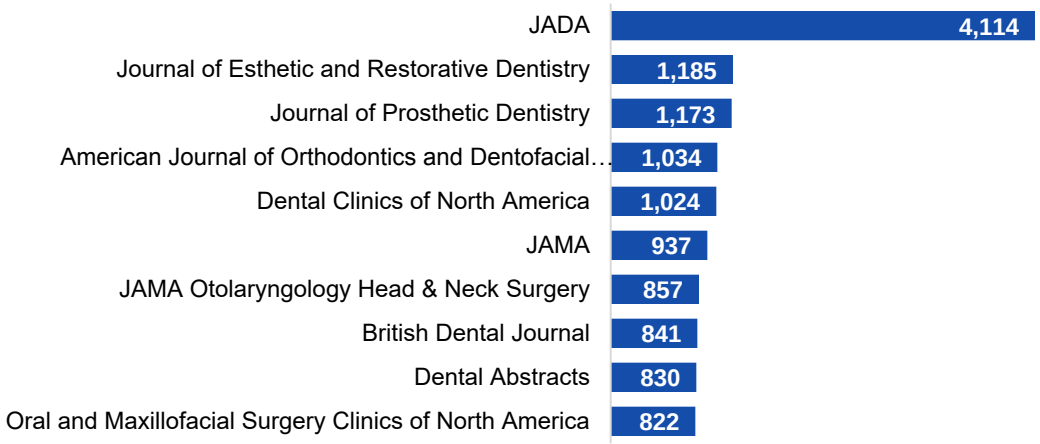
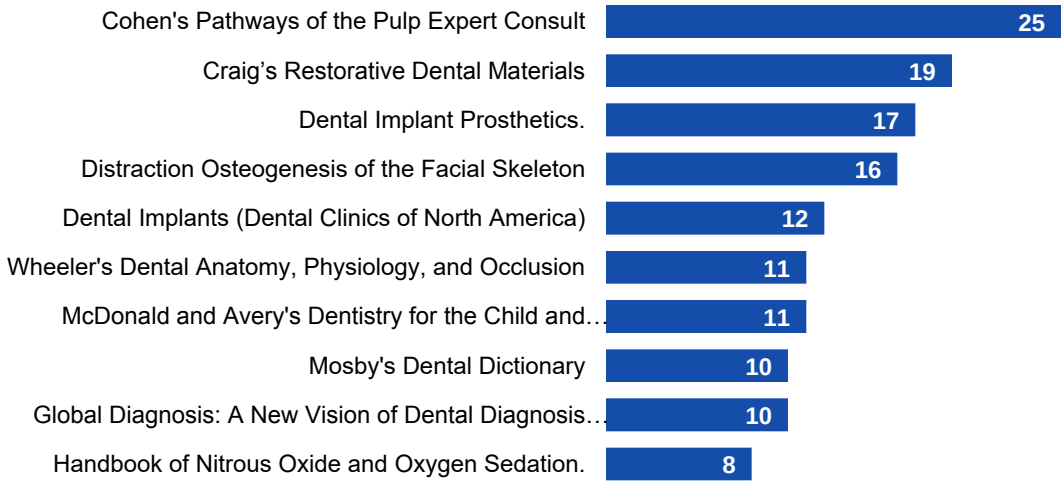


Table 6. Top 10 eBook Title Usage, 2020



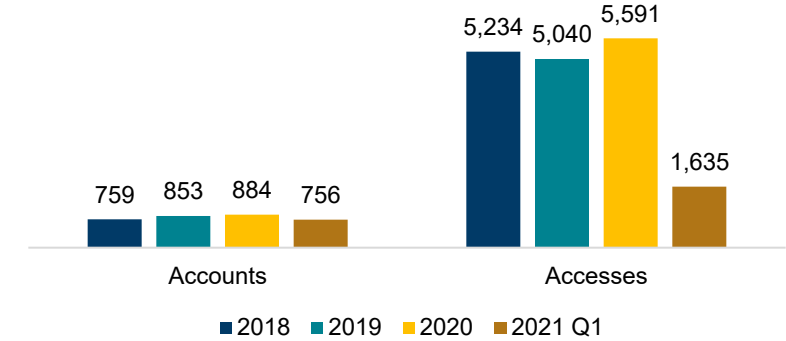
Emerging Issues and Trends

Libraries continue to maximize resources through the expanded use of digital and electronic means to convey information to their patrons. The ADA Library & Archives continually reviews these rapid changes in order to remain relevant to ADA Members and the profession. The LAAB is committed to:

