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Legislative Health Governance and Related Matters

Resolution No. 1 New
 Report: N/A Date Submitted: June 2021
 Submitted By: Council on Government Affairs
 Reference Committee: D (Legislative, Health, Governance 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: Not Applicable

1 **PROPOSED POLICY, RANK AND STATUS OF DENTISTS IN THE UNIFORMED SERVICES**

2 **Background:** In accordance with Resolution 97H-2020, Special Order of Referral Consent Calendar,
 3 which directed the appropriate ADA agencies to report back to the 2021 House of Delegates on each
 4 Referred Resolution, Resolution 11-2020, Proposed Policy, Rank and Status of Dentists in the Armed
 5 Forces, Military Reserves, and Public Health Service, was referred to the Council.

6 After consideration, the Council is proposing a modified version of the resolution presented in 2020 to
 7 address vernacular-related issues for dentists in the U.S. Public Health Service, which is often overlooked
 8 as one of the eight uniformed services of the United States. Specifically, the Council is proposing to
 9 change the terminology from “armed forces, military reserves, and Public Health Service” to the more
 10 inclusive term “uniformed services”. No other changes are proposed. Resolution 11-2020 is appended to
 11 this report.

12 In accordance with Resolution 170H-2012 (*Trans.*2012:370), Regular Comprehensive Policy Review, the
 13 Council on Government Affairs reviewed the following Association policies to determine their adequacy
 14 (or obsolescence) in modern times, and the merits of any revisions.

- 15 • Compensation of Dental Specialists in the Federal Dental Services (*Trans.*1990:557; 2012:496)
- 16 • Restoration of the Rank of Brigadier General to the Army Reserve Position of Deputy Assistant
 17 Surgeon General for Dental Services (*Trans.*1992:622)
- 18 • Dentistry in the Armed Forces (*Trans.*1972:718; 2012:496)
- 19 • Rank Equivalency for Chief Dental Officers of the Federal Dental Services (*Trans.*2012:496)

20 The Council found that the policies were so similar in content that all four could be combined. The Council
 21 agreed that it would be preferable to broaden the language governing support for rank and status, update
 22 the vernacular for special pay, and acknowledge that dental specialties are now determined by the
 23 National Commission on Recognition of Dental Specialties.

24 The Council on Government Affairs recommends that the following resolution be adopted:

25 **Resolution**

26 **1. Resolved,** that the following policy titled Rank and Status of Dentists in the Uniformed Services be
 27 adopted:

1 **Rank and Status of Dentists in the Uniformed Services**

2 **Resolved**, that flag rank(s) of dental officers should be protected and enhanced in all branches of
3 the uniformed services, and their offices should have the appropriate status and funding to carry
4 out their missions effectively, and be it further

5 **Resolved**, that the American Dental Association supports a 2-star equivalent rank or higher for
6 the chief dental officers for the uniformed services and the Veterans Administration, and be it
7 further

8 **Resolved**, that graduates of a two year comprehensive dental residency or a dental specialty
9 residency recognized by the National Commission on Recognition of Dental Specialties should be
10 awarded special pay while serving in the federal dental services, and be it further

11 **Resolved**, that the following policies be rescinded:

- 12 • Compensation of Dental Specialists in the Federal Dental Services
13 (*Trans.*1990:557; 2012:496)
- 14 • Restoration of the Rank of Brigadier General to the Army Reserve Position of Deputy
15 Assistant Surgeon General for Dental Services (*Trans.*1992:622)
- 16 • Dentistry in the Armed Forces (*Trans.*1972:718; 2012:496)
- 17 • Rank Equivalency for Chief Dental Officers of the Federal Dental Services (*Trans.*2012:496)

18 **BOARD RECOMMENDATION: Vote Yes.**

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

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WORKSHEET ADDENDUM**2020 RESOLUTION 11—COUNCIL ON GOVERNMENT AFFAIRS—PROPOSED POLICY, RANK AND STATUS OF DENTISTS IN THE ARMED FORCES, MILITARY RESERVES AND PUBLIC HEALTH SERVICE**

11. Resolved, that flag rank(s) of dental officers should be protected and enhanced in all branches of the armed forces, military reserves and Public Health Service, and their offices should have the appropriate status and funding to carry out their missions effectively, and be it further

Resolved, that the American Dental Association supports a 2-star equivalent rank or higher for the chief dental officers for the U.S. Army, U.S. Navy, U.S. Air Force, U.S. Public Health Service and the Veterans Administration, and be it further

Resolved, that graduates of a two year comprehensive dental residency or a dental specialty residency recognized by the National Commission on Recognition of Dental Specialties should be awarded special pay while serving in the federal dental services, and be it further

Resolved, that the following policies be rescinded:

- Compensation of Dental Specialists in the Federal Dental Services (*Trans.*1990:557; 2012:496)
- Restoration of the Rank of Brigadier General to the Army Reserve Position of Deputy Assistant Surgeon General for Dental Services (*Trans.*1992:622)
- Dentistry in the Armed Forces (*Trans.*1972:718; 2012:496)
- Rank Equivalency for Chief Dental Officers of the Federal Dental Services (*Trans.*2012:496)

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**WORKSHEET ADDENDUM
COUNCIL ON GOVERNMENT AFFAIRS
ADA POLICIES TO BE RESCINDED**

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Dentistry in the Armed Forces (*Trans.1972:718; 2012:496*)

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Resolved, that in order to ensure the provision of high quality health care to those in active military service, the American Dental Association affirms the dental officer's proper role in command functions relating to the provision of oral health care and supports dental corps control over the financial and other resources needed to carry out their health care missions.

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Restoration of the Rank of Brigadier General to the Army Reserve Position of Deputy Assistant Surgeon General for Dental Services (*Trans.1992:622*)

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Resolved, that the American Dental Association support the reinstatement of the Brigadier General rank for the position of Deputy Assistant Surgeon General for Dental Services, Army Reserves.

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Rank Equivalency for Chief Dental Officers of the Federal Dental Services (*Trans.2012:496*)

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Resolved, that the American Dental Association supports a 2-star equivalent rank or higher for the chief dental officers for the U.S. Army, U.S. Navy, U.S. Air Force, U.S. Public Health Services and the Veterans Administration.

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Compensation of Dental Specialists in the Federal Dental Services (*Trans.1990:557; 2012:496*)

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Resolved, that the American Dental Association recommends that graduates of all ADA-recognized dental specialties and other Commission on Dental Accreditation-accredited two year residency programs be eligible for special remuneration in the federal dental services.

Resolution No. 2 New

Report: N/A Date Submitted: June 2021

Submitted By: Council on Government Affairs

Reference Committee: D (Legislative, Health, Governance 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: Not Applicable

1 **AMENDMENT OF THE POLICY, DENTAL RESEARCH BY MILITARY DEPARTMENTS**

2 **Background:** In accordance with Resolution 97H-2020, Special Order of Referral Consent Calendar,
3 which directed the appropriate ADA agencies to report back to the 2021 House of Delegates on each
4 Referred Resolution, Resolution 12-2020, Amendment of the Policy, Dental Research by Military
5 Departments, was referred to the Council.

6 After consideration, the Council respectfully re-offers its recommendation to amend the policy titled Dental
7 Research by Military Departments (*Trans.*1970:451; 2016:316). Resolution 12-2020 is appended to this
8 report.

9 In accordance with Resolution 170H-2012 (*Trans.*2012:370), Regular Comprehensive Policy Review, the
10 Council on Government Affairs reviewed the policy titled Dental Research by Military Departments
11 (*Trans.*1970:451; 2016:316), to determine its adequacy (or obsolescence) in modern times, and the
12 merits of any revisions.

13 The Council felt that it was critical to have a policy governing the Association’s support for military dental
14 research since it plays a unique role in improving dental readiness for combat, minimizing in-theater
15 dental emergencies and ameliorating combat-related disfigurement and loss of facial function.

16 The Council questioned whether the policy should be expanded to include the oral health needs of the
17 public, or focus on military needs exclusively. Mission creep and funding were identified as two potential
18 barriers to expanding military dental research beyond the needs of the military.

19 Additionally, the Council questioned why the current policy was limited to “basic” and “applied” research,
20 and determined that the Association’s support for military research did not need to be qualified in such a
21 prescriptive way.

22 The Council agreed that the current policy could be amended with modern verbiage expressing support
23 for military dental research without being too prescriptive.

24 The Council on Government Affairs recommends that the following resolution be adopted:

25 **Resolution**

26 **2. Resolved,** that policy titled Dental Research by Military Departments (*Trans.*1970:451; 2016:316)
27 be amended as follows (additions are underscored; deletions are ~~stricken~~):

1 **Resolved**, that ~~the ADA considers oral and craniofacial research to be an integral component of~~
2 ~~the military dental corps' mission and believes that each military branch should continue to~~
3 ~~support such research at the basic and applied science levels.~~ military dental research is unique
4 in that it focuses on the oral and craniofacial needs of active duty military personnel, such as:

- 5 • Improving dental readiness.
6 • Minimizing in-theater dental emergencies.
7 • Treating and ameliorating combat-related disfigurement and loss of facial function.

8 and be it further

9 **Resolved**, that each military branch should continue to support such research.

10 **BOARD RECOMMENDATION: Vote Yes.**

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

1 **WORKSHEET ADDENDUM**

2 **2020 RESOLUTION 12—COUNCIL ON GOVERNMENT AFFAIRS—AMENDMENT OF THE POLICY,**
3 **DENTAL RESEARCH BY MILITARY DEPARTMENTS**

4 **12. Resolved**, that policy titled Dental Research by Military Departments (*Trans.*1970:451; 2016:316)
5 be amended as follows (additions are underscored; deletions are ~~stricken~~):

6 **Resolved**, that ~~the ADA considers oral and craniofacial research to be an integral component of~~
7 ~~the military dental corps' mission and believes that each military branch should continue to~~
8 ~~support such research at the basic and applied science levels.~~ military dental research is unique
9 in that it focuses on the oral and craniofacial needs of active duty military personnel, such as:

- 10 • Improving dental readiness.
11 • Minimizing in-theater dental emergencies.
12 • Treating and ameliorating combat-related disfigurement and loss of facial function.

13 and be it further

14 **Resolved**, that each military branch should continue to support such research.

1 **Resolved**, that the policy titled ERISA Reform (*Trans.*1998:738) be rescinded.

2 **BOARD RECOMMENDATION: Vote Yes.**

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

4 **BOARD DISCUSSION)**

1 **WORKSHEET ADDENDUM**
2 **2020 RESOLUTION 65—COUNCIL ON GOVERNMENT AFFAIRS—PROPOSED POLICY,**
3 **ANESTHESIA COVERAGE UNDER HEALTH PLANS**

4 **65. Resolved**, that the following policy titled Anesthesia Coverage Under Health Plans be adopted:

5 **Anesthesia Coverage Under Health Plans**

6 **Resolved**, the ADA supports the position that all health plans, including those governed by the
7 Employee Retirement Income Security Act, should be required to cover general anesthesia
8 and/or hospital or outpatient surgical facility charges incurred by covered persons who receive
9 dental treatment under anesthesia, due to a documented physical, mental or medical reason as
10 determined by the treating dentist(s) and/or physician, and be it further

11 **Resolved**, that the policy titled ERISA Reform (*Trans.*1998:738) be rescinded.

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**WORKSHEET ADDENDUM
COUNCIL ON GOVERNMENT AFFAIRS
ADA POLICY TO BE RESCINDED**

ERISA Reform (*Trans.1998:738*)

Resolved, that the ADA seek federal legislation and/or regulation that would prohibit ERISA and all health benefit plans from excluding coverage of general anesthesia and/or hospital or outpatient surgical facility charges incurred by covered persons who receive dental treatment under anesthesia, due to a documented physical, mental or medical reason as determined by the treating dentist(s) and/or physician.

Resolution No. 4 New
 Report: N/A Date Submitted: June 2021
 Submitted By: Council on Government Affairs
 Reference Committee: D (Legislative, Health, Governance 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: Not Applicable

1 **PROPOSED POLICY, PROVISIONS FOR ERISA PLANS**

2 **Background:** In accordance with Resolution 97H-2020, Special Order of Referral Consent Calendar,
 3 which directed the appropriate ADA agencies to report back to the 2021 House of Delegates on each
 4 Referred Resolution, Resolution 69-2020, Proposed Policy, Provisions for ERISA Plans, was referred to
 5 the Council.

6 After consideration, the Council respectfully re-offers its recommendation to adopt a policy titled
 7 Provisions for ERISA Plans. Resolution 69-2020 is appended to this report.

8 In accordance with Resolution 170H-2012 (*Trans.*2012:370), Regular Comprehensive Policy Review, the
 9 Council on Government Affairs reviewed the following Association policies to determine their adequacy
 10 (or obsolescence) in modern times, and the merits of any revisions:

- 11 • Support Legislation Amending the Employee Retirement Income Security Act (*Trans.*1982:550;
 12 1989:561)
- 13 • Employee Retirement Income Security Act (ERISA) Enforcement Activities (*Trans.*1992:622)
- 14 • Amendment of Employee Retirement Income Security Act (*Trans.*1994:644)
- 15 • Amendments to ERISA to Achieve Greater Protections for Patients and Providers
 16 (*Trans.*1995:649)

17 The Council found that all of the above mentioned polices are worded as time-limited assignments that
 18 effectively were fulfilled once the tasks to “initiate and actively support legislation,” “continue its efforts...to
 19 achieve vigorous enforcement,” “seek federal legislation,” and “support legislative activities” were
 20 completed (*Reports* 1990:157; 1993:114; 1995:106; 1996:107).

21 The Council also determined that the subject matter was relevant enough to be retained in the form of
 22 more enduring statements of policy or position—and that many of the resolving clauses are similar
 23 enough to be bundled into a single umbrella policy with modest changes for brevity and clarity.

24 After consulting the Council on Dental Benefit Programs and the Council on Dental Practice, the Council
 25 on Government Affairs recommends that the following resolution be adopted:

26 **Resolution**

27 **4. Resolved,** that the following policy titled Provisions for ERISA Plans be adopted:

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Provisions for ERISA Plans

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Resolved, that the American Dental Association supports the following provisions for ERISA plans:

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1. Beneficiaries of employee health benefit plans should have the right to receive health care from the providers of their choice

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2. Employee health benefit plans should be prohibited from discriminating against legally qualified health care providers and to assure the solvency of such plans

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3. Plan subscribers in Employee Retirement Income Security Act-regulated dental benefit programs should have the same protections that are commonly enjoyed by subscribers of state-regulated programs

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4. Self-insured payers and/or utilization review organizations should be held liable for any negligent utilization review decision that overturns the health care provider's clinical decision

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5. Patients who suffer as the result of negligent utilization review decisions should be entitled to meaningful remedies and fair compensation

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6. Patients who are denied benefits should have the right to an appropriate appeal mechanism under self-funded group health plans

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and be it further

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Resolved, that the policies titled Support Legislation Amending the Employee Retirement Income Security Act (*Trans.*1982:550; 1989:561), Employee Retirement Income Security Act (ERISA) Enforcement Activities (*Trans.*1992:622), Amendment of Employee Retirement Income Security Act (*Trans.*1994:644), and Amendments to ERISA to Achieve Greater Protections for Patients and Providers (*Trans.*1995:649) be rescinded.

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BOARD RECOMMENDATION: Vote Yes.

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

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WORKSHEET ADDENDUM
COUNCIL ON GOVERNMENT AFFAIRS
ADA POLICIES TO BE RESCINDED

4 **Support Legislation Amending the Employee Retirement Income Security Act (*Trans.1982:550*;**
5 **1989:561)**

6 **Resolved**, that the ADA initiate and actively support legislation amending the Employee Retirement
7 Income Security Act (ERISA) to assure that beneficiaries of employee health benefit plans have the right
8 to receive health care from the providers of their choice, to prevent plans from discriminating against
9 legally qualified health care providers and to assure the solvency of such plans.

10 **Employee Retirement Income Security Act (ERISA) Enforcement Activities (*Trans.1992:622*)**

11 **Resolved**, that the American Dental Association continue its efforts in concert with appropriate public and
12 private entities to achieve vigorous enforcement of the provisions of the Employee Retirement Income
13 Security Act in order to provide plan subscribers in ERISA-regulated dental benefit programs with the
14 same protections as are commonly enjoyed by subscribers of state-regulated programs.

15 **Amendment of Employee Retirement Income Security Act (*Trans.1994:644*)**

16 **Resolved**, that the appropriate agencies of the American Dental Association seek federal legislation to
17 amend the Employee Retirement Income Security Act (ERISA) to hold self-insured payers and/or
18 utilization review organizations liable for any negligent utilization review decision which overturns the
19 health care provider's clinical decision, and ensure meaningful remedies and fair compensation to
20 patients who suffer as a result of such negligent utilization review decisions, and be it further

21 **Resolved**, that the appropriate agencies of the American Dental Association work to ensure that any
22 health system reform proposals address the problems of remedy and compensation created by ERISA for
23 patients in self-funded plans.

24 **Amendments to ERISA to Achieve Greater Protections for Patients and Providers (*Trans.1995:649*)**

25 **Resolved**, that the Association support legislative activities to directly amend the ERISA statute in an
26 effort to achieve greater protections for patients and providers, and be it further

27 **Resolved**, that one of these protections assure that patients who are denied benefits have the right to an
28 appropriate appeal mechanism.

Resolution No. 5 NewReport: N/A Date Submitted: June 2021Submitted By: Council on Government AffairsReference Committee: D (Legislative, Health, Governance 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: Not Applicable

1 RESCISSION OF THE POLICY, ADVOCATING FOR ERISA REFORM

2 **Background:** In accordance with Resolution 97H-2020, Special Order of Referral Consent Calendar,
3 which directed the appropriate ADA agencies to report back to the 2021 House of Delegates on each
4 Referred Resolution, Resolution 63-2020, Rescission of the Policy, Advocating for ERISA Reform, was
5 referred to the Council.

6 After consideration, the Council respectfully re-offers its recommendation to rescind the policy titled
7 Advocating for ERISA Reform (*Trans.*2009:474; 2014:500). Resolution 63-2020 is appended to this
8 report.

9 In accordance with Resolution 170H-2012 (*Trans.*2012:370), Regular Comprehensive Policy Review, the
10 Council on Government Affairs reviewed the Association policy titled Advocating for ERISA Reform
11 (*Trans.*2009:474; 2014:500), to determine its adequacy (or obsolescence) in modern times, and the
12 merits of any revisions.

13 The Council determined that this policy is redundant of the policies titled Employee Retirement Income
14 Security Act (ERISA) Enforcement Activities (*Trans.*1992:622) and Amendment of Employee Retirement
15 Income Security Act (*Trans.*1994:644). The Council also determined that the policy titled Advocating for
16 ERISA Reform was worded as a time-limited assignment that effectively was fulfilled once the tasks to
17 “identify those features” and “seek legislation” were complete (*Reports* 2010:149).

18 After consulting the Council on Dental Benefit Programs and the Council on Dental Practice, the Council
19 on Government Affairs recommends that the following resolution be adopted:

20 Resolution

21 **5. Resolved**, that the policy titled Advocating for ERISA Reform (*Trans.*2009:474; 2014:500) be
22 rescinded.

23 BOARD RECOMMENDATION: Vote Yes.

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

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WORKSHEET ADDENDUM
2020 RESOLUTION 63—COUNCIL ON GOVERNMENT AFFAIRS—RESCISSION OF THE POLICY,
ADVOCATING FOR ERISA REFORM

63. Resolved, that the policy titled Advocating for ERISA Reform (*Trans.*2009:474; 2014:500) be rescinded.

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**WORKSHEET ADDENDUM
COUNCIL ON GOVERNMENT AFFAIRS
ADA POLICY TO BE RESCINDED**

Advocating for ERISA Reform (*Trans.2009:474; 2014:500*)

Resolved, that the appropriate agencies of the ADA identify those features of ERISA that exempt some plans from state regulation to protect consumers, and be it further

Resolved, that the ADA aggressively seek legislation to change the Act to create these consumer safeguards under federal law or allow regulation of these plans by the states.

Resolution No. 6 New
 Report: N/A Date Submitted: June 2021
 Submitted By: Council on Government Affairs
 Reference Committee: D (Legislative, Health, Governance 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: Not Applicable

1 **AMENDMENT OF THE POLICY, USE OF EXPERT WITNESSES IN LIABILITY CASES**

2 **Background:** In accordance with Resolution 97H-2020, Special Order of Referral Consent Calendar,
3 which directed the appropriate ADA agencies to report back to the 2021 House of Delegates on each
4 Referred Resolution, Resolution 42-2020, Amendment of the Policy, Use of Expert Witnesses in Liability
5 Cases, was referred to the Council.

6 After consideration, the Council respectfully re-offers its recommendation to amend the policy titled Use of
7 Expert Witnesses in Liability Cases (*Trans.*1986:531). Resolution 42-2020 is appended to this report.

8 In accordance with Resolution 170H-2012 (*Trans.*2012:370), Regular Comprehensive Policy Review, the
9 Council on Government Affairs reviewed the Association policy titled Use of Expert Witnesses in Liability
10 Cases (*Trans.*1986:531), to determine its adequacy (or obsolescence) in modern times, and the merits of
11 any revisions.

12 The Council determined that the policy was worded as a time-limited assignment that effectively became
13 moot once the task to “urge constituent dental societies” was complete (*Reports* 1987:122). However,
14 the Council agreed that the subject matter was relevant enough to retain in a more enduring form.

15 The Council noted that the national organization has no real authority to interfere with the policies,
16 positions, priorities, and activities of state dental societies.

17 After consulting the Council on Dental Practice, the Council on Government Affairs recommends that the
18 following resolution be adopted.

19 **Resolution**

20 **6. Resolved**, that the policy titled Use of Expert Witnesses in Liability Cases (*Trans.*1986:531) be
21 amended to read as follows (additions are underscored; deletions are ~~stricken~~):

22 **Resolved**, that ~~the American Dental Association urge constituent dental societies to actively~~
23 ~~support legislation and changes in court rules that would require~~ plaintiffs and their attorneys in
24 professional liability actions should be required to include with each complaint the affidavit of a
25 health care professional, who practices in the same field or specialty as the defendant and who
26 has reviewed the patient record and related materials, stating that there is reasonable and
27 meritorious cause for filing the action, and be it further

1 **Resolved**, that ~~constituent dental societies be urged to actively support legislation and changes~~
2 ~~in court rules that would require expert witnesses in court proceedings should be required to~~
3 possess the clinical knowledge and skill to qualify them on the subject of their testimony and
4 familiarity with the practices and customs of practitioners in good standing in the locality where
5 the defendant practiced when the incident occurred, and be it further

6 **Resolved**, that ~~constituent dental societies also be urged to actively support legislation and~~
7 ~~changes in court rules requiring courts in appropriate cases to instruct should require that~~
8 juries be instructed on the availability of alternative treatments and the role of patients in their own
9 care, as appropriate.

10 **BOARD RECOMMENDATION: Vote Yes.**

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

1 **WORKSHEET ADDENDUM**2 **2020 RESOLUTION 42—COUNCIL ON GOVERNMENT AFFAIRS—AMENDMENT OF THE POLICY,**
3 **USE OF EXPERT WITNESSES IN LIABILITY CASES**

4 **42. Resolved**, that the policy titled Use of Expert Witnesses in Liability Cases (*Trans.*1986:531) be
5 amended to read as follows (additions are underscored; deletions are ~~stricken~~):

6 **Resolved**, that ~~the American Dental Association urge constituent dental societies to actively~~
7 ~~support legislation and changes in court rules that would require~~ plaintiffs and their attorneys in
8 professional liability actions should be required to include with each complaint the affidavit of a
9 health care professional, who practices in the same field or specialty as the defendant and who
10 has reviewed the patient record and related materials, stating that there is reasonable and
11 meritorious cause for filing the action, and be it further

12 **Resolved**, that ~~constituent dental societies be urged to actively support legislation and changes~~
13 ~~in court rules that would require~~ expert witnesses in court proceedings should be required to
14 possess the clinical knowledge and skill to qualify them on the subject of their testimony and
15 familiarity with the practices and customs of practitioners in good standing in the locality where
16 the defendant practiced when the incident occurred, and be it further

17 **Resolved**, that ~~constituent dental societies also be urged to actively support legislation and~~
18 ~~changes in court rules requiring courts in appropriate cases to instruct~~ should require that
19 juries be instructed on the availability of alternative treatments and the role of patients in their own
20 care, as appropriate.

Resolution No. 7 New
 Report: N/A Date Submitted: June 2021
 Submitted By: Council on Government Affairs
 Reference Committee: D (Legislative, Health, Governance 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: Not Applicable

1 **RESCISSION OF THE POLICY, PROFESSIONAL LIABILITY INSURANCE LEGISLATION**

2 **Background:** In accordance with Resolution 97H-2020, Special Order of Referral Consent Calendar,
 3 which directed the appropriate ADA agencies to report back to the 2021 House of Delegates on each
 4 Referred Resolution, Resolution 45-2020, Rescission of the Policy, Professional Liability Insurance
 5 Legislation, was referred to the Council.

6 After consideration, the Council respectfully re-offers its recommendation to rescind the policy titled
 7 Professional Liability Insurance Legislation (*Trans.*1984:548). Resolution 45-2020 is appended to this
 8 report.

9 In accordance with Resolution 170H-2012 (*Trans.*2012:370), Regular Comprehensive Policy Review, the
 10 Council on Government Affairs reviewed the Association policy titled Professional Liability Insurance
 11 Legislation (*Trans.*1984:548), to determine its adequacy (or obsolescence) in modern times, and the
 12 merits of any revisions.

13 The basis for the policy was that “professional liability premiums are increasing at significant rates” and
 14 that “a legislative approach is likely to be one of the viable alternatives to addressing this complex and
 15 growing problem” (*Supplement* 1984:240). The Council also concluded that this 30 year-old directive is
 16 no longer relevant to the current situation.

17 The Council determined that professional liability insurance premiums are negligible in modern times.
 18 They are not “rapidly increasing” and do not “contribute significantly to higher costs of health care
 19 services for patients,” as the policy states. The Council also concluded that 28H-1984 was worded as a
 20 time-limited assignment that effectively had been fulfilled once the task to “support federal and state
 21 legislation” was completed (*Reports* 1985:137).

22 After consulting the Council on Dental Practice, the Council on Government Affairs recommends that the
 23 following resolution be adopted:

24 **Resolution**

25 **7. Resolved,** that the policy titled Professional Liability Insurance Legislation (*Trans.*1984:548) be
 26 rescinded.

27 **BOARD RECOMMENDATION: Vote Yes.**

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

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WORKSHEET ADDENDUM
2020 RESOLUTION 45—COUNCIL ON GOVERNMENT AFFAIRS—RESCISSION OF THE POLICY,
PROFESSIONAL LIABILITY INSURANCE LEGISLATION

45. Resolved, that the policy titled Professional Liability Insurance Legislation (*Trans.*1984:548) be rescinded.

1 **WORKSHEET ADDENDUM**
2 **COUNCIL ON GOVERNMENT AFFAIRS**
3 **ADA POLICY TO BE RESCINDED**

4 **Professional Liability Insurance Legislation (*Trans.1984:548*)**

5 **Resolved**, that the American Dental Association and constituent dental societies support federal and
6 state legislation, as appropriate, to deal fairly and equitably with the problems of rapidly increasing
7 professional liability insurance costs which contribute significantly to higher costs of health care services
8 for patients, and be it further

9 **Resolved**, that legislative or other approaches to the professional liability problem be studied and
10 developed in cooperation with other health organizations and interested parties.

Resolution No. 7S-1 Substitute

Report: N/A Date Submitted: October 2021

Submitted By: Thirteenth Trustee District

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

Total Net Financial Implication: None Net Dues Impact: _____

Amount One-time _____ Amount On-going _____

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: Not Applicable

1 **AMENDMENT TO THE POLICY, PROFESSIONAL LIABILITY INSURANCE LEGISLATION**

2 The following amendment for Resolution 7 (Worksheet:5021) was submitted by the Thirteenth Trustee
3 District and transmitted on October 6, 2021, by Jillian Andolina, Strategic Operations Director, California
4 Dental Association.

5 **Background:** In accordance with Resolution 97H-2020, Special Order of Referral Consent Calendar,
6 which directed the appropriate ADA agencies to report back to the 2021 House of Delegates on each
7 Referred Resolution, Resolution 45-2020, Rescission of the Policy, Professional Liability Insurance
8 Legislation, was referred to the Council on Government Affairs.

9 In Resolution 7-2021, the Council has re-offered its recommendation to rescind the policy titled
10 Professional Liability Insurance Legislation (*Trans.*1984:548). However, the Thirteenth District considers
11 it important to have a policy in place should another crisis of skyrocketing professional liability insurance
12 premiums arise.

13 While professional liability insurance premiums have stabilized over the years, largely due to new tort
14 reform laws, the ADA and state dental societies must be in a position to respond quickly should liability
15 insurance premiums begin to skyrocket again. The Thirteenth Trustee District Delegation recommends
16 that the following substitute resolution be adopted:

17 **Resolution**

18 **7S-1. Resolved**, that the policy titled Professional Liability Insurance Legislation (*Trans.*1984:548) be
19 amended to read as follows (additions are underscored; deletions are ~~stricken~~):

20 **Resolved**, that the American Dental Association monitor and constituent dental societies ~~support~~
21 be urged to monitor federal and state legislation for challenges to tort reform that would result in
22 liability insurance premiums skyrocketing and leading to increased health care costs for patients,
23 ~~as appropriate, to deal fairly and equitably with the problems of rapidly increasing professional~~
24 ~~liability insurance costs which contribute significantly to higher costs of health care services for~~
25 ~~patients~~, and be it further

26 **Resolved**, that the ADA should stand ready to aid and assist constituent dental societies
27 experiencing a crisis of rising malpractice insurance premiums due to tort reform challenges.

1 ~~legislative or other approaches to the professional liability problem be studied and developed in~~
2 ~~cooperation with other health organizations and interested parties.~~

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

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WORKSHEET ADDENDUM
2020 RESOLUTION 45—COUNCIL ON GOVERNMENT AFFAIRS—RESCISSION OF THE POLICY,
PROFESSIONAL LIABILITY INSURANCE LEGISLATION

45. Resolved, that the policy titled Professional Liability Insurance Legislation (*Trans.*1984:548) be rescinded.

Resolution No. 8 New
 Report: N/A Date Submitted: June 2021
 Submitted By: Council on Government Affairs
 Reference Committee: D (Legislative, Health, Governance 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: Not Applicable

1 **RESCISSION OF THE POLICY, COSTS FOR THE SUBMISSION OF ELECTRONIC DENTAL CLAIMS**

2 **Background:** In accordance with Resolution 97H-2020, Special Order of Referral Consent Calendar,
 3 which directed the appropriate ADA agencies to report back to the 2021 House of Delegates on each
 4 Referred Resolution, Resolution 61-2020, Rescission of the Policy, Costs for the Submission of Electronic
 5 Dental Claims, was referred to the Council.

6 After consideration, the Council respectfully re-offers its recommendation to rescind the policy titled Costs
 7 for the Submission of Electronic Dental Claims (*Trans.*1995:623). Resolution 61-2020 is appended to this
 8 report.

9 In accordance with Resolution 170H-2012 (*Trans.*2012:370), Regular Comprehensive Policy Review, the
 10 Council on Government Affairs reviewed the Association policy titled Costs for the Submission of
 11 Electronic Dental Claims (*Trans.*1995:623), to determine its adequacy (or obsolescence) in modern times,
 12 and the merits of any revisions.

13 The Council determined that the policy was worded as a time-limited assignment that effectively was
 14 fulfilled once the tasks to “work to protect” and “[seek] to minimize or eliminate” were complete (*Reports*
 15 1996:50). The Council also found no added value in maintaining a directive that is not particularly
 16 relevant in modern times.

17 The “current dynamics” of the “electronic claims payment marketplace” have changed significantly in the
 18 30-plus years since the policy titled Costs for the Submission of Electronic Dental Claims was adopted,
 19 particularly with the evolution of the Internet. The administrative simplification provisions in the Health
 20 Insurance Portability and Accountability Act of 1996 have also transformed the way electronic claims are
 21 used in the marketplace.

22 After consulting the Council on Dental Practice, the Council on Government Affairs recommends that the
 23 following resolution be adopted:

24 **Resolution**

25 **8. Resolved,** that the policy titled Costs for the Submission of Electronic Dental Claims
 26 (*Trans.*1995:623) be rescinded.

27 **BOARD RECOMMENDATION: Vote Yes.**

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

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WORKSHEET ADDENDUM
**2020 RESOLUTION 61—COUNCIL ON GOVERNMENT AFFAIRS—RESCISSION OF THE POLICY,
COSTS FOR THE SUBMISSION OF ELECTRONIC DENTAL CLAIMS**

61. Resolved, that the policy titled Costs for the Submission of Electronic Dental Claims
(*Trans.*1995:623) be rescinded.

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**WORKSHEET ADDENDUM
COUNCIL ON GOVERNMENT AFFAIRS
ADA POLICY TO BE RESCINDED**

Costs for the Submission of Electronic Dental Claims (*Trans.1995:623*)

Resolved, that because of the current dynamics of the electronic claims payment marketplace, the ADA should work to protect the interest of the dentist by seeking to minimize or eliminate the costs to the dentist for the submission of electronic dental claims.

Resolution No. 9 New

Report: N/A Date Submitted: June 2021

Submitted By: Council on Government Affairs

Reference Committee: D (Legislative, Health, Governance 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: Not Applicable

1 **AMENDMENT OF THE POLICY, FEE-FOR-SERVICE MEDICAID PROGRAMS**

2 **Background:** In accordance with Resolution 97H-2020, Special Order of Referral Consent Calendar,
3 which directed the appropriate ADA agencies to report back to the 2021 House of Delegates on each
4 Referred Resolution, Resolution 46-2020, Amendment of the Policy, Fee-For-Service Medicaid Programs,
5 was referred to the Council.

6 After consideration, the Council respectfully re-offers its recommendation to amend the policy titled Fee-
7 For-Service Medicaid Programs (*Trans.*1999:957). Resolution 46-2020 is appended to this report.

8 In accordance with Resolution 170H-2012 (*Trans.*2012:370), Regular Comprehensive Policy Review, the
9 Council on Government Affairs reviewed the Association policy titled Fee-For-Service Medicaid Programs
10 (*Trans.*1999:957), to determine its adequacy (or obsolescence) in modern times, and the merits of any
11 revisions.

12 The Council determined that the policy was worded as time-limited assignment that effectively became
13 moot once the task to “support and encourage states to adopt” was completed (*Reports* 2000:118). The
14 Council also considered the subject matter relevant enough to retain in a more enduring form.

15 The Council noted that the national organization has no real authority to interfere with the policies,
16 positions, priorities, and activities of state dental societies.

17 After consulting the Council on Advocacy for Access and Prevention and the Council on Dental Benefit
18 Programs, the Council on Government Affairs recommends that the following resolution be adopted.

19 **Resolution**

20 **9. Resolved,** that the policy titled Fee-For-Service Medicaid Programs (*Trans.*1999:957) be
21 amended to read as follows (additions are underscored; deletions are ~~stricken~~):

22 **Resolved,** that ~~the ADA support and encourage states to~~ states should adopt adequately funded
23 fee-for-service models for Medicaid programs to increase dentist participation and increase
24 access to care for Medicaid participants.

25 **BOARD RECOMMENDATION: Vote Yes.**

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

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WORKSHEET ADDENDUM
2020 RESOLUTION 46—COUNCIL ON GOVERNMENT AFFAIRS—AMENDMENT OF THE POLICY,
FEE-FOR-SERVICE MEDICAID PROGRAMS

46. Resolved, that the policy titled Fee-For-Service Medicaid Programs (*Trans.*1999:957) be amended to read as follows (additions are underscored; deletions are ~~stricken~~):

Resolved, that ~~the ADA support and encourage states to~~ states should adopt adequately funded fee-for-service models for Medicaid programs to increase dentist participation and increase access to care for Medicaid participants.

Resolution No. 10 NewReport: N/A Date Submitted: June 2021Submitted By: Council on Government AffairsReference Committee: D (Legislative, Health, Governance 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: Not Applicable

1 **AMENDMENT OF THE POLICY, MEDICAID AND INDIGENT CARE FUNDING**

2 **Background:** In accordance with Resolution 97H-2020, Special Order of Referral Consent Calendar,
3 which directed the appropriate ADA agencies to report back to the 2021 House of Delegates on each
4 Referred Resolution, Resolution 47-2020, Amendment of the Policy, Medicaid and Indigent Care Funding
5 (*Trans.*2006:338; 2014:499), was referred to the Council.

6 After consideration, the Council respectfully re-offers its recommendation to amend the policy titled
7 Medicaid and Indigent Care Funding (*Trans.*2006:338; 2014:499). Resolution 47-2020 is appended to this
8 report.

9 In accordance with Resolution 170H-2012 (*Trans.*2012:370), Regular Comprehensive Policy Review, the
10 Council on Government Affairs reviewed the Association policy titled Medicaid and Indigent Care Funding
11 (*Trans.*2006:338; 2014:499), to determine its adequacy (or obsolescence) in modern times, and the
12 merits of any revisions.

13 The Council determined that the 2014 House of Delegates adopted technical amendments to the policy
14 on Medicaid and Indigent Care Funding, which was worded as time-limited directive that effectively has
15 been fulfilled once the tasks to “make lobbying a priority,” “carry out an intensive educational program,”
16 and “study how to improve health outcomes” were completed (*Reports* 2007:114). The Council also
17 considered the subject matter relevant enough to retain in a more enduring form.

18 The Council noted that the national organization has no real authority to interfere with the policies,
19 positions, priorities, and activities of constituent and component dental societies.

20 After consulting the Council on Advocacy for Access and Prevention, the Council on Government Affairs
21 recommends that the following resolution be adopted.

22 **Resolution**

23 **10. Resolved**, that the policy titled Medicaid and Indigent Care Funding (*Trans.*2006:338; 2014:499)
24 be amended to read as follows (additions are underscored; deletions are ~~stricken~~):

25 **Resolved**, that the ADA ~~make lobbying for adequate funds~~ American Dental Association supports
26 adequate funding to provide oral health care to Medicaid and other indigent care populations ~~a~~

1 ~~high priority and that the constituent and component societies be urged to do the same, and be it~~
2 ~~further.~~

3 ~~**Resolved**, that the ADA and its constituent and component societies carry out an intensive~~
4 ~~educational program, subject to current budgetary limits, to enlighten the public and government~~
5 ~~agencies of the value of oral health care and the consequences of untreated oral health disease~~
6 ~~to the overall health of our citizens and to health care payment systems, and be it further~~

7 ~~**Resolved**, that the appropriate ADA agency study how to improve health outcomes through~~
8 ~~greater accountability and responsibility of dental patients to the care, educational and preventive~~
9 ~~opportunities provided to them.~~

10 **BOARD RECOMMENDATION: Vote Yes.**

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

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WORKSHEET ADDENDUM
2020 RESOLUTION 47—COUNCIL ON GOVERNMENT AFFAIRS—AMENDMENT OF THE POLICY,
MEDICAID AND INDIGENT CARE FUNDING

47. Resolved, that the policy titled Medicaid and Indigent Care Funding (*Trans.2006:338; 2014:499*) be amended to read as follows (additions are underscored; deletions are ~~stricken~~):

Resolved, that the ADA ~~make lobbying for adequate funds~~ American Dental Association supports adequate funding to provide oral health care to Medicaid and other indigent care populations ~~a high priority~~ and that the constituent and component societies be urged to do the same, and be it further.

~~**Resolved,** that the ADA and its constituent and component societies carry out an intensive educational program, subject to current budgetary limits, to enlighten the public and government agencies of the value of oral health care and the consequences of untreated oral health disease to the overall health of our citizens and to health care payment systems, and be it further~~

~~**Resolved,** that the appropriate ADA agency study how to improve health outcomes through greater accountability and responsibility of dental patients to the care, educational and preventive opportunities provided to them.~~

Resolution No. 11 New

Report: N/A Date Submitted: June 2021

Submitted By: Council on Government Affairs

Reference Committee: D (Legislative, Health, Governance 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: Not Applicable

1 **AMENDMENT OF THE POLICY, USE OF DENTIST-TO-POPULATION RATIOS**

2 **Background:** In accordance with Resolution 97H-2020, Special Order of Referral Consent Calendar,
3 which directed the appropriate ADA agencies to report back to the 2021 House of Delegates on each
4 Referred Resolution, Resolution 4-2020, Amendment of the Policy, Use of Dentist-to-Population Ratios,
5 was referred to the Council.

6 After consideration, the Council respectfully re-offers its recommendation to amend the policy titled Use of
7 Dentist-to-Population Ratios (*Trans.*1984:538; 1996:681). Resolution 4-2020 is appended to this report.

8 In accordance with Resolution 170H-2012 (*Trans.*2012:370), Regular Comprehensive Policy Review, the
9 Council on Government Affairs reviewed the Association policy titled Use of Dentist-to-Population Ratios
10 (*Trans.*1984:538; 1996:681), to determine its adequacy (or obsolescence) in modern times, and the
11 merits of any revisions.

12 The Council determined that the policy titled Use of Dentist-to-Population Ratios (*Trans.*1984:538) was
13 worded as a time-limited directive that became moot once the task to urge various entities to “refrain from
14 using” was completed (*Reports* 1985:90)—and that the language directing the Association to complete
15 the task did not change when it was amended by the 1996 House of Delegates (*Trans.*1996:681)
16 (*Reports* 1997:66, 126). The Council also determined that the subject matter is relevant enough to retain
17 as a more enduring statement of policy or position.

18 The Council on Government Affairs recommends that the following resolution be adopted:

19 **Resolution**

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21 **11. Resolved**, that the policy titled Use of Dentist-to-Population Ratios (*Trans.*1984:538; 1996:681)
22 be amended as follows (additions are underscored; deletions are ~~stricken~~):

23 **Resolved**, that ~~the American Dental Association urges all governmental, professional and public~~
24 ~~agencies, and schools of dentistry to refrain from using dentist-to-population ratios exclusively~~
25 in-should not be used as the exclusive measure for designating dental health professional
26 shortage areas or for evaluating or recommending programs for dental education or dental care.

27 **BOARD RECOMMENDATION: Vote Yes.**

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

1 **WORKSHEET ADDENDUM**

2 **2020 RESOLUTION 4—COUNCIL ON GOVERNMENT AFFAIRS—AMENDMENT OF THE POLICY,**
3 **USE OF DENTIST-TO-POPULATION RATIOS**

4 **4. Resolved,** ~~that the policy titled~~ that the policy titled Use of Dentist-to-Population Ratios
5 (*Trans.*1984:538; 1996:681) be amended as follows (additions are underscored; deletions
6 are ~~stricken~~):

7 **Resolved,** ~~that the American Dental Association urges all governmental, professional and public~~
8 ~~agencies, and schools of dentistry to refrain from using dentist-to-population ratios exclusively~~
9 ~~in~~ should not be used as the exclusive measure for designating dental health professional
10 shortage areas or for evaluating or recommending programs for dental education or dental care.

Resolution No. 12 New
 Report: N/A Date Submitted: June 2021
 Submitted By: Council on Government Affairs
 Reference Committee: D (Legislative, Health, Governance 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: Not Applicable

1 RESCISSION OF THE POLICY, MALDISTRIBUTION OF THE DENTAL WORKFORCE

2 **Background:** In accordance with Resolution 97H-2020, Special Order of Referral Consent Calendar,
 3 which directed the appropriate ADA agencies to report back to the 2021 House of Delegates on each
 4 Referred Resolution, Resolution 53-2020, Rescission of the Policy, Maldistribution of the Dental
 5 Workforce, was referred to the Council.

6 After consideration, the Council respectfully re-offers its recommendation to rescind the policy titled
 7 Maldistribution of the Dental Workforce (*Trans.2001:442; 2014:500*). Resolution 53-2020 is appended to
 8 this report.

9 In accordance with Resolution 170H-2012 (*Trans. 2012:370*), Regular Comprehensive Policy Review, the
 10 Council on Government Affairs reviewed the Association policy titled Maldistribution of the Dental
 11 Workforce (*Trans.2001:442; 2014:500*), to determine its adequacy (or obsolescence) in modern times,
 12 and the merits of any revisions.

13 The Council agreed that the policy was worded as a time-limited directive that effectively was fulfilled
 14 once the task to “develop a framework” was complete (*Supplement 2002:6020*). Moreover, the Council
 15 observed that all aspects of this assignment—legislation, taxes, student loan forgiveness, and
 16 scholarships—are covered elsewhere in ADA policy, including some that were adopted as recently as
 17 2019.

- 18 • Federal Student Loan Repayment Incentives (*Trans.2019:297*) addresses payback of all or a
 19 portion of dental school tuition if a new dentist practices in an underserved area, as well as loan
 20 forgiveness for dental students and post-doctoral residents and students who practice in
 21 underserved areas after graduation. The policy was adopted in 2019.
- 22 • Tax Treatment of Student Loan Interest, Scholarships and Stipends (*Trans.2019:298*) and
 23 Federal Student Loan Repayment Incentives (*Trans.2019:297*) both address scholarships for
 24 dental students and post-doctoral residents and students who practice in underserved areas
 25 after graduation. Both policies were adopted in 2019.
- 26 • Universal Healthcare Reform (*Trans.2008:433*) addresses tax incentives for dentists to practice
 27 in underserved areas. The policy was reviewed and retained as written in 2019.

- 1 • Access to Dental Services for the Underserved (*Trans.2000:500*) outlines a series of model
- 2 practices to resolve access issues for the underserved, indigent, and special needs groups.

3 The Council concluded that there was no added value in maintaining an assignment that is now moot and
4 simply rephrases what is addressed elsewhere in Association policy.

5 After consulting the Council on Advocacy for Access and Prevention, the Council on Government Affairs
6 recommends that the following resolution be adopted:

7 **Resolution**

8 **12. Resolved**, that the policy titled Maldistribution of the Dental Workforce (*Trans.2001:442;*
9 *2014:500*) be rescinded.

10 **BOARD RECOMMENDATION: Vote Yes.**

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

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WORKSHEET ADDENDUM
2020 RESOLUTION 53—COUNCIL ON GOVERNMENT AFFAIRS—RESCISSION OF THE POLICY,
MALDISTRIBUTION OF THE DENTAL WORKFORCE

53. Resolved, that the policy titled Maldistribution of the Dental Workforce (*Trans.*2001:442; 2014:500) be rescinded.

1 **WORKSHEET ADDENDUM**
2 **COUNCIL ON GOVERNMENT AFFAIRS**
3 **ADA POLICY TO BE RESCINDED**

4 **Maldistribution of the Dental Workforce (*Trans.2001:442; 2014:500*)**

5 **Resolved**, that appropriate agencies of the ADA develop a framework to help those states with a
6 maldistribution of the dental workforce, and be it further

7 **Resolved**, that the framework may include, but is not limited to:

- 8 • Model legislation to help attract dentists to underserved areas of states. The legislation may
9 include, but is not limited to:
 - 10 a. Tax incentives for dentists practicing in underserved areas.
 - 11 b. Payback of all or a portion of dental school tuition if the new dentist practices in an
12 underserved area.
 - 13 c. Scholarships for dental students and post-doctoral residents and students who practice in
14 underserved areas after graduation.
 - 15 d. Loan forgiveness for dental students and post-doctoral residents and students who
16 practice in underserved areas after graduation.
- 17 • Establishing a list of opportunities that are available from rural communities who are willing to
18 provide financial support to dentists moving to their area.