World-wide Remote Access

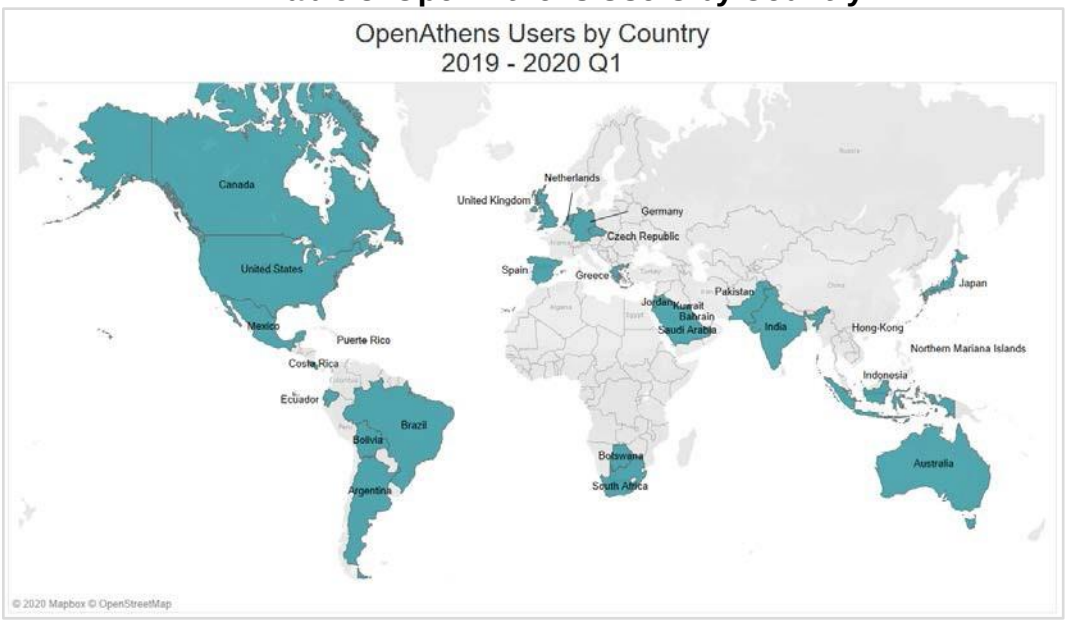
Providing efficient searching using current eResources and making the Library & Archives a 24/7 knowledge center. This is partially accomplished by the implementation of DISCOVERY and OpenAthens, an identity access management tool that allows members to access subscribed electronic content 24/7, and augmented by document delivery and interlibrary loan services.

Table 7. OpenAthens Usage



*On-site (ADA building at 211 E. Chicago) usage is not reflected in these statistics; complete resource use is much higher and includes staff use, in-house research, etc. Coming fall 2021 in the new Digital Members Experience, all library traffic will be pushed through OpenAthens.

Table 8. Open Athens Users by Country



Interlibrary loan (ILL) services provide ADA Staff and members with scholarly articles not held in the collections of the ADA Library & Archives (borrowing) and provide those same services to outside researchers via other libraries (lending). In 2020, the ADA Library & Archives fulfilled 49% of ILL requests from outside libraries. Outside libraries fulfilled 94% of the ILL requests from ADA members and staff.

Like many university and public libraries, COVID-19 restrictions limited access to the print collection of books and journals. Library staff are adept at leveraging existing library networks to obtain articles and books for members and staff. Additionally, a catalog maintenance project prior to and during the pandemic ensured ADA Library holdings were accurate in the global library catalog that is visible to other libraries.

Table 9. ILL Lending Requests

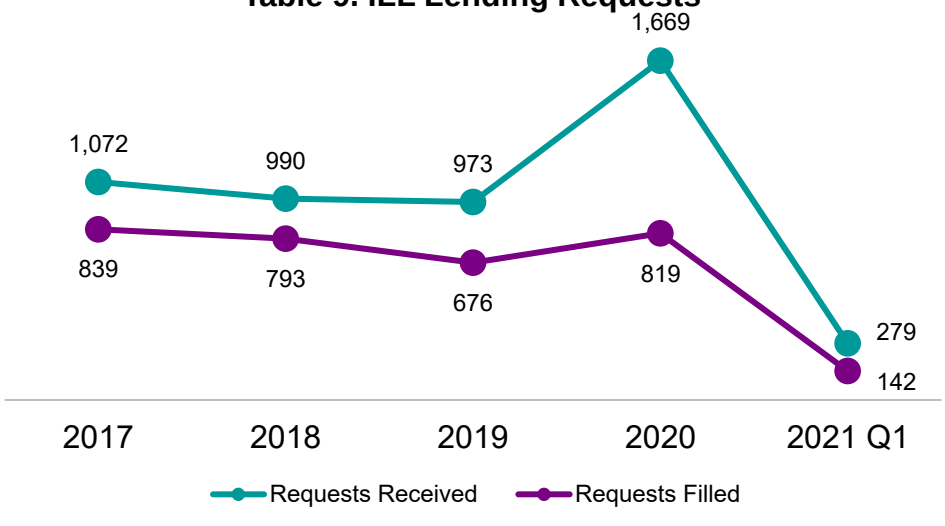
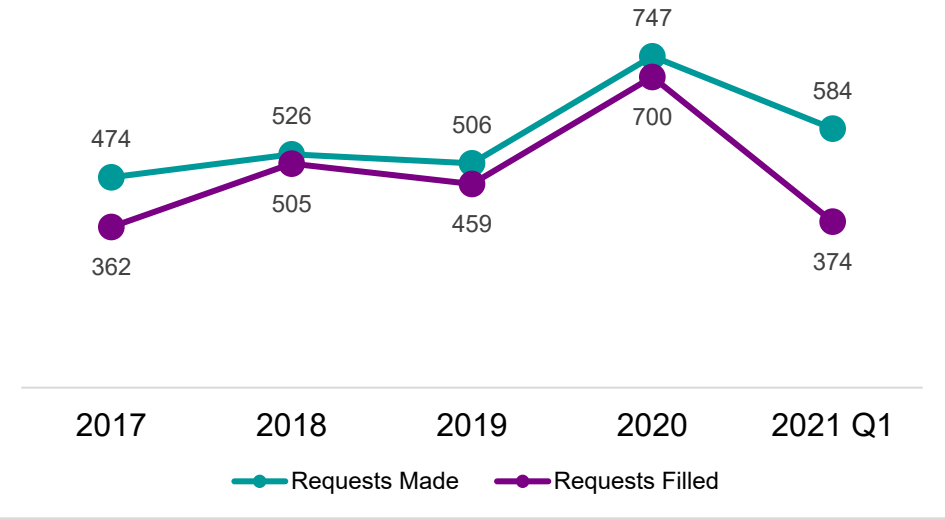