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

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WORKSHEET ADDENDUM
2020 RESOLUTION 58—COUNCIL ON GOVERNMENT AFFAIRS—PROPOSED POLICY,
GUARANTEEING PATIENT’S FREEDOM OF CHOICE OF DENTIST

58. Resolved, that the following policy titled *Guaranteeing Patient’s Freedom of Choice of Dentist* be adopted:

Guaranteeing Patient’s Freedom of Choice of Dentist

Resolved, that the patient’s right to choose any licensed dentist to deliver his or her oral health care without any type of coercion must be preserved, and be it further

Resolved, that the American Dental Association opposes any arrangement that eliminates, interferes with, or otherwise limits the patient’s freedom of choice, and be it further

Resolved, that the policy titled *Legislation to Guarantee Patient’s Freedom of Choice of Dentist (Trans.1995:631)* be rescinded.

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**WORKSHEET ADDENDUM
COUNCIL ON GOVERNMENT AFFAIRS
ADA POLICY TO BE RESCINDED**

4 **Legislation to Guarantee Patient's Freedom of Choice of Dentist (*Trans.1995:631*)**

5 **Resolved**, that the American Dental Association actively pursue legislation that will guarantee the
6 patient's right to choose any licensed dentist to deliver his or her oral health care without any type of
7 coercion, and be it further

8 **Resolved**, that the American Dental Association take legislative action to oppose any arrangement that
9 eliminates, interferes with, or otherwise limits the patient's freedom of choice.

Resolution No. 14S-1 Amendment

Report: N/A Date Submitted: September 2021

Submitted By: Third Trustee District

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

Total Net Financial Implication: None Net Dues Impact: _____

Amount One-time _____ Amount On-going _____

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

1 **AMENDMENT TO RESOLUTION 14: PROPOSED POLICY, GUARANTEEING PATIENT’S FREEDOM**
 2 **OF CHOICE OF DENTIST**

3 The following amendment to Resolution 14 (Worksheet:5046) was submitted by the Third Trustee District
 4 and transmitted on September 24, 2021, by Mr. Ward Blackwell, executive director, Pennsylvania Dental
 5 Association.

6 **Background:** The Third District supports the objectives of Resolution 14. That said, some of the
 7 language in the original resolution could have connotations or consequences that diminish the potency of
 8 the policy statement. Specifically, “coercion” is a term that seems ill-defined with the potential to be easily
 9 distorted. Does an impediment to freedom of choice have to be “coercive” to be problematic? Is not what
 10 the ADA stands against clearly indicated in the second resolving clause? In our collective opinion, stating
 11 that freedom of choice must be preserved in the first resolving clause, along with the verbiage in the
 12 second resolving clause, is more than sufficient to define the principle on which the profession should
 13 stand, and use of the term “coercion” adds little but potential for misinterpretation.

14 Also, to state that freedom to choose a dentist “to deliver his or her oral health care” also adds
 15 superfluous language. Removing those words do not change the meaning of the statement. However,
 16 their removal does make the policy gender neutral and better-aligned with the ADA’s intentions regarding
 17 diversity and inclusion.

18 Accordingly, the Third District proposes the following amendment for Resolution 14 (deletions are
 19 ~~stricken~~):

20 **Resolution**

21
 22 **14S-1. Resolved**, that the following policy titled **Guaranteeing Patient’s Freedom of Choice of Dentist**
 23 be adopted:

24 **Guaranteeing Patient’s Freedom of Choice of Dentist**

25
 26 **Resolved**, that the patient’s right to choose any licensed dentist ~~to deliver his or her oral health~~
 27 ~~care without any type of coercion~~ must be preserved, and be it further

28
 29 **Resolved**, that the American Dental Association opposes any arrangement that eliminates,
 30 Interferes with, or otherwise limits the patient’s freedom of choice, and be it further

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Resolved, that the policy titled Legislation to Guarantee Patient's Freedom of Choice of Dentist
(*Trans.*1995:631) be rescinded.

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

1 **Resolution**
2 **15. Resolved**, that the following policy titled Discrimination of Benefit Payment Based on Professional
3 Degree of Provider be adopted:

4 **Discrimination of Benefit Payment Based on Professional Degree of Provider**

5 **Resolved**, that that the American Dental Association opposes discrimination of benefit payment
6 based on the type of license and/or professional degree of the dentist and/or physician, and be it
7 further

8 **Resolved**, that the policy titled Legislation Prohibiting Discrimination of Benefit Payment Based
9 on Professional Degree of Provider (*Trans.*1989:562) be rescinded.

10 **BOARD RECOMMENDATION: Vote Yes.**

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

WORKSHEET ADDENDUM

**2020 RESOLUTION 57—COUNCIL ON GOVERNMENT AFFAIRS—PROPOSED POLICY,
DISCRIMINATION OF BENEFIT PAYMENT BASED ON PROFESSIONAL DEGREE OF PROVIDER**

57. Resolved, that the following policy titled Discrimination of Benefit Payment Based on Professional Degree of Provider be adopted:

Discrimination of Benefit Payment Based on Professional Degree of Provider

Resolved, that that the American Dental Association opposes discrimination of benefit payment based on the type of license and/or professional degree of the dentist and/or physician, and be it further

Resolved, that the policy titled Legislation Prohibiting Discrimination of Benefit Payment Based on Professional Degree of Provider (*Trans.*1989:562) be rescinded.

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**WORKSHEET ADDENDUM
COUNCIL ON GOVERNMENT AFFAIRS
ADA POLICY TO BE RESCINDED**

4 **Legislation Prohibiting Discrimination of Benefit Payment Based on Professional Degree of**
5 **Provider (*Trans.1989:562*)**

6 **Resolved**, that appropriate agencies of the American Dental Association prepare model legislation and,
7 upon request, actively assist constituent dental societies in the pursuit of any legislative and
8 administrative initiatives that may be needed to ensure that all states prohibit discrimination of benefit
9 payment based on the type of license and/or professional degree of the dentist and/or physician.

Resolution No. 16 New

Report: N/A Date Submitted: June 2021

Submitted By: Council on Government Affairs

Reference Committee: D (Legislative, Health, Governance 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: Not Applicable

1 **AMENDMENT OF THE POLICY, FREEDOM OF CHOICE IN PUBLICLY FUNDED AID PROGRAMS**

2 **Background:** In accordance with Resolution 97H-2020, Special Order of Referral Consent Calendar,
3 which directed the appropriate ADA agencies to report back to the 2021 House of Delegates on each
4 Referred Resolution, Resolution 54-2020, Amendment of the Policy, Freedom of Choice in Publicly
5 Funded Aid Programs, was referred to the Council.

6 After consideration, the Council respectfully re-offers its recommendation to amend the policy titled
7 Freedom of Choice in Publicly Funded Aid Programs (*Trans.2006:344*). Resolution 54-2020 is appended
8 to this report.

9 In accordance with Resolution 170H-2012 (*Trans.2012:370*), Regular Comprehensive Policy Review, the
10 Council on Government Affairs reviewed the Association policy titled Freedom of Choice in Publicly
11 Funded Aid Programs (*Trans.2006:344*), to determine its adequacy (or obsolescence) in modern times,
12 and the merits of any revisions.

13 The Council determined that the policy was worded as time-limited directive that effectively became moot
14 once the task to “pursue regulatory or legislative action” was completed (*Supplement 2007:6031*). The
15 Council also considered the subject matter relevant enough to retain in a more enduring form.

16 After consulting the Council on Dental Benefit Programs, the Council on Government Affairs recommends
17 that the following resolution be adopted.

18 **Resolution**

19 **16. Resolved**, that the policy titled Freedom of Choice in Publicly Funded Aid Programs
20 (*Trans.2006:344*) be amended to read as follows (additions are underscored; deletions are ~~stricken~~):

21 **Resolved**, that ~~the ADA pursue regulatory or legislative action to mandate that~~ any licensed
22 dentist ~~may~~ should be able to participate in a publicly funded program without joining a third-party
23 network that requires them to also see privately funded commercial patients under a managed
24 care contract.

25 **BOARD RECOMMENDATION: Vote Yes.**

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

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WORKSHEET ADDENDUM
2020 RESOLUTION 54—COUNCIL ON GOVERNMENT AFFAIRS—AMENDMENT OF THE POLICY,
FREEDOM OF CHOICE IN PUBLICLY FUNDED AID PROGRAMS

54. Resolved, that the policy titled Freedom of Choice in Publicly Funded Aid Programs
(*Trans.*2006:344) be amended to read as follows (additions are underscored; deletions are ~~stricken~~):

Resolved, that ~~the ADA pursue regulatory or legislative action to mandate that~~ any licensed
dentist ~~may~~ should be able to participate in a publicly funded program without joining a third-party
network that requires them to also see privately funded commercial patients under a managed
care contract.

Resolution No. 17 New
 Report: N/A Date Submitted: June 2021
 Submitted By: Council on Government Affairs
 Reference Committee: D (Legislative, Health, Governance 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: Not Applicable

1 **AMENDMENT OF THE POLICY, LIMITED ENGLISH PROFICIENCY**

2 **Background:** In accordance with Resolution 97H-2020, Special Order of Referral Consent Calendar,
 3 which directed the appropriate ADA agencies to report back to the 2021 House of Delegates on each
 4 Referred Resolution, Resolution 56-2020, Amendment of the Policy, Limited English Proficiency, was
 5 referred to the Council.

6 After consideration, the Council respectfully re-offers its recommendation to amend the policy titled
 7 Limited English Proficiency (*Trans.2005:338*). Resolution 56-2020 is appended to this report.

8 In accordance with Resolution 170H-2012 (*Trans.2012:370*), Regular Comprehensive Policy Review, the
 9 Council on Government Affairs reviewed the Association policy titled Limited English Proficiency
 10 (*Trans.2005:338*), to determine its adequacy (or obsolescence) in modern times, and the merits of any
 11 revisions.

12 The Council found that portions of the policy are worded as time-limited assignments were fulfilled once
 13 the tasks to “work with the appropriate federal agencies,” “support appropriate legislation,” and
 14 “[encourage] constituent and component dental societies” were complete (*Reports 2006:89*). The Council
 15 also observed that the intent of the policy on Limited English Proficiency was to address proposals dating
 16 back to when President Clinton was in office.

17 Although the basis for the policy is nearly 20 years old, the Council determined that Sec. 1557 of the
 18 Affordable Care Act also contains certain nondiscrimination provisions that warrant having such a policy
 19 in a more enduring form.

20 After consulting the Council on Advocacy for Access and Prevention and the Council on Dental Practice,
 21 the Council on Government Affairs recommends that the following resolution be adopted.

22 **Resolution**

23 **17. Resolved**, that the policy titled Limited English Proficiency (*Trans.2005:338*) be amended to read
 24 as follows (additions are underscored; deletions are ~~stricken~~):

25 **Resolved**, that the American Dental Association ~~work with the appropriate federal agencies,~~
 26 ~~advocacy groups, trade associations, and other stakeholders to ensure~~
 27 ~~that~~ considers ~~accommodating the language needs of English-limited patients is recognized as to~~

1 be a shared responsibility, which cannot be fairly visited upon any one segment of a community,
2 and be it further

3 ~~**Resolved**, that the Association support appropriate legislation and initiatives that would enhance~~
4 ~~the ability of individuals of limited English proficiency to effectively communicate in English with~~
5 ~~their dentist and the dental office staff, and be it further~~

6 ~~**Resolved**, that the Association oppose federal legislative and regulatory ADA opposes efforts~~
7 ~~that would unreasonably add to the administrative, financial, or legal liability of providing dental~~
8 ~~services to limited English proficient patients, such as being required to provide interpreters on~~
9 ~~demand as a condition of treating patients receiving state and/or federal benefits, and be it further~~

10 ~~**Resolved**, that constituent and component dental societies be encouraged to support state, local,~~
11 ~~and private sector efforts to address the language needs of English-limited patients, and be it~~
12 ~~further~~

13 ~~**Resolved**, that dental and allied dental programs be encouraged to educate students about the~~
14 ~~challenges associated with treating patients of limited English proficiency.~~

15 **BOARD RECOMMENDATION: Vote Yes.**

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

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WORKSHEET ADDENDUM
2020 RESOLUTION 56—COUNCIL ON GOVERNMENT AFFAIRS—AMENDMENT OF THE POLICY,
LIMITED ENGLISH PROFICIENCY

56. Resolved, that the policy titled Limited English Proficiency (*Trans.2005:338*) be amended to read as follows (additions are underscored; deletions are ~~stricken~~):

Resolved, that the American Dental Association ~~work with the appropriate federal agencies, advocacy groups, trade associations, and other stakeholders to ensure~~ that considers accommodating the language needs of English-limited patients ~~is recognized as to~~ be a shared responsibility, which cannot be fairly visited upon any one segment of a community, and be it further

~~**Resolved**, that the Association support appropriate legislation and initiatives that would enhance the ability of individuals of limited English proficiency to effectively communicate in English with their dentist and the dental office staff, and be it further~~

~~**Resolved**, that the Association oppose federal legislative and regulatory~~ ADA opposes efforts that would unreasonably add to the administrative, financial, or legal liability of providing dental services to limited English proficient patients, such as being required to provide interpreters on demand as a condition of treating patients receiving state and/or federal benefits, ~~and be it further~~

~~**Resolved**, that constituent and component dental societies be encouraged to support state, local, and private sector efforts to address the language needs of English-limited patients, and be it further~~

~~**Resolved**, that dental and allied dental programs be encouraged to educate students about the challenges associated with treating patients of limited English proficiency.~~

Resolution No. 18 New
 Report: N/A Date Submitted: June 2021
 Submitted By: Council on Government Affairs
 Reference Committee: D (Legislative, Health, Governance 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: Not Applicable

1 **AMENDMENT OF THE POLICY, PROTECTION OF RETIREMENT ASSETS**

2 **Background:** In accordance with Resolution 97H-2020, Special Order of Referral Consent Calendar,
 3 which directed the appropriate ADA agencies to report back to the 2021 House of Delegates on each
 4 Referred Resolution, Resolution 28-2020, Amendment of the Policy, Protection of Retirement Assets, was
 5 referred to the Council.

6 After consideration, the Council respectfully re-offers its recommendation to amend the policy titled
 7 Protection of Retirement Assets (*Trans.*1987:521). Resolution 28-2020 is appended to this report.

8 In accordance with Resolution 170H-2012 (*Trans.*2012:370), Regular Comprehensive Policy Review, the
 9 Council on Government Affairs reviewed the Association policy titled Protection of Retirement Assets
 10 (*Trans.*1987:521), to determine its adequacy (or obsolescence) in modern times, and the merits of any
 11 revisions.

12 The Council determined that the policy is worded as a time-limited assignment that effectively became
 13 moot once the task to “strongly support efforts by the constituent society at the state legislature level” was
 14 complete (*Reports* 1988:143). The Council also found that the 30 year-old policy is woefully outdated,
 15 particularly given that some of the retirement accounts now go by different names (e.g., Keogh plan vs.
 16 “qualified plan”) or hardly exist (e.g., corporate pensions).

17 It is unclear why the policy contains the term “nondomestic judgment.” The impetus for the policy was a
 18 New York law “to protect retirement plan assets from creditors” (*Supplement* 1987:355). The Eighth
 19 District asserted that the New York law did not protect Individual Retirement Accounts (IRAs), leading to a
 20 House assignment to urge state dental societies to advocate for IRAs to be included in similar state laws.

21 After consulting the Council on Dental Practice, the Council on Government Affairs recommends that the
 22 following policy be adopted:

23 **Resolution**

24 **18. Resolved**, that the policy titled Protection of Retirement Assets (*Trans.*1987:521) be amended as
 25 follows (additions are underscored; deletions are ~~stricken~~):

26 **Resolved**, that ~~the ADA strongly support efforts by the constituent society at the state legislature~~
 27 ~~level to enact laws which exempt IRS qualified Keogh, Corporate Pension or Profit Sharing Plans,~~

1 ~~and Individual Retirement Accounts from attachment to satisfy any nondomestic~~
2 ~~judgment retirement savings accounts should be exempt from nondomestic judgments.~~

3 **BOARD RECOMMENDATION: Vote Yes.**

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

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WORKSHEET ADDENDUM
2020 RESOLUTION 28—COUNCIL ON GOVERNMENT AFFAIRS—AMENDMENT OF THE POLICY,
PROTECTION OF RETIREMENT ASSETS

28. Resolved, that the policy titled Protection of Retirement Assets (*Trans.1987:521*) be amended as follows (additions are underscored; deletions are ~~stricken~~):

Resolved, that ~~the ADA strongly support efforts by the constituent society at the state legislature level to enact laws which exempt IRS qualified Keogh, Corporate Pension or Profit Sharing Plans, and Individual Retirement Accounts from attachment to satisfy any nondomestic judgment~~ retirement savings accounts should be exempt from nondomestic judgments.

Resolution No. 19 New

Report: N/A Date Submitted: June 2021

Submitted By: Council on Government Affairs

Reference Committee: D (Legislative, Health, Governance 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: Not Applicable

1 **AMENDMENT OF THE POLICY, SUGGESTED DENTAL PRACTICE ACTS**

2 **Background:** In accordance with Resolution 97H-2020, Special Order of Referral Consent Calendar,
3 which directed the appropriate ADA agencies to report back to the 2021 House of Delegates on each
4 Referred Resolution, Resolution 5-2020, Amendment of the Policy, Suggested Dental Practice Acts, was
5 referred to the Council.

6 After consideration, the Council respectfully re-offers its recommendation to amend the policy titled
7 Suggested Dental Practice Acts (*Trans.1978:529*). Resolution 5-2020 is appended to this report.

8 In accordance with Resolution 170H-2012 (*Trans.2012:370*), Regular Comprehensive Policy Review, the
9 Council on Government Affairs reviewed the Association policy titled Suggested Dental Practice Acts
10 (*Trans.1978:529*), to determine its adequacy (or obsolescence) in modern times, and the merits of any
11 revisions.

12 The Council observed that the policy was worded as a time-limited directive that became moot once the
13 tasks to “support” only those dental practice acts that were consistent with Association policies and
14 “provide” analysis were completed (*Reports 1979:149*).

15 The Council noted that the assignment was made in response to a specific Council of State Governments
16 study of state dental practice acts and corresponding model legislation, both of which are now 40 years-
17 old. The Council also questioned how the ADA would practically “support” any suggested dental practice
18 acts, since the national organization has no real authority to interfere with the policies, positions, priorities,
19 and activities of state dental societies.

20 The Council believes that the policy on Suggested Dental Practice Acts can be amended to reflect the
21 ADA’s desire to see that state dental practice acts are generally consistent with ADA policy, while also
22 acknowledging that state laws vary and the national organization has no real power to interfere with the
23 positions or actions of state dental societies.

24 The Council on Government Affairs recommends that the following resolution be adopted:

25 **Resolution**

26 **19. Resolved,** that the policy titled Suggested Dental Practice Acts (*Trans.1978:529*) be amended as
27 follows (additions are underscored; deletions are ~~stricken~~):

1 ~~Resolved, that the ADA supports only those suggested dental practice acts that are consistent~~
2 ~~with Association policies, and be it further~~

3 ~~Resolved, that the appropriate agency of the Association provide a timely, ongoing analysis to~~
4 ~~constituent societies of any suggested state dental laws that are developed by any agency~~
5 ~~outside the Association, with particular references as to how such proposed dental practice acts~~
6 ~~may be in conflict with Association policies state dental practice acts should be consistent with~~
7 ~~American Dental Association policies, as appropriate and feasible.~~

8 **BOARD RECOMMENDATION: Vote Yes.**

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

WORKSHEET ADDENDUM

2020 RESOLUTION 5—COUNCIL ON GOVERNMENT AFFAIRS—AMENDMENT OF THE POLICY,
SUGGESTED DENTAL PRACTICE ACTS

5. Resolved, that the policy titled that the policy titled Suggested Dental Practice Acts
(Trans.1978:529) be amended as follows (additions are underscored; deletions are ~~stricken~~):

~~Resolved, that the ADA supports only those suggested dental practice acts that are consistent
with Association policies, and be it further~~

~~Resolved, that the appropriate agency of the Association provide a timely, ongoing analysis to
constituent societies of any suggested state dental laws that are developed by any agency
outside the Association, with particular references as to how such proposed dental practice acts
may be in conflict with Association policies~~ state dental practice acts should be consistent with
American Dental Association policies, as appropriate and feasible.

Resolution No. 20 New
 Report: N/A Date Submitted: June 2021
 Submitted By: Council on Government Affairs
 Reference Committee: D (Legislative, Health, Governance 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: Not Applicable

- 1 **RESCISSION OF THE POLICY, STATE REGULATION OF ADVERTISING**
- 2 **Background:** In accordance with Resolution 97H-2020, Special Order of Referral Consent Calendar,
- 3 which directed the appropriate ADA agencies to report back to the 2021 House of Delegates on each
- 4 Referred Resolution, Resolution 6-2020, Rescission of the Policy, State Regulation of Advertising, was
- 5 referred to the Council.
- 6 After consideration, the Council respectfully re-offers its recommendation to rescind the policy titled State
- 7 Regulation of Advertising (*Trans.*1984:549). Resolution 6-2020 is appended to this report.
- 8 In accordance with Resolution 170H-2012 (*Trans.*2012:370), Regular Comprehensive Policy Review, the
- 9 Council on Government Affairs reviewed the Association policy titled State Regulation of Advertising
- 10 (*Trans.*1984:549), to determine its adequacy (or obsolescence) in modern times, and the merits of any
- 11 revisions.
- 12 The Council determined that the current policy on State Regulation of Advertising was a time-limited
- 13 directive that became moot once the task to “urge [constituent societies] to consider state legislation” was
- 14 completed (*Reports* 1985:137). The Council also noted that the national organization has no real
- 15 authority to interfere with the policies, positions, priorities, and activities of state dental societies.
- 16 In the context of relevance, the Council observed that many state advertising statutes and regulations
- 17 have been updated in the 25 years since the policy was adopted. In some instances, the states have
- 18 adopted a general rule prohibiting false or misleading advertising and have judged each case on its own
- 19 merits. In other states, the legislature or state dental board has endeavored to develop more detailed
- 20 statutes or regulations.
- 21 The Council concluded that there was no added value in maintaining an already completed directive
- 22 addressing an issue that seems to no longer exist.
- 23 The Council on Government Affairs recommends that the following resolution be adopted:
- 24 **Resolution**
- 25 **20. Resolved**, that the policy titled State Regulation of Advertising (*Trans.*1984:549) be rescinded.
- 26 **BOARD RECOMMENDATION: Vote Yes.**

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

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WORKSHEET ADDENDUM
2020 RESOLUTION 6—COUNCIL ON GOVERNMENT AFFAIRS—RESCISSION OF THE POLICY,
STATE REGULATION OF ADVERTISING

6. Resolved, that the policy titled State Regulation of Advertising (*Trans.*1984:549) be rescinded.

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**WORKSHEET ADDENDUM
COUNCIL ON GOVERNMENT AFFAIRS
ADA POLICY TO BE RESCINDED**

4 **State Regulation of Advertising (*Trans.1984:549*)**

5 **Resolved**, that constituent dental societies be urged to consider state legislation, consistent with the
6 recognized rights of commercial speech, that will authorize the appropriate agencies of state government
7 to regulate dentist advertising in the public interest to ensure the dissemination of complete and accurate
8 information through appropriate means of communications including time, manner and place.

Resolution No. 21 New
 Report: N/A Date Submitted: June 2021
 Submitted By: Council on Government Affairs
 Reference Committee: D (Legislative, Health, Governance 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: Not Applicable

1 **RESCISSION OF THE POLICY, ADA ASSISTANCE IN LEGISLATIVE INITIATIVES**

2 **Background:** In accordance with Resolution 97H-2020, Special Order of Referral Consent Calendar,
 3 which directed the appropriate ADA agencies to report back to the 2021 House of Delegates on each
 4 Referred Resolution, Resolution 60-2020, Rescission of the Policy, ADA Assistance in Legislative
 5 Initiatives, was referred to the Council.

6 After consideration, the Council respectfully re-offers its recommendation to rescind the policy titled ADA
 7 Assistance in Legislative Initiatives (*Trans.*1982:513). Resolution 60-2020 is appended to this report.

8 In accordance with Resolution 170H-2012 (*Trans.*2012:370), Regular Comprehensive Policy Review, the
 9 Council on Government Affairs reviewed the Association policy titled ADA Assistance in Legislative
 10 Initiatives (*Trans.*1982:513), to determine its adequacy (or obsolescence) in modern times, and the merits
 11 of any revisions.

12 The Council found that the title of the policy to be misleading. “ADA Assistance in Legislative Initiatives”
 13 suggests that the policy is about the foundational authority for the national organization to help constituent
 14 societies address legislative issues. However, the policy is not about the national organization’s authority
 15 to provide technical assistance, but the manner in which that assistance is provided—with an emphasis
 16 on constituent control over media and messaging.

17 The Council appreciated the desire not to undermine constituent lobbying on sensitive state issues.
 18 However, the Council questioned whether the national organization’s reputation and lobbying efforts
 19 could also be compromised should a national media outlet ask a constituent society to comment on a
 20 sensitive national issue without input from the national organization.

21 Additionally, the Council on Communications (CC) agreed that the policy should be rescinded. The CC
 22 determined that the 28 year-old policy is outdated and addresses association operations (rather than
 23 policy). The CC noted that the successful media messaging in the State Public Affairs program is a prime
 24 example of why the policy is no longer needed.

25 The Council notes that the basis for offering technical assistance to constituent societies is codified in
 26 Chapter VIII, Section K.7.d. of the *ADA Governance and Organizational Manual*, which states that one of
 27 the Council’s core responsibilities is to “disseminate information which will assist the constituents and
 28 components involving legislation and regulation affecting the dental health of the public.”

1 After consulting the Council on Communications, the Council on Government Affairs recommends that
2 the following resolution be adopted:

3 **Resolution**

4 **21. Resolved**, that the policy titled ADA Assistance in Legislative Initiatives (*Trans.1982:513*) be
5 rescinded.

6 **BOARD RECOMMENDATION: Vote Yes.**

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

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WORKSHEET ADDENDUM
2020 RESOLUTION 60—COUNCIL ON GOVERNMENT AFFAIRS—RESCISSION OF THE POLICY,
ADA ASSISTANCE IN LEGISLATIVE INITIATIVES

60. Resolved, that the policy titled ADA Assistance in Legislative Initiatives (*Trans.*1982:513) be rescinded.

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**WORKSHEET ADDENDUM
COUNCIL ON GOVERNMENT AFFAIRS
ADA POLICY TO BE RESCINDED**

ADA Assistance in Legislative Initiatives (*Trans.1982:513*)

Resolved, that when a state dental association notifies the American Dental Association that it is involved in the signature gathering phase of an initiative petition which would adversely affect dentistry in that state, then the American Dental Association shall assist the state dental association in developing strategy for media releases, and be it further

Resolved, that all media responses during the signature gathering phase be released through the state dental association.

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

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WORKSHEET ADDENDUM
2020 RESOLUTION 3—COUNCIL ON GOVERNMENT AFFAIRS—RESCISSION OF THE POLICY,
DENTAL FOCUS IN FEDERAL HEALTH AGENCIES

3. Resolved, that the policy titled Dental Focus in Federal Health Agencies (*Trans.2012:497*) be rescinded.

**WORKSHEET ADDENDUM
COUNCIL ON GOVERNMENT AFFAIRS
ADA POLICY TO BE RESCINDED**

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Dental Focus in Federal Health Agencies (*Trans.2012:497*)

Resolved, that the American Dental Association seek to establish within the Department of Health and Human Services a policy level office for dental activities with appropriate status and funding administered by dentists and in close liaison with organized dentistry, and be it further

Resolved, that the ADA seek to protect and enhance the status and funding of federal dental agencies, the integrity of federal dental programs and the roles and duties of federal dental officers, and be it further

Resolved, that the ADA seek to ensure that the views of organized dentistry are appropriately reflected in the work of federal advisory committees.

Resolution No. 23 New

Report: N/A Date Submitted: June 2021

Submitted By: Council on Government Affairs

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

1 **AMENDMENT OF THE POLICY, CONFIDENTIALITY AND PRIVACY REGARDING HEALTH**
2 **INFORMATION**

3 **Background:** In accordance with the policy titled Regular Comprehensive Policy Review
4 (*Trans*.2012:370), the Council on Government Affairs reviewed the Association policy titled Confidentiality
5 and Privacy Regarding Health Information (*Trans*.1999:951; 2000:507).

6 The policy was originally proposed by the Council on Government Affairs (*Reports* 1999:116) and
7 adopted by the 1999 House of Delegates (*Trans*.1999:951). The intent was to guide the Association’s
8 positions on HIPAA-related health information privacy and confidentiality legislation and regulations,
9 which were expected in the 106th Congress (1999-2000). The policy was amended in 2000 to address
10 minimum safeguards for health information clearinghouses to transmit individually identifiable health
11 information online (*Supplement* 2000:6029).

12 The Council agreed that a policy is still needed to guide the ADA’s position(s) on periodic adjustments to
13 the HIPAA privacy, security, and administrative simplification rules. However, the Council questioned
14 whether modern times warrant the same level of action called for in the policy, as reflected in the last two
15 resolving clauses.

16 The Council observed that the policy was adopted at a time when these sweeping HIPAA rules were still
17 being developed. Members were understandably anxious about the compliance costs, regulatory
18 burdens, and enforcement deadlines, which were still unknown. This sense of urgency is reflected in the
19 last two resolving clauses, which are worded as time-limited assignments instead of statements of
20 philosophy or position.

21 The HIPAA-related privacy, security, and administrative simplification rules were finalized in the early
22 2000s. Compliance is now a standard part of dental practice. The ADA routinely monitors federal agency
23 activity and comments on proposed amendments when necessary. However, the updates have not been
24 of the same magnitude—and have not generated the same level of angst—as the original rules. This is
25 typical of most regulations.

26 The Council determined that the existing policy is appropriate and sufficient for the Association’s
27 advocacy efforts. However, there is no added value in retaining the last two resolving clauses, which are
28 outdated directives to complete specific, time-limited tasks.

1 After consulting the Council on Dental Practice, the Council on Government Affairs recommends that the
2 following resolution be adopted:

3 **Resolution**

4 **23. Resolved**, that the policy titled Confidentiality and Privacy Regarding Health Information
5 (*Trans.*1999:951; 2000:507) be amended to read as follows (additions are underscored; deletions
6 are ~~stricken~~):

7 **Resolved**, that the following be adopted as the American Dental Association's policy on health
8 information confidentiality and privacy.

9 **Legislation**

- 10
- 11 • The Association supports legislative and regulatory actions that protect the confidentiality
12 and privacy of patient health information.
 - 13 • In particular, the Association believes minimum safeguards are needed to protect
14 patients against wrongful disclosure and/or use of patient identifiable information, and to
15 protect their providers as a result of wrongful disclosure or use by third parties who are
properly given access to that information.

16 **Limits on disclosure and use of patient-identifiable information**

- 17
- 18 • Generally, the disclosure and/or use of patient-identifiable information by health care
19 providers should be limited to that which is necessary for the proper care of the patient,
or authorized by the patient and/or other applicable law.
 - 20 • Use of patient-identifiable health information by an entity that receives that information
21 from a patient's health care provider should be limited to that necessary for the proper
22 care of the patient, except for research purposes as identified herein.
 - 23 • Subsequent holders of patient information should be prohibited from changing health
24 information or conclusions submitted by the patient's health care provider.

25 **Patients' rights**

- 26
- 27 • Patients should have the right to know who has access to their personally identifiable
health information and how that information has been used.
 - 28 • A patient's general consent to the release of confidential health information to a third
29 party, such as a health plan, should not be legally sufficient to permit subsequent release
30 by that third party of the information.
 - 31 • With appropriate limitations designed to protect the integrity of the attending doctor's
32 records and to ensure against unauthorized disclosure or unduly burdensome requests,
33 patients should be afforded the opportunity to see their treatment records and obtain
34 copies.

35 **Unauthorized disclosure of patient-identifiable health information**

- 36
- 37 • Patients should have a fair opportunity to seek legal redress if their personally identifiable
health information has been willfully and wrongly released.
 - 38 • No liability should arise against a provider who, in good faith and for the purpose of
39 providing appropriate health care, unintentionally releases confidential health information
40 in a manner not permitted by law.
 - 41 • A health care provider who has properly disclosed patient-identifiable health information
42 to a third party should be immune from liability for subsequent disclosure or misuse of
43 that information by that third party.

1 **Use of health information for research**

- 2 • Generally, all identifying information should be removed when health records are used for
- 3 research purposes. Identifiable data should be released only after approval of an
- 4 Institution Review Board, pursuant to applicable review procedures and protocols.
- 5 • Legislative exemptions to patient consent requirements for research purposes should be
- 6 narrowly drawn.

7 **Use of health information by law enforcement**

- 8 • Except as otherwise provided by applicable laws, law enforcement officials should be
- 9 required to obtain a binding court order, warrant or subpoena before having access to
- 10 patient records.

11 **Practice considerations**

- 12 • Dentists should know their ethical and legal obligations regarding patient confidentiality
- 13 and privacy.
- 14 • Dentists should engage in sound risk management techniques to ensure compliance,
- 15 including office protocols, record maintenance and training to protect such information.

16 ~~and be it further~~

17 ~~**Resolved**, that the Association track and advocate privacy laws governing the Internet in their~~

18 ~~applicability to the privacy of patient records, and be it further~~

19 ~~**Resolved**, that the Association advocate in its legislative and regulatory efforts that all points of~~

20 ~~potential interception, sale or unauthorized electronic transmission from doctor to third party be~~

21 ~~included in consideration of electronic privacy laws.~~

22 **BOARD RECOMMENDATION: Vote Yes.**

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

24 **BOARD DISCUSSION)**

Resolution No. 24 New

Report: N/A Date Submitted: June 2021

Submitted By: Council on Government Affairs

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

1 AMENDMENT OF THE POLICY, NEED FOR HIPAA STANDARDS REFORM

2 **Background:** In accordance with the policy titled Regular Comprehensive Policy Review
3 (*Trans.*2012:370), the Council on Government Affairs reviewed the Association policy titled Need for
4 HIPAA Standards Reform (*Trans.*2003:384; 2016:317).

5 The policy was proposed by the American Association of Oral and Maxillofacial Surgeons, via a Florida
6 delegate (*Supplement* 2003:6034), and adopted by the 2003 House of Delegates (*Trans.*2003:384). The
7 intent was to guide the Association’s positions on HIPAA compliance, with an emphasis on delaying
8 enforcement of the privacy standards, narrowing the scope of how penalties would be applied, and
9 providing a reasonable transition to the new electronic claims submission standards.

10 The 2016 House removed three of the original resolving clauses (*Trans.*2016:309), which were deemed
11 inaccurate and outdated (*Supplement* 2016:5050).

12 The Council agreed that a policy is still needed to guide the ADA’s position(s) on periodic adjustments to
13 the HIPAA privacy, security, and administrative simplification and electronic claim standards. However,
14 the Council questioned whether modern times warrant the same level of action called for in the policy.

15 The HIPAA-related privacy, security, and administrative simplification and electronic claim standards were
16 finalized in the early 2000s. Compliance is now a standard part of dental practice. The ADA routinely
17 monitors federal agency activity, and comments on proposed rule and standard changes whenever
18 necessary. However, the HIPAA rule updates have not been of the same magnitude—and have not
19 generated the same level of angst—as the original rules. This is typical of most regulations.

20 The Council noted that the policy was adopted at a time when these sweeping rules were still being
21 developed. Members were understandably anxious about the compliance costs, regulatory burdens, and
22 enforcement deadlines, which were still unknown. This sense of urgency is reflected in the third resolving
23 clause and perhaps others, which are worded as time-limited assignments instead of statements of
24 philosophy, principle, or position. Most (if not all) of those concerns have been resolved in the 17 years
25 since the policy was adopted.

26 After consulting the Council on Dental Practice, the Council on Government Affairs recommends that the
27 following resolution be adopted:

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Resolution

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24. Resolved, that the policy titled Need for HIPAA Standards Reform (*Trans.*2003:384; 2016:317) be amended to read as follows (additions are underscored; deletions are ~~stricken~~):

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Resolved, that the appropriate agencies of the American Dental Association work with the dental specialty organizations and other health care associations to continue to make every effort to limit the adverse effects of the HIPAA regulations for dentists and their patients, and be it further

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Resolved, that the appropriate Association agency seek the establishment of reasonable transition periods between proposed new versions of the electronic dental claim standard so as to reduce the substantial financial burden placed on small providers, such as dentists, to implement new electronic claims standards, ~~and be it further~~

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~~**Resolved**, that the appropriate Association agency encourage educational efforts by HHS to clarify the HIPAA regulations and counter the misrepresentations and misunderstandings that interfere with the doctor-patient relationship and are impeding the effective delivery of quality health care.~~

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BOARD RECOMMENDATION: Vote Yes.

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

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Resolution No. 25 New

Report: N/A Date Submitted: June 2021

Submitted By: Council on Government Affairs

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

1 **RESCISSION OF THE POLICY, LEGISLATION PROHIBITING WAIVER OF PATIENT**
2 **COPAYMENT/OVERBILLING**

3 **Background:** In accordance with Resolution 170H-2012 (*Trans.*2012:370), Regular Comprehensive
4 Policy Review, the Council on Government Affairs reviewed the policy titled Legislation Prohibiting Waiver
5 of Patient Copayment/Overbilling (*Trans.*1990:534), to determine its adequacy (or obsolescence) in
6 modern times, and the merits of any revisions.

7 The policy was originally proposed by the Council on Dental Care Programs (*Reports* 1990:53) and
8 adopted by the 1990 House of Delegates. The intent was to address the insurance industry’s aggressive
9 pursuit of fraudulent activity in health benefits plans, namely the practice of waiving patient copayments
10 without disclosing such to the payer.

11 The Council first questioned whether the policy is needed. It was the Council’s sense was that most
12 states have addressed this issue in the 30 years since the policy was adopted. The issue is also
13 addressed in Section 5.B.1 of the ADA *Principles of Ethics and Code of Professional Conduct* (rev.
14 November 2020).

15 *A dentist who accepts a third party payment under a copayment plan as payment in full without*
16 *disclosing to the third party that the patient’s payment portion will not be collected, is engaged in*
17 *overbilling. The essence of this ethical impropriety is deception and misrepresentation; an overbilling*
18 *dentist makes it appear to the third party that the charge to the patient for services rendered is higher*
19 *than it actually is.*

20 Second, the Council observed that the Association seems to have done its diligence in encouraging
21 dental societies to pursue state legislation prohibiting routine copayment waivers and requiring payers to
22 be notified when copayments are waived. The policy was incorporated into the Council on Dental Benefit
23 Programs’ Policies on Dental Care Programs. The Association also shared its policy and concerns with
24 third-party payer organizations (*Reports* 1991:70).

25 After consulting the Council on Dental Benefit Programs and the Council on Dental Practice, the Council
26 on Government Affairs recommends that the following resolution be adopted:

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Resolution

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25. Resolved, that the policy titled Legislation Prohibiting Waiver of Patient Copayment/Overbilling
(*Trans.*1990:534) be rescinded.

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BOARD RECOMMENDATION: Vote Yes.

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

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**WORKSHEET ADDENDUM
COUNCIL ON GOVERNMENT AFFAIRS
ADA POLICY TO BE RESCINDED**

Legislation Prohibiting Waiver of Patient Copayment/Overbilling (*Trans.1990:534*)

Resolved, that constituent dental societies be urged to pursue enactment of legislation that: (1) prohibits systematic nondisclosure of waiver of patient copayment/overbilling by a dentist and (2) prohibits bad faith insurance practices by third-party payers, consistent with Association policy, and be it further

Resolved, that third-party payers be urged to support this legislative objective.

Resolution No. 26 New
 Report: N/A Date Submitted: June 2021
 Submitted By: Council on Government Affairs
 Reference Committee: D (Legislative, Health, Governance and Related 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

1 **RESCISSION OF THE POLICY, LEGISLATION REFLECTING ADA POLICY ON PRIMARY DENTAL**
 2 **HEALTH CARE PROVIDER**

3 **Background:** In accordance with the policy titled Regular Comprehensive Policy Review
 4 (*Trans.*2012:370), the Council on Government Affairs reviewed the Association policy titled Legislation
 5 Reflecting ADA Policy on Primary Dental Health Care Provider (*Trans.*1981:564; 1990:559).

6 The policy was proposed by the Council on Dental Health and Health Planning and adopted by the 1981
 7 House of Delegates (*Trans.*1981:564). The intent was to address questions about what constitutes
 8 primary dental care and who provides that care (*Reports* 1981:80).

9 The House amended the policy in 1990 (*Trans.*1990:559) to address concerns about the potential for
 10 third-party payers to downgrade fee schedules should dental hygienists be recognized as the “primary
 11 dental care provider” in state dental practice acts (*Reports* 1990:423).

12 The Council first questioned whether the concerns expressed in 1981 and 1990 are now outdated. It was
 13 the Council’s sense that most states have addressed this issue in the 30 years since the policy was last
 14 amended.

15 Second, the Council observed that the Association seems to have done its diligence in fulfilling the
 16 specific, time-limited assignments to develop model legislation and encourage dental societies to pursue
 17 state legislation to that effect (*Reports* 1991:144).

18 After consulting the Council on Dental Benefit Programs and the Council on Dental Practice, the Council
 19 on Government Affairs recommends that the following resolution be adopted:

20 **Resolution**

21 **26. Resolved**, that the policy titled Legislation Reflecting ADA Policy on Primary Dental Health Care
 22 Provider (*Trans.*1981:564; 1990:559) be rescinded.

23 **BOARD RECOMMENDATION: Vote Yes.**

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

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**WORKSHEET ADDENDUM
COUNCIL ON GOVERNMENT AFFAIRS
ADA POLICY TO BE RESCINDED**

Legislation Reflecting ADA Policy on Primary Dental Health Care Provider (*Trans.*1981:564; 1990:559)

Resolved, that the American Dental Association urge constituent societies to reinforce the intent of the policy (*Trans.*1981:564) to reflect by legislative initiative that the dentist is the primary dental health care provider to the public, and be it further

Resolved, that the appropriate agencies of the Association develop model legislation that will assist requesting states to enact legislation which will direct third-party payers, when paying benefits for dental services to health care providers, to do so only to a licensed dentist.

Resolution No. 27 New
 Report: N/A Date Submitted: June 2021
 Submitted By: Council on Government Affairs
 Reference Committee: D (Legislative, Health, Governance 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: Not Applicable

1 **AMENDMENT TO THE POLICY, SUPPORT FOR ADULT MEDICAID DENTAL SERVICES**

2 **Background:** In accordance with Resolution 97H-2020, Special Order of Referral Consent Calendar,
3 which directed the appropriate ADA agencies to report back to the 2021 House of Delegates on each
4 Referred Resolution, Resolution 48-2020, Amendment to the Policy, Support for Adult Medicaid Dental
5 Services, was referred to the Council.

6 After consideration, the Council is proposing a modified version of the resolution that is consistent with a
7 substitute resolution offered by the Sixteenth Trustee District, 48S-1-2020, which seeks to reinforce the
8 role that oral health plays in overall health. No other changes are proposed. Resolutions 48-2020 and
9 48S-1-2020 are appended to this report.

10 In accordance with Resolution 170H-2012 (*Trans.*2012:370), Regular Comprehensive Policy Review, the
11 Council on Government Affairs reviewed the Association policy titled Support for Adult Medicaid Dental
12 Services (*Trans.*2004:327), to determine their adequacy (or obsolescence) in modern times, and the
13 merits of any revisions.

14 The Council determined that the policy was worded as time-limited assignment that effectively became
15 moot once the tasks to “adopt policy” and “educate policy makers” were completed (*Reports* 2005:94).
16 However, the Council considered the subject matter relevant enough to retain in a more enduring form.

17 After consulting the Council on Advocacy for Access and Prevention, the Council on Government Affairs
18 recommends that the following resolution be adopted.

19 **Resolution**

20 **27. Resolved**, that the policy titled Support for Adult Medicaid Dental Services (*Trans.*2004:327) be
21 amended to read as follows (additions are underscored; deletions are ~~stricken~~):

22 **Resolved**, that ~~the ADA adopt policy supporting the inclusion of adult dental services should be~~
23 included in the federal Medicaid program as an integral part of overall health, and be it further

24 **Resolved**, that ~~the ADA take every opportunity to educate policy makers that, consistent with~~
25 ADA’s position on health system reform (*Trans.*1993:664; *Trans.*1994:656) oral health is an
26 integral part of overall health, and be it further

1 **Resolved, that** adult coverage under Medicaid should not be left to the discretion of individual
2 states but rather, should be provided consistent with all other basic health care services.

3 **BOARD RECOMMENDATION: Vote Yes.**

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

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WORKSHEET ADDENDUM
2020 RESOLUTIONS
2020 RESOLUTION 48—AMENDMENT TO THE POLICY, SUPPORT FOR ADULT MEDICAID
DENTAL SERVICES
2020 RESOLUTION 48S-1—SIXTEENTH TRUSTEE DISTRICT

48. Resolved, that the policy titled Support for Adult Medicaid Dental Services (*Trans.*2004:327) be amended to read as follows (additions are underscored; deletions are ~~stricken~~):

Resolved, that ~~the ADA adopt policy supporting the inclusion of adult dental services~~ should be included in the federal Medicaid program, and be it further

~~**Resolved**, that the ADA take every opportunity to educate policy makers that, consistent with ADA’s position on health system reform (*Trans.*1993:664; *Trans.*1994:656) oral health is an integral part of overall health, and be it further~~

Resolved, that adult coverage under Medicaid should not be left to the discretion of individual states, but rather should be provided consistent with all other basic health care services.

48S-1. Resolved, that the policy titled Support for Adult Medicaid Dental Services (*Trans.*2004:327) be amended to read as follows (additions are underscored; deletions are ~~stricken~~):

Resolved, that ~~the ADA adopt policy supporting the inclusion of adult dental services~~ should be included in the federal Medicaid program as an integral part of overall health, and be it further

~~**Resolved**, that the ADA take every opportunity to educate policy makers that, consistent with ADA’s position on health system reform (*Trans.*1993:664; *Trans.*1994:656) oral health is an integral part of overall health, and be it further~~

Resolved, that adult coverage under Medicaid should not be left to the discretion of individual states, but rather should be provided consistent with all other basic health care services.