Table 10. ILL Borrowing Requests



Information Services

The current staff roles allow for faster, more robust reference assistance and user education, expert searching, and new means of engaging with members. In addition to multiple daily rapid reference questions, library staff addressed over 300 complex literature searches and clinical queries for ADA staff and members.

Continuous support of various information needs of ADA Science and Research Institute (ADASRI). Informationist Kelly O'Brien actively engages in expert searching for clinical practice guideline development and systematic reviews, provides education and access to evidence-based clinical tools and drug information, and provides expert support for initiatives such as the ADA/FDA joint statement on The

Selection of Patients for Dental Radiographic Examinations, and ADA COVID-19 Interim Recommendation & Guidance. Coordinator Laura Pontillo has retrieved and uploaded well over 1,000 full-text articles into DistillerSR, an important systematic review and literature review software tool used by ADASRI.

ADA Archives and Dental History

Provide expert reference and research assistance to ADA staff, members, and other dental organizations and institutions, searching for information on ADA history, history of dentistry and biographical information on individuals involved in the profession. This year in spite of the COVID-19 lockdown, remote work, and isolation from the archival collections, ADA Archivist Andrea Matlak answered daily queries from ADA staff and members as well as members of the public on a variety of different topics including ADA / dental profession response to the 1918 “Spanish” influenza pandemic, dental instrument sterilization history, ADA tracking of dentists mortality. Moreover, Ms. Matlak provided information on the history of women in dentistry to the writer/editor of an article on the topic that was published in the May 2020 Bulletin of The Second District Dental Society of New York. She also updated the ADA history timeline on ADA.org (https://www.ada.org/en/about-the-ada/ada-history-and-presidents-of-the-ada), adding entries for 2015-2020.

Data Visualization Services

Providing expertise in data visualization to drive policy, planning, and other decision making in support of ADA initiatives, publications, and strategic goals. Informationist Nicole Strayhorn continues to create and enhance data dashboards such as the National Dashboard in collaboration with the Membership Data and Reporting Team (MDAR) by incorporating more visualizations related to member acquisitions, retention, and conversion. ADA staff members continue to use this dashboard daily to improve data-driven decision making for membership growth, perform membership outreach to state societies and associations, and eliminate paper reports.

Ms. Strayhorn also re-designed the Dental Licensure dashboard to incorporate Continuing Education information and COVID-19 related information to help established dentists and dentists working across state lines navigate continuously changing information and upcoming deadlines on requirements from all states. Finally, in collaboration with the former ADA Center for Professional Success (CPS), Ms. Strayhorn designed and launched the ADA Practice Location Tool for Dentists (https://www.ada.org/en/member-center/member-benefits/practice-resources/ada-practice-state-map-for-dentists) utilizing Tableau to enable dentists to make more informed decisions on where to start a dental practice or relocate a practice, and capitalize on untapped business opportunities using spatial information.

COVID-19 Response

Leveraging expertise to support COVID-19 efforts at the ADA. The staff created an FAQ Site for COVID-19-related questions and answers to assist the Member Service Center and other Association staff, volunteers, and the Board of Trustees in finding accurate, up-to-date information to reflect and supplement the ADA.org/virus webpages. The FAQ site had more than 500 entries at its height (370 currently). The ADA Archives has archived the items that no longer are current.

Ms. Pontillo continues to engage with Science, Dental Practice, Membership, and others departments and divisions to ensure a continuously-updated COVID-19 repository that is accessible to all ADA Board of Trustees, state societies and association staff, and ADA staff. Mrs. Nickisch Duggan served as the Scrum Master for the Education & Licensure COVID-19 Rapid Response Team and as a member of the ADA’s COVID-19 Rapid Response Team. Ms. O’Brien provided expert searching for the ADA COVID-19 Interim Recommendation & Guidance and other toolkits. She has also developed an alert system for ADASRI to stay on top of new literature regarding COVID-19 infection control with new variants & COVID-19 long term vaccination response.

Ms. Strayhorn collaborated with the COVID-19 Rapid Response Team and Member & Client Services Division to develop three dashboards:

- COVID-19 State Mandates and Recommendations (over 500,000 views) - https://success.ada.org/en/practice-management/patients/covid-19-state-mandates-and-recommendations
- COVID-19 Vaccine Regulations for Dentists Map (over 111,000 views) - https://success.ada.org/en/practice-management/patients/covid-19-vaccine-regulations-for-dentists-map
- Clinical Laboratory Improvement Amendments (CLIA) State Information for Dentists (over 4,000 views) - https://www.ada.org/en/member-center/member-benefits/practice-resources/clinical-laboratory-improvement-amendments-clia-state-information-for-dentists

Professional Contributions/Education

Contributing to professional activities and remaining active in the library and archive community-at-large by participating in professional organization committees and building partnerships. All library & archives staff members engage in professional development via professional association conferences and other learning opportunities.

Ms. O'Brien served as a reviewer for the peer-reviewed publication *Journal of the Medical Library Association (JMLA)*.

Ms. Strayhorn became Tableau certified after taking the Tableau Desktop Specialist Exam to enhance her skills as an effective leader in Tableau, a powerful data-visualization tool.

Ms. Pontillo earned her Masters of Library and Information Science (MLIS) degree from the University of Illinois at Urbana-Champaign in December 2020.

Ms. Fleming served as Chair of the Medical Library Association's Donald A. B. Lindberg Research Fellowship Jury. The fellowship funds research linking the information services provided by librarians to improved health care and advances in biomedical research.

Ms. Matlak collaborated with the Sindecuse Museum of Dentistry at the University of Michigan School of Dentistry in the loan of a tooth fairy themed electric toothbrush from the Archives Artifacts Collection (Object 83.2) for use in its Tooth Fairy Exhibit. View the item in situ in the exhibit: https://www.flickr.com/photos/dentalmuseum/47698713702/in/album-72157706865199851/. The item was donated to the ADA Library & Archives in 1983 by Dr. Rosemary Wells, an Illinois dentist who was an expert on dental folklore and operated a tooth fairy museum from her home during her lifetime.

Ms. Nickisch Duggan served as a Special Emphasis Panel (SEP) member for the National Institutes of Health, National Library of Medicine: Regional Medical Libraries for the National Network of the National Library of Medicine (UG4) and Network of the National Library of Medicine Evaluation Center (U24). She continues to serve as a reviewer and panel member for Institutional Review Boards (IRBs) at Northwestern University, Ann & Robert H. Lurie Children's Hospital of Chicago, and the ADA.

Policy Review

Donation of ADA Library Materials (*Trans.*1993:684; 2012:512)
Resolved, that the ADA donate its excess library materials to organizations in need of these materials, and be it further
Resolved, that the ADA encourage its allied dental organizations to also donate their excess materials.

The policy was a directive that became moot once the task to **Donation of ADA Library Materials (*Trans*.1993:684; 2012:512)**" was completed. Accordingly, the Speaker directed that the policy not be published in future editions of Current Policies.

Resolution No. 80 New

Report: N/A Date Submitted: August 26, 2021

Submitted By: Ninth District, Co-Sponsored by Districts Two and Thirteen

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

Total Net Financial Implication: $5,000 Net Dues Impact: $0.05

Amount One-time $5,000 Amount On-going

ADA Strategic Plan Objective: Organizational Obj-7: Improve overall organizational effectiveness at the national and state levels.

How does this resolution increase member value: See Background

ELECTRONIC ARCHIVING OF STATE AND COMPONENT DENTAL PUBLICATIONS

Background: For many years, the ADA library was the repository and archivist for almost every dental publication in the world. Dental editors from around the globe would mail each issue of their respective publication to the ADA Library where it would be catalogued and stored for both reference and historical purposes. Maintaining this archive was discontinued by the ADA and much of the historical content has been lost. For a time, the National Library of Medicine (NLM) accepted dental publications through an agreement with the ADA. NLM index is given to articles that can be searched through PubMed. Up until 2017, many if not all, state journals were included in PubMed listings. Since that time, to be consistent with their mission, PubMed will only archive professional journals that meet rigid criteria that exclude most dental publications. Many tripartite publications publish peer-reviewed clinical and scientific articles, however, they also present promotional and news content on the activities of their professional organization. Because this blended content is not viewed to be consistent with NLM and PubMed's inclusion criteria, most state and local dental publications are not accepted.

State and local journals rank among the most read by dental professionals. Many authors choose not to publish in journals not indexed by PubMed. The result is that valuable clinical information is not archived and not available to the profession through our blended journals, diminishing awareness of and access to the evolving literature. This is a loss to the dental profession.

During the COVID-19 Pandemic, ADA Executive Director Kathleen O'Loughlin called on the profession to document and archive the issues they face in dealing with this event. It was that sentiment that drove the creation of the ADA's JADA+COVIDE-19 monograph – a digital collection of stories, reflections and accounts intended to archive dentistry's response to the pandemic.