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WORKSHEET ADDENDUM
2020 RESOLUTION 55, AMENDMENT TO THE POLICY, LEGISLATIVE SEPARATION OF
MEDICINE AND DENTISTRY

55. Resolved, that the policy titled Legislative Separation of Medicine and Dentistry (*Trans.*1996:715) be amended to read as follows (additions are underscored; deletions are ~~stricken~~):

Resolved, that ~~the American Dental Association work to assure that~~ dentistry is should be addressed separately from medicine in any health care reform legislation.

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**WORKSHEET ADDENDUM
COUNCIL ON GOVERNMENT AFFAIRS
ADA POLICY TO BE RESCINDED**

4 **Legislative Separation of Medicine and Dentistry (*Trans.1996:715*)**

5 **Resolved**, that the American Dental Association work to assure that dentistry is addressed separately
6 from medicine in any health care reform legislation.

Resolution No. 30 New

Report: N/A Date Submitted: June 2021

Submitted By: Council on Government Affairs

Reference Committee: D (Legislative, Health, Governance 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: Not Applicable

1 **AMENDMENT OF THE POLICY, ANTITRUST REFORM**

2 **Background:** In accordance with Resolution 97H-2020, Special Order of Referral Consent Calendar,
3 which directed the appropriate ADA agencies to report back to the 2021 House of Delegates on each
4 Referred Resolution, Resolution 14-2020, Amendment of the Policy, Antitrust Reform, was referred to the
5 Council.

6 After consideration, the Council is proposing a modified version of the resolution to reflect passage of the
7 Competitive Health Insurance Reform Act of 2020, which rendered the first resolving clause moot.
8 Resolution 14-2020 is appended to this report.

9 In accordance with Resolution 170H-2012 (*Trans.*2012:370), Regular Comprehensive Policy Review, the
10 Council on Government Affairs reviewed three policies directly tied to reforming federal antitrust laws (i.e.,
11 McCarran-Ferguson), to determine their adequacy (or obsolescence) in modern times, and the merits of
12 any revisions:

- 13 • Antitrust Reform (*Trans.*2016:314)
- 14 • Legislative Support to Allow Collective Bargaining by Professional Societies
15 (*Trans.*2001:440; 2015:271)
- 16 • Financial, Political and Administrative Consequences of Collective Bargaining Legislation
17 (*Trans.*2000:506)

18 The Council considered the policy titled Antitrust Reform (*Trans.*2016:314) to be foundational to the
19 ADA's efforts to repeal certain provisions in McCarran-Ferguson, and should be retained.

20 The Council found that the policy titled Legislative Support to Allow Collective Bargaining by Professional
21 Societies (*Trans.*2001:440; 2015:271) is worded as a time-limited directive that became moot once the
22 assignment to "support legislation" was fulfilled (*Reports* 2002:6016). However, the Council also found
23 the subject matter is relevant enough to warrant retaining as a more enduring statement of policy or
24 position. In fact, it is similar enough to be merged with the policy Antitrust Reform (*Trans.*2016:314) (in
25 lieu of retaining as a stand-alone policy).

26 Additionally, the Council determined that the policy titled Financial, Political and Administrative
27 Consequences of Collective Bargaining Legislation (*Trans.*2000:506) was not necessary since the ADA
28 routinely uses outside consultants on an as needed basis—including legal, lobbying, and public relations

1 firms—to advise the Association on technically complex topics, such as antitrust and environmental
2 policies. A policy supporting this function for a singular issue is not necessary.

3 The Council suggests combining the policies titled Legislative Support to Allow Collective Bargaining by
4 Professional Societies (*Trans.*2001:440; 2015:271) and Antitrust Reform (*Trans.*2016:314), with minor
5 changes for brevity and clarity, and rescinding the policy titled Financial, Political and Administrative
6 Consequences of Collective Bargaining Legislation (*Trans.*2000:506).

7 The Council on Government Affairs recommends that the following resolution be adopted:

8 **Resolution**

9 **30. Resolved**, that the policy titled Antitrust Reform (*Trans.*2016:314) be amended as follows
10 (additions are underscored; deletions are ~~stricken~~):

11 ~~**Resolved**, that the ADA strongly supports eliminating the current insurance industry exemption
12 from anti-trust laws including support for legislation to clarify, Amend or, if necessary, repeal the
13 McCarran-Ferguson Act's antitrust immunity for the business of health insurance, and be it further~~

14 **Resolved**, that the ADA American Dental Association strongly opposes any legislation that would
15 extend an antitrust exemption to the insurance industry for information gathering endeavors such
16 as collecting and distributing information on cost and utilization of health care services, and be it
17 further

18 **Resolved**, that the ADA supports changes in federal antitrust laws that will enable dentists to
19 practice effectively within the health care system, and be it further

20 **Resolved**, that the ADA supports legislative and regulatory activities to change the antitrust safe
21 harbor guideline for dental networks based on percentage of provider participation in favor of a
22 guideline relying on a health plan's market share, and be it further

23 **Resolved**, that the ADA work closely with constituent and component societies to provide them
24 the most current and comprehensive antitrust information and guidance available, on an as-
25 needed basis, and be it further

26 **Resolved**, that the ADA utilize appropriate resources to work with other provider groups to
27 amend antitrust laws to allow dentists and other providers to negotiate collectively with health
28 care purchasers, and be it further

29 **Resolved**, that the ADA support effective regulation of insurance companies including: the
30 establishment of requirements for disclosure to dentists prior to signing network participation
31 contracts; and current and complete information relating to the establishment of payment
32 reimbursement rates and claims experience-, and be it further

33 **Resolved**, that professional societies and their members should be exempt from antitrust scrutiny
34 for the narrow area of collective bargaining, so that dental societies can collectively negotiate on
35 behalf of members.

36 and be it further

37 **Resolved**, that the policies titled Legislative Support to Allow Collective Bargaining by Professional
38 Societies (*Trans.*2001:440; 2015:271) and Financial, Political and Administrative Consequences of
39 Collective Bargaining Legislation (*Trans.*2000:506) be rescinded.

40 **BOARD RECOMMENDATION: Vote Yes.**

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

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WORKSHEET ADDENDUM
2020 RESOLUTION 14—COUNCIL ON GOVERNMENT AFFAIRS—AMENDMENT OF THE POLICY,
ANTITRUST REFORM

14. Resolved, that the policy titled Antitrust Reform (*Trans.*2016:314) be amended as follows (additions are underscored; deletions are ~~stricken~~):

Resolved, that the ADA strongly supports eliminating the current insurance industry exemption from anti-trust laws including support for legislation to clarify, amend or, if necessary, repeal the McCarran-Ferguson Act's antitrust immunity for the business of health insurance, and be it further

Resolved, that the ADA strongly opposes any legislation that would extend an antitrust exemption to the insurance industry for information gathering endeavors such as collecting and distributing information on cost and utilization of health care services, and be it further

Resolved, that the ADA supports changes in federal antitrust laws that will enable dentists to practice effectively within the health care system, and be it further

Resolved, that the ADA supports legislative and regulatory activities to change the antitrust safe harbor guideline for dental networks based on percentage of provider participation in favor of a guideline relying on a health plan's market share, and be it further

Resolved, that the ADA work closely with constituent and component societies to provide them the most current and comprehensive antitrust information and guidance available, on an as-needed basis, and be it further

Resolved, that the ADA utilize appropriate resources to work with other provider groups to amend antitrust laws to allow dentists and other providers to negotiate collectively with health care purchasers, and be it further

Resolved, that the ADA support effective regulation of insurance companies including: the establishment of requirements for disclosure to dentists prior to signing network participation contracts; and current and complete information relating to the establishment of payment reimbursement rates and claims experience, and be it further

Resolved, that professional societies and their members should be exempt from antitrust scrutiny for the narrow area of collective bargaining, so that dental societies can collectively negotiate on behalf of members.

and be it further

Resolved, that the policies titled Legislative Support to Allow Collective Bargaining by Professional Societies (*Trans.*2001:440; 2015:271) and Financial, Political and Administrative Consequences of Collective Bargaining Legislation (*Trans.*2000:506) be rescinded.

1 **WORKSHEET ADDENDUM**
2 **COUNCIL ON GOVERNMENT AFFAIRS**
3 **ADA POLICIES TO BE RESCINDED**

4 **Legislative Support to Allow Collective Bargaining by Professional Societies (*Trans.2001:440*;**
5 **2015:271)**

6 **Resolved**, that the Association support legislation that would allow professional societies and their
7 members to be considered as “one” and exempt from antitrust scrutiny for the narrow area of collective
8 bargaining, so that dental societies could collectively negotiate on behalf of members.

9 **Financial, Political and Administrative Consequences of Collective Bargaining Legislation**
10 **(*Trans.2000:506*)**

11 **Resolved**, that in pursuing antitrust relief as mandated by current policies, the Association be mindful of
12 any such concerns raised by consultants with respect to legal and economic aspects of collective
13 bargaining legislation, to assure legislation is in the best interests of the profession.

Resolution No. 33 New

Report: N/A Date Submitted: June 2021

Submitted By: Council on Government Affairs

Reference Committee: D (Legislative, Health, Governance 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: Not Applicable

- 1 **AMENDMENT OF THE POLICY, LEGISLATIVE DELEGATIONS**
- 2 **Background:** In accordance with Resolution 97H-2020, Special Order of Referral Consent Calendar,
- 3 which directed the appropriate ADA agencies to report back to the 2021 House of Delegates on each
- 4 Referred Resolution, Resolution 13-2020, Amendment of the Policy, Legislative Delegations, was referred
- 5 to the Council.
- 6 After consideration, the Council respectfully re-offers its recommendation to amend policy titled
- 7 Legislative Delegations (*Trans.*1995:648). Resolution 13-2020 is appended to this report.
- 8 A Sixteenth District substitute resolution, Resolution 13S-1-2020, is also appended to this report. The
- 9 substance of Resolution 13S-1-2020 is essentially identical to the substance of the original policy.
- 10 In accordance with Resolution 170H-2012 (*Trans.*2012:370), Regular Comprehensive Policy Review, the
- 11 Council on Government Affairs reviewed the Association policy titled Legislative Delegations
- 12 (*Trans.*1995:648), to determine its adequacy (or obsolescence) in modern times, and the merits of any
- 13 revisions.
- 14 The Council observed that the policy was worded as a time-limited assignment that was fulfilled once the
- 15 task to “encourage individual ADA members” was completed (*Reports* 1996:107). The Council also noted
- 16 that the policy was created 25 years ago, when the only opportunities for individual dentists to participate
- 17 in the political process were as individuals or through their constituent and component societies.
- 18 Today, the American Dental Association Political Action Committee’s Grassroots Program is solidly
- 19 established. Compared to its condition in 1996, the program is thriving. Dentists now have plenty of
- 20 opportunities to participate in the political process. Much of that is owed to the success of ADPAC’s
- 21 Grassroots Program.
- 22 As with any business endeavor, a desire to improve the program will be ever present. For example, more
- 23 states can and should be participating in the program. In the context of the policy review, however, the
- 24 Council questioned whether there is added value to having a policy that merely restates what is already in
- 25 Article II of the ADPAC charter (July 2016): “To assist dentists and others in organizing themselves for
- 26 more effective political action.”

1 It was the sense of the Council that the ADPAC Board understands its charter and will always be looking
2 to improve the program. Ultimately, the Association would be better served by a broad statement of
3 support for the program than a reiteration of what is already in ADPAC's charter.

4 The Council on Government Affairs recommends that the following resolution be adopted:

5 **Resolution**

6 **33. Resolved**, that the policy titled Legislative Delegations (*Trans.*1982:550; 1995:648) be amended
7 as follows (additions are underscored; deletions are ~~stricken~~):

8 ~~Resolved~~, that the Association continue to encourage individual ADA members to join the ADA
9 ~~Grassroots Program, and be it further~~

10 ~~Resolved~~, that ADA members representing constituent and component societies who travel to
11 Washington, D.C. be encouraged to visit with their senators and representatives to discuss
12 legislative issues of importance to the profession and to coordinate this activity with the ADA
13 Washington Office American Dental Association continue to encourage members to join and
14 actively participate in the American Dental Political Action Committee's Grassroots Program.

15 **BOARD RECOMMENDATION: Vote Yes.**

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

1 **WORKSHEET ADDENDUM**
 2 **2020 RESOLUTIONS**
 3 **2020 RESOLUTION 13—COUNCIL ON GOVERNMENT AFFAIRS**
 4 **2020 RESOLUTION 13S-1—SIXTEENTH TRUSTEE DISTRICT**
 5 **AMENDMENT OF THE POLICY, LEGISLATIVE DELEGATIONS**

6 **13. Resolved**, that the policy titled Legislative Delegations (*Trans.*1982:550; 1995:648) be amended
 7 as follows (additions are underscored; deletions are ~~stricken~~):

8 ~~**Resolved**, that the Association continue to encourage individual ADA members to join the ADA~~
 9 ~~Grassroots Program, and be it further~~

10 ~~**Resolved**, that ADA members representing constituent and component societies who travel to~~
 11 ~~Washington, D.C. be encouraged to visit with their senators and representatives to discuss~~
 12 ~~legislative issues of importance to the profession and to coordinate this activity with the ADA~~
 13 ~~Washington Office American Dental Association continue to encourage members to join and~~
 14 ~~actively participate in the American Dental Political Action Committee's Grassroots Program.~~

15 **13S-1. Resolved**, that the Association encourage individual ADA members to join and actively
 16 participate in the ADA Grassroots Program, and be it further

17 **Resolved**, that ADA members representing constituent and component societies be encouraged to
 18 visit with their senators and representatives to discuss legislative issues of importance to the
 19 profession and to coordinate this activity with the ADA.

Resolution No. 34 New

Report: N/A Date Submitted: June 2021

Submitted By: Council on Ethics, Bylaws and Judicial Affairs

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

Total Net Financial Implication: None Net Dues Impact: _____

Amount One-time _____ Amount On-going _____

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

1 **AMENDMENT AND SIMPLIFICATION OF BYLAWS CHAPTER I., SECTION 20.B.**

2 **Background:** In accordance with Resolution 97H-2020, Special Order of Referral Consent Calendar,
3 which directed the appropriate ADA agencies to report back to the 2021 House of Delegates on each
4 Referred Resolution, Resolution 32-2020, Amendment and Simplification of Bylaws Chapter I., Section
5 20.B., was referred to the Council on Ethics, Bylaws and Judicial Affairs. Resolution 32-2020 is appended
6 to this report.

7 After consideration, the Council respectfully resubmits its recommendation to amend Chapter I., Section
8 20.B. of the ADA *Bylaws*.

9 Pursuant to the *Governance and Organizational Manual of the American Dental Association (Governance*
10 *Manual)*, Chapter VIII., Section K.6.b.ii., the Council on Ethics, Bylaws and Judicial Affairs (CEBJA)
11 reviews the governance documents of the Association to correct punctuation, grammar spelling and
12 syntax. Different portions of the ADA’s governing documents are reviewed by CEBJA each year so that
13 the entirety of the Association’s governance material is reviewed every four (4) years. Among the
14 material reviewed in 2020 was Chapter I. of the *Bylaws*.

15 During the course of the Council’s editorial review, if the Council finds an area in the governance
16 documentation that it believes could be better stated, simplified or made clearer, and, in the judgment of
17 the Council, that revision does not fall within the type of revision that can be the made upon the
18 unanimous vote of the Council without approval of the House of Delegates under Chapter VIII., Section
19 K.6.b.ii. of the *Governance Manual*, CEBJA proposes a revision to the House of Delegates for
20 consideration and adoption.

21 **Discussion:** Section B. of Chapter I. of the ADA *Bylaws* specifies the criteria under which a member
22 qualifies to be a life member of the Association. One of the listed criteria is the length of time the member
23 has been a member in good standing of the ADA. Subsection a. of Section B. states that a member must
24 either be an active and or retired member in good standing of the ADA for thirty (30) consecutive years or
25 for at least forty (40) non-consecutive years to qualify for life membership. Subsection d. of Section B.
26 currently states that a member can be eligible for life membership if the member has held ADA
27 membership for at least ten (10) years and has reached the age of sixty-five (65) if, prior to holding ADA
28 membership, the member was a member of the National Dental Association for (25) twenty-five years.
29 However, it should be remembered that, commencing at the close *sine die* of the 2021 House of
30 Delegates the requirement of achieving the age of 65 years to be eligible for life member status will be
31 eliminated per operation of Resolution 68H-2020.

1 To simplify and clarify the ADA *Bylaws*, CEBJA believes that subsections a. and d. of Chapter I., Section
2 B. of the *Bylaws* should combined as follows:

3 B. LIFE MEMBER. Any person holding a D.D.S., D.M.D. or equivalent degree shall be eligible to be a
4 life member of this Association if he or she meets the following qualifications:

5 a. Association Membership. The member:

6 1. Has been an active and/or retired member in good standing of this Association for at least
7 thirty (30) consecutive years or a total of at least forty (40) non-consecutive years; or

8 2. Has been or was a member of the National Dental Association for twenty-five (25) years
9 and has been an active and/or retired member in good standing of this Association for at
10 least ten (10) years;

11 Combining subsections a. and d. of Section B. places the length of membership eligibility criterion in a
12 single subsection, rather than having that the membership criterion in two separate subsections that are
13 separated by listing additional eligibility criteria for becoming a life member. The proposed amendment
14 thus simplifies the *Bylaws* and makes the *Bylaws* more understandable to and readable for the average
15 member.

16 In light of the above analysis, CEBJA proposes that Chapter I, Section 20.B. of the ADA *Bylaws* be
17 amended as follows:

18 **Resolution**

19 **34. Resolved**, that Chapter I, Section B. of the ADA *Bylaws* be amended as follows
20 (additions underscored, deletions ~~stricken through~~):

21 B. LIFE MEMBER. Any person holding a D.D.S., D.M.D. or equivalent degree shall be eligible to
22 be a life member of this Association if he or she meets the following qualifications:

23 a. Association Membership. The member has been:

24 1. An active and/or retired member in good standing of this Association for
25 at least thirty (30) consecutive years or a total of at least forty (40) non-consecutive
26 years; ~~or~~

27 2. A member of the National Dental Association for twenty-five (25) years and has
28 been an active and/or retired member in good standing of this Association for at least ten
29 (10) years;

30 b. Reached the age of at least sixty-five (65) during the previous calendar year; and

31 c. Maintains membership in good standing in a constituent and component, if such exists,
32 and in this Association.

33 ~~d. A member may also qualify for life member status by having been a member of the~~
34 ~~National Dental Association for twenty five (25) years and subsequently holding~~
35 ~~membership in this Association for at least ten (10) years and having reached the age of at~~
36 ~~least sixty five (65) during the previous calendar year.~~

1 **BOARD RECOMMENDATION: Vote Yes.**

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

1 **WORKSHEET ADDENDUM**
2 **2020 RESOLUTION 32—COUNCIL ON ETHICS, BYLAWS AND JUDICIAL AFFAIRS—AMENDMENT**
3 **OF BYLAWS CHAPTER I., SECTION 20.B.**

4 **32. Resolved**, that Chapter I, Section B. of the ADA *Bylaws* be amended as follows
5 (additions underlined, deletions ~~stricken through~~):

6 B. LIFE MEMBER. Any person holding a D.D.S., D.M.D. or equivalent degree shall be eligible to
7 be a life member of this Association if he or she meets the following qualifications:

8 a. Association Membership. The member has been:

9 1. ~~Has been an~~ An active and/or retired member in good standing of this Association for
10 at least thirty (30) consecutive years or a total of at least forty (40) non-consecutive
11 years; or

12 2. ~~Was a~~ A member of the National Dental Association for twenty-five (25) years and has
13 been an active and/or retired member in good standing of this Association for at least ten
14 (10) years;

15 b. Reached the age of at least sixty-five (65) during the previous calendar year; and

16 c. Maintains membership in good standing in a constituent and component, if such exists,
17 and in this Association.

18 ~~d. A member may also qualify for life member status by having been a member of the~~
19 ~~National Dental Association for twenty-five (25) years and subsequently holding~~
20 ~~membership in this Association for at least ten (10) years and having reached the age of at~~
21 ~~least sixty-five (65) during the previous calendar year.~~

Resolution No. 35 New

Report: CEBJA Report 1 Date Submitted: June 2021

Submitted By: Council on Ethics, Bylaws and Judicial Affairs

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

Total Net Financial Implication: None Net Dues Impact: _____

Amount One-time _____ Amount On-going _____

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

1 **COUNCIL ON ETHICS, BYLAWS AND JUDICIAL AFFAIRS REPORT 1 TO THE HOUSE OF**
2 **DELEGATES: RESPONSE TO REFERRED RESOLUTION 64-2020, AMENDMENT OF CHAPTER III.,**
3 **SECTION 120. OF THE ADA BYLAWS**

4 **Background:** In accordance with Resolution 97H-2020, Special Order of Referral Consent Calendar,
5 which directed the appropriate ADA agencies to report back to the 2021 House of Delegates on each
6 Referred Resolution, Resolution 64-2020 was reviewed by the Council on Ethics, Bylaws and Judicial
7 Affairs. Resolution 64-2020 is appended to this report.

8 After consideration, the Council on Ethics, Bylaws and Judicial Affairs decided to amend Resolution 64-
9 2020 and respectfully submits the following resolution in its place.

10 Pursuant to the *Governance and Organizational Manual of the American Dental Association (Governance*
11 *Manual)*, Chapter VIII., Section K.6.b.ii., the Council on Ethics, Bylaws and Judicial Affairs (CEBJA)
12 reviews the governance documents of the Association to correct punctuation, grammar spelling and
13 syntax. Different portions of the ADA's governing documents are reviewed each year so that the entirety
14 of the Association's governance material is reviewed every four (4) years.

15 Chapter III. of the ADA *Bylaws* was reviewed during the course of CEBJA's 2020 editorial review process.
16 In the course of that study, some members of CEBJA requested clarification of the meaning of the term
17 "non-cumulative," in the second numbered paragraph of *Bylaws* Chapter III., Section 120., as the
18 meaning of that term was not understood in relation to voting scenarios.

19 On referral pursuant to 97H-2020, the Council on Ethics, Bylaws and Judicial Affairs (the Council) refined
20 the amendments proposed by Resolution 64-2020 in a further effort to make Chapter III., Section 120 of
21 the ADA *Bylaws* more understandable to the average member.

22 **Discussion:** CEBJA believes that one of the most important attributes for the Association's governance
23 documents to have is to be written with clarity and precision, in such a way to be accessible to and easily
24 understood by members of the Association. Consequently, when a provision in the *Bylaws* or
25 *Governance Manual* is not understood, CEBJA reviews that provision very carefully and looks for
26 alternative language to more simply and clearly express the provision without altering the provision's
27 import or meaning.

28 That is the case here. The Council on Ethics, Bylaws and Judicial Affairs proposes amendment to the
29 second numbered paragraph of Chapter III., *Section 120.* of the ADA *Bylaws* as follows:

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Resolution

35. Resolved, that Chapter III., Section 120. of the ADA *Bylaws* be amended as shown below (additions underscored, deletions ~~stricken through~~):

Section 120. METHOD OF ELECTION: Elective officers and members of councils and committees shall be elected by ballot, except that when there is only one candidate, such candidate may be declared elected by the Speaker of the House of Delegates. The Secretary shall provide facilities for voting.

1. When one is to be elected, and more than one has been nominated, the majority of the ballots cast shall elect. In the event no candidate receives a majority on the first ballot, the candidate with the fewest votes shall be removed from the ballot and the remaining candidates shall be balloted upon again. This process shall be repeated until one (1) candidate receives a majority of the votes cast.
2. When more than one is to be elected, and the nominees exceed the number to be elected, ~~the votes cast shall be non-cumulative, and the following applies:~~
 - a. Each voting member may vote for a number of nominees not to exceed the number to be elected; and
 - b. For any single nominee, only one vote may be cast by each voting member;
 - c. The candidates receiving the greatest number of votes shall be elected.

BOARD RECOMMENDATION: Vote Yes.

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

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WORKSHEET ADDENDUM
2020 RESOLUTION 64—COUNCIL ON ETHICS, BYLAWS AND JUDICIAL AFFAIRS—AMENDMENT
OF CHAPTER III., SECTION 120. OF THE ADA BYLAWS

64. Resolved, that Chapter III., Section 120. of the ADA *Bylaws* be amended as shown below (additions underscored, deletions ~~stricken through~~):

Section 120. METHOD OF ELECTION: Elective officers and members of councils and committees shall be elected by ballot, except that when there is only one candidate, such candidate may be declared elected by the Speaker of the House of Delegates. The Secretary shall provide facilities for voting.

1. When one is to be elected, and more than one has been nominated, the majority of the ballots cast shall elect. In the event no candidate receives a majority on the first ballot, the candidate with the fewest votes shall be removed from the ballot and the remaining candidates shall be balloted upon again. This process shall be repeated until one (1) candidate receives a majority of the votes cast.
2. When more than one is to be elected, and the nominees exceed the number to be elected, ~~the votes cast shall be non-cumulative,~~ votes equal to or less than the number to be elected may be cast by each voting member, but only one vote may be cast per nominee, and the candidates receiving the greatest number of votes shall be elected.

Resolution No. 36 New

Report: N/A Date Submitted: June 2021

Submitted By: Council on Advocacy for Access and Prevention

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

Total Net Financial Implication: None Net Dues Impact: _____

Amount One-time _____ Amount On-going _____

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: Not Applicable

1 **PROPOSED POLICY, SUPPORT FOR THE AMERICAN ACADEMY OF PEDIATRIC DENTISTRY**
 2 **POLICY ON EARLY CHILDHOOD CARIES**

3 **Background:** The Council on Advocacy for Access and Prevention reviewed the American Academy of
 4 Pediatric Dentistry’s recently updated policy titled Policy on Early Childhood Caries (ECC): Unique
 5 Challenges and Treatment Options (2021). This Policy is attached as an Appendix. The Council found it
 6 to be all encompassing in the efforts to decrease the disease burden suffered by young children.

7 The Council on Advocacy for Access and Prevention recommends that the following resolution be
 8 adopted:

9 **Resolution**

10 **36. Resolved,** that the following policy titled Support for the American Academy of Pediatric Dentistry
 11 Policy on Early Childhood Caries be adopted:

12 **Support for the American Academy of Pediatric Dentistry Policy on Early Childhood Caries**

13 **Resolved,** that the American Dental Association supports the Policy Statement of the American
 14 Academy of Pediatric Dentistry (AAPD) on Early Childhood Caries (2021):

15 The AAPD recognizes the unique and often virulent nature of ECC. Non-dental healthcare
 16 providers who identify ECC in a child should refer the patient to a dentist for treatment and
 17 establishment of a dental home (AAPD Dental home) immediate intervention is indicated, and
 18 non-surgical interventions should be implemented when possible to postpone or reduce the
 19 need for surgical treatment approaches. Because children who experience ECC are at
 20 greater risk for subsequent caries development, preventive measures (e.g., dietary
 21 counseling, reinforcement of toothbrushing with fluoridated toothpaste), more frequent
 22 professional visits with applications of topical fluoride, and restorative care are necessary.

23 **BOARD RECOMMENDATION: Vote Yes.**

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

APPENDIX
AMERICAN ACADEMY OF PEDIATRIC DENTISTRY POLICY ON EARLY CHILDHOOD CARIES
(ECC): UNIQUE CHALLENGES AND TREATMENT OPTIONS (2021)

Latest Revision, 2021

Abbreviations

AAPD: American Academy of Pediatric Dentistry

ECC: Early childhood caries

ITR: Interim therapeutic restorations

Purpose

The American Academy of Pediatric Dentistry (**AAPD**), to promote appropriate, quality oral health care for infants and children with early childhood caries (**ECC**), must educate the health community and society about the unique challenges and management of this disease, including the need for advanced preventive, restorative, and behavioral guidance techniques.

Methods

This policy was developed by the Council on Clinical Affairs and adopted in 2000 (AAPD P_ECC Challenges 2000). This document is a revision of the previous version, revised in 2016.(AAPD P_ECC Challenges 2016) The update used electronic and hand searches of English written articles in the dental and medical literature within the last 10 years using the search terms infant oral health, infant oral health care, and early childhood caries. When information from these articles did not appear sufficient or was inconclusive, policies were based upon expert and/or consensus opinion by experienced researchers and clinicians.

Background

Epidemiologic data from a 2011-2012 national survey clearly indicate that ECC remains highly prevalent in poor and near poor U.S. preschool children.(Dye et al. 2015) For the overall population of preschool children, the prevalence of ECC, as measured by decayed and filled tooth surfaces (dfs), is unchanged from previous surveys, but the filled component (fs) has greatly increased indicating that more treatment is being provided.(Dye et al. 2015) The consequences of ECC often include a higher risk of new caries lesions in both the primary and permanent dentitions,(O'Sullivan and Tinanoff 1996; Al-Shalan et al. 1997) hospitalizations and emergency room visits,(Griffin et al. 2000; Ladrillo et al. 2006) high treatment costs,(AHRQ 2010) loss of school days,(Edelstein and Reisine 2015) diminished ability to learn,(Blumenshine et al. 2008) and reduced oral health-related quality of life.(Filstrup et al. 2003)

Because restorative care to manage ECC on young children often requires the use of sedation and general anesthesia with its associated high costs and possible health risks,(Sinner et al. 2014) and because there is high recurrence of lesions following the procedures,(Berkowitz et al. 2011) there now is more emphasis on prevention and arrestment of the disease processes. Approaches include methods that have been referred to as:

1. chronic disease management, which includes parent engagement to facilitate and promote preventive measures while encouraging the identification and reduction of individual risk factors. The aim is to sustain oral health in the long term (Edelstein and Ng 2015, Featherstone et al 2020), in combination with:
2. active surveillance, which emphasizes careful monitoring of caries progression and prevention programs (e.g., frequent fluoride varnish applications) in children with incipient lesions;(AAPD BP_Caries-risk assessment, Weintraub et al 2006) and

- 1 3. minimal intervention approaches. That includes caries arrest with Silver Diamine Fluoride (AAPD
2 SDF guideline), interim therapeutic restorations (ITR) that temporarily restore teeth in young
3 children until a time when traditional cavity preparation and restoration is possible(AAPD P_ITR)
4 and the use of Hall-style crowns. (Crystal et al JADA 2020)

5 Those children with known risk factors for ECC should have care provided by a practitioner who has the
6 training and expertise to manage both the child and the disease process. The use of anticariogenic
7 agents, especially twice daily brushing with fluoridated toothpaste and the frequent application of fluoride
8 varnish, may reduce the risk of development and progression of caries. In some children where
9 preventive programs are not successful, areas of demineralization and hypoplasia can rapidly develop
10 cavitation and, if untreated, the disease process can rapidly involve the dental pulp, leading to infection
11 and possibly life-threatening fascial space involvement. Such infections may result in a medical
12 emergency requiring hospitalization, antibiotics, and extraction of the offending tooth.(Sheller et al. 1997)

13 The extent of the disease process as well as the patient's developmental level and comprehension skills
14 affect the practitioner's management decisions. The establishment of a dental home when the first tooth
15 erupts is imperative to be able to implement preventive and early intervention treatments before
16 advanced disease becomes established. Definitive restorative treatment in young children, in many
17 cases, can be postponed by use of ITR or silver diamine fluoride treatments).(Crystal & Niederman 2016)
18 For advanced cases of ECC, the practitioner may need the aid of advanced behavior guidance
19 techniques to complete the necessary treatment.(AAPD BP Behavior guidance) Also in such situations,
20 stainless steel crowns often are indicated to restore teeth with large caries lesions, interproximal lesions,
21 and extensive white spot lesions since stainless steel crowns are less likely than other restorations to
22 require retreatment.(Adzani EN, et al, 2020). The success of restorations may be influenced by the child's
23 level of cooperation during treatment, and general anesthesia may provide better conditions to perform
24 restorative procedures.

25 26 **Policy statement**

27 The AAPD recognizes the unique and often virulent nature of ECC. Non-dental healthcare providers who
28 identify ECC in a child should refer the patient to a dentist for treatment and establishment of a dental
29 home (AAPD Dental home). Immediate intervention is indicated, and non-surgical interventions should be
30 implemented when possible to postpone or reduce the need for surgical treatment approaches. Because
31 children who experience ECC are at greater risk for subsequent caries development, preventive
32 measures (e.g., dietary counseling, reinforcement of toothbrushing with fluoridated toothpaste), more
33 frequent professional visits with applications of topical fluoride, and restorative care are necessary.

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Resolution No. 37 New

Report: N/A Date Submitted: June 2021

Submitted By: Council on Advocacy for Access and Prevention

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

Total Net Financial Implication: None Net Dues Impact: _____

Amount One-time _____ Amount On-going _____

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: Not Applicable

1 **RESCISSION OF THE POLICY, PREVENTIVE DENTAL PROCEDURES**

2 **Background:** In accordance with Resolution 97H-2020, Special Order of Referral Consent Calendar,
3 which directed the appropriate ADA agencies to report back to the 2021 House of Delegates on each
4 Referred Resolution, Resolution 24-2020, Rescission of the Policy, Preventive Dental Procedures, was
5 referred to the Council.

6 After consideration, the Council respectfully re-offers its recommendation to rescind the policy titled
7 Preventive Dental Procedures (*Trans.*1967:325; 2013:342). Resolution 24-2020 is appended to this
8 report.

9 In accordance with Resolution 170H-2012 (*Trans.*2010:370), Regular Comprehensive Policy Review, the
10 Council on Advocacy for Access and Prevention reviewed the Association policy titled Preventive Dental
11 Procedures (*Trans.*1967:325; 2013:342).

12 The Council felt that the language was very broad and non-specific with the importance of various
13 preventive procedures already noted in other policies.

14 The Council on Advocacy for Access and Prevention recommends that the following resolution be
15 adopted:

16 **Resolution**

17 **37. Resolved,** that the policy titled Preventive Dental Procedures (*Trans.*1967:325; 2013:342) be
18 rescinded.

19 **BOARD RECOMMENDATION: Vote Yes.**

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

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WORKSHEET ADDENDUM
2020 RESOLUTION 24—COUNCIL ON ADVOCACY FOR ACCESS AND PREVENTION—
RESCISSION OF THE POLICY, PREVENTIVE DENTAL PROCEDURES

24. Resolved, that the policy titled Preventive Dental Procedures (*Trans.*1967:325; 2013:342) be rescinded.

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**WORKSHEET ADDENDUM
COUNCIL ON ADVOCACY FOR ACCESS AND PREVENTION
ADA POLICY TO BE RESCINDED**

Preventive Dental Programs (*Trans.1967:325; 2013:342*)

Resolved, that constituent dental societies support the use of preventive procedures in all dental offices,
and be it further

Resolved, that constituent and component societies support continuing education programs in the
effective use of preventive procedures.

Resolution No. 38 New

Report: N/A Date Submitted: June 2021

Submitted By: Council on Advocacy for Access and Prevention

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

Total Net Financial Implication: None Net Dues Impact: _____

Amount One-time _____ Amount On-going _____

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

1 **AMENDMENT OF THE POLICY, HEALTH PLANNING GUIDELINES**

2 **Background:** In accordance with Resolution 97H-2020, Special Order of Referral Consent Calendar,
3 which directed the appropriate ADA agencies to report back to the 2021 House of Delegates on each
4 Referred Resolution, Resolution 37-2020, Amendment of the Policy, Health Planning Guidelines, was
5 referred to the Council.

6 After consideration, the Council respectfully re-offers its recommendation to amend the policy titled Health
7 Planning Guidelines (*Trans.*1983:545; 2014:503). Resolution 37-2020 is appended to this report.

8 The Sixteenth Trustee District offered a substitute resolution, Resolution 37S-1-2020, to address
9 concerns regarding alignment of dental association objectives and state planning guidelines. Resolution
10 37S-1-2020 is also appended to this report. The Council felt it necessary to add language to show the
11 importance of the ADA support of collaboration with state and local oral health coalitions to complete
12 these items.

13 The Council on Advocacy for Access and Prevention recommends that the following resolution be
14 adopted:

15 **Resolution**

16 **38. Resolved,** that the policy titled Health Planning Guidelines (*Trans.*1983:545; 2014:503) be
17 amended to read as follows (additions are underscored; deletions are ~~stricken~~):

18 **Resolved,** that the following health planning objectives be adopted:

- 19 1. The Association supports a voluntary system of cooperative health planning at the state
20 and local level.
- 21 2. Health planning should be directed at locally determined efforts to improve access to
22 health care and avoid duplication of effort to maximize limited resources.
- 23 3. Dentists should have equal input along with other health care providers
- 24 4. Public and private sector financing for health planning should have adequate
25 appropriations designated to accomplish the state objectives

- 1 5. The Association supports collaboration with state and local oral health coalitions to
2 complete the objectives of effective health planning in areas of common ground between
3 the organizations.

4 **BOARD RECOMMENDATION: Vote Yes.**

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

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1 **WORKSHEET ADDENDUM**
 2 **2020 RESOLUTIONS**
 3 **2020 RESOLUTION 37—COUNCIL ON ADVOCACY FOR ACCESS AND PREVENTION—**
 4 **2020 RESOLUTION 37S-1—SIXTEENTH TRUSTEE DISTRICT**
 5 **AMENDMENT OF THE POLICY, HEALTH PLANNING GUIDELINES**

6 **37. Resolved**, that the policy titled Health Planning Guidelines (*Trans.*1983:545; 2014:503)
 7 be amended to read as follows (additions are underscored; deletions are ~~stricken~~):

8 **Resolved**, that the following health planning objectives be adopted:

- 9 1. The Association supports a voluntary system of cooperative health planning at
10 the state and local level.
- 11 2. Health planning should be directed at locally determined efforts to improve
12 access to health care and avoid duplication of effort to maximize limited
13 resources.
- 14 3. Dentists should have equal input along with other health care providers
- 15 4. Public and private sector financing for health planning should have adequate
16 appropriations designated to accomplish the state objectives.
- 17 5. The Association supports collaboration with state and local oral health coalitions
18 to complete these objectives.

19 **37S-1. Resolved**, that the policy titled Health Planning Guidelines (*Trans.*1983:545;
20 2014:503) be amended to read as follows (additions are double underscored; deletions are
21 double ~~stricken~~):

22 **Resolved**, that the following health planning objectives be adopted:

- 23 1. The Association supports a voluntary system of cooperative health planning at the
24 state and local level.
- 25 2. Health planning should be directed at locally determined efforts to improve access
26 to health care and avoid duplication of effort to maximize limited resources.
- 27 3. Dentists should have equal input along with other health care providers
- 28 4. Public and private sector financing for health planning should have adequate
29 appropriations designated to accomplish the state objectives.
- 30 5. The Association supports collaboration with state and local oral health
31 coalitions ~~to complete these objectives~~ when the objectives of said coalition are
32 consistent with Association policy.

1 **WORKSHEET ADDENDUM**
2 **2020 RESOLUTION 26—COUNCIL ON ADVOCACY FOR ACCESS AND PREVENTION—**
3 **RESCISSION OF THE POLICY, HIGH BLOOD PRESSURE PROGRAMS**

4 **26. Resolved,** that the Policy titled High Blood Pressure Programs (Trans.1974:643; 2013:343) be
5 rescinded.

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**WORKSHEET ADDENDUM
COUNCIL ON ADVOCACY FOR ACCESS AND PREVENTION
ADA POLICY TO BE RESCINDED**

High Blood Pressure Programs (*Trans.*1974:643; 2013:343)

Resolved, that the ADA support members participation in the National High Blood Pressure Program.

1 that is not part of the existing policy and is shown above in brackets. Bracketed text will be
2 removed by the Reference Committee, and is shown above to identify the correction.

3 For clarity, the text of the existing policy, as published in *Current Policies*, reads as follows:

4 **Communications and Dental Practice (Trans.2008:454; 2013:342)**

5 **Resolved**, that the ADA affirms that clear, accurate and effective communication is an essential skill
6 for patient-centered dental practice.

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WORKSHEET ADDENDUM
2020 RESOLUTION 36—COUNCIL ON ADVOCACY FOR ACCESS AND PREVENTION—
AMENDMENT OF THE POLICY, COMMUNICATION AND DENTAL PRACTICE

36. Resolved, that the policy titled Communication and Dental Practice (*Trans.*2008:454; 2013:342) be amended to read as follows (additions are underscored; deletions are ~~stricken~~):

Resolved, ADA affirms that culturally competent, plain language, accurate ~~clear, accurate and effective~~ language communication is an essential skill for patient-centered dental practice.

Resolution No. 40S-1 Amendment

Report: N/A Date Submitted: September 2021

Submitted By: Eleventh Trustee District

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

Total Net Financial Implication: None Net Dues Impact: _____

Amount One-time _____ Amount On-going _____

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

1

AMENDMENT OF THE POLICY, COMMUNICATION AND DENTAL PRACTICE

2 The following amendment to Resolution 40 (Worksheet:5122) was submitted by the Eleventh Trustee
3 District and transmitted on September 22, 2021, by Mr. Kainoa Trotter, assistant executive director,
4 Washington State Dental Association.

5 **Background:** We believe that all communication should be clear, accurate and effective. Those
6 adjectives deal with word choice, and the patient understanding what is being said.

7 We feel that communicating in a culturally competent manner deals with more than just word choice and
8 therefore should stand alone.

9

Resolution

10 **40S-1. Resolved**, that the policy titled Communication and Dental Practice (*Trans.*2008:454;
11 2013:342) be amended to read as follows (additions are double underscoring; deletions are
12 double ~~stricken~~):

13 **Resolved**, that the ADA affirms that ~~culturally competent, plain language, accurate~~ clear, accurate
14 and effective communication is an essential skill for patient-centered dental practice, and be it
15 further

16 **Resolved**, that this communication be delivered in a culturally competent manner.

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

Resolution No. 41 New

Report: N/A Date Submitted: June 2021

Submitted By: Council on Advocacy for Access and Prevention

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

Total Net Financial Implication: None

Net Dues Impact: _____

Amount One-time _____

Amount On-going _____

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

1 **AMENDMENT OF THE POLICY, ENCOURAGING THE DEVELOPMENT OF ORAL HEALTH**
2 **LITERACY CONTINUING EDUCATION PROGRAMS**

3 **Background:** In accordance with Resolution 97H-2020, Special Order of Referral Consent Calendar,
4 which directed the appropriate ADA agencies to report back to the 2021 House of Delegates on each
5 Referred Resolution, Resolution 23-2020, Amendment of the Policy, Encouraging the Development of
6 Oral Health Literacy Continuing Education Programs, was referred to the Council.

7 After consideration, the Council respectfully re-offers its recommendation to amend the policy
8 titled Encouraging the Development of Oral Health Literacy Continuing Education Programs
9 (*Trans.2006:316*). Resolution 23-2020 is appended to this report.

10 In accordance with the Resolution 170H-2012 (*Trans.2010:370*), Regular Comprehensive Policy Review,
11 the Council on Advocacy for Access and Prevention reviewed the Association policy titled Encouraging
12 the Development of Oral Health Literacy Continuing Education Programs (*Trans.2006:316*).

13 The Council moved forward the importance of continuing education in health literacy due to the
14 importance of patient understanding from both a quality aspect as well as a risk management strategy.

15 The Council on Advocacy for Access and Prevention recommends that the following resolution be
16 adopted:

17 **Resolution**

18 **41. Resolved**, that the policy titled Encouraging the Development of Oral Health Literacy Continuing
19 Education Programs (*Trans.2006:316*) be amended as follows (additions are underscored; deletions
20 are ~~stricken~~):

21 **Resolved**, that the Council on Dental Education and Licensure and other appropriate ADA
22 agencies encourage the development of undergraduate, graduate and continuing education
23 programs to train dentists and allied dental team members to effectively communicate in a
24 culturally-competent, plain language, accurate manner with all patients. ~~with limited literacy skills.~~

25 **BOARD RECOMMENDATION: Vote Yes.**

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

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WORKSHEET ADDENDUM
2020 RESOLUTION 23—COUNCIL ON ADVOCACY FOR ACCESS AND PREVENTION—
AMENDMENT OF THE POLICY, ENCOURAGING THE DEVELOPMENT OF ORAL HEALTH
LITERACY CONTINUING EDUCATION PROGRAMS

23. Resolved, that the policy titled Encouraging the Development of Oral Health Literacy Continuing Education Programs (*Trans.*2006:316) be amended as follows (additions are underscored; deletions are ~~stricken~~):

Resolved, that the Council on Dental Education and Licensure and other appropriate ADA agencies encourage the development of undergraduate, graduate and continuing education programs to train dentists and allied dental team members to effectively communicate in a culturally-competent, plain language, accurate manner with all patients. ~~with limited literacy skills.~~

Resolution No. 45 New
 Report: N/A Date Submitted: June 2021
 Submitted By: Council on Ethics, Bylaws and Judicial Affairs
 Reference Committee: D (Legislative, Health, Governance and Related Matters)
 Total Net Financial Implication: None Net Dues Impact: _____
 Amount One-time _____ Amount On-going _____

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

1 **AMENDMENT TO SECTION 3.A. OF THE ADA PRINCIPLES OF ETHICS AND CODE OF**
 2 **PROFESSIONAL CONDUCT**

3 **Background:** In accordance with Resolution 97H-2020, Special Order of Referral Consent Calendar,
 4 which directed the appropriate ADA agencies to report back to the 2021 House of Delegates on each
 5 Referred Resolution, Resolution 29-2020, Amendment to Section 3.A. of the ADA *Principles of Ethics and*
 6 *Code of Professional Conduct*, was referred to the Council on Ethics, Bylaws and Judicial Affairs.
 7 Resolution 29-2020 is appended to this report.

8 After consideration, the Council respectfully resubmits its recommendation to amend Section 3.A. of the
 9 ADA *Principles of Ethics and Code of Professional Conduct*.

10 To emphasize that oral health is integral in the oral health of the population, the Council on Ethics, Bylaws
 11 and Judicial Affairs believes that the ADA *Principles of Ethics and Code of Professional Conduct* should
 12 be amended to explicitly state that dentists have an obligation to use their skills and training to improve
 13 not only the dental health, but the overall health of the public.

14 **Discussion:** Former Surgeon General C. Everett Koop has been cited as saying “You’re not healthy
 15 without good oral health.”¹ Oral health is an integral component of primary care, especially since more
 16 than 64% of adults have visited the dentist in the last year according to the Centers for Disease
 17 Control. *Healthy People 2020*, in recognition of this has as one of its goals to: “Prevent and control oral
 18 and craniofacial diseases, conditions, and injuries, and improve access to preventive services and dental
 19 care.”² This is not only a public health goal, but arguably, is a professional obligation. All professions earn
 20 the trust of society based on agreeing to a common set of rules, including self-regulating, licensing,
 21 lifelong learning, and service to the community including trying to help all in need of service. This also
 22 includes a special duty to care for or protect the most vulnerable including the disabled, the uninsured,
 23 and the undocumented. According to Chalmers, et al. “improving health in the United States will require a
 24 coordinated multisystem solution, and oral health is a key to improving the overall health of the nation.”³

25 From pediatric care⁴ to geriatric care⁵ the role of oral health in overall health is apparent.

26 This comports with the dentist’s obligation under the ADA *Principles of Ethics and Code of Professional*
 27 *Conduct* (the Code) under the Principle of Beneficence which states that “the dentist’s primary obligation
 28 is service to the patient **and the public at large.**”⁶ (emphasis added)

1 In addition to the ethical support of the importance oral health to overall health, there is economic support
2 as well. According to work done by the ADA's Health Policy Institute in partnership with the Dartmouth
3 Institute in 2016, "Better coordination of oral care should be motivated by the opportunity to improve
4 population health through preventive dental care and oral screening while reducing costs of emergency
5 department visits and late stage treatments."⁷

6 The current pandemic has demonstrated the important role that dentists play in protecting and promoting
7 the public's health.