We believe it is appropriate for the American Dental Association, the Voice of the profession, to reestablish itself as the repository and archive for all U.S. dental state and component publications in a searchable electronic format. Dentistry is defined by its professional literature. The progress and history of our tripartite must be preserved to guide the advancement of the profession and lend historical perspective. Digital publishing is currently offered across the dental community. These digital efficiencies offer the most reasonable and financially feasible way to accomplish archiving our profession's literature.

Resolution

80. Resolved, that the appropriate ADA agencies explore creating or facilitating a searchable digital archive for tripartite publications and report back to the 2022 House of Delegates.

BOARD RECOMMENDATION: Vote Yes.

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

Resolution No. 81 New

Report: Board Report 8 Date Submitted: August 2021

Submitted By: Board of Trustees

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

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

Amount One-time Amount On-going

ADA Strategic Plan Objective: Public Goal Obj-9: The ADA will be the preeminent driver of trusted oral health information for the public and profession.

How does this resolution increase member value: See Background

BOARD REPORT 8 TO THE HOUSE OF DELEGATES: RESOLUTION 74-2020—ELDER CARE WORK GROUP—ELDER CARE STRATEGIES FOR CONTINUING EDUCATION

Background: In accordance with Resolution 97H-2020, Special Order of Referral Consent Calendar, which directed the appropriate ADA agencies to report back to the 2021 House of Delegates on each Referred Resolution, Resolution 74-2020, Elder Care Strategies for Continuing Education, was reviewed by the Advisory Committee on Annual Meetings (in collaboration with the Council on Dental Practice). Resolution 74-2020 is appended to this report.

At its September meeting, the Board of Trustees considered the review of Resolution 74-2020 by the Advisory Committee and is proposing a modified version of the resolution presented in 2020 by removing the education of the public as well as clarifying some of the language of the second resolved based on the following:

- Continuing education developers throughout the ADA agencies provide CE opportunities for the profession and do not provide education for the public. References to the public have been removed from the second resolved.
- Items one and two under the second resolved have been combined to cover the elevation of both the oral-systemic connection and the dental management of the medically complex older adult through the delivery of education and continuing education granting opportunities via all ADA delivery channels.
- Item three has been removed because the ADA is always seeking out the most qualified speakers and subject matter experts to present continuing education for all delivery modalities and currently maintains a database of scouted speakers which includes elder care. The mechanism for this work is already in place and is ongoing.
- Item four remains as is.

Therefore, the Board of Trustees proposes the following resolution (additions <u>underscored</u>; deletions ~~stricken~~):

Resolution

81. Resolved, that in order to prepare the profession for the increased demographic shift to an older population, the appropriate ADA agencies should consider integrating the following elder care strategies on both the oral-systemic connection and the dental management of the medically complex older adult as priority projects, and be it further

Resolved, elevate the importance of both the oral-systemic connection and the dental management of the medically complex older adult to ~~members and the public~~ the dental community, as appropriate, by:

~~1. providing educational opportunities for the profession on the oral-systemic connection.~~
~~2. promoting dental continuing education on treating the medically, functionally or cognitively complex patients through the Annual Meeting or other ADA meetings.~~
~~3. developing and maintaining a roster of qualified speakers both the oral-systemic connection and the dental management of the medically complex older adult.~~
1. developing and delivering dental continuing education on both the oral-systemic connection and the dental management of the medically complex older adult through ADA online CE, SmileCon programs, and other ADA meetings, publications and programming as appropriate.

~~4.~~2. developing presentations on both the oral-systemic connection and the dental management of the medically complex older adult for use by member state or local dental societies, and to be shared with other Associations and other Health Care Professionals

BOARD RECOMMENDATION: Vote Yes.

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

Resolution No. 81S-1 Amendment

Report: N/A Date Submitted: September 2021

Submitted By: Third Trustee District

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

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

Amount One-time Amount On-going

ADA Strategic Plan Objective: Public Goal Obj-9: The ADA will be the preeminent driver of trusted oral health information for the public and profession.

How does this resolution increase member value: See Background

ELDER CARE STRATEGIES FOR CONTINUING EDUCATION

The following amendment to Resolution 81 (Worksheet: 4101) was submitted by the Third Trustee District and transmitted on September 24, 2021 by Mr. Ward Blackwell, executive director, Pennsylvania Dental Association.

Background: The Third District supports the objectives of Resolution 81. However, medically complex older adults who also happen to be institutionalized, home-bound or in similar long-term care settings may pose a particular challenge when it comes to the maintenance of good oral health and the delivery of care. Accordingly, the Third District would offer the following amendment to Resolution 81 that includes an additional program objective that explicitly addresses this area of particular need. (Additions are double underscored; deletions are ~~double stricken~~.)

Resolution

81S-1. Resolved, that in order to prepare the profession for the increased demographic shift to an older population, the appropriate ADA agencies should consider integrating the following elder care strategies on both the oral-systemic connection and the dental management of the medically complex older adult as priority projects, and be it further

Resolved, elevate the importance of both the oral-systemic connection and the dental management of the medically complex older adult to ~~members and the public~~ the dental community, as appropriate, by:

~~1. providing educational opportunities for the profession on the oral-systemic connection.~~
~~2. promoting dental continuing education on treating the medically, functionally or cognitively complex patients through the Annual Meeting or other ADA meetings.~~
~~3. developing and maintaining a roster of qualified speakers both the oral-systemic connection and the dental management of the medically complex older adult.~~
1. developing and delivering dental continuing education on both the oral-systemic connection and the dental management of the medically complex older adult through ADA online CE, SmileCon programs, and other ADA meetings, publications and programming as appropriate.
~~4.~~2. developing presentations on both the oral-systemic connection and the dental management of the medically complex older adult for use by member state or local dental societies, and to be shared with other Associations and other Health Care Professionals.
3. the development of educational curricula for the delivery of preventive and quality of life dental care for institutional, long-term care and home-bound individuals to allow for greater access in their respective environments.

BOARD COMMENT: Received after the September 2021 Board of Trustees Meeting.

WORKSHEET ADDENDUM

2020 RESOLUTION 74—ELDER CARE WORK GROUP—ELDER CARE STRATEGIES FOR CONTINUING EDUCATION

74-2020. Resolved, that in order to prepare the profession for the increased demographic shift to an older population, the appropriate ADA agencies should consider integrating the following elder care strategies on both the oral-systemic connection and the dental management of the medically complex older adult as priority projects, and be it further

Resolved, elevate the importance of both the oral-systemic connection and the dental management of the medically complex older adult to members and the public, as appropriate, by:

1. providing educational opportunities for the profession on the oral-systemic connection.
2. promoting dental continuing education on treating the medically, functionally or cognitively complex patients through the Annual Meeting or other ADA meetings.
3. developing and maintaining a roster of qualified speakers both the oral-systemic connection and the dental management of the medically complex older adult.
4. developing presentations on both the oral-systemic connection and the dental management of the medically complex older adult for use by member state or local dental societies, and to be shared with other Associations and other Health Care Professionals.

Resolution No. 92 New

Report: N/A Date Submitted: August 2021

Submitted By: Fourteenth Trustee District

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

Total Net Financial Implication: $190,000 Net Dues Impact: $1.90

Amount One-time $190,000 Amount On-going

ADA Strategic Plan Objective: Public Goal Obj-9: The ADA will be the preeminent driver of trusted oral health information for the public and profession.

How does this resolution increase member value: See Background

STUDY DENTAL SCHOOL DEMOGRAPHICS: ALL DENTAL SCHOOLS ARE NOT CREATED EQUAL

The following was submitted by the Submitted by the Fourteenth Trustee District and transmitted on August 31, 2021, by Dr. Julius N. Manz.

Background: It is incumbent upon the ADA to provide information that allows pre-dental students to make an informed decision concerning their future dental education along with an adequate understanding of what sort of return they should expect on their investment 5, 10- and 20-years post-graduation.

When considering law degrees, schools are ranked on the quality of the education they provide. If you are fortunate enough to go to a quality law school, it is not unreasonable to expect I higher return on your academic efforts and financial investment. It has become apparent the cost of a dental education has gotten out of control while the quality of dental education is questionable.

Aspiring dental students typically don't have comprehensive ways to find the answers to many of the most important questions related to choosing a dental school. We believe that the ADA with all of its resources can and should provide ethical and trustworthy guidance for these young individuals who have their entire life hanging in the balance.

Approximately 25 years prior, dental schools were closing across the country mostly due to costly expenses suffered by the sponsoring institution. Now however, it is apparent that dental education seems to a profitable venture. But at whose expense?

Most CODA approved dental schools across the country appear to lack sufficient faculty, especially in the ADA approved specialties.

Some members of the ADA, have expressed confusion and frustration with the ability to evaluate the current status of, and activities going on within, dental education and the Commission on Dental Accreditation.

New dentists accept that being part of a large group practice is the new norm, and whether large group or private practice, existing owners of those practices expect a reasonable level of competency from a new dentist they intend to hire.

Resolution

92. Resolved, the ADA form a task force that establishes metrics to compare the dental school educational experience and financial implications across CODA accredited dental schools to assist prospective dental students in making choices to include but not limited to the following:

1. Evaluates the value of new dentists' education experience 1, 5 and 10 years after graduation.
2. Evaluates Student: Teacher ratios at dental schools.
3. Evaluates the cost of education and breakdown of expenses.
4. Compiles a data bank of the number and type of procedures performed by each student prior to graduation.
5. Evaluates Student: Specialist-Teacher ratios at dental schools.
6. Evaluates the feasibility of using ADA resources to provide guidance for pre-dental students on selecting a dental school.
7. Review CODA standards in dental education.

and be it further

Resolved, that this task force report back to the 2022 House of Delegates with their findings.

BOARD COMMENT: Delivered to the House of Delegates absent Board of Trustees evaluation, recommendation or comment due to inadequate process time of resolution.

Resolution No. 97 New

Report: N/A Date Submitted: August 2021

Submitted By: Fourteenth Trustee District

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

Total Net Financial Implication: None Net Dues Impact:

Amount One-time Amount On-going

ADA Strategic Plan Objective: Public Goal Obj-9: The ADA will be the preeminent driver of trusted oral health information for the public and profession.