8 Citations to the material referenced in the foregoing discussion are included in **Appendix 1**.

9 For these reasons, the Council on Ethics, Bylaws and Judicial Affairs proposes to amend Section 3.A. of
10 the *Principles of Ethics & Code of Professional Conduct* by deleting the word "dental," as illustrated in the
11 following resolution.

12 **Resolution**

13 **45. Resolved**, that Section 3.A. of the ADA *Principles of Ethics & Code of Professional Conduct* be
14 amended by deletion as follows (deletion ~~stricken through~~):

15 **3.A. COMMUNITY SERVICE.**

16 Since dentists have an obligation to use their skills, knowledge and experience for the
17 improvement of the ~~dental~~ health of the public and are encouraged to be leaders in their
18 community, dentists in such service shall conduct themselves in such a manner as to maintain or
19 elevate the esteem of the profession.

20 **BOARD RECOMMENDATION: Vote Yes.**

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

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WORKSHEET ADDENDUM
2020 RESOLUTION 29—COUNCIL ON ETHICS, BYLAWS AND JUDICIAL AFFAIRS—AMENDMENT
TO SECTION 3.A. OF THE ADA *PRINCIPLES OF ETHICS AND CODE OF PROFESSIONAL*
CONDUCT

29. Resolved, that Section 3.A. of the ADA *Principles of Ethics & Code of Professional Conduct* be amended by deletion as follows (deletion ~~stricken through~~):

3.A. COMMUNITY SERVICE.

Since dentists have an obligation to use their skills, knowledge and experience for the improvement of the ~~dental~~ health of the public and are encouraged to be leaders in their community, dentists in such service shall conduct themselves in such a manner as to maintain or elevate the esteem of the profession.

APPENDIX 1**REFERENCES**

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14 Conduct. [https://www.ada.org/~media/ADA/Member%20Center/Ethics/Code_of_Ethics_Book_With_Advisory_Opinions_Revised_to_November_2018.pdf?la=en#:~:text=Section%203%20PRINCIPLE%3A%20BENEFICENCE%20\(%E2%80%9C,for%20the%20benefit%20of%20others.](https://www.ada.org/~media/ADA/Member%20Center/Ethics/Code_of_Ethics_Book_With_Advisory_Opinions_Revised_to_November_2018.pdf?la=en#:~:text=Section%203%20PRINCIPLE%3A%20BENEFICENCE%20(%E2%80%9C,for%20the%20benefit%20of%20others.) [Accessed on 16 July 2020]
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Resolution No. 52 New

Report: N/A Date Submitted: June 2021

Submitted By: Council on Advocacy for Access and Prevention

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

Total Net Financial Implication: None Net Dues Impact: None

Amount One-time _____

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

1 AMENDMENT OF THE POLICY, BOTTLED WATER, HOME WATER TREATMENT SYSTEMS AND
2 FLUORIDE EXPOSURE

3 Background: In accordance with Resolution 170H-2012 (*Trans.*2010:370) Regular Comprehensive
4 Policy Review, the Council on Advocacy for Access and Prevention reviewed the Association policy titled
5 Bottled Water, Home Water Treatment Systems and Fluoride Exposure (*Trans.*2002:390; 2013:342).

6 The addition of language to include the patient community in the educational process was felt by the
7 Council and its National Fluoridation Advisory Committee to be an important advocacy strategy
8 supporting optimal fluoride exposure for disease prevention.

9 This additional language also highlights the need for fluoride content labeling for bottled water products,
10 which have experienced an increase in consumption by consumers.

11 The Council on Advocacy for Access and Prevention recommends that the following resolution be
12 adopted:

13 Resolution

14 52. Resolved, that policy titled Bottled Water, Home Water Treatment Systems and Fluoride
15 Exposure (*Trans.*2002:390; 2013:342) be amended as follows (additions are underscored; deletions
16 are ~~stricken~~):

17 Resolved, that in order to ensure optimal fluoride intake, the American Dental Association
18 supports actions by its members to educate their patients and communities regarding the level of
19 fluoride in bottled water and the possible removal of fluoride by some home water treatment
20 systems, and be it further

21 Resolved, that the American Dental Association urges its members to inquire about their
22 patients' primary and secondary water source as part of the health history and be it further

23 Resolved, that the American Dental Association supports the labeling of bottled water with the
24 fluoride concentration of the product and company contact information including address, ~~and~~
25 telephone and website, and be it further

26 Resolved, that the American Dental Association urges its members and the public to refer to the
27 International Bottled Water Association's "List of Brands Containing Fluoride", and be it further

1 **Resolved**, that the American Dental Association supports the inclusion of information on
2 the effect of various home water treatment system's effect on water fluoride levels ~~with each~~
3 ~~home water treatment system~~.

4 **BOARD RECOMMENDATION: Vote Yes.**

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

Resolution No. 53 New

Report: N/A Date Submitted: June 2021

Submitted By: Eighth Trustee District

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

Total Net Financial Implication: None Net Dues Impact: _____

Amount One-time _____ Amount On-going _____

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

How does this resolution increase member value: See Background

1 **THE NEW DENTIST COMMITTEE CHAIR SERVING ON THE BOARD OF TRUSTEES**

2 The following resolution was adopted by the Eighth Trustee District and transmitted on June 18, 2021, by
3 Eric Larson, executive director, Illinois State Dental Society.

4 **Background:** In 2018, the ADA Board of Trustees proposed a resolution to change the *Bylaws* to
5 include the New Dentist Committee Chair to serve as a voting member of the ADA Board of Trustees
6 (Sept. 2018, Resolution No. 27, page 5035 of Reference Committee D, Board Report 6 to the House of
7 Delegates: The New Dentist Committee Chair Serving on the Board of Trustees – See Appendix 1). At
8 that time, it was not considered by the ADA House of Delegates due to a ruling of the Speaker. The New
9 Dentist Committee Chair has been a regular guest at the ADA Board of Trustee meetings since 2015
10 however, does not participate in closed or executive sessions of the Board and does not vote. In addition,
11 the New Dentist Committee Chair does not participate in the Board Retreat.

12 Since 2017, the New Dentist liaisons on the ADA Councils have full voting privileges. The New Dentist
13 members have been a valuable resource and they have been successfully incorporated into the Councils.
14 Like any Council Member or Delegate, they are expected to share their point of view and always vote in
15 the best interest of the Association.

16 There is evidence that it is a smart business decision to increase diversity among the executive decision
17 makers in any organization. A May 2020 report by McKinsey & Company concluded that “the business
18 case for inclusion and diversity (I&D) is stronger than ever. For diverse companies, the likelihood of
19 outperforming industry peers on profitability has increased over time, while the penalties are getting
20 steeper for those lacking diversity.”¹

21 The report goes on to outline how companies with the least diverse executive leadership (the lowest, or
22 fourth-quartile companies) are less profitable:

23 “In 2019, fourth-quartile companies for executive-team gender diversity were 19 percent more likely
24 than companies in the other three quartiles to underperform on profitability. This is up from 15 percent
25 in 2017 and nine percent in 2015. And for companies in the fourth quartile of both gender and ethnic
26 diversity the penalty is even steeper in 2019: they are 27 percent more likely to underperform on
27 profitability than all other companies in our data set.”

28 Organizations that are not embracing diversity in their executive leadership ranks are paying a financial
29 penalty for this choice.

1 It is now time to incorporate the New Dentist Committee Chair as a full voting member of the ADA Board
2 of Trustees.

3 **Resolution**

4 **53. Resolved**, that Chapter V. BOARD OF TRUSTEES, Section 10. COMPOSITION and Section 40
5 INSTALLATION of the Bylaws be amended as follows (Additions are underscored, deletions
6 are ~~stricken~~):

7 Section 10. COMPOSITION: The Board of Trustees shall consist of one (1) trustee from
8 each trustee district. Such trustees, the President-elect, and the two Vice-Presidents and
9 the chair of the New Dentist Committee shall constitute the voting members of the Board
10 of Trustees. The President, the Treasurer and the Executive Director of the Association,
11 except as otherwise provided in the Bylaws, shall be non-voting members of the Board of
12 Trustees.

13 * * *

14 Section 40. INSTALLATION: The installation of trustee nominees and the New Dentist
15 Committee chair shall be as provided in the Governance Manual.

16 and be it further

17 **Resolved**, that Chapter V, Section B. Nomination, Declaration of Election and Installation Procedure
18 of the Governance and Organizational Manual of the American Dental Association be amended as
19 follows (additions are underscored, deletions are ~~stricken~~).

20 B. Nomination, Declaration of Election and Installation Procedure. The name of each
21 nominee for the office of trustee brought forward by the nominee's trustee district shall be
22 read to the House of Delegates by the Speaker of the House of Delegates. Because
23 there is only a single nominee provided by each trustee district, following the reading of
24 names, the Speaker of the House of Delegates shall declare the nominees elected. The
25 newly elected trustees and the New Dentist Committee chair shall be installed by the
26 President or the President's designee.

27 **BOARD COMMENT:** The Board of Trustees unanimously supports Resolution 53. This has been
28 considered by the Board for several years and with the changing age demographics, the Board feels it is
29 time to support having the New Dentist Chair as one of its voting members with full privileges.

30 The Board thanks the Eighth District for its very important resolution. Both the Board and Governance
31 Committee concur that it is a timely approach.

32 40 respondents of the 53 dental societies with new dentist participation on their boards overwhelmingly
33 (93%) have voting privileges for those members.

34 In 2017, Resolution 47H-2017 converted new dentist liaisons to full voting members of Councils. This
35 Resolution has now been successfully implemented. The Board believes that now is the time to bring this
36 same innovation to the Board.

37 By allowing the chair of the New Dentist Committee a vote on the Board, the ADA will help to better align
38 its leadership with its membership.

- 39 • The New Dentist Committee Chair is in the ideal position to carry forward the voice of the new
40 dentist. This individual would join the Board after having served three years at the national level

- 1 as a member of the New Dentist Committee and continue to have access to the full New Dentist
2 Committee for additional input.
- 3 • The New Dentist Committee is an Advisory Committee of the ADA Board of Trustees and the chair
4 has been participating in ADA Board meetings as a guest of the Board since 2015. While the New
5 Dentist Committee Chair is currently invited to Board meetings, the chair is not a voting member.
 - 6 • As a guest, the chair's participation in the retreat, in closed sessions, and full access to the Board
7 agenda, has been at the discretion of the Board. This exclusion led to the lack of full access to
8 complete information and the inability to provide a perspective of the New Dentist Committee on
9 various discussions.

10 Concerning the issue of providing a district with more than one representative on the Board by this
11 addition of the chair of the New Dentist Committee, we need to be reminded that it already occurs with
12 both the Vice President positions. The Board of Trustees does not foresee negative consequences, but
13 only positive results with the addition of a different perspective.

14 The Board looks forward to welcoming the New Dentist Committee Chair to the Board as a full voting
15 member.

16 **BOARD RECOMMENDATION: Vote Yes.**

17 **BOARD VOTE: UNANIMOUS.**

18 **Sources:**

19 **McKinsey & Company Report**

- 20 1. [https://www.mckinsey.com/featured-insights/diversity-and-inclusion/diversity-wins-how-](https://www.mckinsey.com/featured-insights/diversity-and-inclusion/diversity-wins-how-inclusion-matters)
21 [inclusion-matters](https://www.mckinsey.com/featured-insights/diversity-and-inclusion/diversity-wins-how-inclusion-matters)

Resolution No. 57 New
 Report: N/A Date Submitted: June 2021
 Submitted By: Council on Advocacy for Access and Prevention
 Reference Committee: D (Legislative, Health, Governance and Related Matters)
 Total Net Financial Implication: None Net Dues Impact:
 Amount One-time Amount On-going

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

PROPOSED POLICY, AMERICAN ACADEMY OF PEDIATRIC DENTISTRY STATEMENT ON PERINATAL AND INFANT ORAL HEALTH CARE (2021)

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Background: In an effort to strengthen the importance of oral health services for pregnant women and infants, the Council on Advocacy for Access and Prevention reviewed the policy on this topic from the American Academy of Pediatric Dentistry (AAPD). This Policy is attached as an Appendix. The Council felt that rather than "reinvent the wheel", it would be strategic to align with the current anticipatory guidance of AAPD, as updated in 2021.

The Council on Advocacy for Access and Prevention recommends that the following resolution be adopted.

Resolution

57. Resolved, that the following policy titled Support for the American Academy of Pediatric Dentistry Guideline on Perinatal and Infant Oral Health Care be adopted:

Support for the American Academy of Pediatric Dentistry Guideline on Perinatal and Infant Oral Health Care

Resolved, that the American Dental Association supports the American Academy of Pediatric Dentistry Anticipatory Guideline on Perinatal and Infant Oral Health Care (2021):

Anticipatory guidance in the perinatal and infant period includes assessment of any growth and development issues that the parents should be aware of or need referral to the child’s medical provider. AAPD BP Periodicity Schedule Assessment of caries risk that should be considered in counselling the parents regarding the child’s fluoride exposure, including consumption optimally fluoridated water, appropriate frequency and quantity of brushing with fluoridated toothpaste, and need for professional topical fluoride applications. (AAPD BP Fluoride) Anticipatory guidance during this infant period also entails oral hygiene instruction, dietary counselling regarding sugar consumption, frequency of periodic oral examinations (AAPD Periodicity Schedule), and information regarding non-nutritive habits that if prolonged may result in flaring of the maxillary incisor teeth, open bite, and a posterior cross bite. (Dogramaci and Rossi-Fedele, 2016). Counselling regarding safety and prevention of orofacial trauma would include discussions of play objects, pacifiers, car seats, electrical cords, and injuries due to falls when learning to walk.

1 **Recommendations**

- 2 1. Advise expecting and new parents regarding the importance of their own oral health
3 and the possible transmission of cariogenic bacteria from parent/primary caregiver to
4 the infant.
- 5 2. Provide caries preventive information regarding: high frequency sugar consumption;
6 brushing twice-daily with optimal amount fluoridated toothpaste; safety and efficacy of
7 optimally-fluoridated community water; and for children at risk for dental caries,
8 fluoride varnish and dietary fluoride supplements (if not consuming optimally-
9 fluoridated water).
- 10 3. Assess caries risk to facilitate the appropriate preventive strategies as the primary
11 dentition begins to erupt.
- 12 4. Provide information to parents regarding common oral conditions in newborns and
13 infants, non-nutritive oral habits (e.g., digit sucking, use of a pacifier), teething
14 (including use of analgesics and avoidance of topical anesthetics), growth and
15 development, and orofacial trauma (including play objects, pacifiers, car seats,
16 electric cords, and falls when learning to walk).
- 17 5. When ankyloglossia results in functional limitations or causes symptom, the need to
18 surgical intervention should be assessed on an individual basis.
- 19 6. When a patient presents with a prematurely erupted primary tooth (i.e., natal or
20 neonatal tooth), decisions regarding intervention should be individualized, based on
21 the interference with feeding, the risk of detachment and aspiration, and any medical
22 or contributing considerations.

23 **BOARD RECOMMENDATION: Vote Yes.**

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

1 **APPENDIX**
2 **AMERICAN ACADEMY OF PEDIATRIC DENTISTRY ANTICIPATORY GUIDANCE ON PERINATAL**
3 **AND INFANT ORAL HEALTH CARE (2021)**

4 Perinatal and Infant Oral Health Care

5 Latest Revision, 2021

6 **Abbreviations**

7 **AAPD:** American Academy Pediatric Dentistry

8 **ECC:** Early childhood caries

9 **FDA:** U.S. Food and Drug Administration

10 **MS:** Mutans streptococci

11 **Purpose**

12 The American Academy of Pediatric Dentistry (**AAPD**) recognizes that perinatal and infant oral health are
13 the foundations upon which preventive education and dental care must be built to enhance the
14 opportunity for a child to have a lifetime free from preventable oral disease. Recognizing that dentists,
15 physicians, allied health professionals, and community organizations must be involved as partners to
16 achieve this goal, the AAPD proposes best practices for perinatal and infant oral health care, including
17 caries risk assessment, anticipatory guidance, preventive strategies, and therapeutic interventions, to be
18 followed by the stakeholders in pediatric oral health.

19 **Methods**

20 Recommendations on perinatal and infant oral health care were developed by the Infant Oral Health
21 Subcommittee of the Clinical Affairs Committee and adopted in 1986.(AAPD 1986) The *Guideline on*
22 *Perinatal Oral Health Care* was originally developed by the Infant Oral Health Subcommittee of the
23 Council on Clinical Affairs and adopted in 2009.(AAPD 2009) This document is an update of the 2016
24 merger of those guidelines.(AAPD 2016) This revision of the combined guideline included a search of the
25 PubMed®/MEDLINE database using the terms: infant oral health, infant oral health care, early childhood
26 caries, perinatal, perinatal oral health, and early childhood caries prevention; fields: all; limits: within the
27 last 10 years, humans, English, and clinical trials, resulting in 261 papers that were reviewed by title and
28 abstract. From those, 26 papers were used to update this document. When data did not appear sufficient
29 or were inconclusive, recommendations were based upon expert and/or consensus opinion by
30 experienced researchers and clinicians.

31 **Background**

32 **Role of oral health providers in perinatal and infant oral health care**

33 The perinatal period is the period beginning with the completion of the 20th to 28th week of gestation and
34 ending one to four weeks after birth. The infant period extends to the child's first birthday. Oral health
35 providers have an important role in perinatal and infant oral health care, particularly regarding the
36 establishment of a dental home, (AAPD Dental Home) educating new parents, and the timing of a child's
37 first dental visit. Oral health providers need knowledge regarding the child's perinatal period and first year

1 of life regarding common oral conditions, anticipatory guidance, and early dental caries preventive care
2 including oral cleaning, dietary recommendations, and optimal fluoride exposure.

3 **Common oral conditions in newborns and infants**

4 Bohn nodules are small developmental anomalies located along the buccal and lingual aspects of the
5 mandibular and maxillary ridges and in the hard palate of the neonate. These lesions arise from remnants
6 of mucous gland tissue. Dental lamina cysts may be found along the crest of the mandibular and
7 maxillary ridges of neonates. These lesions arise from epithelial remnants of the dental lamina. Epstein
8 pearls are keratin-filled cysts found in the mid-palatal raphe at the junction of the hard and soft palates.
9 These three developmental remnants generally disappear shortly after birth, and no treatment is
10 necessary. (Dhar, 2020) Fordyce granules are very common aberrant yellow-white sebaceous glands
11 most commonly on the buccal mucosa or lips. No management is needed as these lesions are
12 inconsequential and resolve on their own.(Dhar, 2020) Ankyloglossia is characterized by an abnormally
13 short lingual frenum that can hinder the tongue movement and may interfere with feeding or speech. The
14 frenum might spontaneously lengthen as the child gets older. Surgical correction, on an individual basis,
15 may be indicated for functional limitations and symptomatic relief. (AAPD Policy on Frenulum, 2019)

16 Oropharyngeal candidiasis appears as white plaques covering the oropharyngeal mucosa which, if
17 removed, leaves an inflamed underlying surface. Candidiasis is usually self-limiting in the healthy
18 newborn infant, but topical application of nystatin to the oral cavity of the baby and to the nipples of
19 breast-feeding mothers may have benefit.(Dhar 2020) Primary herpetic gingivostomatitis presents with
20 oral feature such as erythematous gingiva, mucosal hemorrhages, and clusters of small vesicles
21 throughout the mouth. Somatic signs may include fever, malaise, lymphadenopathy, and difficulty with
22 eating and drinking. Usually, symptoms regress within two weeks, and lesions heal without scarring.
23 (Dhar 2020) Fluids should be encouraged to prevent dehydration, and analgesics may make the child
24 more comfortable.(Dhar 2020) Oral acyclovir may be beneficial in shortening the duration of symptoms.
25 (Santosh 2020) Caution by practitioners and parents is necessary to prevent autoinoculation or
26 transmission of infection to the eyes, other body parts, and other individuals. Other less common viral
27 conditions with oral symptoms in infants are herpangina and hand-foot-mouth disease. (Dhar, 2020)

28 The prevalence of cleft lip with or without cleft palate in 2004-2006 was 10.6 per 10,000 live births in the
29 U.S. and for cleft palate alone was 6.4 per 10,000 live births in the U.S.(NIDRC, 2021) Cleft lip may vary
30 from a small notch in the vermilion border to a complete separation involving skin, muscle, mucosa, tooth,
31 and bone. Clefts may be unilateral or bilateral and may involve the alveolar ridge. Isolated cleft palate
32 occurs in the midline and may involve only the uvula or may extend into or through the soft and hard
33 palates to the incisive foramen. Rehabilitation for the child with a cleft lip or palate may require years of
34 specialized treatment by a cleft lip/palate team. Surgical closure of a cleft lip usually is performed around
35 three months of age; closure of the palate usually occurs around one year.(Dhar, 2020)

36 **Dental eruption (teething)**

37 Natal teeth are present at birth, whereas neonatal teeth erupt in the first month of life. Attachment of natal
38 and neonatal teeth generally is limited to the gingival margin due to little root formation or bony support.
39 These teeth may be a supernumerary or prematurely erupted primary tooth. Natal or neonatal teeth
40 occasionally result in pain and refusal to feed and can produce maternal discomfort because of abrasion
41 or biting of the nipple during nursing. Ulceration, bleeding, and discomfort of the tongue due to repetitive
42 rubbing across a natal tooth during swallowing and movement is called Riga-Fede disease.(Dhar 2020) If
43 the tooth is mobile with a danger of detachment and aspiration, extraction may be warranted. Decisions

1 regarding extraction of prematurely erupted primary teeth and smoothing the incisal edge should be made
2 on an individual basis.

3 Eruption of teeth (teething) can lead to intermittent localized discomfort, irritability, low-grade fever, and
4 excessive salivation; however, many children have no apparent difficulties. Treatment of symptoms
5 includes oral analgesics and teething rings for the child to 'gum'.(Dhar 2020) Use of topical anesthetics
6 or homeopathic remedies to relieve discomfort should be avoided due to potential harm of these products
7 in infants. Because of the risk of methemoglobinemia, benzocaine use is contraindicated in children
8 younger than two years of age. (US FDA, May 2018).

9 **Pregnancy and the perinatal period**

10 The perinatal period is the period beginning with the completion of the 20th to 28th week of gestation and
11 ending one to four weeks after birth. The perinatal period plays a crucial role for the well-being of
12 pregnant women and the health and well-being of their newborn children.(WHO 2020) Mothers' poor oral
13 health is associated with poor oral health of their offspring (Shearer 2011) Yet, many women do not seek
14 dental care during their pregnancy, and those who do often confront unwillingness of dentists to provide
15 care.(Bertness 2017) A systematic review has shown the efficacy of prenatal dental education and
16 preventive therapies in reducing MS in children.(Xiao 2019) Physicians, nurses, and other health care
17 professionals, when aware of the risk factors for dental caries, can help new parents make appropriate
18 decisions regarding timely and effective oral health interventions for their newborns.(Frese 2021)

19 Some medications may pose a risk to infants during the peri-natal period, lactating mothers, and women
20 and men of reproductive potential. Current U.S. Food and Drug Administration (**FDA**) recommendations
21 can assist health care providers when using in-office, prescribed, and over-the-counter medications for
22 these individuals. (U.S.FDA, 2014) While in 2020 the FDA recommended that dental amalgam should be
23 avoided in pregnant women, women planning to become pregnant, women who are nursing, and children
24 under the age of six (U.S. FDA, 2020), it is important to emphasize that dental visits during pregnancy are
25 safe, effective, and should be encouraged. (National Mat Child Oral Health Resource Center, 2012)

26 Newborns and infants frequently have non-nutritive habits, such as digit sucking or use of a pacifier.
27 Prolonged digit sucking can cause flaring of the maxillary incisor teeth, an open bite, and a posterior
28 cross bite. (Dogramaci 2016) However, there should be little concern about the effects of such oral habits
29 during infancy.

30 **Diet for newborns and infants**

31 Benefits of breastfeeding in a child's first year of life are clear (Salone 2013); however, breastfeeding and
32 baby bottle beyond 12 months, especially if frequent and/or nocturnal, are associated with ECC. (Peres
33 2018). Also, allowing a child to drink from a bottle, transportable covered cup, open cup, or box of juice
34 throughout the day may be harmful.(Heyman 2017) Importantly, frequent consumption of free sugars (i.e.,
35 sugars added to food and beverages and sugars naturally present in honey, syrups, fruit juices and fruit
36 juice concentrates) promotes the carious process.(Moynihan 2014) Cohort studies provide evidence that
37 two key characteristics are critical perinatal/infant dietary practices to prevent dental caries: the age at
38 which sugar is introduced to a child and the frequency of its consumption. (Chaffee 2015; Feldens 2018)
39 The American Heart Association recommends that sugar in foods and drink should be avoided in children
40 under two years. (Vos, Kaar, Welsh 2017) Additionally, the American Academy of Pediatrics recommends
41 that 100 percent fruit juice should not be introduced before 12 months of age and be limited to no more
42 than four ounces a day for children between the ages of one and three years. (Heyman 2017).

1 **Dental caries risk in newborns and infants**

2 Early childhood caries (**ECC**) is defined as the presence of one or more decayed (non-cavitated or
3 cavitated lesions), missing or filled (due to caries) surfaces, in any primary tooth of a child under six years
4 of age. (Drury 1999) ECC, like other forms of caries, is a bacterial-mediated, sugar-driven, multifactorial,
5 dynamic disease that results in the phasic demineralization and remineralization of dental hard tissues.
6 (Pitts 2019) Traditional microbial risk markers for ECC include acidogenic-aciduric bacterial species,
7 namely mutans streptococci (MS) and Lactobacillus species.(Kanasi 2010) MS maybe transmitted
8 vertically from caregiver to child through salivary contact, affected by the frequency and amount of
9 exposure.(Douglass 2008). Horizontal transmission (e.g., between other members of a family or children
10 in daycare) also occurs.(Berkowitz 2006) Dental caries in primary teeth may lead to chronic pain,
11 infections, and other morbidities. ECC has major impact on the quality of life of children and their families
12 and is an unnecessary health and financial burden to society.(Pitts 2019)

13 Prevention for ECC needs to begin in infancy. Physicians, nurses, and other health care workers may
14 have more opportunities to educate the parent/caregivers than dental professionals because of the
15 frequency of contact with the family in the first year of the child's life.(Chi 2013) Therefore, they need to
16 be aware of caries risk and protective factors and use this information to promote primary care preventive
17 messages that include: limiting sugar intake in foods and drink; avoiding night-time bottle feeding with
18 milk or drinks containing sugars; avoiding baby bottle usage and breastfeeding beyond 12 months,
19 especially if frequent and/or nocturnal, and having the child's teeth brushed twice daily with a 'smear' of
20 fluoridated toothpaste.(Wright 2014) Additionally, for children who are at high risk for dental caries,
21 professionally-applied fluoride varnish and dietary fluoride supplements (for infants living in non-
22 fluoridated areas) may be part of an individualized preventive plan. (AAPD Caries Risk Assessment 2019)
23 However, a growing number of caregivers are hesitant about professionally-applied topical fluorides. (Chi
24 2018) Fluoride hesitancy mirrors vaccination hesitancy observed in pediatric medicine.(Chi 2014)
25 Inaccurate information about fluoride may be shared among caregivers within online social networks.
26 (Seymour 2015)

27 **Anticipatory Guidance**

28 Anticipatory guidance in the perinatal and infant period includes assessment of any growth and
29 development issues that the parents should be aware of or need referral to the child's medical provider.
30 (AAPD BP Periodicity Schedule) Assessment of caries risk that should be considered in counselling the
31 parents regarding the child's fluoride exposure, including consumption optimally fluoridated water,
32 appropriate frequency and quantity of brushing with fluoridated toothpaste, and need for professional
33 topical fluoride applications. (AAPD BP Fluoride) Anticipatory guidance during this infant period also
34 entails oral hygiene instruction, dietary counselling regarding sugar consumption, frequency of periodic
35 oral examinations (AAPD Periodicity Schedule), and information regarding non-nutritive habits that if
36 prolonged may result in flaring of the maxillary incisor teeth, open bite, and a posterior cross bite.
37 (Dogramaci and Rossi-Fedele, 2016). Counselling regarding safety and prevention of orofacial trauma
38 would include discussions of play objects, pacifiers, car seats, electrical cords, and injuries due to falls
39 when learning to walk.

40 **Recommendations**

- 41 1. Advise expecting and new parents regarding the importance of their own oral health and the possible
42 transmission of cariogenic bacteria from parent/primary caregiver to the infant.
- 43 2. Encourage establishment of a dental home that includes medical history, dental examination, risk
44 assessment, and anticipatory guidance for infants by 12 months of age.

- 1 3. Provide caries preventive information regarding: high frequency sugar consumption; brushing twice-
2 daily with optimal amount fluoridated toothpaste; safety and efficacy of optimally-fluoridated
3 community water; and for children at risk for dental caries, fluoride varnish and dietary fluoride
4 supplements (if not consuming optimally-fluoridated water).
- 5 4. Assess caries risk to facilitate the appropriate preventive strategies as the primary dentition begins to
6 erupt.
- 7 5. Provide information to parents regarding common oral conditions in newborns and infants, non-
8 nutritive oral habits (e.g., digit sucking, use of a pacifier), teething (including use of analgesics and
9 avoidance of topical anesthetics), growth and development, and orofacial trauma (including play
10 objects, pacifiers, car seats, electric cords, and falls when learning to walk).
- 11 6. When ankyloglossia results in functional limitations or causes symptom, the need to surgical
12 intervention should be assessed on an individual basis.
- 13 7. When a patient presents with a prematurely erupted primary tooth (i.e., natal or neonatal tooth),
14 decisions regarding intervention should be individualized, based on the interference with feeding, the
15 risk of detachment and aspiration, and any medical or contributing considerations.

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33 childhood caries prevention: A systematic review and meta-analysis. *Caries Res.* 2019;53(4), 411-21.

Resolution No. 58 New

Report: N/A Date Submitted: June 2021

Submitted By: Council on Advocacy for Access and Prevention

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

Total Net Financial Implication: None Net Dues Impact: _____

Amount One-time _____ Amount On-going _____

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

1 **PROPOSED POLICY, ORAL HEALTH EQUITY**

2 **Background:** Despite many oral health advancements over the last half century, oral health disparities
3 and inequities continue. The Surgeon General’s 2000 report titled “Oral Health in America,” identified
4 systemic disparities and inequities in social determinants of oral health that disproportionately prevent
5 those in vulnerable communities from accessing the resources needed to achieve and maintain their oral
6 health, and in turn, their overall health.

7 Failing to successfully address the social determinants as an underlying contributor to oral health
8 disparities will certainly continue what the Surgeon General’s report defined as the “silent epidemic” of
9 dental disease leading to devastating consequences for individuals and communities.

10 As the nation’s leading oral health advocate, the American Dental Association (ADA) needs to adopt a
11 policy clearly defining oral health equity and the principles that will guide the ADA’s efforts in helping to
12 achieve it.

13 **Resolution**

14 **58. Resolved,** that the American Dental Association (ADA) defines oral health equity as optimal oral
15 health for all people. The ADA is committed to promoting equity in oral health care by continuing
16 research and data collection, advocating to positively impact the social determinants of oral health,
17 reinforcing the integral role of oral health in overall health, supporting cultural competency and
18 diversity in dental treatment, disease prevention education, and supporting efforts to improve
19 equitable access to oral health care.

20 **BOARD RECOMMENDATION: Vote Yes.**

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

Resolution No. 59 New

Report: N/A Date Submitted: June 2021

Submitted By: Council on Advocacy for Access and Prevention

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

Total Net Financial Implication: None Net Dues Impact: _____

Amount One-time _____ Amount On-going _____

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

1 **AMENDMENT OF THE POLICY, WOMEN'S ORAL HEALTH: PATIENT EDUCATION**

2 **Background:** In accordance with Resolution 97H-2020, Regular Special Order of Referral Consent
3 Calendar, which directed the appropriate ADA agencies to report back to the 2021 House of Delegates on
4 each Referred Resolution, Resolution 35-2020, Amendment of the Policy titled Women's Oral Health:
5 Patient Education, was referred to the Council.

6 After consideration, the Council respectfully offers the option to amend the policy titled Women's Oral
7 Health: Patient Education (*Trans.*2001:428; 2014:504). Resolution 35-2020 is appended to this report.

8 The Council found that the language referring only to women was prescriptive and limiting.

9 The Council on Advocacy for Access and Prevention recommends that the following resolution be
10 adopted:

11 **Resolution**

12 **59. Resolved,** that the policy titled Women's Oral Health: Patient Education (*Trans.*2001:428;
13 2014:504), be amended to read as follows (additions are underscored; deletions are ~~stricken~~):

14 ~~Women's Parent and Caregiver Oral Health: Patient Education~~

15 **Resolved,** that the ADA work with federal and state agencies, constituent and component
16 societies and other appropriate organizations to incorporate oral health education information
17 into health care educational outreach efforts directed at ~~mothers~~ parents, caregivers and their
18 children, and be it further

19 **Resolved,** that the ADA work with the ~~obstetric prenatal and perinatal~~
20 professional community to ensure that ~~pregnant mothers~~ expectant parents and caregivers
21 are provided relevant oral health care information during the perinatal period.

22 **BOARD RECOMMENDATION: Vote Yes.**

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

1 **WORKSHEET ADDENDUM**

2 **2020 RESOLUTION 35—COUNCIL ON ADVOCACY FOR ACCESS AND PREVENTION—**
3 **AMENDMENT OF THE POLICY, WOMEN'S ORAL HEALTH: PATIENT EDUCATION**

4 **35. Resolved**, that the policy titled Women's Oral Health: Patient Education (*Trans.*2001:428;
5 2014:504), be amended to read as follows (additions are underscored; deletions are ~~stricken~~):

6 ~~Women's~~ Parent and Caregiver Oral Health: Patient Education

7 **Resolved**, that the ADA work with federal and state agencies, constituent and component
8 societies and other appropriate organizations to incorporate oral health education information
9 into health care educational outreach efforts directed at ~~mothers~~ parents, caregivers and their
10 children, and be it further

11 **Resolved**, that the ADA work with the ~~obstetric prenatal and perinatal~~
12 professional community to ensure that ~~pregnant mothers~~ expectant parents and caregivers
13 are provided relevant oral health care information during the perinatal period.

Resolution No. 60 New

Report: N/A Date Submitted: June 2021

Submitted By: Council on Advocacy for Access and Prevention

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

Total Net Financial Implication: None Net Dues Impact: _____

Amount One-time _____ Amount On-going _____

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

1 **AMENDMENT OF THE POLICY, NON-DENTAL PROVIDERS COMPLETING EDUCATIONAL**
2 **PROGRAM ON ORAL HEALTH**

3 **Background:** In accordance with Resolution 97H-2020, Special Order of Referral Consent Calendar,
4 which directed the appropriate ADA agencies to report back to the 2021 House of Delegates on each
5 Referred Resolution, Resolution 39-2020, Amendment of the Policy, Non-Dental Providers Completing
6 Educational Program on Oral Health, was referred to the Council. Resolution 39-2020 is appended to this
7 report.

8 After consideration, the Council respectfully seeks to amend the policy titled Non-Dental Providers
9 Completing Educational Program on Oral Health (*Trans.*2004:301) to correct an error in language carried
10 over from last year.

11 The Council found the language to be prescriptive to local dental societies and the expectation of oral
12 pathology knowledge for non-dental providers to be unrealistic The Council on Advocacy for Access and
13 Prevention recommends that the following resolution be adopted:

14 **Resolution**

15 **60. Resolved,** that the policy titled Non-Dental Providers Completing Educational Program on Oral
16 Health (*Trans.*2004:301; 2014:505) to be amended as follows (additions are underscored; deletions
17 are ~~stricken~~):

18 **Resolved,** that only dentists, physicians and their properly supervised and trained designees, be
19 allowed to provide preventive dental services ~~to patients of all ages~~ to infants and young children,
20 and be it further

21 **Resolved,** that anyone that provides preventive dental services to infants and young children
22 should have completed an appropriate educational program on oral health, ~~common oral~~
23 ~~pathology,~~ dental disease risk assessment, dental caries and dental preventive techniques
24 appropriate for ~~the age groups under their care~~ this age group, and be it further

25 **Resolved,** that the ADA ~~urge~~ encourage constituent societies to support this policy.
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1 **BOARD RECOMMENDATION: Vote Yes.**

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

4 **Administrative Note: Resolution 60 was editorially corrected by the Speaker on October 4, 2021. It**
5 **was brought to the Speaker’s attention that the proposed resolution as submitted by CAAP**
6 **contained some inadvertent technical errors. The word “appropriate,” as indicated in the above**
7 **Resolution, is language from the existing policy. For clarity, the text of the existing policy, as**
8 **published in *Current Policies*, reads as follows:**

9 **Non-Dental Providers Completing Educational Program on Oral Health (Trans.2004:301; 2014: 505)**

10 **Resolved**, that only dentists, physicians, and their properly supervised and trained designees, be allowed
11 to provide preventive dental services to patients of all ages, and be it further

12 **Resolved**, that anyone that provides preventive dental services should have completed an appropriate
13 educational program on oral health, common oral pathology, dental disease risk assessment, dental caries
14 and dental preventive techniques appropriate for the age groups under their care, and be it further

15 **Resolved**, that the ADA urge constituent societies to support this policy.
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**WORKSHEET ADDENDUM
2020 RESOLUTION 39—COUNCIL ON ADVOCACY FOR ACCESS AND PREVENTION—
AMENDMENT OF THE POLICY, NON-DENTAL PROVIDERS COMPLETING EDUCATIONAL
PROGRAM ON ORAL HEALTH**

39. Resolved, that the policy titled Non-Dental Providers Completing Educational Program on Oral Health (*Trans.*2004:301) to be amended as follows (additions are underscored; deletions are ~~stricken~~):

Resolved, that only dentists, physicians and their properly supervised and trained designees, be allowed to provide preventive dental services to infants and young children, and be it further

Resolved, that anyone that provides preventive dental services to infants and young children should have completed an appropriate educational program on oral health, ~~common oral pathology~~, dental disease risk assessment, dental caries and dental preventive techniques for this age group, and be it further

Resolved, that the ADA encourage constituent societies to support this policy.

Resolution No. 60S-1 Amendment

Report: N/A Date Submitted: October 2021

Submitted By: Sixteenth Trustee District

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

Total Net Financial Implication: None Net Dues Impact: _____

Amount One-time _____ Amount On-going _____

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, NON-DENTAL PROVIDERS COMPLETING EDUCATIONAL PROGRAM ON ORAL HEALTH

The following substitution for Resolution 60 (Worksheet:5148) was submitted by the Sixteenth Trustee District and transmitted on October 5, 2021, by Mr. Phil Latham, South Carolina Dental Association Executive Director.

Resolution

60S-1. Resolved, that the policy titled Non-Dental Providers Completing Educational Program on Oral Health (*Trans.*2004:301; 2014:505) to be amended as follows (additions are double underscored; deletions are double ~~stricken~~):

Resolved, that only dentists, physicians and their properly supervised and trained designees, be allowed to provide preventive dental services to patients of all ages ~~to infants and young children~~, and be it further

Resolved, that anyone that provides preventive dental services ~~to infants and young children~~ should have completed an appropriate educational program on oral health, ~~common oral pathology~~, dental disease risk assessment, dental caries and dental preventive techniques appropriate for ~~the age groups under their care this age group~~, and be it further

Resolved, that the ADA ~~urge~~ encourage constituent societies to support this policy.

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

Resolution No. 61 New

Report: N/A Date Submitted: June 2021

Submitted By: Council on Advocacy for Access and Prevention

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

Total Net Financial Implication: None Net Dues Impact: _____

Amount One-time _____ Amount On-going _____

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

1 **AMENDMENT OF THE POLICY, NON DENTAL PROVIDERS NOTIFICATION OF PREVENTIVE**
 2 **DENTAL TREATMENT**

3 **Background:** In accordance with Resolution 97H-2020, Special Order of Referred Consent Calendar,
 4 which directed the appropriate ADA agencies to report back to the 2021 House of Delegates on each
 5 Referred Resolution, Resolution 38-2020, Amendment of the Policy, Non Dental Providers Notification of
 6 Preventive Dental Treatment was referred to the Council.

7 After consideration, the Council respectfully offers its recommendation to amend the policy titled Non
 8 Dental Providers Notification of Preventive Dental Treatment (*Trans.*2004:303; 2014:505) to include an
 9 error of omitted language from last year. Resolution 38-2020 is appended to this report.

10 The increasing relevance of medical-dental collaboration utilizes bi-directional referral to provide patients
 11 with integrated medical and dental homes, which increases the quality of care. The importance of
 12 communication in these instances is critical to keep all practitioners informed. Significant collaboration
 13 with the American Academy of Pediatrics emphasizes the necessity of notification to the patient’s dental
 14 home of any oral health services provided within a medical setting. The Council recognizes the gap in
 15 communication between medical and dental software programs, but agreed that this modification to
 16 existing policy is a necessary step.

17 The Council on Advocacy for Access and Prevention recommends that the following resolution be
 18 adopted:

19 **Resolution**

20 **61. Resolved,** that the policy titled Non Dental Providers Notification of Preventive Dental Treatment
 21 (*Trans.*2004:303; 2014:505) be amended to read as follows (additions are underscored; deletions
 22 are ~~stricken~~):

23 **Resolved,** that prior to any preventive dental treatment, a dental disease risk assessment should
 24 be performed by a dentist or appropriately trained medical provider, and be it further

25 **Resolved,** that risk assessments, screenings or oral evaluations of patients by non-dentists are
 26 not to be considered comprehensive dental exams, and be it further

1 **Resolved**, that it is essential that non-dentists who provide preventive dental services utilize care
2 coordination to refer the patient to a dentist for a comprehensive examination and to establish a
3 dental home with a report of the services rendered given to the custodial parent or legal guardian.

4 **BOARD RECOMMENDATION: Vote Yes.**

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

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WORKSHEET ADDENDUM
2020 RESOLUTION 38—COUNCIL ON ADVOCACY FOR ACCESS AND PREVENTION—
AMENDMENT OF THE POLICY, NON DENTAL PROVIDERS NOTIFICATION OF DENTAL
PREVENTIVE DENTAL TREATMENT

38. Resolved, that the policy titled Non Dental Providers Notification of Preventive Dental Treatment (*Trans.*2004:303; 2014:505) be amended to read as follows (additions are underscored; deletions are ~~stricken~~):

Resolved, that prior to any preventive dental treatment, a dental disease risk assessment should be performed by a dentist or appropriately trained medical provider, and be it further

Resolved, that risk assessments, screenings or oral evaluations of patients by non-dentists are not to be considered comprehensive dental exams, and be it further

Resolved, that it is essential that non-dentists who provide preventive dental services utilize care coordination to refer the patient to a dental home with a report of the services rendered given to the custodial parent or legal guardian.

Resolution No. 61S-1 Amendment

Report: N/A Date Submitted: October 2021

Submitted By: Thirteenth Trustee District

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

Total Net Financial Implication: None Net Dues Impact: _____

Amount One-time _____ Amount On-going _____

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

1 **AMENDMENT OF THE POLICY, NON DENTAL PROVIDERS NOTIFICATION OF PREVENTIVE**
 2 **DENTAL TREATMENT**

3 The following amendment for Resolution 61 (Worksheet:5151) was submitted by the Thirteenth Trustee
 4 District and transmitted on October 6, 2021, by Jillian Andolina, Strategic Operations Director, California
 5 Dental Association.

6 **Background:** In accordance with Resolution 97H-2020, Special Order of Referred Consent Calendar,
 7 which directed the appropriate ADA agencies to report back to the 2021 House of Delegates on each
 8 Referred Resolution, Resolution 38-2020, Amendment of the Policy, Non Dental Providers Notification of
 9 Preventive Dental Treatment was referred to the Council.

10 After consideration, the Council respectfully offered its recommendation to amend the policy titled Non
 11 Dental Providers Notification of Preventive Dental Treatment (*Trans.*2004:303; 2014:505) to include an
 12 error of omitted language from last year.

13 The increasing relevance of medical-dental collaboration utilizes bi-directional referral to provide patients
 14 with integrated medical and dental homes, which increases the quality of care. The importance of
 15 communication in these instances is critical to keep all practitioners informed. Significant collaboration
 16 with the American Academy of Pediatrics emphasizes the necessity of notification to the patient's dental
 17 home of any oral health services provided within a medical setting. The Council recognizes the gap in
 18 communication between medical and dental software programs, but agreed that this modification to
 19 existing policy is a necessary step.

20 While California agrees with this policy, the policy limits that a caries/dental disease risk assessment be
 21 conducted by a dentist or trained medical provider, however, in California registered dental hygienists in
 22 alternative practice (RDHAPs) can conduct a risk assessment or a dentist can rely on information
 23 gathered by a registered dental hygienist, registered dental hygienist in alternative practice or registered
 24 dental assistant in extended functions. The proposed amendment would align the policy better with
 25 California law, and simply adding the word "dental" would allow better flexibility for other states and their
 26 licensure categories. As such, the Thirteenth District Delegation recommends that the following resolution
 27 be adopted:

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Resolution

61S-1. Resolved, that the policy titled Non Dental Providers Notification of Preventive Dental Treatment (*Trans.*2004:303; 2014:505) be amended to read as follows (additions are double underscored):

Resolved, that prior to any preventive dental treatment, a dental disease risk assessment should be performed by a dentist or appropriately trained dental or medical provider, and be it further

Resolved, that risk assessments, screenings or oral evaluations of patients by non-dentists are not to be considered comprehensive dental exams, and be it further

Resolved, that it is essential that non-dentists who provide preventive dental services utilize care coordination to refer the patient to a dentist for a comprehensive examination and to establish a dental home with a report of the services rendered given to the custodial parent or legal guardian.

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

Resolution No. 62 New

Report: N/A Date Submitted: June 2021

Submitted By: Council on Advocacy for Access and Prevention

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

Total Net Financial Implication: None Net Dues Impact: _____

Amount One-time _____ Amount On-going _____

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

1 **AMENDMENT OF THE POLICY, LIMITED ORAL HEALTH LITERACY SKILLS AND**
 2 **UNDERSTANDING IN ADULTS**

3 **Background:** In accordance with Resolution 97H-2020, Special Order of Referred Consent Calendar,
 4 which directed the appropriate ADA agencies to report back to the 2021 House of Delegates on each
 5 referred resolution, Resolution 33-2020, Amendment of the Policy, Limited Oral Health Literacy Skills and
 6 Understanding in Adults, was referred to the Council.