How does this resolution increase member value: See Background

DEVELOPMENT OF BEST PRACTICES FOR THE INCLUSION OF RESEARCH WITH NEGATIVE FINDINGS AND FAILED REPLICATIONS STUDIES

The following was submitted by the Submitted by the Fourteenth Trustee District and transmitted on August 31, 2021, by Dr. Julius N. Manz.

Background: In the world of peer-reviewed scientific research, negative experimental findings (those not validating a hypothesis) and failed replication studies are a valuable component of the pool of scientific knowledge because they force a critical re-evaluation of current theories and understandings of how the world works. However, there is currently an overwhelming publication bias in scientific literature (including dental and medical journals) making it extremely difficult to communicate these negative results. Papers are far less likely to be published and cited if they report results which do not validate a hypothesis (negative results) and many researchers are therefore choosing not to proceed with “non-significant” findings that yield less scientific interest and fewer citations. Consequently, the amount of data reported and published which contains these “non-significant” findings is progressively declining, and as a direct result of this, it has been noticed, in what few recent replication studies are available, that there is a large quantity of basic clinical findings which cannot in fact be reproduced. These studies often continue to remain in scientific journals creating a false scientific reality which directly shows the necessity and importance of being able to recognize and minimize positive-result skewed publication biases.

A prominent example of the real-world effect of such bias is seen in the publication by Dr. Andrew Wakefield, who, together with 12 co-authors, published the radical finding that child vaccinations (specifically the MMR vaccine) increases the incidence of autism in young adults. Although there were numerous replication studies yielding dissenting results between the time of the Wakefield article’s publication and its retraction, these studies failed to gain the same level of attention as the original paper yielding serious long-term health consequences. Specifically, the failure to promptly publish dissenting replication results led to a hallmark period of time where the morbidity and mortality of preventable diseases like measles, mumps and rubella was unusually high. In medicine, and dentistry especially, the consequences of failing to publish and circulate information challenging the findings of a previous paper aren’t just academic, they have real, impactful repercussions. That is why it is so important to recognize the value of negative results and the findings of replication studies, they are vital to helping maintain balance and correct previous literature and by reporting instances in which replication of research has failed.

In 2018 a retrospective assessment of publication bias in dental research journals[1] found that articles with positive results are easier to publish compared to articles with negative results. This publication bias toward positive results may therefore skew the information and results obtained from systematic reviews and meta-analysis. Creation of best practices would create an awareness of the potential problems resulting from positive publication bias and provide the tools needed to overcome it. The quality of the research done rather than the result of the study in publishing the article should be the prime criteria.

Resolution

97. Resolved, that the appropriate ADA agency is urged to participate and work with the Editors of professional dental publications and the American Association of Dental Editors and Journalists (AADEJ) to develop best practices for the inclusion of, and publication of, dental research with negative findings as well as failed replication studies and report back to the 2022 ADA HOD.

BOARD COMMENT: Delivered to the House of Delegates absent Board of Trustees evaluation, recommendation or comment due to inadequate process time of resolution.

[1] Gadde P, Penmetsa GS, Rayalla K. Do dental research journals publish only positive results? A retrospective assessment of publication bias. *J Indian Soc Periodontol*. 2018;22(4):294-297. doi:10.4103/jisp.jisp_60_18

Resolution No. 96 New

Report: N/A Date Submitted: August 2021

Submitted By: Fourteenth Trustee District

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

Total Net Financial Implication: $150,000 Net Dues Impact: $1.50

Amount One-time _____ Amount On-going _____

ADA Strategic Plan Objective: Public Goal Obj-9: The ADA will be the preeminent driver of trusted oral health information for the public and profession.

How does this resolution increase member value: See Background

THE PRACTICE OF DENTISTRY AND CANNABIS

The following was submitted by the Fourteenth Trustee District and transmitted on August 31, 2021, by Dr. Julius N. Manz.

Background: With the federal government considering decriminalization of cannabis use and sales, and most of the states with some level of legalization of cannabis, additional research should be conducted regarding how dentists approach working and using anesthesia on patients who use cannabis. Also, medical legal issues may present daunting challenges to our treatment including obtaining informed consent from patients or parents of minor patients who are under the influence.

Although the ADA has resources and information regarding Cannabis on its website, further research and guidelines are needed.

https://disa.com/map-of-marijuana-legality-by-state

Resolution

96. Resolved, that the ADA encourage research and develop best practices for the management of patients who are under the influence of cannabis including the administration of all forms of anesthesia and the continuum of sedation.

BOARD COMMENT: Delivered to the House of Delegates absent Board of Trustees evaluation, recommendation or comment due to inadequate process time of resolution.

Resolution No. 96S-1 Amendment

Report: N/A Date Submitted: September 2021

Submitted By: Third Trustee District

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

Total Net Financial Implication: $160,000 Net Dues Impact: $1.60

Amount One-time _____ Amount On-going _____

ADA Strategic Plan Objective: Public Goal Obj-9: The ADA will be the preeminent driver of trusted oral health information for the public and profession.

How does this resolution increase member value: See Background

THE PRACTICE OF DENTISTRY AND CANNABIS

The following amendment to Resolution 96 (Worksheet: 3025) was submitted by the Third Trustee District and transmitted on September 24, 2021 by Mr. Ward Blackwell, executive director, Pennsylvania Dental Association.

Background: There is little doubt that the number of patients entering dental offices under the influence of cannabis, whether used for medical or recreational purposes, will continue to increase. The Third District concurs with the Fourteenth that there is a need to develop best practices for management of such patients. However, we could contend that such management by definition includes the use of sedation and anesthesia. So, specifying such in the resolution is superfluous.

However, this increased usage is unlikely to be confined to patients, and dentists could benefit from having guidance for managing patients' families and even staff (who may require cannabis for medical purposes) as well.

Furthermore, the expanding role of cannabis as a treatment modality suggests there is merit to assessing its value, if any, to the practice of dentistry. Accordingly, the Third District respectfully offers the following amendment to Resolution 96. (Additions are underscored; deletions ~~are stricken~~.)

Resolution

96S-1. Resolved, that the ADA encourage research and develop best practices for the management of patients, patients' families and employees who are under the influence of cannabis ~~including the administration of all forms of anesthesia and the continuum of sedation.~~, and be it further

Resolved, that the appropriate ADA agencies research the usefulness, if any, of prescribing CBD and medical marijuana in the practice of dentistry, and that the results be reported to the 2022 House of Delegates.

BOARD COMMENT: Received after the September 2021 Board of Trustees Meeting.

Resolution No. 104 New

Report: N/A Date Submitted: September 2021

Submitted By: Third Trustee District

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

Total Net Financial Implication: $750,000 Net Dues Impact: $7.50

Amount One-time $750,000 Amount On-going

ADA Strategic Plan Objective: Membership Obj-2: Maintain a net-positive gain in membership recruitment of all dentists within 70% or more of constituents.

How does this resolution increase member value: See Background

FINANCIAL LITERACY AMONG NEW DENTISTS AND DENTAL STUDENTS

The following substitute resolution was submitted by the Third Trustee District and transmitted on September 24, 2021 by Mr. Ward Blackwell, executive director, Pennsylvania Dental Association.

Background: In response to the report of the Task Force to Study Alternate Student Loan Repayment Strategies, we recognize that there is a notable lack of development with respect to financial literacy for dental students and practicing dentists to carry them through their professional lives. Therefore, the Third District offers the following:

Resolution

104. Resolved, that the appropriate ADA agency be tasked with: 1) a thorough review of existing financial literacy resources within the ADA for practicing dentists to compile an easily accessible and navigable database; 2) development of new resources to provide dentists with an increased understanding of how to manage debt and wealth where members express a remaining need; and 3) creation of a robust marketing strategy to highlight its efforts for this purpose to our membership.

BOARD COMMENT: Received after the September 2021 Board of Trustees Meeting.

NEW BUSINESS-MAJORITY VOTE RECEIVED FOR CONSIDERATION

Resolution No. 108 New

Report: N/A Date Submitted: October 2021

Submitted By: Co-Sponsored by Fifth Trustee District and Sixteenth Trustee District

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

Total Net Financial Implication: None Net Dues Impact:

Amount One-time Amount On-going

ADA Strategic Plan Objective: Public Goal Obj-9: The ADA will be the preeminent driver of trusted oral health information for the public and profession.

How does this resolution increase member value: See Background

NATIONAL COMMISSION ON RECOGNITION OF DENTAL SPECIALTIES AND CERTIFYING BOARDS REQUIREMENTS FOR RECOGNITION REVIEW

The following resolution was submitted and transmitted on October 13, 2021 by Ms. Michele Huebner, secretary, Alabama Dental Association.

Background: The National Commission on Recognition of Dental Specialties and Certifying Boards (National Commission) is to be commended for its work as it reviews applications for dental specialty recognition from organizations wishing to become a recognized dental specialty. The National Commission has been judicious in adhering to the current criteria of Requirements for Recognition that applicants for specialty recognition must satisfy as a part of the application process.

Since this dental specialty recognition process is relatively new, it is a wise course to have the requirements for specialty recognition reviewed periodically by the ADA agency with governance responsibilities for the Requirements, the Council on Dental Education and Licensure (CDEL). The National Commission has already completed three reviews and has requested that CDEL provide additional guidance on the intent of several of the criteria. For this reason, it would be beneficial to request CDEL to begin the full criteria review in 2022.

Resolution

108. Resolved, that the Requirements for Recognition of Dental Specialties and National Certifying Boards for Dental Specialists, currently used by the National Commission on Recognition of Dental Specialties and Certifying Boards, be reviewed by the ADA Council on Dental Education and Licensure in 2022, rather than 2023, and be it further

Resolved, that CDEL report its findings and any proposed revisions to the Requirements for Recognition to the National Commission and to the 2022 ADA House of Delegates.

BOARD COMMENT: Received after the deadline for New Business submission of September 28.