7 After consideration, the Council respectfully offers a corrected recommendation to amend the policy titled
 8 Limited Oral Health Literacy Skills and Understanding in Adults (*Trans.*2006:317; 2013:342). Resolution
 9 33-2020 is appended to this report.

10 The Council noted that according to population health experts from the National Academy of Medicine, an
 11 estimated 88% of Americans lack basic health literacy skills. The National Advisory Committee on Health
 12 Literacy in Dentistry (NACHLD) recommended the following addition to existing policy which was
 13 unanimously accepted by the Council.

14 **Resolution**

15 **62. Resolved**, that the policy titled Limited Oral Health Literacy Skills and Understanding in Adults
 16 (*Trans.*2006:317; 2013:342) be amended to read as follows (additions are underscored; deletions
 17 are ~~stricken~~):

18 **Resolved**, that ADA recognizes health literacy as a significant ~~that limited oral health literacy is~~
 19 ~~a potential~~ barrier to effective prevention, diagnosis and treatment of oral disease, and be it
 20 further

21 **Resolved**, that dental offices encourage staff training in the principles of health literacy to
 22 improve health outcomes.

23 **BOARD RECOMMENDATION: Vote Yes.**

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

WORKSHEET ADDENDUM

2020 RESOLUTION 33—COUNCIL ON ADVOCACY AND PREVENTION—AMENDMENT OF THE POLICY, LIMITED ORAL HEALTH LITERACY SKILLS AND UNDERSTANDING IN ADULTS

33. Resolved, that the policy titled Limited Oral Health Literacy Skills and Understanding in Adults (*Trans.*2006:317; 2013:342) be amended to read as follows (additions are underscored; deletions are ~~stricken~~)

Resolved, that ADA recognizes health literacy as a significant barrier to effective prevention, diagnosis and treatment of oral disease, and be it further

Resolved, that dental offices encourage staff training in the principles of health literacy to improve health outcomes.

Resolution No. 67 New

Report: N/A Date Submitted: June 2021

Submitted By: Council on Advocacy for Access and Prevention

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

Total Net Financial Implication: None Net Dues Impact: _____

Amount One-time _____ Amount On-going _____

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: Not Applicable

1 **AMENDMENT OF THE POLICY, COMPREHENSIVE STATEMENT ON ALLIED DENTAL PERSONNEL**

2 **Background:** In accordance with Resolution 97H-2020, Special Order of Referral Consent Calendar,
3 which directed the appropriate ADA agencies to report back to the 2021 House of Delegates on each
4 Referred Resolution, Resolution 34-2020, Amendment of the Policy, Comprehensive Statement on Allied
5 Dental Personnel, was referred to the Council.

6 After consideration, the Council respectfully re-offers its recommendation to amend the policy titled
7 Comprehensive Policy Statement on Allied Dental Personnel (*Trans.*1996:699; 1998:713; 2001:467;
8 2002:400; 2006:307; 2010:505). Resolution 34-2020 is appended to this report.

9 The Sixteenth Trustee District offered a substitute resolution, Resolution 34S-1-2020, to include specific
10 language calling for licensed dentists to be working with these professionals. Resolution 34S-1-2020 is
11 also appended to this report. The Council felt the original resolution captured the appropriate language
12 regarding dental personnel connecting screened patients to dentists, be they in clinics or licensed in other
13 settings allowed by states.

14 In accordance with Resolution 170H-2012 (*Trans.*2010:370), Regular Comprehensive Policy Review, the
15 Council on Advocacy for Access and Prevention reviewed the Glossary of the Association policy titled
16 Comprehensive Policy Statement on Allied Dental Personnel (*Trans.*1996:699;
17 1998:713;2001:467;2002:400; 2006:307;2010:505).

18 The Council noted that the evolution of the Community Dental Health Coordinator (CDHC) has moved
19 away from the language of the pilot program and into a menu of activities compatible with state dental
20 practice acts.

21 As the CDHC program now has over 600 graduates with a normalized educational structure, the Council
22 on Advocacy for Access and Prevention recommends that the following resolution be adopted:

23 **Resolution**

24 **67. Resolved,** that the definition of the term “Community Dental Health Coordinator” in the policy
25 titled Comprehensive Policy Statement on Allied Dental Personnel (*Trans.*1996:699; 1998:713;
26 2001:467; 2002:400; 2006:307; 2010:505) be amended as follows (additions are underscored,
27 deletions are ~~stricken~~):

**Glossary of Terminology Related to
Allied Dental Personnel Utilization and Supervision**

Community Dental Coordinator (CDHC): ~~An individual trained in an ADA pilot program as a community health worker with dental skills through the ADA-licensed curriculum as a dental trained professional with community health worker skills.~~ Their aim is to improve oral health education and to assist at-risk communities with disease prevention. Working under the supervision of a dentist, a CDHC helps at-risk patients improve their preventive oral health through education and awareness programs, navigate the health system and receive care from a dentist in an appropriate clinic licensed dentists.

~~CDHCs also perform limited clinical duties, such as screenings, fluoride treatments, placement of sealants and temporary restorations and simple teeth cleanings. CDHCs also perform limited clinical duties only as allowed by their State Practice Acts such as screenings, fluoride treatments, and sealant placement until the patient can receive [care] comprehensive services from a dentist or dental hygienist. Upon graduation, they will work primarily in [a] public health and community settings like clinics, schools, churches, faith based settings, senior citizen centers, and Head Start programs in coordination with a variety of dental providers, including clinics, community health centers, the Indian Health Service and private practice dentists dental offices.~~

BOARD RECOMMENDATION: Vote Yes.

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

Administrative Note: Resolution 67 was editorially corrected by the Speaker on October 4, 2021. It was brought to the Speaker's attention that the proposed resolution as submitted by CAAP contained some inadvertent technical errors. The errors are indicated above in yellow. The words "care" and "a" are not part of existing policy and are shown in brackets. This bracketed text will be removed by the Reference Committee and is shown above to identify the correction. For clarity, the text of the existing policy, as published in *Current Policies*, reads as follows:

"Community Dental Health Coordinator" in the policy titled Comprehensive Policy Statement on Allied Dental Personnel (*Trans.*1996:699; 1998:713; 2001:467; 2002:400; 2006:307; 2010:505)

Community Dental Health Coordinator (CDHC): An individual trained in an ADA pilot program as a community health worker with dental skills. Their aim is to improve oral health education and to assist at-risk communities with disease prevention. Working under the supervision of a dentist, a CDHC helps at-risk patients improve their preventive oral health through education and awareness programs, navigate the health system and receive care from a dentist in an appropriate clinic.

CDHCs also perform limited clinical duties, such as screenings, fluoride treatments, placement of sealants and temporary restorations and simple teeth cleanings, until the patient can receive comprehensive services from a dentist or dental hygienist. Upon graduation, they will work primarily in public health and community settings like clinics, schools, churches, senior citizen centers, and Head Start programs in coordination with a variety of dental providers, including clinics, community health centers, the Indian Health Service and private practice dentists.

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**WORKSHEET ADDENDUM
2020 RESOLUTIONS
2020 RESOLUTION 34—COUNCIL ON ADVOCACY FOR ACCESS AND PREVENTION
2020 RESOLUTION 34S-1—SIXTEENTH TRUSTEE DISTRICT
AMENDMENT OF THE POLICY, COMPREHENSIVE POLICY STATEMENT ON ALLIED DENTAL
PERSONNEL**

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34. Resolved, that the terminology describing the Community Dental Health Coordinator provided in the “Glossary of Terminology Related to Allied Dental Personnel Utilization and Supervision” of the ADA Comprehensive Policy Statement on Allied Dental Personnel (*Trans.*1996:699; 1998:713; 2001:467; 2002:400; 2006:307; 2010:505) be amended as follows (new language underscored, deletions ~~stricken through~~):

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Community Dental Coordinator (CDHC): an individual ~~trained in an ADA pilot program as a community health worker with dental skills~~ through the ADA licensed curriculum as a dental trained professional with community health worker skills. Their aim is to improve oral health education and to assist at risk communities with disease prevention. Working under the supervision of a dentist, a CDHC helps at risk patients improve their preventive oral health through education and awareness programs, navigate the health system and receive care from a ~~dentist in an appropriate clinic~~ licensed dentists.

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~~CDHCs also perform limited duties such as screenings, fluoride treatments, placement of sealants and temporary restorations and simple cleanings.~~ CDHCs also perform limited clinical duties only as allowed by their State Practice Acts such as screenings, fluoride treatments, and sealant placement until the patient can receive care from a dentist or dental hygienist. Upon graduation, they will work primarily in a public health and community settings like clinics, schools, ~~churches,~~ faith based settings, senior citizen centers, and Head Start programs in coordination with a variety of dental providers, including clinics, community health centers, the Indian Health Service and private practice ~~dentists~~ dental offices.

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34S-1. Resolved, that the terminology describing the Community Dental Health Coordinator provided in the “Glossary of Terminology Related to Allied Dental Personnel Utilization and Supervision” of the ADA Comprehensive Policy Statement on Allied Dental Personnel (*Trans.*1996:699; 1998:713; 2001:467; 2002:400; 2006:307; 2010:505) be amended as follows (additions are underscored; deletions are ~~stricken~~):

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Community Dental Health Coordinator (CDHC): an individual ~~trained in an ADA pilot program as a community health worker with dental skills~~ through the ADA licensed curriculum as a dental trained professional with community health worker skills. Their aim is to improve oral health education and to assist at risk communities with disease prevention. Working under the supervision of a dentist, a CDHC helps at risk patients improve their preventive oral health through education and awareness programs, navigate the health system and receive care from a ~~dentist in an appropriate clinic~~ licensed dentists.

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~~CDHCs also perform limited duties such as screenings, fluoride treatments, placement of sealants and temporary restorations and simple cleanings.~~ CDHCs also perform limited clinical duties only as allowed by their State Practice Acts such as screenings, fluoride treatments, and sealant placement until the patient can receive care from a licensed dentist or dental hygienist and establishment of a dental home. Upon graduation, they will work primarily in a public health and community settings like clinics, schools, ~~churches,~~ faith based settings, senior citizen centers, and Head Start programs in with a variety of dental providers, including clinics, community health centers, the Indian Health Service and private practice ~~dentists~~ dental offices.

Resolution No. 67S-1 Amendment

Report: N/A Date Submitted: September 2021

Submitted By: Eleventh Trustee District

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

Total Net Financial Implication: None Net Dues Impact: _____

Amount One-time _____ Amount On-going _____

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

1 **AMENDMENT OF THE POLICY, COMPREHENSIVE STATEMENT ON ALLIED DENTAL PERSONNEL**

2 The following amendment to Resolution 67 (Worksheet:5156) was submitted by the Eleventh Trustee
3 District and transmitted on September 22, 2021, by Mr. Kainoa Trotter, assistant executive director,
4 Washington State Dental Association.

5 **Background:** The resolution as written proposes to eliminate placement of temporary fillings in the list of
6 items a CDHC performs, even though some state practice acts allow for a dental hygienist to place
7 temporary restorations. It leaves sealants and other procedures in the example list. We felt that instead
8 of listing sample procedures which could be done by a CDHC, it would be better to just state the
9 allowable procedures are the ones limited to the States Dental Practice Acts. Also, those procedures
10 allowed by the state could be done until a patient sees a licensed dentist and finds a dental home should
11 be the goal, not seeing a dental hygienist.

12 **Resolution**

13 **67S-1. Resolved**, that the definitions of the term “Community Dental Health Coordinator” in the policy
14 titled Comprehensive Policy Statement on Allied Dental Personnel (*Trans.*1996:699; 1998:713;
15 2001:467; 2002:400; 2006:307; 2010:505) be amended as follows (further additions are double
16 underscored and deletions are double ~~stricken~~):

17 **Community Dental Health Coordinator (CDHC):** An individual trained in an ADA pilot program
18 ~~as a community health worker with dental skills~~ through the ADA licensed curriculum as a dental
19 trained professional with community health worker skills. Their aim is to improve oral health
20 education and to assist at-risk communities with disease prevention. Working under the
21 supervision of a dentist, a CDHC helps at-risk patients improve their preventive oral health
22 through education and awareness programs, navigate the health system and receive care from a
23 ~~dentist in an appropriate clinic~~ licensed dentists.

24 ~~CDHCs also perform limited clinical duties, such as screenings, fluoride treatments, placement of~~
25 ~~sealants and temporary restorations and simple teeth cleanings.~~ CDHCs also perform limited
26 clinical duties only as allowed by their State Practice Acts ~~such as screenings, fluoride~~
27 ~~treatments, and sealant placement~~ until the patient can receive comprehensive services from a
28 dentist or dental hygienist. Upon graduation, they will work primarily in public health and
29 community settings like clinics, schools, ~~churches,~~ faith based settings, senior citizen centers,

- 1 and Head Start programs in coordination with a variety of dental providers, including clinics,
- 2 community health centers, the Indian Health Service and private practice ~~dentists~~ dental offices.
- 3 **BOARD COMMENT: Received after the September 2021 Board of Trustees Meeting.**

Resolution No. 68 New
 Report: N/A Date Submitted: June 2021
 Submitted By: Council on Advocacy for Access and Prevention
 Reference Committee: D (Legislative, Health, Governance and Related Matters)
 Total Net Financial Implication: None Net Dues Impact: None
 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

1 **AMENDMENT TO THE POLICY, ORAL HEALTH EDUCATION IN SCHOOLS**
 2 **Background:** In accordance with the Resolution 170H-2012 (*Trans.*2012:370), Regular Comprehensive
 3 Policy Review, the Council on Advocacy for Access and Prevention reviewed the Association policy titled
 4 Oral Health Education in Schools (*Trans.*2014:506; 2016:319).

5 In addition to reflecting the Council’s updated name, the Council felt it appropriate to include detailed
 6 school designations which are part of the modern education system as well as the inclusion of national
 7 educational organizations for their assistance in promoting oral health education.

8 The Council on Advocacy for Access and Prevention recommends that the following resolution be
 9 adopted:

10 **Resolution**

11 **68. Resolved**, that policy titled Oral Health Education in Schools (*Trans.*2014:506; 2016:319) be
 12 amended as follows (additions are underscored; deletions are ~~stricken~~):

13 **Resolved**, that the Council on ~~Access, Prevention and Interprofessional Relations-Advocacy~~
 14 for Access and Prevention work with the appropriate ADA agencies and national education
 15 organizations to increase the number of school districts requiring oral health education for K-12
 16 students based on the ~~2012-2016~~ School Health Policies and Practices Study (SHPPS) data,
 17 and be it further

18 **Resolved**, that, where applicable, the ADA supports the inclusion of the current National Health
 19 Education Standards in the accreditation requirements for all public, ~~and private~~ and charter
 20 elementary and secondary schools.

21 **BOARD RECOMMENDATION: Vote Yes.**

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

Resolution No. 73 New

Report: Board Report 4 Date Submitted: July 2021

Submitted By: Board of Trustees

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

Total Net Financial Implication: None Net Dues Impact: _____

Amount One-time _____ Amount On-going _____

ADA Strategic Plan Objective: None

How does this resolution increase member value: Not Applicable

1 **REPORT 4 OF THE BOARD OF TRUSTEES TO THE HOUSE OF DELEGATES: CLARIFYING**
2 **AMENDMENTS TO THE MANUAL OF THE HOUSE OF DELEGATES RELATING TO DELEGATE**
3 **ALLOCATION**

4 **Background:** In accordance with the delegate allocation methodology set forth in the Manual of the
5 House of Delegates, every four years the Secretary of the House of Delegates reallocates delegates to
6 each constituent and FDS based on the Association’s year-end membership records for the second
7 calendar year preceding the year in which the delegate allocations are to take effect. For example, the
8 Association’s 2012 year-end membership records were used to determine the delegate allocations that
9 took effect with the 2014 House of Delegates (2014-2017 delegate allocation) and in 2017, the Secretary
10 of the House of Delegates used the Association’s 2016 year-end membership records to calculate the
11 number of delegates allocated to each constituent and FDS to take effect with the 2018 House of
12 Delegates (2018-2021 delegate allocation). The 2018- 2021 delegate allocation is scheduled to expire at
13 the close of the 2021 House of Delegates.

14 Pursuant to the Manual of the House of Delegates, the Secretary of the House has notified districts and
15 states of the new allocation for 2022-2025. The notification contained the allocation which will result if the
16 Board’s proposed resolution set forth in this report is adopted and the allocation which will result if the
17 resolution is not adopted. The proposed resolution would primarily amend a single phrase in two places
18 and one additional phrase. As is described below, the issue relates to whether active, life and retired
19 members who are not included in a constituent society or federal dental service should be counted in the
20 allocation formula.

21 **The Proposed Change and its Implications for Delegate Allocation:** The Board of Trustees is
22 proposing to the House of Delegates a resolution to clarify the delegate allocation methodology set forth
23 in the Representation of Constituents and Periodic Reapportionment of Delegates and Alternate
24 Delegates section of the *Manual of the House of Delegates*.

25 Currently the House is comprised of 483 delegates. If the proposed resolution is adopted, the House will
26 grow by one delegate to 484. In this scenario, four states and one Federal Dental Service would lose a
27 single delegate each.

28 If the resolution is not adopted, the House will shrink by eleven delegates to 472 and the same states and
29 the same Federal Dental Service would still lose a single delegate each. In total, twelve states would lose
30 a delegate and five states which would gain a delegate if the resolution were adopted would instead not
31 gain a delegate.

1 Under either scenario, the size of the House will meet the target contained in the House Manual of 473,
2 plus or minus five percent. In other words, either approach—adopting the resolution or not adopting it—
3 would be acceptable under the allocation methodology.

4 Appendix 1 to this report contains the allocation of delegates (column 1) assuming the proposed
5 resolution is adopted and (column 2) assuming the proposed resolution is not adopted.

6 The Board's proposal is centered on a phrase used in the delegate allocation formula. The question is
7 whether that phrase should be "the total membership of the Association" or "the total membership of
8 constituent and federal dental services." These phrases are not equivalent. There are members of the
9 ADA who are active, life or retired members, but are not members of constituent and federal dental
10 service. This includes four ADA Direct Members, 45 Civil Service Members, 720 Graduate Students,
11 1,934 Provisional Members, 173 US Abroad Members and two Unknown. A related amendment is also
12 proposed to Representation of Constituents and Periodic Reapportionment of Delegates and Alternate
13 Delegates, Section A. Goal of Delegate Apportionment of the allocation formula to change "active, life and
14 retired members of the Association" to "active, life and retired members of constituents and federal dental
15 services."

16 The written allocation methodology contained in the *Manual of the House of Delegates*, as adopted by the
17 2013 House in Resolution 2H-2013, states that "*the total membership of the Association*" shall be used to
18 calculate delegate allocations. But Appendix 1 of Resolution 2H-2013 which showed how the resolution's
19 written formula would be implemented used instead "*total membership of constituent and federal dental*
20 *services*" as part of the mathematical formula used in delegate allocation. When this mathematical
21 formula was translated into writing for the resolution; however, "total membership of the Association" was
22 used. This was unintentional as demonstrated by the fact that the actual calculations for the delegate
23 allocations for the 2014-2017 and 2018-2021 were performed using "total membership of constituents
24 and federal dental services" just as set forth and modeled in Appendix 1 of Resolution 2H-2013.¹

25 To use "total membership of the Association" instead of "total membership of constituents and FDS" (as
26 proposed in the Board's resolution) would decrease the number of delegates allocated to constituent
27 societies and Federal Dental Services. In contrast, using "total membership of constituents and federal
28 dental services", as proposed by the Board, favors all constituents and FDS in that it maximizes the
29 number of delegates that each entity may be allocated as described above and seen in the attached
30 appendices. Appendix 1 compares the delegate allocation using "total membership of constituents and
31 federal dental services" versus using "total membership of the Association." Again, either approach
32 satisfies the requirement that the size of the House fall within five percent of the target size as set forth in
33 the House manual.

34
35 **Conclusion:** Given the information above, the Board offers to the House of Delegates a proposed
36 resolution. If it is adopted, the allocation reflected in Appendix 1, column 1 would take effect. If not
37 adopted, the allocation reflected in Appendix 1, column 2 would take effect. While either allocation would
38 satisfy the requirements in the delegate allocation methodology, the Board offers the proposed resolution
39 because it believes the resolution reflects the intent of the House at the time the methodology was
40 adopted.

41 Accordingly, the Board of Trustees proposes the following resolution, which requires a two-thirds (2/3)
42 affirmative vote of the delegates present and voting.

¹ Note: A section of the written allocation methodology already provides that "total constituent and federal dental service membership" shall be used to make a related calculation. (*Manual of the House of Delegates*, Representation of Constituents and Periodic Reapportionment of Delegates and Alternate Delegates, Section B.4.a).

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Resolution

73. Resolved, that the *Manual of the House of Delegates*, Representation of Constituents and Periodic Reapportionment of Delegates and Alternate Delegates, Section A., be amended as follows (additions underscored, deletions ~~stricken through~~):

Section A. Goal of Delegate Apportionment

The allocation of the remaining delegates over the minimum number of delegates allocated to each constituent and the District of Columbia Dental Society shall be made pursuant to the delegate allocation methodology set forth in this section of the *Manual of the House of Delegates*. The goals of the delegate apportionment scheme adopted by the ADA is to (i) achieve as close to proportional representation of active, life and retired members of ~~the Association~~ constituents and federal dental services as possible while providing for the minimum representational requirements set forth in the *Governance and Organizational Manual of the American Dental Association (Governance Manual)*; (ii) providing for representation of the American Student Dental Association; and (iii) maintaining the size of the House of Delegates as close to 473 delegates as possible while meeting the other goals recited in this herein.

and be it further

Resolved, that the *Manual of the House of Delegates*, Representation of Constituents and Periodic Reapportionment of Delegates and Alternate Delegates, Subsection B.3., be amended as follows (additions underscored, deletions ~~stricken through~~):

Subsection B.3. Determination of the True Proportional Delegate Counts for each Constituent and each Federal Dental Service

Divide each constituent's and each federal dental service's total membership by the ~~total membership of the Association~~ total constituent and federal dental service membership of the Association. Multiply the resulting percentage of membership for each constituent and federal dental service by the target number of delegates set forth in section B.1. of this methodology less the number of delegates allocated to the American Student Dental Association in section B.2. of this allocation methodology. The resulting true proportional delegate numbers will be used later in the delegate allocation methodology.

and be it further

Resolved, that the *Manual of the House of Delegates*, Representation of Constituents and Periodic Reapportionment of Delegates and Alternate Delegates, Subsection B.5., be amended as follows (additions underscored, deletions ~~stricken through~~):

Subsection B.5. Calculation of Non-Minimum Membership Total

Subtract the total membership numbers of each constituent and federal dental service identified as being excluded from the remaining steps of the delegate allocation methodology from the ~~total membership of the Association~~ total constituent and federal dental service membership of the Association. The resulting non-minimum membership total will be used in the remaining delegate allocation methodology steps.

BOARD RECOMMENDATION: Vote Yes.

BOARD VOTE: UNANIMOUS.

Column 1: 2022-2025 Delegate Allocation if Proposed Resolution is Adopted
 Column 2: 2022-2025 Delegate Allocation if Proposed Resolution is Not Adopted

State	2018-2021 Delegates	Column 1: If Proposed Resolution is Adopted (2022-2025 Delegates): Calculated using "Total Membership of Constituents and Federal Dental Services"	Delegate Gain/Loss	Column 2: If Proposed Resolution is Not Adopted (2022-2025 Delegates): Calculated using "Total Membership of the Association"	Delegate Gain/Loss
First Trustee District					
Connecticut	7	7	0	7	0
Maine	2	2	0	2	0
Massachusetts	16	16	0	16	0
New Hampshire	2	2	0	2	0
Rhode Island	2	2	0	2	0
Vermont	2	2	0	2	0
Second Trustee District					
New York	36	36	0	35	-1
Third Trustee District					
Pennsylvania	16	15	-1	15	-1
Fourth Trustee District					
Delaware	2	2	0	2	0
Dist of Columbia	2	2	0	2	0
Maryland	7	7	0	7	0
New Jersey	14	14	0	13	-1
Puerto Rico	1	1	0	1	0
Virgin Islands	1	1	0	1	0
Air Force	2	2	0	2	0
Army	2	2	0	2	0
Navy	2	2	0	2	0
Public Health Service	2	1	-1	1	-1
Veterans Affairs	2	2	0	2	0
Fifth Trustee District					
Alabama	5	5	0	5	0
Georgia	10	11	1	10	0
Mississippi	3	3	0	3	0

Column 1: 2022-2025 Delegate Allocation if Proposed Resolution is Adopted
 Column 2: 2022-2025 Delegate Allocation if Proposed Resolution is Not Adopted

State	2018-2021 Delegates	Column 1: If Proposed Resolution is Adopted (2022-2025 Delegates): Calculated using "Total Membership of Constituents and Federal Dental Services"	Delegate Gain/Loss	Column 2: If Proposed Resolution is Not Adopted (2022-2025 Delegates): Calculated using "Total Membership of the Association"	Delegate Gain/Loss
Sixth Trustee District					
Kentucky	5	5	0	5	0
Missouri	7	7	0	7	0
Tennessee	7	7	0	7	0
W Virginia	2	2	0	2	0
Seventh Trustee District					
Indiana	9	9	0	9	0
Ohio	16	16	0	15	-1
Eighth Trustee District					
Illinois	20	19	-1	19	-1
Ninth Trustee District					
Michigan	18	18	0	17	-1
Wisconsin	9	9	0	9	0
Tenth Trustee District					
Iowa	5	5	0	5	0
Minnesota	9	9	0	9	0
Nebraska	3	3	0	3	0
North Dakota	2	2	0	2	0
South Dakota	2	2	0	2	0
Eleventh Trustee District					
Alaska	2	2	0	2	0
Idaho	3	3	0	3	0
Montana	2	2	0	2	0
Oregon	7	7	0	6	-1
Washington	13	13	0	13	0
Twelfth Trustee District					
Arkansas	3	3	0	3	0
Kansas	4	4	0	4	0

Column 1: 2022-2025 Delegate Allocation if Proposed Resolution is Adopted
 Column 2: 2022-2025 Delegate Allocation if Proposed Resolution is Not Adopted

State	2018-2021 Delegates	Column 1: If Proposed Resolution is Adopted (2022-2025 Delegates): Calculated using "Total Membership of Constituents and Federal Dental Services"	Delegate Gain/Loss	Column 2: If Proposed Resolution is Not Adopted (2022-2025 Delegates): Calculated using "Total Membership of the Association"	Delegate Gain/Loss
Louisiana	6	6	0	5	-1
Oklahoma	5	5	0	5	0
Thirteenth Trustee District					
California	71	72	1	71	0
Fourteenth Trustee District					
Arizona	8	8	0	8	0
Colorado	10	11	1	10	0
Hawaii	3	3	0	3	0
Nevada	3	3	0	2	-1
New Mexico	2	2	0	2	0
Utah	5	4	-1	4	-1
Wyoming	2	2	0	2	0
Fifteenth Trustee District					
Texas	27	26	-1	26	-1
Sixteenth Trustee District					
North Carolina	11	12	1	12	1
South Carolina	6	6	0	6	0
Virginia	11	12	1	11	0
Seventeenth Trustee District					
Florida	22	23	1	22	0
American Student Dental Association					
ASDA	5	5	0	5	0
TOTALS	483	484	1	472	-11

Resolution No. N/A N/A

Report: Board Report 3 Date Submitted: July 2021

Submitted By: Board of Trustees

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

Total Net Financial Implication: None Net Dues Impact:

Amount One-time Amount On-going

ADA Strategic Plan Objective: None

How does this resolution increase member value: Not Applicable

1 **REPORT 3 OF THE BOARD OF TRUSTEES TO THE HOUSE OF DELEGATES: REVIEW OF**
2 **TREASURER APPLICATION**

3 **Background:** In accordance with the ADA *Governance and Operation Manual*, an announcement that
4 the ADA is seeking Treasurer Candidates for the 2021-2023 term was placed in an official publication of
5 the Association in November 2020 (the final year of the incumbent Treasurer’s term). The deadline for
6 filing applications with the Association was June 14, 2021, one hundred twenty (120) days prior to the first
7 meeting of the House of Delegates.

8 Resolution B-167-2014 outlines a set of *desirable attributes* and a set of *requirements* for those seeking
9 the office of Treasurer.

10 **B-167-2014. Resolved**, that the Board publish in ADA News prior to the House at which an election
11 for Treasurer will be held, the following set of desirable attributes for those seeking the office of
12 Treasurer and set of requirements for those seeking that office and a standard curriculum vitae form
13 designed to elicit information from candidates about these attributes and requirements for the office of
14 treasurer:

15 Desirable attributes to help inform the House’s consideration of candidates for the office of
16 Treasurer:

- 17 1. Excellent communication skills so as to be able to assist in interpreting Association
18 finances and effectively share financial information with the House of Delegates and the
19 membership;
- 20 2. High integrity; and
- 21 3. Experience with the ADA budget process and finances such as may be obtained from
22 serving as a delegate, trustee, council member or similar service.

23 Requirements for the office of Treasurer to inform the House:

- 24 1. Be an active, life or retired member, in good standing;
- 25 2. Not be a Trustee or elective officer (other than the sitting Treasurer) of the Association;
26 and

- 1 3. Possess a strong background in finance as evidenced by service in roles such as:
2 treasurer of a Constituent Society or Specialty Organization; member for two or more
3 years of a finance committee or audit committee of a Constituent Society or Specialty
4 Organization; member of a board of directors of a for-profit corporation or for-profit
5 subsidiary of a Constituent Society or Specialty Organization; or any other position(s)
6 providing comparable experience.

7 Chapter VI, Section B-2 of the *Governance and Operation Manual* states, in part:

8 "...Each candidate's application shall be reviewed by the Board of Trustees. At least sixty (60) days
9 prior to the convening of the House of Delegates the Executive Director shall provide all members of
10 the House of Delegates, with each candidate's standardized Treasurer *Curriculum Vitae* and the
11 determination of the Board of Trustees as to whether the candidate meets the recommended
12 qualification for the office of Treasurer. No other candidate shall be nominated from the floor of the
13 House of Delegates..."

14 The following individual has submitted their completed curriculum vitae form by the June 14 deadline:

- 15 • John Theodore Sherwin, Virginia
16

17 The candidate's curriculum vitae is attached in Appendix A.

18 In accordance with Chapter VI, Section B-2 of the *Governance and Operation Manual*, the Board of
19 Trustee's reviewed the application for the office of ADA Treasurer. The Board is of the opinion that Dr.
20 John Theodore Sherwin, Virginia meets the required qualifications as identified below.

21 Requirements for the office of Treasurer to inform the House:

- 22 1. Be an active, life or retired member, in good standing;
23 2. Not be a Trustee or elective officer (other than the sitting Treasurer) of the Association;
24 and
25 3. Possess a strong background in finance as evidenced by service in roles such as:
26 treasurer of a Constituent Society or Specialty Organization; member for two or more
27 years of a finance committee or audit committee of a Constituent Society or Specialty
28 Organization; member of a board of directors of a for-profit corporation or for-profit
29 subsidiary of a Constituent Society or Specialty Organization; or any other position(s)
30 providing comparable experience.

31 In addition, the Board offers to the House for its consideration the following desirable attributes for the
32 office of Treasurer:

- 33 1. Excellent communication skills so as to be able to assist in interpreting Association
34 finances and effectively share financial information with the House of Delegates and the
35 membership;
36 2. High integrity; and
37 3. Experience with the ADA budget process and finances such as may be obtained from
38 serving as a delegate, trustee, council member or similar service.

39 The Board offers no opinion with respect to the candidate and these attributes, but merely suggests these
40 attributes to the House as part of its considerations.
41

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

APPENDIX A - BOARD REPORT 3 TO THE HOUSE OF DELEGATES:
REVIEW OF TREASURER APPLICATION

Treasurer Curriculum Vitae Form

ADA American Dental Association®

America's leading advocate for oral health

211 East Chicago Avenue
Chicago, Illinois 60611

The ADA Treasurer Curriculum Vitae Form should be completed in its entirety. If additional space is required, attach extra pages with the same section titles and in the same order. Although it is permissible to attach an existing curriculum vitae, the use of "see attached CV" in any section is discouraged. In accordance with the Governance Manual, this document will be distributed to the members of the House of Delegates at least 60 days prior to the convening of the House. No other candidates shall be nominated from the floor of the House.

11/2020

American Dental Association
Treasurer Curriculum Vitae Form

Name: **John Theodore Sherwin, "Ted"**

PERSONAL INFORMATION	Date	1/11/2021
Office Address 462 N Madison Rd	Phone	540-672-2605
Orange, VA 22960	Fax	540-672-0241
	E-mail	info@tedsherwindds.com
Home Address 10212 Little Skyline Drive	Phone	540-672-5574
Orange, VA 22960	Fax	N/A
	E-mail	Tedsherwin@yahoo.com

EDUCATION	Year	Degree
College Florida State University Religion/Philosophy	1973	BA
Dental School Medical College of Virginia	1984	DDS
Dental Specialty Training N/A		
Other Northwestern Kellogg School of Management; Kellogg Executive Scholar Certificate in Non-Profit Management	2017	Certificate

LICENSURE	State	Year
0401006357	Virginia	1984

ACADEMIC or PROFESSIONAL APPOINTMENTS (Location)	Rank	Year(s)
Teaching N/A		

American Dental Association
Treasurer Curriculum Vitae Form

Research	N/A		

PROFESSIONAL SOCIETY MEMBERSHIPS (excluding ADA)	Offices Held
International College of Dentists-Fellow	
American College of Dentists-Fellow	
Pierre Fauchard Academy-Fellow	
Academy of General Dentistry-Fellow	See Below

DENTAL PRACTICE (location)	Dates
Dr. Perry Jones and Associates, Richmond, VA	1984-1985
Ted Sherwin DDS PC, Orange, VA-sole owner	1985-Present

HONORS and AWARDS
Presidential Citation, ADA, Budget and Finance Committee (2014)
Distinguished Dentist Emanuel W. Michaels Award, VDA (2018)
Special Service Award VDA 2019
Presidential Citation, VDA (2015 & 2016)
Fellow, Virginia Dental Association (2005)
Fellow, Academy of General Dentistry (1989)

COMMITTEES—DENTAL ORGANIZATIONS (including ADA)	Dates
ADA Council on Membership	2016-2018
ADA House Res 97H Workgroup- House studies its role in Budget process and Strategic Planning; Author and member	2012-2013
ADA Board Strategic Planning Committee	2010-2012
ADA Board Budget and Finance Committee-Presidential Citation*	2009-2014
ADA Special Committee on Financial Affairs of the HOD	2009-2011

American Dental Association
Treasurer Curriculum Vitae Form

VDA Council on Finance, Chair	2004-2007
AGD Board Audit Committee	2007-2009

OFFICES HELD—DENTAL ORGANIZATIONS (including ADA)	Dates
Treasurer, American Dental Association	2018-2021
President, Virginia Dental Association	2013-2014
Treasurer, Virginia Dental Association	2015-2018 2007-2011
Trustee, Academy of General Dentistry	2006-2011
Chair, Regional Directors, Academy of General Dentistry	2005-2006
President, Virginia Academy of General Dentistry	1994-1995

PRESENTATIONS—LOCAL, STATE, NATIONAL (list five most recent)		
Topic	Society	Date
1. Treasurer’s Address-House of Delegates Treasurer’s Summit	ADA	2019- 2021
2. Virginia’s Success in Access to Care ADA Presidents Elect Conference	ADA	2014
3. Treasure’s Report VDA House of Delegates		2008 2009 2010 2011 2016 2017 2018
4. President’s Address	VDA-HOD	2014
5. Commencement Exercises	Virginia Common- wealth University School of Dentistry	2014

American Dental Association
Treasurer Curriculum Vitae Form

ARTICLES PUBLISHED (list three most recent)
1. ADA Treasurer's Newsletters-2019 & 2020
2. Dental Care for Aging Seniors is Growing Problem - Used in a number of Virginia newspapers. Picked up by Dr. Bicuspid as a Featured Article, August 5, 2014.
3. The Virginia Plan- Improving Access to Care and Medicaid Utilization - VDA Journal, Pages 16-18; Vol 89, Number 4, Oct-Dec 2012

PREVIOUS FINANCIAL and BUDGET EXPERIENCE (including the ADA)	
American Dental Association Financial and Budget Experience	
2018-2021	Treasurer
2018-2021	ADA Board Budget and Finance Committee - Member
2018-2021	ADA Board Audit Committee-Report when requested
2018-2021	ADA Business Innovation Committee - Consultant
2018-2021	ADA Pension Committee - Chair
2018-2021	ADA Compensation Committee - Member (No Vote)
2009-2014	ADA Board Budget and Finance Committee - Finance Committee Workgroup
2009-2014	ADA Board Administrative Committee
2010-2012	ADA Board Strategic Planning Committee
2009-2011	ADA House Special Committee on Finance Affairs
2012-2013	ADA House Res 97H Workgroup - Author and member
2016-2018	ADA Council on Membership
2017	16th District Caucus Observer Team on Budget, Business, Membership, and Administrative Affairs - Chair
2006, 2008, 2010, 2012, 2014	16 th District Caucus Observer Team on Budget, Business and Administrative Matters - Chair

American Dental Association
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PREVIOUS FINANCIAL and BUDGET EXPERIENCE (including the ADA)

2004 - 2018	16 th District Caucus Observer Team on Budget, Business and Administrative Matters - Member
2014-2018	Delegate
2004-2013	Alternate Delegate

Virginia Dental Association Financial and Budget Experience

2015-2018	Treasurer
2007-2011	Treasurer
2013-2014	President
2004-2007	Chair, Council on Finance
2006-2007	Chair, Council on Sessions
2004-2005	President, Shenandoah Valley Dental Association
1996-1997	President, Shenandoah Valley Dental Association
2002	Chair, Sponsorship Committee
2014-2016	Chair, Student Debt Taskforce
1994-2007	Member, House of Delegates

Academy of General Dentistry Financial and Budget Experience

2007-2009	AGD Board Audit Committee
2006-2011	AGD Trustee
2009-2011	Chair, AGD Board Futures Committee
2005-2006	Chair, AGD Regional Directors
2003-2006	AGD Regional Director
2004-2005	Chair, AGD Leadership Conference

Virginia Academy of General Dentistry Finance and Budget Experience

1994-1995	President
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General Practice Finance and Budget Experience

1985-Present	Sole owner of Ted Sherwin, DDS, PC; 9 staff; two locations
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Civic Finance and Budget Experience

1999-2000	Member, Orange County School Board, Orange, VA
1994-1995	President, Library Foundation, Orange, VA
1990-1997	Chairman, Library Board, Orange, VA
2014-2018	Chair of Finance Committee, Orange Presbyterian Church
1997-1998	Orange Rotary Club - President
1993-1994	Orange Rotary Club - Fund Raising Czar

American Dental Association Treasurer Curriculum Vitae Form

Describe your background in finance and any service in roles such as: Treasurer of a constituent society or specialty organization; member for two or more years of a Finance Committee or Audit Committee of a constituent society or specialty organization; member of a board of directors of a for-profit corporation or for-profit subsidiary of a constituent society or specialty organization; or any other position(s) providing comparable experience.

As the current ADA Treasurer, I have gained 3 years of knowledge and experience that is essential to the role of Treasurer. Being intimately involved and helping to guide the Budget process while working with the Finance Team, the Executive Director, the Budget and Finance Committee, the Board of Trustees, and the House of Delegates has been the ideal background to serve a second term as Treasurer of the American Dental Association.

In 2017, I completed my Executive Scholar Certificate in Non-Profit Management at Kellogg School of Management/Northwestern. This unique program offered me an in-depth study of structural and functional leadership in non-profit finances and how that intersects with strategic planning, budgeting, and long term financial planning.

I was honored to be selected to serve on the Special Committee on Financial Affairs for the ADA HOD (2009-2011). Our Committee did a rigorous top to bottom review of all ADA financial processes where I gained a unique understanding of the finances of the ADA. While serving 5 years on the ADA Board's Finance and Administrative Committees (2009-2014), and 2 years on Strategic Planning (2010-2012), I acquired a comprehensive working knowledge of the ADA budgeting process and how it is driven by the Strategic Plan.

Utilizing my experience as Virginia Dental Association Treasurer for 7 years (2015-2018, 2007-2011), as well as serving as VDA President (2013-2014), I have a strong background in how a strategic plan drives the budget process and the leadership skills necessary to navigate our Association through the intricacies of the budget process and the essential communications that need to occur with the House of Delegates. As VDA Chair of the Council on Finances (2004-2007) and VDA Treasurer, I became well versed in implementing the Strategic Plan through a budget process and how important visionary thinking is for long term financial sustainability of our Association. As VDA Treasurer, working with our talented staff, it was my responsibility to develop the budget, and shepherd it through the Council on Finance, the Board of Directors, as well as the House of Delegates. Together these experiences have taught me how fundamental good communication and transparency are to maintaining the trust of the House of Delegates.

Serving on the Academy of General Dentistry's Audit Committee (2007-2009) taught me a great deal about risk management including an unbiased and broad view of both internal and external risks and how important it is to be able to demonstrate integrity in finances, management, and the operations of the organization. Being involved in the Academy of General Dentistry, both as state President and at the national level, serving 5 years as a national Trustee (2006-2011), and national Chair of AGD's Futures Committee (2009-2011) were opportunities that gave me important additional practical experience in risk management, the budget process, strategic planning, and anticipating future needs and managing sustainability of finances of a national organization.

My financial and budget experience began in my local community 30 years ago, where I served 7 years as Chair of our non-profit Orange County Library Board (1990-1997) which was primarily funded by our local government. There was never an easy pathway with public funding--it required a vision,

American Dental Association
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PREVIOUS FINANCIAL and BUDGET EXPERIENCE (including the ADA)

communicating the vision effectively, and leadership to achieve that vision. That vision of future opportunities and good communications was essential as we transitioned the growth of a private non-profit 90-year-old single building library to a 3 branch County public library system. This transformation was grounded in finances as our County Supervisors had to see the benefits, but we also needed to manage the financial cost of change. Serving as a member of the Orange County School Board (1999-2000) gave me an early glimpse of the finances of a public funded entity that had a large staff, numerous buildings, and a state retirement plan. These early experiences shaped my skills in finances, communication, and leadership, in challenging and adverse environments.

Describe your experience with the ADA budget process and finances, including any experience gained from serving as a delegate, trustee, council member or similar service.

Serving as ADA Treasurer for 3 years is the best teaching experience possible. It represents on the job training in all aspects of the ADA budget process and financial systems.

Serving on the 16th District's Budget, Business and Administrative Matters Observer Team for 13 years, 6 times as Chair, has led to a constantly evolving understanding of ADA's complex budget process. As Chair of the 16th District's Caucus on Budget, Business and Administrative Matters Observer Team (2006, 2008, 2010, 2012, 2014, 2017) beginning my 3rd year on the Caucus, it was my job to have a good working knowledge of the finances and budget process so that I could report and educate my Caucus on Board Report 2 and other key financial and administrative matters.

I was fortunate to be appointed to the HOD Special Committee on Financial Affairs (2009-2011). Those two years were a great opportunity for me to better understand the complex work undertaken by the Board Committees of Finance, Administration, Pension, Compensation, Audit, and Strategic Planning. The ADA Special Committee was given the chance to rethink the budget process and suggest ways to build trust and transparency in our financial systems given the complexity of our governance structure as dictated by our Constitution and Bylaws. The Committee did an in-depth study of all ADA financial systems, which included reviewing our C&B, Board Rules, legal issues including the impact of Illinois State law, and structural and operational issues related to financial and accounting problems as identified in reports issued by KPMG and Collins Law Firm. As a result, I was part of the Committee's review of KPMG corrective measures and the Committee's suggestions for a new budget process that included improved House input, transparency, communications, and better decision making during the budget process. The Board adapted many of Special Committee's suggestions, and the framework of these suggestions can still be seen in our current budget process.

My two years as a member of the ADA Special Committee also deepened my insight to some of the inherent problems our Association struggles with due to its complex governance structure. It taught me the value of continually evaluating how we make financial decisions during the budget process. Being a member of the Special Committee educated me as to why we must be relentless in protecting the trust given to our financial systems--through transparency and communications.

I have also served five years on the ADA Board's Finance and Administrative Committees over five different administrations which was both an honor and excellent training opportunity on the many different facets of planning the Budget. Each year involved reviewing activities of the Association. At that time we used Board Priorities as a way of developing comparative ranking and, therefore, partially evaluating the value of the activity to the Association in an empirical way. We gained additional insight

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listening to Staff and Council Chairs to better understand the intangibles of the activities, especially those activities that were below the funding line. Since 2010, the budget process has been, and should continue to be, an evolving process; always seeking the most effective means of blending and balancing metrics and observations for the purpose of successful implementation of our Strategic Plan.

In addition, serving five years on the ADA Board's Finance and Administrative Committees was great training on the overall financial life of the organization. For example, I enhanced my knowledge of how the Board carries out its fiduciary role by establishing appropriate goals and objectives for reserve assets through the ADA Reserve Investment Policy along with the importance of constant monitoring. Another example of the training I received was being part of the review and then advising the Board on the financial impact of new resolutions and challenges to the long term sustainability of the ADA. It was truly an honor to receive the **ADA President's Citation** at the end of my service to the Board.

These years of experience as ADA Treasurer and earlier experiences at the ADA Board level have significantly improved my understanding of how the roles of the Board, staff, Strategic Plan, our complex governance structure, Board financial committees, and Budget process, all interplay as parts in the ADA's financial systems and decisions.

Finally, Membership dues is our single largest source of revenue. The opportunity to learn and contribute as a member of the Council on Membership (2016-2018) provided me a thorough understanding of this critical component, especially with our concerns of declining full dues paying members. Serving on Membership has expanded my understanding of where we are as an association--both our challenges and opportunities that will be essential for our future financial well-being.

Explain how you plan to assist in interpreting Association finances and effectively share financial information with the House of Delegates and membership.

Serving as Treasurer during the most challenging financial crisis in ADA's long history required innovative and agile responses. For example, we needed to take a new and effective approach to managing through uncertainty by being more agile in re-forecasting the Budget as we anticipated significant reductions in revenues. Another example is recommending and developing an ongoing management level 3-year budget guide that provides, among other things, a plan for recovery, surplus budgets, and rebuilding our Long Term Reserves. Much like a pilot flying in a strong cross wind, the ADA needs to be agile in adjusting budgets as information changes in order to achieve our goals set by a 3-year budget plan. By using these innovative and strategic approaches and striving for a surplus budget within the next 3 years, the ADA will be better equipped to achieve long term success in a chaotic environment.

A vital role of the Treasurer is maintaining trust and transparency in our Association's finances, particularly during a chaotic time of crisis. Layered on top of a clear perspective of our current financial position and our best understanding of the future, a Treasurer must be able to boil it all down to clear and calm messaging. To be an effective Treasurer one must be able to communicate this perspective in a consistent, unambiguous, and effective way. Keeping in mind the audience, some of whom want the details, some who just want to know "Are we alright?" I believe communication skills is a strength I have

American Dental Association Treasurer Curriculum Vitae Form

PREVIOUS FINANCIAL and BUDGET EXPERIENCE (including the ADA)

honed over 30 years in civic activities, in our profession at local, state, and national levels, as well as in my studies at Kellogg School of Management. I believe one of the best means to fulfill that role is for the Treasurer to be in dialog with the House throughout the budget process. One essential way to do that is to engage Council members in discussions during the budget process. These aren't always easy discussions. Nevertheless, in my view, they are critical to maintaining the trust in our Association's finances. A second way I have maintained trust and transparency is through the Treasurer's Newsletter. Additionally, I have worked to enhance trust and transparency by communicating the status of ADA finances in the House through both the Treasurer's Address to the House and the Treasurer's Summit. It is gratifying that the House, through the HOD Evaluation, has a 94% satisfaction of my Address and 93% satisfaction of the Summit. Also, the Summit attendance has grown 250% in just the last 2 years.

What experience in dental association service, dental practice, dental education or private business would qualify you to serve as treasurer of the American Dental Association? What special skills or knowledge do you offer? (250 words or less)

- 1) 3 years experience and continuity as current ADA Treasurer
- 2) During the unprecedented financial crisis of the pandemic, determination and direction helped outline required discipline towards recovery. With the unpredictable nature of the current crisis, we must continue careful and judicious financial management
- 3) Experience and knowledge base critical during transition to a new Executive director
- 4) Instrumental in the ongoing development of a new management tool to reduce risks in budget decisions- Mission Based Report. Critical pathway with our future implementation and recovery from crisis management
- 5) Open Communicator. Continuing a legacy of trust members have in our financial systems and maintain transparency in all finances of the ADA crucial to long term sustainability
- 6) As advisor to the Board, the House, and the Staff, establishing this mutual reliance is critical to Trust. Trust in our financial systems is necessary for the ADA to effectively navigate the fine line between spending from reserves and living slightly below our means. Success requires determined discipline to provide for the needs of our members while staying focused on ROI.
- 7) 2 Budgets passed with 94% satisfaction rate of house members and open communication with House Treasurer Summits even managed in Virtual world.
- 8) I have and will continue to dedicate myself to continuing the great tradition that the office of ADA Treasurer represents.
- 9) I have and will continue to be a bridge between ADA's past, present, and future.

American Dental Association
Treasurer Curriculum Vitae Form

Why do you want to be the ADA Treasurer? What do you hope to accomplish?

When I became a dentist, I never dreamed of the opportunities and benefits that being a dentist would provide me. I feel so fortunate to have received so much and have looked for occasions to give back in my church, my community, and my profession. I believe in the ADA Mission and Core Values in a way that calls me to action. In addition to learning key leadership skills, my education received in achieving my Kellogg Executive Scholar Certificate is beneficial in understanding how finances play a significant role in the life of a successful non-profit association. Using the depth and breadth of my financial experience, the ADA Treasurer is the ultimate way I can help give back for the gifts I have been given. My 35 years practicing as a sole proprietor dentist, 3 years as ADA Treasurer, three decades of leadership contributions, tested by adversity and change, have grown my competence and expertise. It is my desire to capitalize on those competencies to sustain the trust in ADAs finances through communications and transparency. I have also had the opportunity, throughout my experiences as the ADA Treasurer, House (2004-2018), the ADA Special Committee on Financial Affairs (2009-2011), the ADA Board Committees on Administration(2009-2011), Finance Committee (2009-2014), Strategic Planning (2010-2012) and Council on Membership (2016-2018) to deepen my skills and knowledge of strategic planning and how it drives the ADA budget process, financial systems, structural challenges, revenue sources, and our expert staff.

I genuinely enjoy these experiences, so if I am fortunate to be re-elected ADA Treasurer, my Goals would be:

- Successful implementation of the Strategic Plan through overseeing the budget process.
- Maintain the trust in our financial systems through effective communication, transparency, and accuracy.
- Provide appropriate leadership in the financial life of our Association.
- Provide a long term view that goes beyond the current annual budget, audits, and financial reports.
- Work with staff to study ways of reducing risks to the Association in our budget process and financial decision making, both at the Board and the House.
- Help ensure that the finances of the Association are adequate to the task of meeting our needs today and well into our future.

Resolution No. 29 New

Report: N/A Date Submitted: September 2021

Submitted By: Council on Government Affairs

Reference Committee: D (Legislative, Health, Governance 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: Not Applicable

1 **RESCISSION OF THE POLICY, ADDING THE ADA DEFINITION OF DENTISTRY TO EXISTING**
2 **DENTAL REGULATORY PROVISIONS**

3 **Background:** In accordance with Resolution 97H-2020, Special Order of Referral Consent Calendar,
4 which directed the appropriate ADA agencies to report back to the 2021 House of Delegates on each
5 Referred Resolution, Resolution 59-2020, Proposed Policy, Regulatory Definitions of Dentistry, was
6 referred to the Council.

7 Council on Government Affairs Resolution 59-2020 proposed to amend the 2001 policy titled ADA
8 Definition of Dentistry to Existing Dental Regulatory Provisions (*Trans.*2001:440). The resolution was
9 offered in accordance with the policy titled Regular Comprehensive Policy Review (*Trans.*2012:370), to
10 determine its adequacy (or obsolescence) in modern times, and the merits of any revisions.

11 After further consideration, the Council on Government Affairs proposes to rescind the 2001 policy
12 altogether. The Council determined that the 20 year-old policy is antiquated and, more important, directly
13 conflicts with at least four other (more recent) Association policies.

- 14 - Dentistry (*Trans.*1997:687; 2015:254; 2020:XXX)
- 15 - Policy on State Dental Board Recognition of the National Commission on Recognition of
16 Dental Specialties and Certifying Boards (*Trans.*2018:323)
- 17 - Requirements for Recognition of Dental Specialties and National Certifying Boards for Dental
18 Specialists (*Trans.*2001:470; 2004:313; 2009:443; 2013:328; 2018:326)
- 19 - Specialty Areas of Dental Practice (*Trans.*1995:633; 2018:330)

20 For example, the 2001 policy urges states to include “the ADA Definition of Dentistry” and “the ADA
21 definitions of existing dental specialties” in their statutory and regulatory processes. That position is in
22 direct conflict with the 2018 policy titled Policy on State Dental Board Recognition of the National
23 Commission on Recognition of Dental Specialties and Certifying Boards (NCRDSCB) (*Trans.*2018:323),
24 which “urges all state dental boards to recognize the National Commission on Recognition of Dental
25 Specialties and Certifying Boards”, not the ADA, “as the agency responsible for the recognition of dental
26 specialties and dental specialty certifying boards.”

27 The 2001 policy also specifies that states should use an outdated “ADA Definition of Dentistry” (from
28 1997)—instead of the modern definition, which was updated in 2020. The 1997 definition falls short in
29 several areas, including terminology. It uses the term “maxillofacial”, which has since been replaced by

1 the term “craniomaxillofacial”. It also fails to account for the specialties of Dental Anesthesiology, Oral
2 Medicine, and Orofacial Pain, which the NCRDSCB has recognized in the years since.

3 The current definition of dentistry, as adopted by the 2020 ADA House of Delegates, is as follows:

4 **Dentistry**

5 **Resolved**, that the profession of dentistry is essential and defined as the evaluation, diagnosis,
6 prevention and/or treatment (nonsurgical, surgical or related procedures) of diseases, disorders
7 and/or conditions of the oral cavity, craniomaxillofacial area and/or the adjacent and associated
8 structures and their impact on the human body, provided by dentists, within the scope of their
9 education, training and experience, in accordance with the ethics of the profession and applicable
10 law, and be it further

11 **Resolved**, that dentistry is essential and should remain an independent health care profession that
12 safeguards, promotes and provides care for the health of the public which may be in collaboration
13 with other health care professionals.

14 Other deficiencies exist in the twenty year-old policy, such as failing to acknowledge that it is now up to
15 the specialty sponsoring organizations to formally petition the NCRDSCB for any revisions to the name,
16 definition, and/or scope of their respective specialties. It is also worded as time-limited assignment that
17 effectively became moot once the task to “encourage” states was fulfilled (*Supplement* 2002:6020).

18 The Council on Government Affairs recommends that the following resolution be adopted:

19 **Resolution**

20 **29. Resolved**, that the policy titled Adding the ADA Definition of Dentistry to Existing Dental
21 Regulatory Provisions (*Trans.*2001:440) be rescinded.

22 **BOARD RECOMMENDATION: Vote Yes.**

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

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WORKSHEET ADDENDUM
2020 RESOLUTION 59—COUNCIL ON GOVERNMENT AFFAIRS—PROPOSED POLICY,
REGULATORY DEFINITIONS OF DENTISTRY

59. Resolved, that the following policy titled Regulatory Definitions of Dentistry be adopted:

Regulatory Definitions of Dentistry

Resolved, that the American Dental Association’s definitions of dentistry and the dental specialties should be reflected in all dental statutory and regulatory provisions to delineate the scope of dental education and training for dentistry and the dental specialties, as appropriate and feasible, and be it further

Resolved, that the policy titled Adding the ADA Definition of Dentistry to Existing Dental Regulatory Provisions (*Trans.2001:440*) be rescinded.

Resolution No. 82 New

Report: N/A Date Submitted: August 2021

Submitted By: Council on Advocacy for Access and Prevention

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

Total Net Financial Implication: None Net Dues Impact: _____

Amount One-time _____ Amount On-going _____

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

1 PROPOSED POLICY: A CULTURE OF SAFETY IN DENTISTRY – VOLUNTARY REPORTING

2 **Background:** The dental profession has been diligent in its embrace of evidence-based dentistry and its
3 benefits; but we continue to trail our medical colleagues in building a solid evidence foundation of safety
4 for our patients, our dental staff and ourselves as providers.¹ Most dental professionals consider dental
5 care to be a safe and effective endeavor; but “we don’t know, what we don’t know.” As traumatic as the
6 COVID experience has been to the profession, a positive outcome of the pandemic has been a raised
7 awareness of the importance of safety within our individual practices. Yet when it comes to collective
8 learning so that we can benefit from the experience of others without having to experience that incident
9 themselves, we fall short. Dentists understand the ultimate value of transparency; yet “telling our story”
10 opens up fears of potential litigation and we remain silent.

11 The ADA’s Culture of Safety in Dentistry workgroup² has begun collaborating with the Dental Patient
12 Safety Foundation ([DPSE](#)), which is an independent, non-profit organization whose only mission is to
13 improve safety and quality of dental care, regardless of specialty, by non-partisan collecting, aggregating
14 and analyzing information about patient safety events (adverse incidents, near misses or unsafe
15 conditions), **which can be safely, voluntarily and confidentially reported in a non-discoverable**
16 **manner.**³ By soliciting self-reporting, DPSE can swiftly and frequently report back to the dental
17 profession ways to reduce risk, minimize hazards and improve the quality of care the delivery of dental
18 care. In an analogous manner, the Federal Aviation Agency has utilized similar reporting and collective
19 learning to make air travel one of the safest means of transportation available.

20 The DPSE shared an [overview](#) and an invitation to participate in anonymous and non-discoverable
21 reporting with the Council on Advocacy for Access and Prevention (CAAP) in January of this year and

¹ See Appendix 1 for current ADA policies addressing safety.

² Members include: David Perrott, dentist, The Joint Commission; Paul Casamassimo, AAPD pediatric dentist; Charles S. Czerepak, AAPD pediatric dentist; David White, Council on Government Affairs, general dentist; Leslie Grant, dentist, OSAP past board chair; Ana Karina Mascarenhas, Woody L. Hunt School of Dental Medicine, public health dentist; Rich Herman, former CAAP chair and safety workgroup chair; Lou Rafetto, AAOMS representative; Muhammad Walji, University of Texas at Houston, dental safety consultant; Elsbeth Kalendarian, UCSF, dental safety consultant; Gregory Heintschel, MetroHealth System, chair of oral health and dentistry; Dan Klemmedson, oral surgeon and physician, ADA president; and Steve Geiermann, CAAP staff dentist.

³ The Dental Patient Safety Foundation is a listed Patient Safety Organization (P0198) in compliance with the Patient Safety Rule of the Federal Department of Health and Human Services, which legally protects and maintains the confidentiality of all disclosures. The Patient Safety Rule was enacted to encourage voluntary reporting of sensitive information without the risk of liability.

1 subsequently with representatives of the ADA Board of Trustees in March. The Council and the trustees
2 present acknowledged the importance of accumulated experiential learning and the value of dentists
3 seeing themselves in the stories shared within the [DPSF reports](#).⁴

4 Therefore, the Council on Advocacy for Access and Prevention recommends that the following resolution
5 be adopted:

6 **Resolution**

7 **82. Resolved**, that the American Dental Association acknowledges the value of self-reporting
8 dental patient safety issues to a certified Patient Safety Organization that complies with the
9 Patient Safety Rule of the Department of Health and Human Services, as critical to our
10 professional responsibility for education and self-regulation, and be it further

11 **Resolved**, the American Dental Association encourages the voluntary reporting of near misses
12 and adverse incidents to the Dental Patient Safety Foundation in an anonymous and non-
13 discoverable manner, and be it further

14 **Resolved**, that the American Dental Association utilizes submitted reports to develop and report
15 on improved safety measures for the profession of dentistry.

16 **BOARD RECOMMENDATION: Vote Yes.**

17

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

20 **Appendix 1: Current ADA Safety Policies**

21 **Appendix 2: Frequently Asked Questions**

⁴ For additional information about establishing a culture of safety in dentistry, see Appendix 2.

APPENDIX 1**Current ADA Safety Policies****Establishing a Culture of Safety in Dentistry (Resolution 78H-2019)**

Resolved, that the appropriate ADA agency be tasked with implementing, in a measured and methodical manner, a three year framework for action that will begin to:

- Develop a curriculum on patient safety and encourage its adoption into training;
- Disseminate information on patient and dental team safety through a variety of in-person, print, web and social media communication vehicles on a regular basis;
- Recognize patient safety considerations in practice guidelines and in standards;
- Work collaboratively to develop community-based initiatives for error reporting and analysis; and
- Collaborate with other dental and healthcare professional associations and disciplines in a national summit on dentistry's role in patient safety and be it further,

Resolved, that an annual report be submitted to the ADA House of Delegates detailing progress in nurturing this culture of safety in order to raise awareness, while alleviating fear and anxiety associated with making the dental environment safe for patients, providers and the dental team.

Developing a Culture of Safety in Dentistry (Resolution 55H-2018)

Resolved, that the American Dental Association commit to establishment of a "Culture of Safety" in all aspects of dental practice; and be it further

Resolved, that the appropriate ADA agency or agencies be tasked with a comprehensive review of patient and provider safety in dentistry; and be it further

Resolved, that a report be submitted to the 2019 ADA House of Delegates detailing the incidence and severity of patient and provider safety issues in dentistry, and recommendations for development of a plan to address the identified issues of concern.

Patient Safety and Quality of Care (Trans.2005:321)

Resolved, that it is the ADA's position that health care should be:

- *safe*—avoiding injuries to patients from the care that is intended to help them
- *effective*—providing services based on scientific knowledge to all who could benefit and refraining from providing services to those not likely to benefit (avoiding underuse and overuse, respectively)
- *patient-centered*—providing care that is respectful of and responsive to individual patient preferences, needs and values and ensuring that patient values guide all clinical decisions
- *timely*—reducing waits and sometimes harmful delays for both those who receive and those who give care
- *efficient*—avoiding waste, including waste of equipment, supplies, ideas and energy
- *equitable*—providing care that does not vary in quality because of personal characteristics such as gender, ethnicity, geographic location and socioeconomic status

Patient Safety (Trans.2001:429; 2014:504)

Resolved, the Association work in cooperation with constituent and component dental societies and other major health care organizations to encourage the development of collaborative projects regarding patient safety, and be it further

Resolved, that appropriate Association agencies disseminate information on patient safety to the membership.

Funding and Authority for Patient Protection (*Trans.1983:560*)

Resolved, that constituent dental societies be encouraged to lobby legislatures to provide additional state dental board funding and authority for patient protection activities.

State Responsibility for Health, Safety and Welfare (*Trans.1978:530*)

Resolved, and reaffirmed, that the constitutional responsibility for the health, safety and welfare of the citizens of each respective state is the responsibility of each state and that state alone, and should not be abrogated, and be it further

Resolved, that the ADA does constantly reflect these feelings in their dealings with political leaders in all areas of government, and be it further

Resolved, that each dentist through his or her every area of influence do all in his or her power to preserve this constitutional responsibility and right.

APPENDIX 2**Culture of Safety in Dentistry – Voluntary Reporting
Frequently Asked Questions****What is safety in dentistry?**

- Safety is the reduction of preventable harm to patients, caregivers, our staff and ourselves.
- We are protecting ourselves, our staff and our patients.

What are examples of safety issues in dentistry?

- Examples include: use of nitrous oxide, sedation issues, contaminated water lines, pain management, infection control, needle sticks, wrong site/wrong procedure, or medication errors.

Doesn't dentistry already address safety?

- Yes, but consider this mantra: "We are relatively safe, but could we do better!"
- The simplest concepts of "time outs" to verify the patient and procedure, as well as written checklists to make sure we are fully prepared, are good starts.
- We generally address individual events within our own practice. How can we learn collectively from others without fear of punitive retribution?
- Dentists in the U.S. average one emergency per year.

If I talk about safety issues, won't I be putting myself at risk?

- No, this is about finding a way to create systems to benefit all, so that everyone can learn from others without having to experience the adverse event themselves (whatever that might be).
- Studies have shown that consistent transparency with patients reduced litigation by 59%.⁵

What do you mean creating a system to promote safety?

- Consider the safety of flying. One does not have to crash a plane to learn how not to crash one! The Federal Aviation Administration tracks adverse events in aviation, citing suspected causes and making recommendations on how to avoid those situations in the future, which are available to all pilots. Flying is considered one of the safest activities due to this adherence to a "zero harm" goal.
- Dental safety programs should focus on system improvements rather than punitive measures. Don't create a culture of blame, rather create an environment of transparency, where all can learn and improve. Adverse event reporting can be anonymous, not mandated.
- The safest systems do not rely upon the practitioner to avoid making errors; they rely upon a series of safety barriers that prevent the harm from occurring.

Doesn't dentistry have such a reporting system for adverse events?

- Pediatric dentists and oral surgeons have begun to create national registries where they might voluntarily contribute information, so that others can learn from and avoid similar events.
- The Dental Patient Safety Foundation is the only Patient Safety Organization authorized by the federal government to collect information on near misses and adverse events in dentistry in a manner, which is safe, voluntary and confidentially reported in a non-discoverable manner.

What is a Patient Safety Organization?

- The Patient Safety Act authorizes the Agency for Healthcare Research and Quality (AHRQ) to list or designate entities as Patient Safety Organizations (PSOs) that attest to having expertise in identifying the causes of, and interventions to reduce the risk of, threats to the quality and safety of patient care.

⁵ For more information, see: [Liability Claims and Costs Before and After Implementation of a Medical Error Disclosure Program](#)

Why would I volunteer my experiential information to the Dental Patient Safety Foundation?

- Your protected information, once shared, can be analyzed and aggregated to develop insights into the root causes of patient safety events – near misses, adverse events, unsafe conditions.
- This data will be a valuable resource to make positive improvements in patient safety.

Will my submitted reports be safe?

- All information is protected by governmental regulations from discovery in a court of law. The DPSF will only be reporting de-identified information.

What would I gain from this as a practitioner?

- You would be able to learn from the experience of other dentists without having to personally experience the adverse incident yourself.
- As safety in aviation has demonstrated, pilots do not have to personally crash a plane to know how not to. The reports issued regularly by the Federal Aviation Administration are read religiously by all pilots.

What is the cost of implementing a safety program?

- Minimal, when you see it as a return on investment mitigating or avoiding preventable harm to yourself, your staff or your patient.
- When we fail to govern ourselves, others could step in and do it for us.
- We have the ability to be proactive and limit reactivity to an environment that is focused on increasing accountability for safety, transparency and improvement.

What are the essential elements of such a safety initiative?

- Identify threats to patient/staff safety
- Identify and evaluate effective safety practices
- Educate, disseminate info, implement best practices and raise awareness
- Monitor threats to patient/staff safety to ensure that a safe environment continues

What needs to be done to move safety forward?

- Organizations can work to improve and promote the culture of safety
- Academia can help educate future and current oral health professionals about safety
- Practitioners can implement and evaluate steps taken towards improving safety.

Safety is an ethical issue. How so?

- All professions have a code of conduct. Ours includes beneficence (doing good), patient autonomy, veracity (truthfulness), justice and non-maleficence (do no harm). These are commonly stated as an expectation of:
 - **Selflessness:** placing the needs and concerns of our patients above our own
 - **Skill/competence:** excellence in our knowledge and expertise
 - **Trustworthiness:** we will be responsible in our personal behavior towards others
 - **Discipline:** following prudent procedures in functioning with others
- Discipline is hard. We have to work at it.

Are we talking about deaths in the dental office? What does the data show?

- There is little comprehensive data on adverse events in the dental office, and “death” is only a small aspect of safety. To the best of our knowledge, 218 people died in the dental chair between 1955 and 2017 as far as we can determine considering that there is no mandatory reporting of such incidents.
- This was drawn from 20 studies that reported death due to a dental procedure over this period of time.

Resolution No. 83 New
 Report: N/A Date Submitted: August 2021
 Submitted By: Council on Advocacy for Access and Prevention
 Reference Committee: D (Legislative, Health, Governance and Related Matters)
 Total Net Financial Implication: None Net Dues Impact: None
 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

1 ESTABLISHMENT OF A MEDICAID TASK FORCE

2 Background: One out of every two births now in the United States is a Medicaid child. Current statistics
3 from the Center for Medicare and Medicaid Services (CMS) show that over 81 million people are now
4 covered beneficiaries.

5 While children within the Medicaid program have seen an increase in access to care, adults continue to
6 be subjected to sporadic coverage, confusing benefits and state directed protocols which often add
7 barriers to practitioners willing to participate.

8 Medicaid continues to be the largest payer for emergency department (ED) dental related visits. In 2016,
9 there were 2.2 million ED visits related to dental issues, mostly in states with no or very limited adult
10 dental benefits.

11 Administrative burdens, fiscal unpredictability and misguided program integrity practices often drive
12 practitioners away from Medicaid when the opposite action is needed. With dentistry now viewed as
13 essential healthcare, the Council on Advocacy for Access and Prevention believes it is time to develop an
14 overall plan to elevate advocacy to implement changes in Medicaid which can drive effective results to
15 benefit both patients and clinicians.

16 The Council on Advocacy for Access and Prevention recommends that the following resolution be
17 adopted:

18 Resolution

19 83. Resolved, that a Task Force meet virtually and develop a cohesive and broad-reaching strategy
20 for federal and state Medicaid and Children's Health Insurance Program advocacy to reduce
21 administrative burdens and create sustainable reimbursement for participating dentists. Issues
22 addressed should include, but not be limited to:

- 24** • Credentialing
- 25** • Funding and reasonable reimbursement
- 26** • Benefit design and administration
- 27** • Appropriate auditing practices
- 28** • Coordination when multiple state program administrators exist

- 1 • Managed care design and implementation
- 2 • Requirements for stakeholder involvement
- 3 • Best practices and model programs to use as benefit and policy benchmarks

4 and be it further,

5 **Resolved**, that the Task Force be comprised of equal representation from the Board of Trustees,
 6 Council on Dental Benefit Programs, Council on Government Affairs, Council on Advocacy for Access
 7 and Prevention, at-large Delegates or Alternate Delegates of the 2021 House of Delegates, with
 8 Medicaid provider experience when possible, and state dental association staff with public program
 9 advocacy experience, with such representatives and the task force chair appointed by the ADA
 10 President, and be it further

11 **Resolved**, the advocacy strategy should include policy actions that the ADA and state advocates can
 12 pursue at the federal and state level, including adequate ADA public affairs support to ensure
 13 successful outcomes, and be it further

14 **Resolved**, that the Task Force shall report its recommendations to the 2022 ADA House of
 15 Delegates.

16 **BOAR RECOMMENDATION: Vote Yes.**

17 **Vote: Resolution 83**

ARMSTRONG	Yes	HIMMELBERGER	Yes	MARANGA	Yes	RODRIGUEZ	Yes
DOROSHOW	Yes	KESSLER	Yes	MEDOVIC	Yes	ROSATO	Yes
EDGAR	Yes	LEARY	Yes	MORRISON	Yes	SABATES	Yes
FIDDLER	Yes	LEIGHTY	Yes	OYSTER	No	SHEPLEY	Yes
HARRINGTON	Yes	LIDDELL	No	RAPINI	Yes	STEPHENS	Yes

Resolution No. 86 New
Report: N/A Date Submitted: September 2021
Submitted By: Council on Ethics, Bylaws and Judicial Affairs
Reference Committee: D (Legislative, Health, Governance and Related Matters)
Total Net Financial Implication: None Net Dues Impact: _____
Amount One-time _____ Amount On-going _____

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

1 **PROPOSED AMENDMENTS TO THE COMPREHENSIVE ADA POLICY STATEMENT ON**
2 **TELEDENTISTRY**

3 **Background:** In 2020, the House of Delegates adopted Resolution 16-2020, amending the
4 Comprehensive ADA Policy Statement on Teledentistry (*Trans*.2015:244; 2020:107). Unfortunately, the
5 policy as it was amended, in some circumstances conflicts with the ADA *Principles of Ethics and Code of*
6 *Professional Conduct* (“the *Code of Ethics*”). The resolution proposed for adoption seeks to amend the
7 ADA’s comprehensive teledentistry policy to solve that conflict issue and also adds additional patient
8 safeguards and otherwise modifies the teledentistry policy pursuant to the ethical principles of Patient
9 Autonomy and Nonmaleficence.

10 **Discussion and Analysis:**

11 **A. Resolving the Conflict between the Teledentistry Policy and the Ethical Prohibition against**
12 **Patient Abandonment.** To provide safeguards for patients engaged in treatments provided through
13 teledentistry techniques, the teledentistry policy as amended by Resolution 16-2020 requires that dentists
14 engaging in teledentistry encounters be licensed in “the state where the patient receives services.” While
15 that licensure requirement may adequately protect and safeguard patients who are receiving their initial
16 treatment from a dentist through a teledentistry encounter, it is believed to be too restrictive where a pre-
17 existing doctor-patient relationship exists at the time of the teledentistry treatment. As currently written,
18 should an existing patient of record who is midway through a multi-visit treatment develop treatment-
19 related issues during, for example, a business trip to another jurisdiction, the teledentistry policy adopted
20 in 2020 prohibits the treating dentist from treating the patient through teledentistry by prescribing an
21 antibiotic or pain medication unless the dentist is licensed in that remote jurisdiction. The dilemma the
22 treating dentist faces in that situation is clear. On the one hand, the teledentistry policy prohibits
23 treatment if the dentist is not licensed in the remote jurisdiction. On the other hand, the guidance of the
24 *Code of Ethics* under the ethical principle of Nonmaleficence prohibits abandoning a patient once a
25 course of treatment has begun. That conflict between ADA policies puts the dentist in an untenable
26 situation – either the dentist ignores the teledentistry policy in favor of proceeding in accordance with the
27 guidance of the *Code of Ethics*, or ignores the ethical guidance of the *Code of Ethics* and adheres to the
28 licensure restrictions set forth in the teledentistry policy.

29 An existing doctor-patient relationship signifies that there is a relationship of trust and mutual respect that
30 has developed between the patient and the practitioner. Many dentists have numerous patients whom
31 they have treated for long periods of time. Many, if not most, dentists have experienced patients who
32 relocate substantial distances upon retiring only to return to their former places of residence for periodic

1 dental examinations and treatments with their long-time dentists. Other dentists practicing in areas
2 bordering another jurisdiction have patients who travel across jurisdictional lines for dental treatment,
3 prioritizing the trust and respect signified by the doctor-patient relationship over the protection of the
4 dental practice act protections afforded them by their own jurisdiction's laws and regulations. It is
5 believed that the mutual trust and respect developed by existing doctor-patient relationships, which are
6 continually validated and strengthened each time the patient returns to their dentist's office for an
7 examination or treatment, can safely be relied upon as the principal patient safeguard in a teledentistry
8 encounter between a dentist and a patient of record. Indeed, in such instances, allowing the patient to be
9 treated through teledentistry by their chosen treating dentist allows the practitioner with the most
10 knowledge of the patient's dental history and any ongoing treatment to apply that experience and
11 knowledge to carry out the duty of putting the patient's welfare first, as the ethical principle of Beneficence
12 requires.

13 The proposed amendments to Paragraph No. 1 in the policy's Patients' Rights section allows for there to
14 be different requirements for teledentistry treatment between patients of record and new patients.
15 Modifying the patient safeguards provided in the current teledentistry policy based upon whether a pre-
16 existing doctor-patient relationship exists between the patient and the dentist performing the teledentistry
17 treatment will alleviate the abandonment dilemma faced by practitioners using teledentistry techniques to
18 remotely treat patients-of-record.

19 **B. Providing Additional Safeguards Further Supports the Tenets of the Code of Ethics.** Maintaining
20 the existing licensure requirements of the teledentistry policy for situations where services are delivered
21 to new patients provides some protection of the patient's welfare, and those safeguards should remain in
22 place. Proposed new Paragraph No. 2 in the Patients' Rights section of the teledentistry policy applies
23 the licensure requirements found in the current policy continues when new patients are treated via
24 teledentistry. It is believed, however, that additional safeguards should be added to the teledentistry
25 policy to bolster the patient protections afforded by the policy.

26 Revisions to Patients' Rights Paragraphs 3 and 7 provide additional patient protections and bolster the
27 patient's right to self-determination under the ethical principle of Patient Autonomy by requiring additional
28 basic information concerning the practitioner providing the teledentistry services and a disclosure of the
29 limitations (if any) of teledentistry encounters. These additional measures are added by the amendments
30 to Paragraph Nos. 3 and 7 of the Patients' Rights section of the policy. Also supporting the ethical
31 principles of Patient Autonomy and Nonmaleficence is the addition of Paragraph No. 8 to the Patients'
32 Rights section of the teledentistry policy. Only by allowing patients the right to discuss their treatment
33 with any third party is it possible for patients to exercise their right to seek a second opinion or pursue
34 separate consultations regarding treatment rendered by teledentistry.

35 **C. The Question of Equivalency of Care.** In reviewing the comprehensive teledentistry policy, there
36 was concern expressed regarding the blanket statement of equivalency between in-person (face-to-face)
37 care and care provided by teledentistry techniques that is found in the policy.* Given that providing
38 treatment via teledentistry is a relatively new development and that new technologies are continuing to
39 emerge that have application to telehealth and teledentistry encounters, it may be premature to declare
40 without qualification that all care provided by the provision of teledentistry techniques is equivalent to in-
41 person (face to face) care. It appears that the import of the statement is to urge that insurance
42 reimbursement rates be the same for equivalent in-person (face to face) and teledentistry care. Changing
43 the first word of sentence from "As" to "When" allows that same point to be made without the questionable
44 accuracy of a statement of equivalency between all care delivered in-person (face to face) and via
45 teledentistry.

* Throughout the policy, references to "in-person" care have been revised as needed to "in-person (face to face) care for consistency and to avoid confusion.

1 **D. Remaining Proposed Amendments in the Policy.** The current policy uses the term “state” when
2 referring to, for example, licensure. Technically, licensure in the area served by the American Dental
3 Association is the province of not only states, but also territories and the District of Columbia. For that
4 reason, the amendments to the policy include amending the word “state” to the phrase “state or other
5 territory or jurisdiction.” These amendments have the added benefit of aligning the statement with other
6 policy and governance documents of the Association, including the ADA *Bylaws*.

7 The remaining amendments proposed in the following resolution are conforming in nature, providing
8 amending language needed to make the policy internally consistent with the principal amendments
9 discussed above.

10 The Council on Ethics, Bylaws and Judicial Affairs requests adoption of the following resolution:

11 **Resolution**

12 **86. Resolved**, that the Comprehensive ADA Policy Statement on Teledentistry (*Trans.*2015:244;
13 2020:107) be amended as follows (additions underscored, deletions ~~stricken~~):

14 **Comprehensive ADA Policy Statement on Teledentistry**

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

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

21 Synchronous (live video): Live, two-way interaction between a person (patient, caregiver, or
22 provider) and a provider using audiovisual telecommunications technology.

23 Asynchronous (store and forward): Transmission of recorded health information (for
24 example, radiographs, photographs, video, digital impressions and photomicrographs
25 of patients) through a secure electronic communications system to a practitioner, who
26 uses the information to evaluate a patient’s condition or render a service outside of a
27 real-time or live interaction.

28 Remote patient monitoring (RPM): Personal health and medical data collection from an
29 individual in one location via electronic communication technologies, which is transmitted to a
30 provider (sometimes via a data processing service) in a different location for use in care and
31 related support of care.

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

35 **General Considerations:** While in-person (face to face) ~~direct~~ examination has been
36 historically the most direct way to provide care, advances in technology have expanded the
37 options for dentists to communicate with patients and with remotely located licensed dental
38 team members. The ADA believes that examinations performed using teledentistry can be an
39 effective way to extend the reach of dental professionals, increasing access to care by reducing
40 the effect of distance barriers to care.

41 Teledentistry has the capability to expand the reach of a dental home to provide needed dental
42 care to a population within reasonable geographic distances and varied locations where the

1 services are rendered.

2 In order to achieve this goal, services delivered via teledentistry must be consistent with how they
3 would be delivered in person. Examinations and subsequent interventions performed using
4 teledentistry must be based on the same level of information that would be available in an in-
5 person (face to face) environment, and it is the legal responsibility of the dentist to ensure that all
6 records collected are sufficient for the dentist to make a diagnosis and treatment plan. The
7 treatment of patients who receive services via teledentistry must be properly documented and
8 should include providing the patient with a summary of services. A dentist who uses teledentistry
9 shall have adequate knowledge of the nature and availability of local dental resources to provide
10 appropriate follow-up care to a patient following a teledentistry encounter. A dentist shall refer a
11 patient to an acute care facility or an emergency department when referral is necessary for the
12 safety of the patient or in case of emergency.

13 ~~As~~ When the care provided is equivalent to in-person (face to face) care, insurer reimbursement
14 of services provided must be made at the same rate that it would be made for the services when
15 provided in-person, including reimbursement for the teledentistry codes as appropriate.

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

- 18 1. That any dentist delivering, directing or supervising services to a patient of record using
19 teledentistry technologies will be licensed in ~~the a state or other territory or jurisdiction of~~
20 the United States, where the patient receives services, or be providing these services as
21 otherwise authorized by ~~the that state's~~ the dental board of that state, territory or
22 jurisdiction.
- 23 2. That any dentist delivering, directing or supervising services to a new patient using
24 teledentistry technologies will be licensed in the state or other territory or jurisdiction of
25 the United States where the patient receives the services.
- 26 23. Access to the name, practice address, telephone number, email address, licensure and
27 board certification qualifications and emergency contact information of ~~the all~~ oral health
28 care practitioners who is providing the provide care via teledentistry techniques in
29 advance of the visit will be made available to the patient prior to such encounter.
- 30 34. That the delivery of services through teledentistry technologies will follow evidence-
31 based practice guidelines, to the degree they are available, as a means of ensuring
32 patient safety, quality of care and positive health outcomes.
- 33 45. That patients will be informed about the identity of the providers collecting or evaluating
34 their information or providing treatment, and of any costs they will be responsible for in
35 advance of the delivery of services.
- 36 56. That relevant patient information will be collected prior to performing services using
37 teledentistry technologies and methods including medical, dental, and social history,
38 and other relevant demographic and personal information.
- 39 67. That the provision of services using teledentistry technologies will be properly
40 documented, that and the records and documentation collected will be provided to the
41 patient upon request and that the limitations (if any) of teledentistry encounters should
42 be disclosed to a patient prior to the initiation of any teledentistry encounter.
- 43 8. That any patient has the right to discuss their treatment with any third party. A patient
44 should not be required to agree to any provision that restricts the patient's freedom to

1 bring any concerns about their dental treatment to the attention of an entity of the
2 patient's choosing.

3 79. That services provided using teledentistry technologies and methods include care
4 coordination as a part of a dental home and that the patient's records be made
5 available to any entity that is serving as the patient's dental home.

6 810. That the patient will be actively involved in treatment decisions, will be able to choose
7 how they receive a covered service, including considerations for urgency, convenience
8 and satisfaction and without such penalties as higher deductibles, co-payments or
9 coinsurance relative to that of in-person (face to face) services.

10 911. That the dentist shall determine the delivery of services using teledentistry technologies
11 and all services are performed in accordance with applicable laws and regulations
12 addressing the privacy and security of patients' private health information.

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

18 **Supervision of Allied Dental Personnel:** The extent of the supervision of allied dental
19 personnel should conform to the applicable dental practice act in the state, territory or
20 jurisdiction of the United States where the patient receives services and where the dentist is
21 licensed. The dentist should be knowledgeable regarding the competence and qualifications
22 of the allied personnel utilized, and should have the capability of immediately contacting both
23 the allied dental personnel providing service and the patient receiving services. All services
24 delivered by allied dental personnel should be consistent with the ADA Comprehensive
25 Statement on Allied Dental Personnel.

26 **Licensure:** ~~Dentists and allied dental personnel who deliver services through teledentistry~~
27 ~~modalities must be licensed or credentialed in accordance with the laws of the state, territory or~~
28 ~~jurisdiction in which the dentist practices. Allied dental personnel who deliver services through~~
29 ~~teledentistry modalities must be licensed or credentialed in accordance with the laws of the state,~~
30 ~~territory or other jurisdiction in which the patient receives service. The delivery of services via~~
31 ~~teledentistry must comply with the state's scope of practice laws, regulations or rules applicable~~
32 ~~to the encounter. Teledentistry cannot be used to expand the scope of practice or change~~
33 ~~permissible duties of dental auxiliaries allied dental personnel.~~ The American Dental
34 Association opposes a single national federalized system of dental licensure for the purposes of
35 teledentistry.

36 **Reimbursement:** Dental benefit plans and all other third-party payers, in both public (e.g.
37 Medicaid) and private programs, shall provide coverage for services using teledentistry
38 technologies and methods (synchronous or asynchronous) delivered to a covered person to the
39 same extent that the services would be covered if they were provided through in-person (face to
40 face) encounters. Coverage for services delivered via teledentistry modalities will be at the same
41 levels as those provided for services provided through in-person (face to face) encounters and not
42 be limited or restricted based on the technology used or the location of either the patient or the
43 provider as long as the health care provider is licensed ~~in the state where the patient receives~~
44 ~~service as indicated above.~~

45 **Technical Considerations:** Dentists are encouraged to consider conformance with applicable
46 data exchange standards to facilitate delivery of services via teledentistry modalities. These

1 include, but are not limited to, Digital Imaging and Communications in Medicine (DICOM)
2 standards when selecting and using imaging systems, X12/HL7 for the exchange of information
3 and ICD-9/10-CM/SNOMED/SNODENT for documentation consistency.

4 **BOARD COMMENT:** The Board was concerned that the statement “As the care provided is equivalent to
5 in-person (face to face) care” implies that there is a single consistent agreed upon standard for the
6 provision and outcome of care provided in person. Additionally, substitution of the word “When”, was
7 concerning because it leads to the question of who determines the equivalency of care; a regulator, 3rd
8 party payer or the dentist? For these reasons the Board recommendation is to strike the words “As the
9 care provided is equivalent to in-person (face to face) care,” so the sentence now reads: “Insurer
10 reimbursement of services provided must be made at the same rate that would be made for the services
11 when provided in-person, including reimbursement for the teledentistry codes as appropriate.”

12 Accordingly, the Board urges adoption of the following substitute resolution:

13 **86BS-1. Resolved**, that the Comprehensive ADA Policy Statement on Teledentistry (*Trans.*2015:244;
14 2020:107) be amended as follows (additions double underscored, deletions double ~~stricken~~):

15 **Comprehensive ADA Policy Statement on Teledentistry**

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

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

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23 provider) and a provider using audiovisual telecommunications technology.

24 Asynchronous (store and forward): Transmission of recorded health information (for
25 example, radiographs, photographs, video, digital impressions and photomicrographs
26 of patients) through a secure electronic communications system to a practitioner, who
27 uses the information to evaluate a patient’s condition or render a service outside of a
28 real-time or live interaction.

29 Remote patient monitoring (RPM): Personal health and medical data collection from an
30 individual in one location via electronic communication technologies, which is transmitted to a
31 provider (sometimes via a data processing service) in a different location for use in care and
32 related support of care.

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

36 **General Considerations:** While in-person (face to face) ~~direct~~ examination has been
37 historically the most direct way to provide care, advances in technology have expanded the
38 options for dentists to communicate with patients and with remotely located licensed dental
39 team members. The ADA believes that examinations performed using teledentistry can be an
40 effective way to extend the reach of dental professionals, increasing access to care by reducing
41 the effect of distance barriers to care.

42 Teledentistry has the capability to expand the reach of a dental home to provide needed dental
43 care to a population within reasonable geographic distances and varied locations where the

1 services are rendered.

2 In order to achieve this goal, services delivered via teledentistry must be consistent with how they
 3 would be delivered in person. Examinations and subsequent interventions performed using
 4 teledentistry must be based on the same level of information that would be available in an in-
 5 person (face to face) environment, and it is the legal responsibility of the dentist to ensure that all
 6 records collected are sufficient for the dentist to make a diagnosis and treatment plan. The
 7 treatment of patients who receive services via teledentistry must be properly documented and
 8 should include providing the patient with a summary of services. A dentist who uses teledentistry
 9 shall have adequate knowledge of the nature and availability of local dental resources to provide
 10 appropriate follow-up care to a patient following a teledentistry encounter. A dentist shall refer a
 11 patient to an acute care facility or an emergency department when referral is necessary for the
 12 safety of the patient or in case of emergency.

13 ~~As When the care provided is equivalent to in person (face to face) care, i~~ Insurer reimbursement
 14 of services provided must be made at the same rate that it would be made for the services when
 15 provided in-person, including reimbursement for the teledentistry codes as appropriate.

16 Insurer reimbursement of services provided must be made at the same rate that it would be
 17 made for the services when provided in-person, including reimbursement for the teledentistry
 18 codes as appropriate.

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

- 21 1. That any dentist delivering, directing or supervising services to a patient of record using
 22 teledentistry technologies will be licensed in the a state or other territory or jurisdiction of
 23 the United States, where the patient receives services, or be providing these services as
 24 otherwise authorized by the that state's dental board of that state, territory or
 25 jurisdiction.
- 26 2. That any dentist delivering, directing or supervising services to a new patient using
 27 teledentistry technologies will be licensed in the state or other territory or jurisdiction of
 28 the United States where the patient receives the services.
- 29 23. Access to the name, practice address, telephone number, email address, licensure and
 30 board certification qualifications and emergency contact information of the-all oral health
 31 care practitioners who is providing the provide care via teledentistry techniques in
 32 advance of the visit will be made available to the patient prior to such encounter.
- 33 34. That the delivery of services through teledentistry technologies will follow evidence-
 34 based practice guidelines, to the degree they are available, as a means of ensuring
 35 patient safety, quality of care and positive health outcomes.
- 36 45. That patients will be informed about the identity of the providers collecting or evaluating
 37 their information or providing treatment, and of any costs they will be responsible for in
 38 advance of the delivery of services.
- 39 56. That relevant patient information will be collected prior to performing services using
 40 teledentistry technologies and methods including medical, dental, and social history,
 41 and other relevant demographic and personal information.
- 42 67. That the provision of services using teledentistry technologies will be properly
 43 documented, that and the records and documentation collected will be provided to the

1 patient upon request and that the limitations (if any) of teledentistry encounters should
2 be disclosed to a patient prior to the initiation of any teledentistry encounter.

3 8. That any patient has the right to discuss their treatment with any third party. A patient
4 should not be required to agree to any provision that restricts the patient’s freedom to
5 bring any concerns about their dental treatment to the attention of an entity of the
6 patient’s choosing.

7 79. That services provided using teledentistry technologies and methods include care
8 coordination as a part of a dental home and that the patient’s records be made
9 available to any entity that is serving as the patient’s dental home.

10 810. That the patient will be actively involved in treatment decisions, will be able to choose
11 how they receive a covered service, including considerations for urgency, convenience
12 and satisfaction and without such penalties as higher deductibles, co-payments or
13 coinsurance relative to that of in-person (face to face) services.

14 911. That the dentist shall determine the delivery of services using teledentistry technologies
15 and all services are performed in accordance with applicable laws and regulations
16 addressing the privacy and security of patients’ private health information.

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

22 **Supervision of Allied Dental Personnel:** The extent of the supervision of allied dental
23 personnel should conform to the applicable dental practice act in the state, territory or
24 jurisdiction of the United States where the patient receives services and where the dentist is
25 licensed. The dentist should be knowledgeable regarding the competence and qualifications
26 of the allied personnel utilized, and should have the capability of immediately contacting both
27 the allied dental personnel providing service and the patient receiving services. All services
28 delivered by allied dental personnel should be consistent with the ADA Comprehensive
29 Statement on Allied Dental Personnel.

30 **Licensure:** ~~Dentists and allied dental personnel~~ who deliver services through teledentistry
31 modalities must be licensed or credentialed in accordance with the laws of the state, territory or
32 jurisdiction in which the dentist practices. Allied dental personnel who deliver services through
33 teledentistry modalities must be licensed or credentialed in accordance with the laws of the state,
34 territory or other jurisdiction in which the patient receives service. The delivery of services via
35 teledentistry must comply with the ~~state’s~~ scope of practice laws, regulations or rules applicable
36 to the encounter. Teledentistry cannot be used to expand the scope of practice or change
37 permissible duties of ~~dental auxiliaries~~ allied dental personnel. The American Dental
38 Association opposes a single national federalized system of dental licensure for the purposes of
39 teledentistry.

40 **Reimbursement:** Dental benefit plans and all other third-party payers, in both public (e.g.
41 Medicaid) and private programs, shall provide coverage for services using teledentistry
42 technologies and methods (synchronous or asynchronous) delivered to a covered person to the
43 same extent that the services would be covered if they were provided through in-person (face to
44 face) encounters. Coverage for services delivered via teledentistry modalities will be at the same
45 levels as those provided for services provided through in-person (face to face) encounters and not
46 be limited or restricted based on the technology used or the location of either the patient or the

1 provider as long as the health care provider is licensed ~~in the state where the patient receives~~
 2 ~~service as indicated above.~~

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

8 **BOARD RECOMMENDATION: Vote Yes on the Substitute.**

9 **Vote: Resolution 86BS-1**

ARMSTRONG	Yes	HIMMELBERGER	Yes	MARANGA	Yes	RODRIGUEZ	Yes
DOROSHOW	Yes	KESSLER	Yes	MEDOVIC	Yes	ROSATO	Yes
EDGAR	Yes	LEARY	Yes	MORRISON	Yes	SABATES	No
FIDDLER	Yes	LEIGHTY	Yes	OYSTER	Yes	SHEPLEY	Yes
HARRINGTON	Yes	LIDDELL	Yes	RAPINI	Yes	STEPHENS	Yes

Resolution No. 86BS-2 New

Report: N/A Date Submitted: October 12, 2021

Submitted By: Thirteenth Trustee District

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

Total Net Financial Implication: None Net Dues Impact: _____

Amount One-time _____ Amount On-going _____

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

1 **PROPOSED AMENDMENTS TO THE COMPREHENSIVE ADA POLICY STATEMENT ON**
 2 **TELEDENTISTRY**

3 The following amendment for Resolution 86BS-1 (Worksheet:5190) was submitted by the Thirteenth Trustee
 4 District and transmitted on October 12, 2021, by Jillian Andolina, Strategic Operations Director, California
 5 Dental Association.

6 **Background:** While the Thirteenth Trustee District supports the Board Substitute Resolution 86-BS1, the
 7 delegation members have expressed concerns regarding the privacy of dental team members personal
 8 information. Under patients’ rights, number 3 reads as though all dental team members providing care via
 9 teledentistry would be required to provide their personal contact information to patients prior to each visit.

10 Dental offices are required to display the names and licensure information of office staff, auxiliaries and
 11 associates. However, they are not required to post employee's personal information such as email address
 12 and phone number. Additionally, dental offices are required to have an emergency contact listed for patients,
 13 but not an emergency contact for each staff member. Teledentistry should be expected to provide the same
 14 level of information to patients.

15 Therefore, the Thirteenth Trustee District is proposing amendments to Resolution 86BS-1 under Patients’
 16 Rights specifically to numbers 3 and 4 (additions are highlighted and double underscored and deletions are
 17 highlighted and double stricken) as to what information should be published and provided to the patient.

18 **Resolution**

19 **86BS-2. Resolved**, that the Comprehensive ADA Policy Statement on Teledentistry (*Trans.2015:244;*
 20 *2020:107*) be amended as follows (additions highlighted and double underscored, ~~deletions highlighted~~
 21 ~~and double stricken~~):

22 **Comprehensive ADA Policy Statement on Teledentistry**

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

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

1 Synchronous (live video): Live, two-way interaction between a person (patient, caregiver, or
2 provider) and a provider using audiovisual telecommunications technology.

3 Asynchronous (store and forward): Transmission of recorded health information (for
4 example, radiographs, photographs, video, digital impressions and photomicrographs
5 of patients) through a secure electronic communications system to a practitioner, who
6 uses the information to evaluate a patient's condition or render a service outside of a
7 real-time or live interaction.

8 Remote patient monitoring (RPM): Personal health and medical data collection from an
9 individual in one location via electronic communication technologies, which is transmitted to a
10 provider (sometimes via a data processing service) in a different location for use in care and
11 related support of care.

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

15 **General Considerations:** While in-person (face to face) ~~direct~~ examination has been
16 historically the most direct way to provide care, advances in technology have expanded the
17 options for dentists to communicate with patients and with remotely located licensed dental
18 team members. The ADA believes that examinations performed using teledentistry can be an
19 effective way to extend the reach of dental professionals, increasing access to care by reducing
20 the effect of distance barriers to care.

21 Teledentistry has the capability to expand the reach of a dental home to provide needed dental
22 care to a population within reasonable geographic distances and varied locations where the
23 services are rendered.

24 In order to achieve this goal, services delivered via teledentistry must be consistent with how they
25 would be delivered in person. Examinations and subsequent interventions performed using
26 teledentistry must be based on the same level of information that would be available in an in
27 person (face to face) environment, and it is the legal responsibility of the dentist to ensure that all
28 records collected are sufficient for the dentist to make a diagnosis and treatment plan. The
29 treatment of patients who receive services via teledentistry must be properly documented and
30 should include providing the patient with a summary of services. A dentist who uses teledentistry
31 shall have adequate knowledge of the nature and availability of local dental resources to provide
32 appropriate follow-up care to a patient following a teledentistry encounter. A dentist shall refer a
33 patient to an acute care facility or an emergency department when referral is necessary for the
34 safety of the patient or in case of emergency.

35 ~~As When the care provided is equivalent to in-person (face to face) care, i~~ Insurer reimbursement
36 of services provided must be made at the same rate that it would be made for the services when
37 provided in-person, including reimbursement for the teledentistry codes as appropriate.

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

- 40 1. That any dentist delivering, directing or supervising services to a patient of record using
41 teledentistry technologies will be licensed in ~~the a state or other territory or jurisdiction of~~
42 the United States, where the patient receives services, or be providing these services as
43 otherwise authorized by ~~the that state's~~ the state's dental board of that state, territory or
44 jurisdiction.
- 45 2. That any dentist delivering, directing or supervising services to a new patient using

1 teledentistry technologies will be licensed in the state or other territory or jurisdiction of
2 the United States where the patient receives the services.

3 23. Access to the name, practice address, telephone number, emergency contact information, and
4 email address of the virtual practice. Access to the names, licensure information, and
5 board certification qualifications and emergency contact information of the all oral health
6 care practitioners who is providing the provide care via teledentistry techniques in
7 advance of the visit will be made available to the patient prior to such encounter in the practice.
8 Prior to the virtual visit, the patient should be informed of the name, licensure information, and
9 qualification of the oral healthcare practitioner’s conducting the visit and virtual care.

10 34. That the delivery of services through teledentistry technologies will follow evidence-based
11 practice guidelines, to the degree they are available, accepted standards of care as a means of
12 ensuring patient safety, quality of care and positive health outcomes.

14 45. That patients will be informed about the identity of the providers collecting or evaluating
15 their information or providing treatment, and of any costs they will be responsible for in
16 advance of the delivery of services.

17 56. That relevant patient information will be collected prior to performing services using
18 teledentistry technologies and methods including medical, dental, and social history,
19 and other relevant demographic and personal information.

20 67. That the provision of services using teledentistry technologies will be properly
21 documented, that and the records and documentation collected will be provided to the
22 patient upon request and that the limitations (if any) of teledentistry encounters should
23 be disclosed to a patient prior to the initiation of any teledentistry encounter.

24 8. That any patient has the right to discuss their treatment with any third party. A patient
25 should not be required to agree to any provision that restricts the patient’s freedom to
26 bring any concerns about their dental treatment to the attention of an entity of the
27 patient’s choosing.

28 79. That services provided using teledentistry technologies and methods include care
29 coordination as a part of a dental home and that the patient’s records be made
30 available to any entity that is serving as the patient’s dental home.

31 810. That the patient will be actively involved in treatment decisions, will be able to choose
32 how they receive a covered service, including considerations for urgency, convenience
33 and satisfaction and without such penalties as higher deductibles, co-payments or
34 coinsurance relative to that of in-person (face to face) services.

35 911. That the dentist shall determine the delivery of services using teledentistry technologies
36 and all services are performed in accordance with applicable laws and regulations
37 addressing the privacy and security of patients’ private health information.

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

43 **Supervision of Allied Dental Personnel:** The extent of the supervision of allied dental
44 personnel should conform to the applicable dental practice act in the state, territory or
45 jurisdiction of the United States where the patient receives services and where the dentist is

1 licensed. The dentist should be knowledgeable regarding the competence and qualifications
2 of the allied personnel utilized, and should have the capability of immediately contacting both
3 the allied dental personnel providing service and the patient receiving services. All services
4 delivered by allied dental personnel should be consistent with the ADA Comprehensive
5 Statement on Allied Dental Personnel.

6 **Licensure:** ~~Dentists and allied dental personnel~~ who deliver services through teledentistry
7 modalities must be licensed or credentialed in accordance with the laws of the state, territory or
8 jurisdiction in which the dentist practices. Allied dental personnel who deliver services through
9 teledentistry modalities must be licensed or credentialed in accordance with the laws of the state,
10 territory or other jurisdiction in which the patient receives service. The delivery of services via
11 teledentistry must comply with the ~~state's~~ scope of practice laws, regulations or rules applicable
12 to the encounter. Teledentistry cannot be used to expand the scope of practice or change
13 permissible duties of ~~dental auxiliaries~~ allied dental personnel. The American Dental
14 Association opposes a single national federalized system of dental licensure for the purposes of
15 teledentistry.

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

25 **Technical Considerations:** Dentists are encouraged to consider conformance with applicable data
26 exchange standards to facilitate delivery of services via teledentistry modalities. These include, but
27 are not limited to, Digital Imaging and Communications in Medicine (DICOM) standards when
28 selecting and using imaging systems, X12/HL7 for the exchange of information and ICD-9/10-
29 CM/SNOMED/SNODENT for documentation consistency.
30

Resolution No. 91 New

Report: N/A Date Submitted: August 2021

Submitted By: Fourteenth Trustee District

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

Total Net Financial Implication: None Net Dues Impact: _____

Amount One-time _____ Amount On-going _____

ADA Strategic Plan Objective: None

How does this resolution increase member value: See Background

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MID-LEVEL PROVIDER IMPACT STUDY

Background: The following resolution was submitted by the Fourteenth Trustee District and transmitted on August 31, 2021, by Dr. Julius N. Manz, director Dental Hygiene Program, San Juan College.

The ADA staff has indicated that approximately \$17 million has been spent since 2014 through its SPA grant program in opposition to mid-level dental providers. The ADA must be accountable to its membership and is responsible for exploring detailed data to evaluate the impact of the mid-level provider model on access to care.

Resolution

91. Resolved, that the ADA collect data on mid-level providers to evaluate the impact on access to care.

This would include but not be limited to:

- the number in each state
- practice settings
- populations served
- individual state mandates

and be it further

Resolved, that a report be made 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. 94 New
 Report: N/A Date Submitted: August 2021
 Submitted By: Fourteenth Trustee District
 Reference Committee: D (Legislative, Health, Governance and Related Matters)
 Total Net Financial Implication: \$23,000 Net Dues Impact: \$0.23
 Amount One-time _____ Amount On-going On-going
 ADA Strategic Plan Objective: None
 How does this resolution increase member value: Not Applicable

1 **STATE REPRESENTATION AND ALTERNATE DELEGATES**

2 The following resolution was submitted by the Fourteenth Trustee District and transmitted on August 30,
 3 2021, by Dr. Julius N. Manz, director, Dental Hygiene Program, San Juan College.

4 **Background:** With a provisional understanding that Resolution 2021:73 will pass and become
 5 ADA policy, those states which will lose delegates as a result, will suffer loss of representation as well as
 6 the voices that those members bring to the discussion and debate.

7 Potential consequences:

- 8
- 9 • Each state is unique, and has different concerns, statutes and regulations. The number of
- 10 dentists with knowledge, understanding, time, finances and ability for statutory and regulatory
- 11 understanding will be greatly diminished.
- 12 • Leadership development will be restricted.
- 13 • Diversity whether gender, ethnicity, practice style or specific geographic needs (i.e., rural, urban,
- 14 Medicaid practitioners) will be diminished.
- 15 • As a matter of percentage, smaller states will suffer far greater loss of representation than larger
- 16 states.
- 17 • Districts made up of several small states will lose a significantly larger loss of representation. Was
- 18 there ever a time when all the districts had an equal number of delegates?

19 Although it is understandable and acceptable that like any other association the ADA is dependent on the
 20 number of dues paying members. It is also understandable that the ADA can only afford supporting
 21 caucus meetings which reflect revenues that are brought in. It is also understood that there should only
 22 be an appropriate number of delegates representing an agreed upon number of members.

23 ADA policy currently only allows one alternate delegate for every actual delegate. This adds up to two
 24 voices lost with each delegate lost. If every state that loses a delegate be allowed to replace those
 25 delegates with two alternate delegates who are financed by either themselves, local components or
 26 constituencies to attend meetings, then diversity and input will more likely remain constant.

27 Alternate delegates prove to be a highly beneficial addition to the voices of full delegates when included
 28 in the discussion and debate.

1 In light of the above analysis, it is proposed that Chapter III House of Delegates, Section 10. Members. B.
2 of the ADA *Bylaws* be amended as follows:

3 **Resolution**

4 **94. Resolved**, that the Chapter III, Section 10. B. of the ADA *Bylaws* be amended as follows
5 (additions underscored; deletions ~~stricken~~ through):

6 B. ALTERNATE DELEGATES. Each constituent and each federal dental service may
7 select from among its active, life and retired members up to ~~the same number of two~~
8 alternate delegates for each ~~as~~ delegates. The American Student Dental Association
9 may select from among its active members up to the same number of alternate delegates
10 as delegates.

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

Resolution No. 95 New

Report: N/A Date Submitted: August 2021

Submitted By: Fourteenth Trustee District

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

Total Net Financial Implication: \$50,000 Net Dues Impact: \$0.50

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: Not Applicable

1 **PRIORITIZING THE MENTAL HEALTH OF DENTISTS**

2 The following resolution was submitted by the Fourteenth Trustee District and transmitted on August 30,
3 2021, by Dr. Julius N. Manz, director, Dental Hygiene Program, San Juan College.

4 **Background:** Mental Health is a vital part of the health, happiness and overall wellbeing of our
5 members. Dentistry is already well-known as a stressful profession. The changes that the global
6 pandemic has brought to providing oral health care has only served to magnify and increase the levels of
7 stress and anxiety in our profession. As an unfortunate sequela, there has been a significant increase in
8 substance abuse, mental health illness and suicide. Our profession, must, now more than ever, prioritize
9 the mental health of our members so that they can be successful and provide the very best oral health
10 care for the patients we serve.

- 11 • #stopsuicide
- 12 • #itsoktonotbeok
- 13 • #stopthestigma

14 **Resolution**

15 **95. Resolved,** that the ADA analyze, in conjunction with mental health consultants, the
16 availability of resources to support the mental health of dentists to include the collection of
17 information from national, state and local entities about:

- 18 • activities available to support mental health
- 19 • efficacy of current activities
- 20 • prevailing mental health issues in their area

21 and be further

22 **Resolved,** that the ADA partner with mental health experts to:

- 23 • create an effective mental health wellness campaign for our members

- 1 • explore the possibility of partnering with a third-party therapy provider to provide access
- 2 to mental health care for our membership
- 3 • analyze the existing well-being conference and consider how it could be expanded
- 4 • create a toolkit to assist members with regard to practice coverage for short-term, long-
- 5 term and permanent absences
- 6 • study what other health-related professional organizations are doing for mental health
- 7 including ASDA and NDC
- 8 • create guidance around the ethics of reporting mental health crisis and suicide

9 and be it further

10 **Resolved**, that the ADA partner with mental health experts to create a legislative strategy
11 regarding safeguarding dentists from punitive action from state boards as well as third party
12 credentialing; with regard to mental health issues and report back to the 2022 House of
13 Delegates with an actionable plan

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

Resolution No. N/A New
 Report: 2 Date Submitted: August 2021
 Submitted By: Council on Ethics, Bylaws and Judicial Affairs
 Reference Committee: D (Legislative, Health, Governance and Related Matters)
 Total Net Financial Implication: None Net Dues Impact: _____
 Amount One-time _____ Amount On-going _____

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

1 **COUNCIL ON ETHICS, BYLAWS AND JUDICIAL AFFAIRS REPORT 2 TO THE HOUSE OF**
 2 **DELEGATES: EDITORIAL AND CONFORMING AMENDMENTS TO THE ADA BYLAWS AND**
 3 **THE GOVERNANCE MANUAL OF THE AMERICAN DENTAL ASSOCIATION**

4 **Background:** In addition to the editorial and conforming amendments to the ADA *Bylaws* and
 5 *Governance and Organizational Manual of the American Dental Association (Bylaws and Governance*
 6 *Manual, respectively)* reported in the 2021 Annual Report of the Council on Ethics, Bylaws and Judicial
 7 Affairs, the Council also approved the following editorial and conforming amendments by unanimous vote
 8 during its meeting held on July 30-31, 2021. These amendments are reported to the House of Delegates
 9 pursuant to Chapter VIII., Section K.6.b.iii. of the *Governance Manual*.

10 **Discussion and Analysis:**

Amendments to Governance Documents Made Pursuant to Ch. VIII., Section K.6.b.ii. of the Governance Manual Upon Unanimous Vote of the Council on Ethics, Bylaws and Judicial Affairs			
Source	Location	Amendment <i>Additions <u>underscored</u> (except headings), deletions <u>stricken</u>.</i>	Rationale
<i>Governance Manual</i>	Chapter VI, Section B.2., page 16, lines 468-469	Delete as shown: 2. <u>Treasurer</u> . The search for Treasurer shall be announced in an official publication of the Association in November of the final year of the incumbent Treasurer’s term, together with the recommended qualifications for that position as provided in the Bylaws. Candidates for the office of Treasurer shall apply by submitting a standardized Treasurer Curriculum Vitae form to the Executive Director at least one hundred twenty (120) days prior to the convening of the House of Delegates. Each candidate’s application shall be reviewed by	Redundant to sentence at page 16, lines 472-473 (see shaded portion)

		<p>the Board of Trustees. At least sixty (60) days prior to the convening of the House of Delegates the Executive Director shall provide all members of the House of Delegates, with each candidate's standardized Treasurer Curriculum Vitae and the determination of the Board of Trustees as to whether the candidate meets the recommended qualifications for the office of Treasurer. No other candidate shall be nominated from the floor of the House of Delegates. Nominations shall be made in accordance with the order of business. Each nomination may be followed by an acceptance speech not to exceed four (4) minutes by the candidate from the podium, according to the protocol established by the Speaker of the House of Delegates. Seconding a nomination is not permitted. No further nominations for the office of Treasurer shall be accepted from the floor of the House of Delegates. If there are no eligible candidates for the office of Treasurer when the House of Delegates meets, the term of the incumbent Treasurer shall be extended by one (1) year. Should the incumbent Treasurer be unwilling or unable to serve an additional one (1) year term, the office of Treasurer shall be filled in accordance with the vacancy provisions of this chapter of the Governance Manual. Under these circumstances, former Treasurers of this Association not otherwise eligible to serve as Treasurer due to term limits will be eligible to serve as Treasurer until the House of Delegates can elect a Treasurer.</p>	
<p><i>Governance Manual</i></p>	<p>Chapter XI, Section A.1., page 30, line 918-919</p>	<p>Add as shown:</p> <ol style="list-style-type: none"> 1. <u>Member Conduct Subject to Discipline.</u> A member may be disciplined for (1) having been found guilty of a felony, (2) having been found guilty of violating the dental practice act of a state or other jurisdiction of the United States, (3) having been discharged or dismissed from practicing dentistry with one of the federal dental services under dishonorable circumstances, (4) violating the <u>ADA Bylaws</u>, the <u>ADA Principles of Ethics and Code of Professional Conduct</u>, or the bylaws or code of ethics of the constituent or component of which the accused is a member, or (5) violating the Association's <i>Member Conduct Policy</i>. 	<p>"ADA" inserted for clarity and to differentiate from constituents' bylaws and codes of ethics.</p>
<p><i>Governance Manual</i></p>	<p>Chapter XI, Section A.2.b., page 30, line 925 and 926</p>	<p>Add and delete as shown:</p> <ol style="list-style-type: none"> b. <u>Suspension.</u> Suspension means <u>During a suspension period</u> all membership privileges except continued entitlement to coverages under insurance programs are lost during the suspension period. 	<p>Editorial revision to simplify and shorten</p>

		Suspension shall be unconditional and for a specified period at the termination of which full membership privileges are automatically restored. A subsequent violation shall require a new disciplinary procedure before additional discipline may be imposed	
<i>Governance Manual</i>	Chapter XI, Section A.2.e., page 30, line 945	Add as shown: e. <u>Removal from Office</u> . If the member holds any ADA office, disciplinary action may include removal from office as a trustee, delegate, alternate delegate or elective officer for the remaining term. <u>Removal from office</u> may be imposed in addition to, or in lieu of, any of the penalties enumerated above.	Editorial revision to simplify
<i>Governance Manual</i>	Chapter XI, Section B.2.a.ii., page 32, line 1030	Delete as shown: ii. <u>Disciplinary Decision of a Constituent</u> . Any member or component shall have a right to appeal a disciplinary decision that is adverse to it that is issued by a constituent. That appeal shall be made to the Council on Ethics, Bylaws and Judicial Affairs of this Association by filing a notice of appeal in affidavit form with the Chair of the Council on Ethics, Bylaws and Judicial Affairs.	Editorial revision to simplify and clarify
<i>Governance Manual</i>	Chapter XI, Section B.2.c., page 33, line 1042	Add and delete as follows: c. <u>Time for the Filing of Briefs on Appeal</u> . Briefs in appeals brought under this Article II Section must be filed in accordance with the following schedule:	Conforming revision
<i>Governance Manual</i>	Chapter XI, Section B.2.e.v., page 33, line 1066	Add and delete as shown: v. <u>Option to Conduct Telephonic Virtual Hearings</u> . Upon the request by a party and the concurrence of all other parties, the body hearing the appeal may permit one or more of the parties to an appeal to participate in the hearing remotely via telephone or other suitable means. The decision whether to allow remote participation in an appeal hearing is discretionary with the body hearing the appeal and granting such a request can be subject to meeting reasonable terms and conditions set by the hearing body.	Editorial revision to conform to current practice
<i>Governance Manual</i>	Chapter XI, Section B.2.e.xi., page 34, line 1106	Add and delete as shown: xi. <u>Appellate Jurisdiction</u> . The body to which a decision has been appealed shall be required to review the decision appealed from to determine whether the evidence before the component, constituent or body which brought the charges against the accused member supports that decision or warrants the	Editorial revision to simplify

		penalty imposed. The body hearing the appeal shall not be required to consider additional evidence unless there is a clear showing <u>it is clearly shown</u> that a party to the appeal will be unreasonably harmed by failure to consider the additional evidence.	
<i>Governance Manual</i>	Chapter XI, Section B.2.e.xii.(d), page 34, line 1117-1118	Add and delete as shown: (d) Refer the case back to the body that brought the charges for new proceedings, if the rights of the accused member under all applicable bylaws were violated or if the adopted disciplinary procedures were not followed to the detriment of the accused <u>resulting in detriment to the accused</u> ;	Editorial revision to simplify
<i>Governance Manual</i>	Chapter XI, Section C.4., page 35, line 1168	Add and delete as shown: 4. Hearing. In the event of finding of <u>If a possible violation of the Member Conduct Policy is determined,</u> the accused member shall be entitled to a hearing before a panel of three (3) members of the Council on Ethics, Bylaws and Judicial Affairs.	Editorial revision to simplify and clarify
<i>Governance Manual</i>	Chapter XI, Section C.4.b., page 36, line 1175	Delete as shown: b. Purpose. The purpose of the hearing is to provide the accused member with an opportunity to present a defense to the charges brought against him or her.	Editorial revision to simplify
<i>Governance Manual</i>	Chapter XI, Section C.4.d., page 36, line 1180	Delete as shown: d. Continuances. An accused member is entitled to one (1) hearing postponement. The postponement cannot exceed thirty (30) days. Additional requests for postponement may be granted or denied at the discretion of the chair of the Council on Ethics, Bylaws and Judicial Affairs, who may but need not consult with the Council or the hearing panel on the request.	Editorial revision to correct redundancy
<i>Governance Manual</i>	Chapter XI, Section C.6., page 36, line 1201-02	Add and delete as shown: 6. Notice of Right to Appeal. A written notice to the accused member informing the accused member of his or her <u>the</u> right to appeal the decision of the hearing panel must accompany the copies of the decision sent pursuant to these procedures.	Editorial revision to simplify
<i>Governance Manual</i>	Chapter XI, Section D.5.e., page 37, line 1249	Add and delete as shown: e. Option to Conduct Telephonic-Virtual Hearing. Upon the request by a party and the concurrence of all other parties, the Council on Ethics, Bylaws and Judicial Affairs may permit one or more of the parties to an appeal to participate in the hearing remotely via telephone or other suitable means. The decision whether to allow remote participation in an appeal	Editorial revision to conform to current practice

		hearing is discretionary with the Council and granting such a request can be subject to meeting reasonable terms and conditions set by the Council.	
<i>Governance Manual</i>	Chapter XI, Section D.5.f., page 38, line 1259	Add and delete as shown: f. <u>Hearing Notice</u> . The Council on Ethics, Bylaws and Judicial Affairs shall notify the accused member; the Association member or Association staff member bringing the charges; the secretary of the accused member's component, if applicable; and the secretary of the accused member's constituent, if applicable of the time and place of the appeal hearing. The hearing notice will be sent by certified mail, return receipt requested, to the last known addresses <u>address</u> of the parties to the appeal and the other entities receiving notice. The notice of hearing is to be mailed not less than thirty (30) days prior to the hearing date.	Grammatical correction
<i>Governance Manual</i>	Chapter XI, Section D.5.k., page 38, line 1286	Delete as shown: k. <u>Appellate Jurisdiction</u> . The Council on Ethics, Bylaws and Judicial Affairs is required to review the decision appealed from to determine whether the evidence before the hearing panel supports that decision or warrants the penalty(ies) imposed. The Council on Ethics, Bylaws and Judicial Affairs shall not be required to consider additional evidence unless there is a clear showing that a party to the appeal will be unreasonably harmed by failure to consider the additional evidence.	Grammatical correction

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

Resolution No. N/A New

Report: 3 Date Submitted: August 2021

Submitted By: Council on Ethics, Bylaws and Judicial Affairs

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

Total Net Financial Implication: None Net Dues Impact:

Amount One-time Amount On-going

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

1 **COUNCIL ON ETHICS, BYLAWS AND JUDICIAL AFFAIRS REPORT 3 TO THE HOUSE OF**
2 **DELEGATES: DEVELOPMENT OF A STATEMENT ON THE ETHICS OF TELEDENTISTRY**
3 **PURSUANT TO RESOLUTION 106H-2020**

4 **Background:** The 2020 House of Delegates adopted Resolution 106H-2020, which states as follows:

5 **Resolved,** that the appropriate ADA agencies develop legislative principles for inclusion in state
6 dental practice laws consistent with the ADA’s teledentistry policies, and be it further

7 **Resolved,** that the Council on Ethics, Bylaws and Judicial Affairs be requested to develop ethical
8 guidance on teledentistry consistent with the *ADA Principles of Ethics and Code of Professional*
9 *Conduct.*

10 **Discussion and Analysis:** As requested in the second resolving clause of Resolution 106H-2020, the
11 Council has examined teledentistry from an ethics perspective and developed the CEBJA Statement on
12 the Ethics of Teledentistry, a copy of which is appended as **Appendix 1**. In keeping with the philosophy
13 and format of the *ADA Principles of Ethics and Code of Professional Conduct* (the *ADA Code of Ethics*),
14 the guidance developed by the Council is relatively concise and does not provide examples of
15 applications of the *ADA Code of Ethics* to particular teledentistry techniques or uses. Rather, the
16 statement prepared by the Council provides higher level advice and guidance that practitioners can apply
17 to particular situations and scenarios that they may encounter in order to proceed in an ethical manner.
18 The form of the guidance in the statement ensures that the guidance will remain useful into the future
19 without continual updating as teledentistry uses and techniques expand and mature.

20 **Resolution**

21 This report is informational and no resolutions are presented.

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

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

1 **APPENDIX 1**

2 **CEBJA STATEMENT ON THE ETHICS OF TELEDENTISTRY**

3 The COVID-19 Pandemic has necessitated increased attention to telehealth, particularly teledentistry.
4 The first significant use of teledentistry was by the US Army in 1994.¹ The initiative, designed to serve
5 troops and their dependents globally, demonstrated that teledentistry could expand care to remote areas
6 and lead to a reduction in overall cost.²

7 Until the Pandemic, however, the adoption of teledentistry has been slow. With the advent of national
8 “stay at home” orders and limitations on provision of a range of services, teledentistry has been
9 recognized as a significant tool in being able to attend to patient needs. Teledentistry is defined as “the
10 use of health information technology and telecommunications for oral care, consultation, education, and
11 public awareness with the broad goal of improving oral health.”³

12 Use of teledentistry must comply with state dental practice acts and these may vary from jurisdiction to
13 jurisdiction.⁴ The ethical parameters of teledentistry may be guided by a single source, the ADA *Principles*
14 *of Ethics and Code of Professional Conduct* (“the ADA Code”). Ethical provision of teledentistry must
15 remain the same as in-person patient visits to ensure patient safety and quality of care with “the benefit of
16 the patient as [the] primary goal.”⁵

17 As with any visit, patient autonomy must be respected, dentists must refrain from harming patients and
18 strive to promote patient welfare while treating patients fairly and honestly.⁵ Under the ADA Code’s
19 Principle of Autonomy, patients must be actively involved in their treatment decisions and be informed of
20 the risks and benefits of and alternatives to such treatment.⁵ Patients should have ready access to all
21 pertinent information and every effort should be made to ensure the confidentiality and privacy of
22 teledentistry encounters. Complete documentation of the virtual meeting is important with respect to the
23 exam, diagnosis and recommendation on any further care or follow-up and should be held to the same
24 standards as in-person record keeping.

25 The Principle of Nonmaleficence obligates the dentist to keep their knowledge and skills current.⁵ If a
26 dentist is going to utilize teledentistry they need to be familiar with the remote engagement of patients and
27 other health care providers. If they do not have skills necessary to do so, the dentist, in safeguarding the
28 welfare of the patient, may need to seek consultation from dentists “who have special skills, knowledge,
29 and experience.”⁵ Additionally, allied personnel should be supervised and delegated only those
30 responsibilities that can be legally delegated in their jurisdiction.⁵ The dentist must also take care not to
31 abandon patients for whom they have undertaken treatment. If continued care is needed and the dentist
32 cannot continue such care, the patient must receive “adequate notice and the opportunity to obtain the
33 services of another dentist . . .” to avoid running the risk of jeopardizing their oral health.⁵

34 The Principle of Beneficence found in the ADA Code supports the use of teledentistry not only for
35 individual patients but as a means to improve “the dental health of the public.”⁵ Research continues to
36 demonstrate that teledentistry improves access to care and “has the potential to be part of a paradigm
37 shift in healthcare delivery that can play a key role in mitigating barriers and improving health for
38 populations with traditionally poor access to dental care and oral health services.”⁶

39 In conjunction with improving access to care dentists should, in adhering to the Principle of Justice,
40 “actively seek allies throughout society on specific activities that will help improve access to care for all.”⁵
41 This principle also supports the notion that all patients be treated fairly, whether by telehealth or in-
42 person.

43 Finally, the ADA Code’s Principle of Veracity imposes a “duty to communicate truthfully.”⁵ This obligation
44 includes disclosing limitations, if any, of a virtual visit rather than an in-person visit. Dentists must respect
45 “the position of trust inherent in the dentist-patient relationship . . .”.⁵ This relationship is often developed
46 at the initial in-person examination so care must be taken to ensure that a teledentistry examination does
47 not diminish this honored interaction.

1 Ethical guidelines remain the same for virtual appointments as they are for in-person visits. Though
2 teledentistry may not be appropriate for all patients, concentrating on the dentist–patient relationship,
3 informed consent, protecting medical records, and ultimately obtaining optimal outcomes is the primary
4 goal. Maintaining the five ethical principles detailed in the ADA Code when conducting a virtual
5 consultation will help define a true professional.” The ethical dentist strives to do that which is right and
6 good.” The ADA Code is an instrument to help the dentist in this quest.⁵

7 REFERENCES

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Resolution No. N/A New
 Report: Report 1 Date Submitted: August 2021
 Submitted By: Council on Advocacy for Access and Prevention
 Reference Committee: D (Legislative, Health, Governance and Related Matters)
 Total Net Financial Implication: None Net Dues Impact: _____
 Amount One-time _____ Amount On-going _____

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: Not Applicable

1 **COUNCIL ON ADVOCACY FOR ACCESS AND PREVENTION REPORT 1 TO THE HOUSE OF**
 2 **DELEGATES: RESOLUTION 78-2020—ELDER CARE STRATEGIES ON INTRA-PROFESSIONAL**
 3 **ADVOCACY**

4 **Background:** In accordance with Resolution 97H-2020, Special Order of Referral Consent Calendar,
 5 which directed the appropriate ADA agencies to report back to the 2021 House of Delegates on each
 6 Referred Resolution, Resolution 78-2020, Elder Care Workgroup—Elder Care Strategies on Intra-
 7 Professional Advocacy, was referred to the Council on Advocacy for Access and Prevention. Resolution
 8 78-2020 is appended to this report.

9 The Council did not have the opportunity to review the Elder Care Workgroup’s Resolution prior to its
 10 submission to the 2020 House of Delegates. Since that time, the Council has discussed Resolution 78-
 11 2020 at length and reflected on its intent.

12 The Council applauds the Elder Care Workgroup for recognizing the need to mainstream the oral health
 13 of older adults in the medical community. The Council will commit to fulfilling the three actionable items in
 14 the Resolution 78-2020 and submitting a progress report to the 2022 House of Delegates. However, the
 15 Council respectfully submits there is no added value in codifying a time-limited assignment to engage our
 16 medical colleagues, particularly given the Association’s preexisting (and ongoing) efforts to harness the
 17 energy of multiple professions to advance the oral health of older adults.

18 CAAP staff and volunteers routinely include advocacy efforts and interdisciplinary collaboration for older
 19 adults in the Medicaid presentations which were performed in over 35 dental schools, residency programs
 20 and state association meetings in 2021. There has been long standing education and collaboration with
 21 the nursing profession which includes oral health within the risk evaluation tools for older adults. The Oral
 22 Health Nursing Education and Practice (OHNEP) is a strong example of this.

23 Additionally, the US Preventive Services Task Force (USPSTF) has very recently posted their final
 24 research plan screening, referral, behavioral counseling, and preventive interventions for oral health
 25 which supports an analytic framework that includes older adults.

26 Again, the Council applauds the Elder Care Workgroup for recognizing the need to mainstream the oral
 27 health of older adults in the medical community. The Council simply feels there is no added value in
 28 codifying a time-limited assignment that can be fulfilled without memorializing the assignment in policy.

1 The Council on Advocacy for Access and Prevention is opting to not reintroduce Resolution 78-2020 at this
2 time.

3 **Resolution**

4 This report is informational and no resolutions are presented.

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

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

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WORKSHEET ADDENDUM
**2020 RESOLUTION 78—ELDER CARE WORKGROUP—ELDER CARE STRATEGIES ON INTRA-
PROFESSIONAL ADVOCACY**

78. 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 intra-professional advocacy as priority projects, and be it further

Resolved, elevate the importance of oral health care in the elderly to medical professionals by:

1. advocating for the addition of teeth, gums, mucosa, tongue, and palate examination to the traditional head, ears, eyes, nose, and throat (HEENT) examination (HEENOTP23F1P)
2. identifying, evaluating and promoting risk assessment tools for oral health care to nursing professionals
3. advocating for the US Preventive Services Task Force Guidelines to be updated to include additional and revised guidelines on oral health care

- 1 Mobile programs continue to provide needed services within long term care facilities as COVID
2 considerations have subsided enough to permit dental services to resume.
- 3 There have been some internships focused on older adults through the training institutions of the
4 Community Dental Health Coordinator (CDHC) programs which we anticipate reaching larger audiences
5 through continued growth of the population of graduates.
- 6 The Council on Advocacy for Access and Prevention is opting not to reintroduce Resolution 79-2020 at
7 this time.

8 **Resolution**

9 This report is informational and no resolutions are presented.

10 **DRAFT BOARD RECOMMENDATION: Vote Yes to Transmit.**

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

WORKSHEET ADDENDUM

2020 RESOLUTION 79—ELDER CARE WORKGROUP—ELDER CARE STRATEGIES ON LONG TERM CARE FACILITIES

79. 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 long term care facilities as priority projects, and be it further

Resolved, increase oral health care delivery in long term care facilities by:

1. developing an inventory of existing oral health training material and promote its use by care providers and accredited facilities
2. publishing this information to the public through the ADA public facing website
3. developing recommendations in cooperation with State Dental Directors as to how long term care facilities (LTC) should be addressed and include the evaluation of mobile clinics, dental chairs in the facility, teledentistry and other options
4. advocating for dental directors in all Long Term Care facilities, and improving oral health care by utilizing community dental health coordinators (CDHCs) and dental hygienists
5. promoting the educational content from the course developed through the National Elder Care Advisory Committee on working on Long Term Care facilities and making the content available to educational institutions at no charge
6. promoting inter-and intra-professional education and practice in LTC
7. advocating for Long Term Care to be introduced in Health Professional Shortage Areas

1 CAAP will continue to pursue opportunities to connect dental students to loan repayment programs to
2 assist underserved populations with access to oral health services.

3 The Council on Advocacy for Access and Prevention is opting not to reintroduce Resolution 104-2020 at
4 this time.

5 **Resolution**

6 This report is informational and no resolutions are presented.

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

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

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WORKSHEET ADDENDUM
2020 RESOLUTION 104—FOURTEENTH TRUSTEE DISTRICT—FORMULATING INNOVATIONS TO ADDRESS UNDERSERVED AREAS

104. Resolved, that the appropriate ADA agency review and make recommendations regarding the loan forgiveness incentives available to new dentists that practice in rural and underserved areas including community health centers, FQHCs, Indian Health Service clinics and tribally-operated clinics with consideration to whether they adequately reflect increased levels of student debt, flexibility for part-time commitments and the difficulty attracting dentists to these locations and, be it further

Resolved, that the ADA assist graduating dental students to find employment opportunities in underserved areas by:

- Publishing and promoting available loan forgiveness resources
- Actively encouraging them to consult with dentists currently practicing in rural and underserved areas regarding practice opportunities
- Encouraging dentists employers in rural and underserved areas to offer flexible hours, part-time opportunities and extended tenure

Resolution No. N/A New
Report: Report 4 Date Submitted: September 2021
Submitted By: Council on Advocacy for Access and Prevention
Reference Committee: D (Legislative, Health, Governance and Related Matters)
Total Net Financial Implication: None Net Dues Impact:
Amount One-time Amount On-going

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

1 COUNCIL ON ADVOCACY FOR ACCESS AND PREVENTION REPORT 4 TO THE HOUSE OF
2 DELEGATES: 2021 ANNUAL RESPONSE TO RESOLUTION 78H-2019 – CULTURE OF SAFETY IN
3 DENTISTRY
4

5 Background: The dental profession has long identified itself as embracing evidence-based safety
6 practices for the benefit of their patients, staff and themselves. The ongoing COVID-19 pandemic
7 awakened a realization that safety is not a destination, but rather a journey that continues to evolve based
8 on where we find ourselves. Medicine began a similar journey almost three decades ago and dentistry is
9 moving in the right direction.

10
11 As acknowledged in previous Culture of Safety Resolutions 55H-2018 and 78H-2019, most dental
12 professionals consider dentistry to be a safe and effective endeavor; but as our medical colleagues
13 realized: "we do not know, what we do not know." Necessity and evidence-based dentistry are moving the
14 profession toward knowing more about safety-related effectiveness, efficiency and productivity within
15 individual practices, but dentists lack a consistent mechanism and culture to address safety collectively.

16
17 To restate in a clear, simple manner, members of the profession should be able to learn from the real
18 experiences of their peers without having to actually experience the adverse incident themselves. As our
19 aviation colleagues clearly demonstrate, a pilot should not have to crash a plane to know how not to. The
20 Federal Aviation Administration investigates every adverse incident for cause and effect, then offers
21 written recommendations for pilots to incorporate into their daily routines. That is why air travel is one of
22 the safest means of transportation. Pilots openly share their experiences for the good of all.

23
24 The Culture of Safety workgroup believes that a slow and steady methodical education and awareness
25 raising of the profession about the importance of individual and collective culture of safety is the best
26 course of action for long-term positive outcomes.¹ This informational report will outline steps taken thus

1 The expert workgroup members include: David Perrott, oral surgeon and physician, The Joint Commission; Paul Casamassimo, AAPD pediatric dentist; Charles Czerepak, AAPD pediatric dentist; David White, Council on Government Affairs chair, dentist; Leslie Grant, general dentist, OSAP past board chair; Ana Karina Mascarenhas, Nova Southeastern Dental School, public health dentist; Rich Herman, former CAAP chair, general dentist; Lou Rafetto, AAOMS representative, oral surgeon; Muhammad Walji, University of Texas at Houston, dental safety consultant; Elsbeth Kalenderian, dean of the Academic Centre for Dentistry Amsterdam, dental safety consultant; Gregory Heintschel, MetroHealth System, senior associate dean of Case Western Reserve University School of Dental Medicine; Julie Morath, chair of the Collaborative for Accountability and Improvement, safety consultant, nurse; Dan Klemmedson, oral surgeon and physician, ADA president; and Steve Geiermann, retired public health officer, CAAP staff dentist.

1 far and work that is in progress for the future.² The workgroup sincerely acknowledges Dr. Dan
2 Klemmedson for his continued leadership in making a culture of safety in dentistry a growing priority
3 within the profession.

4 The safety workgroup continues to lay a strong, diverse foundation to underpin the framework for action
5 outlined in Resolution 78H-2019. The work is ongoing. Highlights include:

6
7 **Adoption of Simple Principles and Never Events:** The workgroup adopted these simple principles as
8 “guardrails” to keep focus and not overreach as it continues the work:

- 9
- 10 1. Raise awareness of patient safety in the delivery of oral health care.
- 11 2. Identify strategies for improving safety in the delivery of oral health care as a part of an
- 12 integrated, culturally-inclusive patient care delivery model.
- 13 3. Support sharing best practices in patient safety by encouraging mutual continuous learning,
- 14 teaching, and disseminating essential safety and improvement skills at every level. This includes
- 15 students, providers, staff academic institutions and professional organizations.
- 16 4. Support safety measures that will provide value, ensure accountability and advance equity.
- 17 5. While measurement is crucial to identify opportunities for improvement, metric development and
- 18 data collection should be done with the least amount of burden and include the latest technology.
- 19 6. Encourage transparency through the support of a no-blame culture that includes multiple
- 20 stakeholders - patients, staff, and providers.

21
22 According to the [National Quality Forum](#), “never events” are errors in medical care that are clearly
23 identifiable, preventable, and serious in their consequences for patients, which indicate a real problem in
24 the safety and credibility of a health care facility. The workgroup believes the profession would benefit
25 from an enumeration of dental-specific “never events.”

- 26
- 27 1. Surgery, other invasive dental procedures, or non-invasive dental procedures performed on the
- 28 wrong site
- 29 2. Surgery, other invasive dental procedures, or non-invasive dental procedures performed on the
- 30 wrong patient
- 31 3. Performing the wrong surgical, invasive dental, or non-invasive dental procedures on a patient
- 32 4. Unintended retention of a foreign object in a patient after surgery, involving invasive dental
- 33 procedures or non-invasive dental procedures
- 34 5. Intraoperative or immediately postoperative/post-procedure death in a normal, healthy patient,
- 35 ([ASA Class 1](#))
- 36 6. Patient death or serious injury associated with the use of contaminated drugs, devices,
- 37 instruments, or biologics provided by the healthcare setting
- 38 7. Patient death or serious injury associated with a diagnostic or medication error, such as the
- 39 wrong drug, dose, patient, time, rate, preparation, or route of administration
- 40 8. Any incident in which systems designated for oxygen or other gases to be delivered to a patient
- 41 contains no gas, the wrong gas, or are contaminated by toxic substances
- 42 9. Death or permanent disfigurement associated with a preventable error
- 43 10. Sexual abuse/assault on a patient or staff member within or on the grounds of a dental office

44 **Transparency and Reporting:** One of the biggest obstacles for moving such never events forward is
45 transparency and the fear of potential litigation, if discovered. If these two factors could be approached
46 with sensitivity, a culture of safety in dentistry would evolve that much quicker. To that end, the
47 workgroup is collaborating with several significant entities:

² The workgroup apologizes that last year’s annual report was inadvertently not shared with the 2020 House of Delegates due to an administrative error. The 2020 informational report can be requested from Dr. Geiermann at geiermanns@ada.org.

1 [Collaborative for Accountability & Improvement](#): When something goes wrong during healthcare, the
2 best response is timely and compassionate, and promotes healing for all involved. Communication and
3 Resolution Programs (CRPs) guide this response, seeking to meet the current and future needs of
4 patients and families through transparent and ongoing communication about what went wrong and an
5 exploration of what will lead to resolution and healing. CRPs promote healing and diminish provider
6 trauma and burnout by proactively offering support following an unintended harm event. Increasingly
7 viewed as the future of healthcare, these programs are integral to improving patient safety and preventing
8 unintended harm. They are endorsed and adopted by leading national organizations and health systems.

9 Safety workgroup member, Ms. Julie Morath, is chair of this collaborative, which has been assisting
10 medical, nursing and pharmacy professionals for two decades to embrace transparency and alleviate the
11 fear of litigation under the capable direction of [Thomas Gallagher MD](#) from the University of Washington,
12 School of Medicine. This collaborative is willing and eager to adapt its successful interactive and online
13 educational tools for the profession of dentistry. Anticipated next steps include:
14

- 15 1. Start conversations with webinars for members and presentations at national/regional meetings
- 16 2. Establish baselines by surveying the membership about challenges, how they currently respond
17 to adverse events, and what resources they would find helpful, including a culture measurement
- 18 3. Align stakeholders and place this discussion within an interdisciplinary context
- 19 4. Provide education and tools that deliver practical knowledge and skills in person and online
- 20 5. Celebrate success with awards and small grants, while using existing communication vehicles

21 The [Dental Patient Safety Foundation](#) (DPSF) is an independent, non-profit organization whose only
22 mission is to improve safety and quality of dental care, regardless of specialty, by non-partisan collecting,
23 aggregating and analyzing information about patient safety events (adverse incidents, near misses or
24 unsafe conditions), **which can be safely, voluntarily and confidentially reported in a non-**
25 **discoverable manner.**³ By soliciting self-reporting, DPSF can swiftly and frequently report back to the
26 dental profession ways to reduce risk, minimize hazards and improve the quality of care the delivery of
27 dental care. As noted earlier, the Federal Aviation Agency has utilized similar reporting and collective
28 learning to make air travel one of the safest means of transportation available.

29 The safety workgroup has worked diligently to raise awareness of the existence and importance of the
30 DPSF beginning with a [My View](#) in the *ADA News* in November 2020. The DPSF shared an [overview](#) and
31 an invitation to participate in anonymous and non-discoverable reporting with the Council on Advocacy for
32 Access and Prevention (CAAP) in January 2021 and subsequently with representatives of the ADA Board
33 of Trustees in March. CAAP and the trustees acknowledged the importance of accumulated experiential
34 learning and the value of dentists seeing themselves in the stories shared within the [DPSF reports](#).

35 DPSF shared a similar presentation at the annual session of the [Organization for Safety, Asepsis and](#)
36 [Prevention](#) (OSAP) and abstracts have been submitted for sessions at the annual conferences of the
37 National Network for Oral Health Access ([NNOHA](#)) and the Oral Health Progress and Equity Network
38 ([OPEN](#)). Dr. Geiermann is now serving on the OSAP, DPSF and OPEN boards as a means of
39 encouraging greater collaboration among these organizations and the ADA.

40 An action calling for the ADA to encourage such voluntary reporting through DPSF will be brought forth
41 under a separate resolution. In a similar fashion, the American Student Dental Association has brought
42 forth a resolution to investigate the feasibility of developing a policy encouraging dental schools and
43 local/state legislatures to adopt culture of safety guidelines, and report back at the 2022 ASDA House of
44 Delegates Meeting.

³ The Dental Patient Safety Foundation is a listed Patient Safety Organization (P0198) in compliance with the Patient Safety Rule of the Federal Department of Health and Human Services, which legally protects and maintains the confidentiality of all disclosures. The Patient Safety Rule was enacted to encourage voluntary reporting of sensitive information without the risk of liability.

1 **Raising Awareness about the Culture of Safety in Dentistry:** The safety workgroup continues to find
2 innovative ways to educate oral health professionals about the important of a culture of safety in dentistry:
3

- 4 • There is a natural affinity among this workgroup and risk managers as both want to see a
5 decrease in adverse incidents and a greater appreciation of the value of systemic safety
6 measures. The dental insurance industry partnered with Drs. Czerepak and Geiermann to
7 present an introduction to a culture of safety in dentistry to 600 participants at the July 2020
8 Academy of General Dentistry virtual conference and again to 800 additional participants at a
9 virtual November event sponsored by Dentist's Advantage. The evaluations were outstanding.
- 10 • CNA, Aon and Dentist's Advantage offered a recording of this webinar to the ADA's safety
11 workgroup. The ADA CEOnline approved [Embracing a Culture of Safety in Dentistry](#) as a free two
12 hour CDE online to all dentists, both members and non-members. The workgroup thanks the
13 ADA continuing education leadership for their willingness to share this important information.
- 14 • An abbreviated version of this introduction to safety has been offered to dental schools with the
15 University of Michigan, Texas A&M and the University of Nevada at Las Vegas already
16 completed. Future sessions are being negotiated with additional dental schools and state dental
17 associations.
- 18 • Over a dozen state dental associations have published short articles drawn from [Tips for
19 Success: Eleven Practices for Dental Patient Safety](#), which were written by members of the
20 safety workgroup.

21 As the Culture of Safety in Dentistry workgroup continues into the third year of their charge from the 2019
22 ADA House of Delegates, it will continue to seek ways to engage the membership in a spirit of
23 collaboration. Developing a culture of safety in dentistry is not about shame and blame; it is about
24 protecting our patients, our staff and ourselves. When we as a profession fail to govern ourselves, others
25 will step in and do it for us. Now is the time to take responsibility for ourselves and the safety of those in
26 our care.

27 **Resolution**

28 This report is informational and no resolutions are presented.

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

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

Resolution No. N/A N/A

Report: Task Force to Study Alternate Student Loan Repayment Strategies Final Report (81H-2019) Date Submitted: August 2021

Submitted By: Task Force to Study Alternate Student Loan Repayment Strategies

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

REPORT OF THE TASK FORCE TO STUDY ALTERNATE STUDENT LOAN REPAYMENT STRATEGIES (81H-2019)

Background: The 2019 ADA House of Delegates adopted Resolution 81H-2019 (*Trans.*2019:309), which called on the Board of Trustees to form a task force to explore creative solutions to the student debt crisis, and submit a progress report to the 2020 House of Delegates.

81H-2019. Resolved, that the Board form a task force and appoint stakeholders to examine, identify, and creatively address solutions to the student debt crisis, and be it further

Resolved, that the task force will report back on its progress to the 2020 House of Delegates on its recommended initiatives.

In December 2019, following nomination by then ADA President Chad Gehani, the Board of Trustees approved the following individuals to serve on the Task Force: Dr. Deborah Bishop, chair, (District 5), Dr. Emily Mattingly (District 6), Dr. Nader Nadershahi (District 13), and Dr. Lindsey Robinson (District 13) (*Trans.*2019:228).

The Task Force carried out its work via electronic communications, individual phone calls, and two conference calls convened on February 18, 2020, and March 10, 2020. Due to the novel coronavirus (COVID-19) pandemic, the Task Force temporarily suspended its work in March 2020 with the intent of reconvening when the nation achieved some degree of stability. The Task Force detailed its work in a progress report to the 2020 House of Delegates (*Supplement* 2020:5175).

In November 2020, following nomination by ADA President Daniel J. Klemmedson, the Board of Trustees reauthorized the Task Force and approved the following individuals to serve: Dr. Emily Mattingly, chair (District 6); Dr. Deborah Bishop (District 5); Dr. Nader Nadershahi (District 13); Dr. Lindsey Robinson (District 13); Dr. Joseph Vaughn (District 11); Dr. Tricia Quartey-Sagaille (District 2); and Ms. Aditi Desai, American Student Dental Association (*ex officio*).

The reconstituted Task Force carried out its work via electronic communications, individual phone calls, and four conference calls convened December 2, 2020, February 15, 2021, March 1, 2021, and August 4, 2021.

For the purpose of this report, the term “Task Force” does not distinguish between the original Task Force (2019-2020) and the reconstituted Task Force (2020-2021).

- 1 Appendix A: Adopted and Referred House Resolutions (2010-2020)
- 2 Appendix B: ADA Current Policies
- 3 Appendix C: Ideas Gathered During Discovery
- 4 Appendix D: Analysis of Intriguing Ideas
- 5 Appendix E: Recent Data and Trends
- 6 Appendix F: ADA Member Offerings and Ongoing Activities

7 Some content in this report may overlap with Council on Advocacy for Access and Prevention Report 3 to
8 the House of Delegates: Resolution 104-2020 Formulating Innovations to Address Underserved Areas.
9 That report is presented on a separate worksheet.

10 **Mission:** Beginning with its inaugural conference call of February 18, 2020, the Task Force struggled to
11 find clarity in the resolution's charge to "examine, identify, and creatively address solutions to the student
12 debt crisis." The resolution's wording and various background statements did not establish how the report
13 was to be used and whether the expectations were different from the many House panels that had
14 studied the issue in recent years.

15 The background statement for the *original* Resolution 81-2019 provided no context for the Association's
16 existing policy and did not account for what the ADA was already doing (*Supplement* 2019:5096). The
17 Board comment noted that since 2010, the Association had spent over \$500,000, formed several task
18 forces, and devoted considerable volunteer time, staff time, and organizational resources to examine the
19 economics of dental education and the drivers of postgraduate educational debt (see Appendix A). The
20 Board reported as follows (*Trans.*2019:206):

21 The Board recognizes that dental student debt is a very serious issue. However, the Board notes that
22 since 2010 there have been thirteen resolutions calling for actions on student debt, including the
23 formation of several task forces. The work of these task forces has resulted in new programs, debt
24 management tools, accreditation standards and ongoing advocacy and research. The Board
25 estimates that between 2010 and 2017, the ADA spent approximately \$500,000 studying, addressing
26 and advocating for change on this matter. In addition, this year the ADA and ASDA Boards met jointly
27 to discuss student debt and the ADA Board had strategic discussions on the issue. Both Boards will
28 continue to work in collaboration.

29 Moreover, the policy titled Advocacy for Student Loan Forgiveness and Other Educational Debt
30 Reduction Programs (*Trans.*2014:502) already calls on the ADA to support pioneering ways to reduce
31 the burden of dental student debt, including loan repayment incentives to practice in underserved
32 areas. Recently, the ADA has been leading a coalition to reform the Public Service Loan Forgiveness
33 program, which has been under scrutiny for being so poorly managed.

34 The Board believes another task force would not add to the Association's ongoing efforts and
35 therefore recommends that Resolution 81 not be adopted.

36 A substitute resolution, Resolution 81RC-2019, offered by Reference Committee D (Legislative, Health,
37 Governance and Related Matters), also did not establish how the report was to be used and whether the
38 expectations were different from the many House panels that had studied the issue in recent years. The
39 Reference Committee reported as follows (*Trans.*2019:309):

40 The Reference Committee recognizes that the ADA has been looking at ways to mitigate dental
41 student debt for many years. Therefore the Reference Committee recommends the creation of a task
42 force to explore new, innovative, and creative ways to address the problem. The Financial Implication
43 is \$0 because the Reference Committee concluded that the work could be done electronically.

44 The Task Force noted that the House of Delegates had just reviewed and updated all of the Association's
45 policies on student loans and postgraduate educational debt as recently as 2019, the same year that
46 81H-2019 was adopted (see Appendix B). The Board of Trustees had also been collaborating with the

1 New Dentist Committee and the American Student Dental Association to distinguish the Association's role
2 from that of other organizations on this issue.

3 The consensus of the Board, the NDC, and ASDA appears to be that the Association should devote its
4 resources to helping dental students finance their dental education responsibly and helping new dentists
5 manage their outstanding educational debt effectively.

6 To avoid duplicating effort, the Task Force explored the 13 House student debt assignments—and the
7 156 pages of findings and recommendations—produced between 2010 and 2019. Ultimately, the Task
8 Force decided to concentrate on identifying creative proposals that have hopefully never been tried to
9 help mitigate the burden of educational debt.

10 The Task Force agreed there was more value in presenting a few ideas that might be impactful (and
11 attainable) instead of a long list of academic endeavors that might be interesting (but aspirational). The
12 Task Force therefore placed an added emphasis on being impactful, adding value to ADA membership,
13 using the Association's resources responsibly, being reasonably attainable in the next five years, and
14 being in line with the ADA's current policies and strategic plan.

15 The Task Force noted that a resolution pending from 2020 calls for the Association to create another
16 member-led panel to complete essentially the same task, but without mention of the work this Task Force
17 was already doing. Details are provided in Council on Advocacy for Access and Prevention Report 3 to
18 the House of Delegates: Resolution 104-2020 Formulating Innovations to Address Underserved Areas.

19 **Methods:** The Task Force agreed to the following plan to implement the assignment:

- 20 1. Discover ideas from internal and external stakeholders and ADA members by asking: "What
21 innovative ideas do you have—or inventive twists on conventional approaches—to help mitigate
22 the burden of student debt?"
23
- 24 2. Single out a reasonable number of ideas that, on spec, seem creative.
25
- 26 3. Thoroughly analyze the short list to determine if the ideas are indeed original—with an added
27 emphasis on being impactful, adding value to ADA membership, using the Association's
28 resources responsibly, being reasonably attainable in the next five years, and being in line with
29 the ADA's current policies and strategic plan.
30
- 31 4. Discuss the analysis and filter out the ideas that do not meet the Task Force's criteria.
32
- 33 5. Present the most promising ideas to the House of Delegates.

34 **Discovery:** The Task Force began by soliciting ideas from the New Dentist Committee and the American
35 Student Dental Association, then broadened its net to include ADA Business Enterprises and the
36 American Dental Education Association. Eventually, the Task Force sought ideas from a number of
37 outside organizations and businesses, including Equitable, Future Fuel, Laurel Road, the National
38 Association of Community Health Centers, the National Association of Free and Charitable Clinics, the
39 National Governors Association, the National Network for Oral Health Access, SoFi, the Special Care
40 Dentistry Association, US Bank, the U.S. Chamber of Commerce, and others. Those efforts generated 34
41 responses.

42 The Task Force later invited ADA members at-large to submit their ideas through an online request for
43 information. Submissions were accepted from December 16, 2020, to January 29, 2021. The solicitation
44 was publicized in the ADA News print edition of January 11, 2021. It was also promoted online (ADA
45 News Online, 12/16/2020) and through various electronic newsletters (What's Up Wednesday, 1/6/21;
46 ADA Financial Huddle, 1/23/21).

1 The request for information generated 85 ideas from 39 members. The majority (53.8%) were dentists
2 who had been practicing less than 10 years. The remaining respondents had been practicing
3 11-20 years (7.7%), 21-30 years (12.8%), 31-40 years (15.4%), and 41 years or more (10.3%).

4 The Task Force received 119 submissions total (see Appendix C). After filtering out duplicates, editorials,
5 and commercial advertisements, the Task Force screened 87 of the 119 submissions for creativity. The
6 Task Force determined that eleven submissions were seemingly original and creative enough to warrant
7 a more in-depth analysis, based on the following questions:

- 8 • To what extent is the proposal truly original, or a creative twist on a conventional idea?
- 9 • To what extent would the proposal lessen the burden of a new dentist's educational debt? Would
10 it impact a large number of dentists, or just a handful?
- 11 • To what extent would the proposal impact the ADA's budget or require the Association to divert
12 significant resources from existing projects?
- 13 • To what extent would the proposal add value to ADA membership? Would it inspire non-members
14 to join the ADA, or inspire existing members to renew their membership?
- 15 • To what extent could the proposal be achieved in the next five years?
- 16 • To what extent is the proposal consistent with ADA policy and the ADA's strategic plan?

17 **Findings:** The Task Force found that all eleven of the ideas it initially thought clever either already
18 existed and/or would not be impactful, add value to ADA membership, be a responsible use of the
19 Association's resources, be reasonably attainable in the next five years, and/or be in line with the ADA's
20 current policies and/or strategic plan. However, in a good faith effort to fulfill the assignment, the Task
21 Force presents, without endorsement, the extent of its findings in Appendix D.

22 The analysis concentrates on the following ideas:

- Idea 1** Provide a concierge financial literacy and planning program tailored to dental students and new dentists.
- Idea 12** Not all medically underserved are being considered for loan repayment program. The special needs population is vulnerable and is not included. Because it is not included, health centers with this focus do not qualify for a loan repayment program. By adding this group to the Medicaid list, it could boost interest in serving the population and help with loan repayment.
- Idea 13** Allow those with private student loans to take advantage of federal student loan protections and benefits.
- Idea 14** Make federal student loan repayment programs accessible to those who want to self-determine their level of public service (e.g., full-time vs. self-selected hours, two-year commitment vs. a self-selected commitment, designated practice locations vs. self-selected practice locations, etc.).
- Idea 38** Lower the student loan interest rate based on number of underserved patients seen.
- Idea 47** Develop some type of whole life insurance policy that would pay dividends for outstanding student loans while also creating a legacy program.
- Idea 49** Establish turn-key dental practices where a new dentist would receive a certain amount of student loan forgiveness in exchange for working at the location for a specified period of time (e.g., medical clinic boards).

- Idea 95** Establish volunteer clinics where “payment” is solely in the form of student loan forgiveness.
- Idea 103** Explore allowing employers to claim a tax deduction for paying down student loans with an employee’s unused paid time off (PTO).
- Idea 104** Create a tax-advantaged student loan repayment plan (similar to a 401k) where an employer and employee contribute pre-tax dollars, allow investments to grow, and allow the employee to draw from the account expressly for student loan repayment. Or simply allow existing retirement account funds to be withdrawn early—penalty-free and tax-free—for the express purpose of paying down student loans.
- Idea 106** Offer a lower interest rate to dentists who work in public health settings (in lieu of loan repayment).

1 The Task Force considered expounding on more traditional ideas—such as an ADA-financed scholarship
2 program—but ultimately decided that it was beyond its scope to make recommendations about ideas that
3 were more conventional in nature. However, the Task Force did feel it would be valuable to explore
4 developing an oral health education endowment and perhaps non-tuition funding sources for dental
5 school clinics.

6 **Observations:** During the report’s development—particularly during the discovery phase—the Task
7 Force observed the following trends that the Association may wish to consider.

- 8 • There are widespread misperceptions, even among delegates, about what is driving the cost of
9 dental education, why dental students are taking on record levels of educational debt, how their
10 loans are actually being used, and the extent to which outstanding debt (and the promise of debt
11 relief) influences practice choices. Those perceptions often do not reflect the findings of the many
12 task forces empaneled since 2010 (see Appendix A) or latest data examining student loans and
13 postgraduate educational debt (see Appendix E).
- 14
- 15 • There is a well-meaning assumption that student debt relief is an impactful incentive for dentists
16 to practice in underserved areas. The data suggest that making federal student debt relief
17 programs more attractive would not draw a sizable number of dentists to practice in underserved
18 areas. The vast majority of graduating dental school seniors seem interested in treating
19 underserved patients at some point in their career, but debt relief is not the motivating factor (see
20 Appendix E).
- 21
- 22 • Graduating seniors are overwhelmingly more interested in maximizing income and aggressively
23 repaying their student loans than in receiving debt relief through public service (see Appendix E).
24 Lowering student loan interest rates was by far the most common response to the Task Force’s
25 request for creative ideas (see Appendix C).
- 26
- 27 • The perspective on paying down student loans can change dramatically in the time between
28 being a dental student and becoming a new dentist. It may be useful to have data that explores
29 what those changes are and when they occur, including whether dental students understand the
30 financial benefits and drawbacks of becoming a dentist before pursuing a career in dentistry.
- 31
- 32 • There is some confusion about the extent to which commercial borrowers are (or not) eligible to
33 take advantage of federal student loan repayment and forgiveness programs. For most such
34 programs, eligible loans include only those made through the Higher Education Act (e.g.,
35 Direct Loans, Grad PLUS Loans, etc.) or the Public Health Service Act; however, a small number

1 of federal student loan repayment and forgiveness programs are available to those with
2 commercial loans (see Appendix E).

- 3
- 4 • It is critical to understand that the term “private loans” can be used many ways. Private loans from
5 commercial banks may qualify for some federal student debt relief programs; private loans from
6 family and other non-commercial sources do not.
- 7
- 8 • It would be useful to know the extent to which dental students are taking advantage of state
9 programs to help finance their education, as well as dental society best practices (and lessons
10 learned) when advocating for them.
- 11
- 12 • The ADA has no policy to guide its position on blanket student loan forgiveness, means tested
13 student loan forgiveness, or the full and automatic discharge of student loans during bankruptcy.*
- 14
- 15 • Members at-large, including delegates, seem generally unaware of how much the ADA is (and
16 has been) doing to help dental students finance their education responsibly and help dentists
17 manage their outstanding educational debt effectively (see Appendix F). Those activities have
18 been driven by surveying what dental students and new dentists have said is most important to
19 them (e.g., ADA Dental Student Quantitative Survey, etc.).

20 **Conclusion:** The Task Force did not identify any new and workable vehicles to help dental students and
21 new dentists pay down their student debt. But the endeavor revealed that the solution to the student debt
22 crisis will need to come from a force much larger than the American Dental Association.

23 The nation's system of financing higher education needs fixing, and dentistry can and should support
24 reasonable efforts to do so. But the ADA does not have the capacity or the expertise to be the entity that
25 resolves the financial challenges that have arisen following decades of skyrocketing costs in higher
26 education, particularly when those problems transcend dentistry, medicine, and all other health care
27 professions.

28 Given the sheer number of student debt resolutions that have been considered in recent years—and the
29 activities that are ongoing—the Task Force recommends that the House embrace only assignments that
30 will be impactful (and attainable) in lieu of academic endeavors that might be interesting (but aspirational).
31 Ideally, those resolutions will be well researched, put into context, and be consistent with the surveyed
32 interests of dental students and new dentists. Hopefully, they will also be received in time for thoughtful
33 consideration by the Board and any pertinent councils and committees.

34 It remains unclear how this report is intended to be used and whether the expectations are different from
35 the many other House panels that have explored the issue. For now, the Task Force considers that the
36 Association has been doing its diligence to address the student debt crisis.

37 The Task Force recommends that ADA continue focusing on the student debt strategies it has the
38 capacity and expertise to carry out—and are in line with the surveyed priorities of new dentists. That
39 appears to be what the Board of Trustees, the New Dentist Committee, and the American Student Dental
40 Association are already doing: Helping dental students finance their dental education responsibly and
41 helping new dentists manage their outstanding educational debt effectively.

42

* The law currently allows educational loans to be discharged in bankruptcy, but it is not automatic. It requires a separate legal proceeding where petitioners must prove “undue hardship”. Even then, the court may not discharge the debt outright. It might instead alter the repayment terms (e.g. lower monthly payments, lower the interest rate, extend the repayment period, discharge only a portion of the debt, etc.).

1 **Resolution**

2 This report is informational and no resolutions are presented.

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

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

**APPENDIX A
REPORT OF THE TASK FORCE TO STUDY
ALTERNATE STUDENT LOAN REPAYMENT STRATEGIES**

**ADOPTED AND REFERRED HOUSE ACTIONS ON
STUDENT LOANS AND POSTGRADUATE EDUCATIONAL DEBT (2010-2020)**

1 In commenting on the original Resolution 81-2019, the Board of Trustees noted that between 2010 and
2 2017, the House of Delegates had adopted or referred thirteen resolutions calling for actions on student
3 loans and postgraduate educational debt (*Trans.2019:206*).

4 For reference, those thirteen resolutions are:

87-2010 (Referred)	Study Impact of Existing and Emerging Models of Dental Education (<i>Trans.2010:572, 578</i>)	A2
112-2010 (Referred)	A Viable Mid-Level Solution: Improving Access by Reinventing Dentists' Education (<i>Trans.2010:572, 578</i>)	A2
66H-2011 (Adopted)	Deflating the Dental Education Bubble (<i>Trans.2011:409, 463, 481</i>)	A3
91H-2011 (Adopted)	Student Loan Reduction Program (<i>Trans.2011:433, 551</i>)	A3
113H-2012 (Adopted)	Dental Education Economics and Student Debt (<i>Trans.2012:458, 480</i>)	A3
53H-2013 (Adopted)	ADA Advocacy Agenda (<i>Trans.2013:329</i>)	A4
54-2013 (Referred)	Development of a Robust Information Portal (<i>Trans.2013:330</i>)	A4
55H-2013 (Adopted)	Expanding Research Efforts in the Area of Dental Education Financing (<i>Trans.2013:332</i>)	A4
56H-2013 (Adopted)	A Comprehensive Study of the Current Dental Education Model (<i>Trans.2013:332</i>)	A5
57H-2013 (Adopted)	Revision of Accreditation Standards (<i>Trans.2013:334</i>)	A5
91-2013 (Referred)	Disclosure of Costs Incurred by Dental Students (<i>Trans.2013:331</i>)	A6
92-2013 (Referred)	Presentations for Long-Term Financial Implications of Debt Incurred by Students During Dental School (<i>Trans.2013:331</i>).....	A6
35H-2014 (Adopted)	A Comprehensive Study of the Current Dental Education Models (<i>Trans.2014:463</i>)	A6

87-2010 Study Impact of Existing and Emerging Models of Dental Education
(Referred) (*Trans.*2010:572, 578)

- 1 **Resolved**, that the ADA Council on Dental Education and Licensure study the short and long term impact
2 (positive and negative) of existing and emerging models of dental education in resolving the challenge of
3 preservation of the profession as a learned profession while meeting the changing needs of oral health for
4 diverse patient groups in a time of economic challenge, and be it further
- 5 **Resolved**, that relevant stakeholders be invited to participate in the discussion at their expense or the
6 sponsoring organization's expense, and that recommendations include collaborative new strategies for
7 working together as a profession to resolve these important issues through partnerships, and be it further
- 8 **Resolved**, that the Council on Dental Education and Licensure report its findings to the 2011 ADA House
9 of Delegates.

112-2010 A Viable Mid-Level Solution: Improving Access by Reinventing
(Referred) **Dentists' Education** (*Trans.*2010:572, 578)

- 10 **Resolved**, that the ADA invite to a conference of appropriate stakeholders and leaders, to include, but
11 not be limited to representatives of CAPIR, CDEL, CGA, ASDA, CODA, ADEA, AADB, CMS and the
12 Kellogg Foundation to consider development of dental education models that facilitate fourth- and fifth-
13 year dental students and residents to provide care in underserved and unserved settings, and be it further
- 14 **Resolved**, that the conference agenda will include, but not be limited to, the following:
- 15 • Utilization of pre-doctoral dental students as an alternative to mid-level providers for improved
 - 16 access to care and maintaining a high quality single tier delivery system.
 - 17 • Consideration of conversion of some basic science curricula to undergraduate prerequisites.
 - 18 • Education cost-reduction through provision of services by both students and faculty.
 - 19 • Alternative faculty/student supervisory models to reduce barriers to access in remote locations.
 - 20 • Concurrent loan forgiveness programs and stipends for pre-doctoral practice in remote locations.
 - 21 • Statutory consideration of utilizing dental students in alternative settings.
 - 22 • Testing and licensing considerations in alternative educational models.
 - 23 • Applications for teledentistry and distance education via interactive links.
 - 24 • Funding needs for pilot projects and transition to new models.
 - 25 • Accreditation considerations for alternative educational models.
 - 26 • Limitations of public funding and subsidies as educational clinic revenue sources.
- 27 and be it further
- 28 **Resolved**, that the appropriate Association agencies provide a report on the conference with a
29 recommended action plan to the 2011 House of Delegates.

66H-2011 Deflating the Dental Education Bubble
(Adopted) (*Trans.*2011:409, 463, 481)

- 1 **Resolved**, that the Board of Trustees with the assistance of appropriate councils and expert consultants,
2 study, document and analyze the current and future economics of dental education, student debt and the
3 impact on dental practice and access to care, utilizing existing environmental scan and other available
4 data, and be it further
- 5 **Resolved**, that the Board with the assistance of CDEL and consultants with expertise in dental education
6 identify innovations in dental education that reduce costs without diminishing quality and recognize
7 barriers to broader implementation, and be it further
- 8 **Resolved**, that the Board, with the assistance of consultants with expertise in practice economics and
9 subsidized care, consider the role educational institutions, students, residents and new graduates have
10 played in the dental "safety net," and innovative ideas to improve that function while reducing student
11 debt, and be it further
- 12 **Resolved**, that the Board prepare a detailed report including short term and long range action
13 recommendations to reduce dental student debt for consideration at the 2012 House of Delegates.

91H-2011 Student Loan Reduction Program
(Adopted) (*Trans.*2011:433, 551)

- 14 **Resolved**, that the appropriate councils and ADA agencies investigate the development and
15 implementation of a student loan repayment grant program for dentists working in a non-profit community
16 dental clinic, and report to the 2012 House of Delegates.
- 17 **Resolved**, that the appropriate councils and ADA agencies investigate the development and
18 implementation of a student loan repayment grant program for dentists working in a non-profit community
19 dental clinic, and report to the 2012 House of Delegates.

113H-2012 Dental Education Economics and Student Debt
(Adopted) (*Trans.*2012:458, 480)

- 20 **Resolved**, that the Board of Trustees' Taskforce on Dental Education Economics and Student Debt
21 conduct the research as outlined in its 2012 report and report findings to the 2013 House of Delegates,
22 and be it further
- 23 **Resolved**, that any unspent amount from the \$230,000 from the 2012 budget be returned to the
24 Reserves and funding for completion of the study in 2013 come from the Reserve Account.

53H-2013 ADA Advocacy Agenda
(Adopted) (*Trans.2013:329*)

- 1 **Resolved**, that the ADA advocacy agenda on behalf of dental education, dental students, and recent
2 dental school graduates include:
- 3 1. Dental school approval as Federally Qualified Health Centers (FQHC) or ability to partner with
4 FQHC's.
 - 5 2. Graduate Medical Education (GME) funding for non-hospital-based programs (i.e., dental
6 schools).
 - 7 3. Increased Medicaid fees and cost-based reimbursement for dental schools.
 - 8 4. Increased number of loan forgiveness programs at the state and national level, including
9 additional debt relief programs targeting rural/underserved areas.
 - 10 5. Financial incentives to practice in underserved areas through supplemental payments or tax
11 credits.
 - 12 6. Increased eligibility for dental graduates for all health profession loan forgiveness programs.
 - 13 7. Student loan interest rate reform.

54-2013 Development of a Robust Information Portal
(Referred) (*Trans.2013:330*)

- 14 **Resolved**, that the ADA Health Policy Resources Center (HPRC), the ADA/ADEA/CODA Liaison
15 Committee for Surveys and Reports, and the Center for Professional Success (CPS) in collaboration with
16 the communities of interest develop and promote a robust information portal via ADA.org to help current
17 and prospective students be fully informed, financially literate consumers about a career in dentistry,
18 including workforce forecasting reports, student debt, expected income, life-long financial planning, and a
19 central registry of all loan/tuition relief programs.

55H-2013 Expanding Research Efforts in the Area of Dental Education Financing
(Adopted) (*Trans.2013:332*)

- 20 **Resolved**, that the ADA Health Policy Resources Center (HPRC), in preparation for the future of the
21 profession and reexamination of the dental education model, expand its research efforts in the area of
22 dental education financing, the impact of student debt and other factors on career choices in order to
23 better position the ADA as a thought leader and knowledge broker in this area and to strengthen
24 advocacy efforts.

56H-2013 A Comprehensive Study of the Current Dental Education Model
(Adopted) (*Trans.2013:332*)

1 **Resolved**, that the ADA seek collaboration with broad communities of interest, including dental
2 educators, students, practicing dentists, health economists, and others with appropriate expertise to
3 define the scope and specific aims of a comprehensive study of current dental education models, to
4 include:

- 5 1. Evaluation of the long-term sustainability of dental schools.
- 6 2. Evaluation of the efficiency of the current dental school curricula and delivery methods.
- 7 3. Analysis of the impact of student debt on dentistry as a career choice and subsequent practice
8 choices.
- 9 4. A determination of whether dental schools are meeting the appropriate level of scholarship to
10 ensure that dentistry continues to be a learned profession;

11 and be it further

12 **Resolved**, that the ADA's financial implication for this resolution shall not exceed \$80,000, to be used to
13 define the scope and specific aims of the study, to determine the estimated cost of the study, to identify
14 potential funding sources for the study, and to report to the 2014 ADA House of Delegates.

57H-2013 Revision of Accreditation Standards
(Adopted) (*Trans.2013:334*)

15 **Resolved**, that the ADA seek collaboration with broad communities of interest, including dental
16 educators, students, practicing dentists, health economists, and others with appropriate expertise to
17 define the scope and specific aims of a comprehensive study of current dental education models, to
18 include:

- 19 1. Evaluation of the long-term sustainability of dental schools.
- 20 2. Evaluation of the efficiency of the current dental school curricula and delivery methods.
- 21 3. Analysis of the impact of student debt on dentistry as a career choice and subsequent practice
22 choices.
- 23 4. A determination of whether dental schools are meeting the appropriate level of scholarship to
24 ensure that dentistry continues to be a learned profession;

25 and be it further

26 **Resolved**, that the ADA's financial implication for this resolution shall not exceed \$80,000, to be used to
27 define the scope and specific aims of the study, to determine the estimated cost of the study, to identify
28 potential funding sources for the study, and to report to the 2014 ADA House of Delegates.

91-2013 Disclosure of Costs Incurred by Dental Students
(Referred) (*Trans.2013:331*)

- 1 **Resolved**, that the ADA encourage dental schools, as part of their application and interview process, to
2 disclose the actual costs incurred by their students to complete their degrees based on exit data collected
3 for the two most recent classes.

92-2013 Presentations for Long-Term Financial Implications of Debt Incurred by Students
(Referred) **During Dental School** (*Trans.2013:331*)

- 4 **Resolved**, that the appropriate agencies of the ADA develop presentations for pre-dental students
5 explaining the long-term financial implications of debt incurred during dental school, and be it further
6 **Resolved**, that the ADA be urged to make these presentations available in the public area of the Center
7 for Practice Success website.

35H-2014 A Comprehensive Study of the Current Dental Education Models
(Adopted) (*Trans.2014:463*)

- 8 **Resolved**, that the ADA conduct a focused study relative to the following:
9 Domain 3: Impact of Student Debt on Dentistry as a Career Choice and Subsequent Practice Choices
10 1. How does the cost of dental education and/or level of student borrowing influence students'
11 decisions to enter dental education and their future career choices?
12 2. Do higher levels of educational debt have a greater impact on career choices?
13 3. What is the critical point at which the perceived return on investment means that dentistry is no
14 longer seen as a desired profession?
15 4. Are there differences in the perceived return on investment for specific subsets of dental careers?
16 5. At what income/debt ratio are specific labor force choices impacted (disaggregating the data to
17 determine impact on generalist, specialist, public health, Medicaid providers, etc.)?
18 6. How long does it actually take for dentists to pay off their educational debt?
19 7. What is the impact of new loan repayment programs/options on student debt?
20 8. Are there other strategies we can use to reduce the cost to students and/or students' educational
21 debt (e.g., subsidizing loans, level of clinical production while in school, alternative investment
22 pools, philanthropy, and planned giving)?
23 9. What is the impact of educational debt on graduates' decisions to enter subsets of practice such
24 as solo practice, small group practice and large group practice, and to be a practice owner or an
25 employed dentist?
26 10. Does educational debt primarily have a short-term impact on practice choices (i.e., decisions
27 upon graduation or in the first few years of practice) or does it impact longer-term practice
28 choices?

29 and be it further

- 30 **Resolved**, that the ADA pursue a focused study relative to the following:

31 Domain 1: Long-Term Sustainability of Dental Schools

Appendix A (Task Force to Study Alternate Student Loan Repayment Strategies)
Adopted and Referred House Actions

- 1 1. What are the major revenue and expense drivers for dental education, and how do these differ
2 across schools?
- 3 2. What opportunities exist to increase revenue for dental schools other than increases in tuition and
4 fees (for example, increased reimbursement for clinical care, increased net clinical income,
5 private philanthropy, intellectual property and technology transfer, and increased federal and
6 state funding)?
- 7 3. What opportunities exist to reduce the cost of dental education (for example, sharing of faculty
8 and educational resources, increasing the productivity of clinical faculty, use of technology,
9 addressing the financial impact of accreditation standards and state regulations)?

10 Domain 2: Efficiency of the Current Dental School Curricula and Delivery Methods

- 11 1. Which dental schools are utilizing each of the curricular models and what is the financial model
12 that supports each approach?

13 Domain 4: Appropriate Level of Scholarship to Ensure that Dentistry Continues to Be a Learned
14 Profession

- 15 1. Is the profession attracting and retaining the highest quality faculty who can lead the research
16 enterprise?
- 17 2. How can the dental community provide more effective advocacy for research support?

18 and be it further

19 **Resolved**, that the study results be reported to the 2016 House of Delegates.

APPENDIX B
REPORT OF THE TASK FORCE TO STUDY
ALTERNATE STUDENT LOAN REPAYMENT STRATEGIES

ADA CURRENT POLICIES ON STUDENT LOANS AND
POSTGRADUATE EDUCATIONAL DEBT

- 1 The following major policies were adopted by the American Dental Association House of Delegates and
2 are still in effect in 2021.

36H-2019. Federal Student Loan Programs
(Trans.2019:297)

Resolved, that the American Dental Association supports the federal graduate and professional degree student loan programs authorized under the Higher Education Act of 1965, with an emphasis on:

1. Protecting access to federal Direct Unsubsidized Stafford Loans (Direct Loans) and Grad PLUS loans for graduate and professional degree students.
2. Reinstating eligibility for graduate and professional degree students to take advantage of federal Direct Subsidized Stafford Loans.
3. Removing annual and cumulative borrowing limits on federal student loans.
4. Lowering the interest rates and fees on federal student loans.
5. Capping total amount of interest that can accrue on federal student loans.
6. Halting the accrual of federal student loan interest while a dentist is completing a medical/dental internship or residency.
7. Extending the period of federal student loan deferment until after a new dentist has completed his or her medical/dental internship or residency.
8. Permitting federal graduate student loans to be refinanced more than once.
9. Simplifying and adding more transparency to the federal graduate student loan application process.
10. Encouraging institutions of higher education and lenders to offer training to help students make informed decisions about how to finance their graduate education.

11. Encouraging collaborative approaches to handling borrowers who fail (or are at risk of failing) to fully repay their federal student loan(s) in the required time period.

and be it further

Resolved, that the ADA's position on allowing private lenders to have a role in the federal student loan program shall depend on whether the loan terms and conditions and borrower protections are guaranteed to be as favorable or better than the existing system of federal student loans, and be it further

Resolved, that the ADA supports strengthening federal regulations for the protection of all student loan borrowers.

37H-2019. Federal Student Loan Repayment Incentives (Trans.2019:297)

Resolved, that the American Dental Association supports using state and federal funds to provide payments toward a dental professional's outstanding federal student loans in exchange for practicing in underserved areas, entering and remaining in public service and academic teaching and research positions, and filling other gaps in areas of national need, and be it further

Resolved, that the ADA supports removing barriers that prohibit those with private graduate student loans from taking advantage of state and federal student loan repayment programs.

38H-2019. Tax Treatment of Federal Student Loan Interest, Scholarships and Stipends
(Trans.2019:298)

Resolved, that the American Dental Association supports the tax deductibility of interest on health profession student loans, and be it further

Resolved, that the ADA supports a tax exemption for scholarship assistance and stipends awarded to health professions students under federal program.

National Health Service Corps Policy on Scholarships and Loan Repayments
(Trans.1988:488; 2016:347)

Resolved, that the ADA work to expand the availability of National Health Service Corps (NHSC) scholarships and loan repayments for dentists and dental students who agree to work in a NHSC-approved site.

**APPENDIX C
REPORT OF THE TASK FORCE TO STUDY
ALTERNATE STUDENT LOAN REPAYMENT STRATEGIES**

IDEAS GATHERED DURING DISCOVERY

- 1 The following responses were received from ADA members and a variety of internal and external
- 2 stakeholders in answer to the following question: “What innovative ideas do you have – or inventive twists
- 3 on conventional approaches – to help mitigate the burden of student debt?”
- 4 The Task Force redacted the names of several for-profit companies that used “member comments” as a
- 5 vehicle for commercial advertising.

<i>No.</i>	<i>Idea</i>
01	Provide concierge financial service with features such as a free first meeting with a financial advisor. Provide access to contract advisors, such as related to associateship and insurance. The first contract review will be free, but further meetings will be available at a substantial discount via bulk discounts from advisors. Could be a benefit to dental student members as well as dental benefits.
02	Help states or regions have an ongoing 24-7 loan refinancing marketplace where banks compete to refinance or provide business loans or student loans. Financial institutions look at dentists as high earners, no matter their practice type. Allow for more competition.
03	Develop financial literacy program through partners instead of coming up with it on our own (ADA). Include data and interactive resources.
04	What are the current practice ownership trends for lending? Some members have heard that there were changes in how acceptance has been calculated (not based on how much they pay per month as was done previously). What are the “likelihood to lend” trends? Where is the market going? What are the default numbers for dentist loans? Ask for numbers of default numbers (have heard less than .1% that default in the dental space).
05	Explore whether and how practice owners are using student loan repayment as a way to attract new associates.
06	Explore a convincing study examining whether student loan repayment programs are (or are not) drawing dentists to practice in underserved areas—using the most recent data available.
07	Explore creating a model educational loan repayment program that states can implement to attract indebted dentists to rural areas. Kansas has a program where they are placing dentists in rural areas called RIDE. Ohio has a dentist-funded student loan repayment program that is doubling in size next year. This is a good step toward placing more dentists in rural and low income areas. It also allows new graduates to reduce their debt burden but still maintaining a healthy income. License fee can be deducted. Wisconsin is currently actively supporting legislation that would create a Rural Track Scholarship program that would support up to 5 dental students a year for a 4-year \$40k/year scholarship

Appendix C (Task Force to Study Alternate Student Loan Repayment Strategies)
 Ideas Gathered During Discovery

No.	Idea
	<p>and require 4 years of “payback” time in a rural location in Wisconsin to boost long-term retention of a rural workforce. This bill recently had a hearing and was discussed within our January 15 2020 Legislative Day. It’s a substantial opportunity should it pass.</p> <p>There is an opportunity for the states to recruit future dentists from rural communities – encourage populations from rural areas to become dentists.</p>
08	<p>Explore offering a convenient place where ADA-member dentists can easily find the state and federal student loan repayment programs available to them.</p>
09	<p>Explore collaborating with other health professions and dental associations on advocacy activities.</p> <p>Expand collaborations with other healthcare associations to create greater influence. For example, we’ve worked together on ER referral programs can we add student debt related topics? Nutritionist came up as another example. Need to work with others to lobby to invest in affordable foods and long term health.</p>
10	<p>Explore increasing the student loan interest deduction for dentists and other health professions.</p> <p>Dentists are only eligible for \$2500 in student loan deduction (SLID), which is not enough if you 300k in debt. And only if you qualify. Many dentist income is too high, especially if in dual-professional marriage. This would benefit not just dentists – but nurses pharmacists and others. Could be a possible DSO partnership to advocate together. Strategy could be to encourage more payments instead of defaulting on loans, which could increase and put government funding at risk.</p> <p>Need to streamline FAFSA.</p>
11	<p>Explore increasing the portability of loan repayment (to increase use and benefit of program).</p> <p>Loan repayment can require a multi-year commitment but doesn’t give the option to move the repayment to another low shortage area if the dentist moves. New dentists, especially, are more mobile. Someone can lose their repayment or need to pay it back if this happens.</p> <p>Also, dentists have commented that HPSA doesn’t accurately reflect the shortage area needs.</p>
12	<p>Not all medically underserved are being considered for loan repayment program. The special needs population is vulnerable and is not included. Because it is not included, health centers with this focus do not qualify for a loan repayment program. By adding this group to the Medicaid list, it could boost interest in serving the population and help with loan repayment.</p>
13	<p>Explore reforms that would allow those with private student loans to take advantage of federal student loan repayment programs.</p>
14	<p>Explore reforms that would make federal student loan repayment programs accessible to those who want to self-determine their level of public service (e.g., full-time vs. self-selected hours, two-year commitment vs. a self-selected commitment, designated practice locations vs. self-selected practice locations, etc.).</p>

Appendix C (Task Force to Study Alternate Student Loan Repayment Strategies)
 Ideas Gathered During Discovery

No.	Idea
15	Work Part. Time. while in school
16	The very high federal interest rates is what really adds to the pressure. When switching to a private insurer, although the interest is lower, the terms are much shorter, so the payment is still very high. Finding financial routes in which the interest is lower and the terms are longer is key - and then connecting them with younger dentists.
17	[FOR-PROFIT COMPANY URL]
18	Better education about finances for dental students starting at first year orientation
19	Check out [FOR-PROFIT COMPANY]. They are a B-Corp.
20	Cut back the number of graduating seniors by 50% immediately. This by elimination of some dental programs & class reduction by 50% in others. New grads could have their pick of jobs upon graduation, & the debt load wouldn't feel nearly as heavy.
21	My Daughter was able to save money by working with a company called [FOR-PROFIT COMPANY]. It may be worth considering for the ADA.
22	Expand rural loan repayment programs to reduce the burden on local entities which are often required to provide "matching funds" for those programs.
23	Mandatory service in the US Armed Forces or Public Health
24	Do not allow dental students to take out more funding than is necessary for tuition, room and board(reasonable) and equipment.
25	Reduce the cost of a dental school education. It is crazy that the average debt that a dental school graduate has at graduation is over \$300,000. The cost of the education has far exceeded the cost of living index. This is only causing new grads to go to work for a DSO in record numbers that will only increase. And it leaves a solo dental practitioner that has spent his whole career building his practice, hoping to sell it to fund some of their retirement, unable to sell and having to close their doors.
26	After loosing my job, I was referred to [FOR-PROFIT COMPANY] by my States Department of Labor to help with my student debt. The ADA should partner with them.
27	ADA can pay for our student loans since contributions are now tax deductible
28	The student loan pause has been extended until September, which is great but I still need help with my PSLF Certification and making sure that payments for my loan that do not qualify for the payment pause are still being applied towards my PSLF forgiveness. Can you please find a partner who can help me with this situation that I am sure many other ADA members who work for Nonprofit Employers are facing or will face. Thank you :)

Appendix C (Task Force to Study Alternate Student Loan Repayment Strategies)
 Ideas Gathered During Discovery

No.	Idea
29	Lower the rates. At 6.8% I am paying \$20,000 a year before any principle gets paid.
30	Allow loan forgiveness, and if that is not possible, provide SIGNIFICANT federal tax breaks for providing dental care to the underserved, in the office of the debtor. Having volunteered many times in many other facilities, it was always like "cooking in someone else's kitchen". A young dentist could give 2-4 days a month to such an endeavor and significantly impact their debt over time. I have discussed this with Senator Jeanne Shaheen and members of her staff years ago and they were very interested. In both urban and rural environs this could help address access to care. I believe the challenge is in vetting or qualifying patients and preventing fraud.
31	Forgive and remove interest on student loans.
32	Easier access to student loan forgiveness for practicing in an underserved area, or simply, being a medicaid provider. Not many dentists accept Medicaid for children and adults, and access to care is often limited for many people because of this. We choose to be reimbursed at a lower rate to be able to provide dental care to everyone. We should be repaid for this.
33	Increase the amount of scholarship funds available (through the ADA, state, and local component societies).
34	Student Loans(Consulate or not) on over 65 years old regardless of their balance they would be forgiven. They can not go to grave with student loans. In return of their loans they have don the service to society even if they get paid for it.
35	Allow those dentists that consolidated years ago under much higher interest rates to easily obtain a lower fixed rate now
36	Give students 0% interest loans
37	Eliminate interest while students are in school. It is unfair for interest to accrue when students have no means to work and pay off loans.
38	Have an incentive to see more Medicaid patients by paying a percentage of student loan debt based on number of underserved people they see...example....since reimbursement rates are ~60 cents on the dollar...incentivize by adding 10-50 cents on the dollar to student loan forgiveness.
39	Set a budget and financial goals, prioritize debt
40	No student loans should accrue interest while in school - zero.
41	Lower dental school tuition. cutting back on expenses unrelated to the student experience. ie. faculty and administrations' salary, mandatory textbooks that no one reads

Appendix C (Task Force to Study Alternate Student Loan Repayment Strategies)
 Ideas Gathered During Discovery

No.	Idea
42	Provide a prototype curriculum to prospective dentist that complete all dental school requirements for application in 3 years of undergrad. This is not unique , but is not universally understood. University's do not want to give up the fourth year hold on the students.
43	Work one day a week (or more depending on comfort) for a government clinic or something of the sort. No direct pay. Instead for each dollar you would make, you get paid double that towards your loan.
44	Advocate for dental students directly to the universities so that we don't have overpriced dental education that leads us to debt in the first place.
45	Forgiveness or partial forgiveness
46	No income limit for medical/dental providers for any student loan forgiveness.
47	Use of SPECIALLY DESIGNED Participating, Dividend Paying whole life insurance policies to create a debt repayment program while also creating a legacy program.
48	Rather than loan forgiveness, revert to pre-Reagan era ability to tax deduct student loan payments. Especially for people getting advanced degrees, these should really be considered CE and an expense involved in doing business, as it is training to actually do a specific type of business, and advanced training, in many cases, is required for licensure to practice (law, healthcare, medicine, etc.) This also helps people in proportion to their loan amount and the deductions encourage people to pay more and get out of debt faster. The yearly max of \$5000 is useless and many people don't qualify.
49	Have towns without dentists (or in an underserved area) establish a turn key dental office that a new dentist works in for 5 years for debt forgiveness. or a certain % each year of debt forgiveness. Who knows. He/she may want to stay! or on Indian reservations or ??
50	90% of dentists who've been practicing for 7 years still have student loan debt and are either · anxious and confused about how to pay them off · living paycheck to paycheck · delaying buying a house, buying a practice, starting a family, to name a few I am [FOR-PROFIT COMPANY OWNER], general dentist in Manchester, NH. I am a debt repayment strategist. I'm the founder of [FOR-PROFIT COMPANY] [URL]. I help doctors (dentists, physicians, pharmacists and veterinarians) get out of debt and create generational wealth. I am working on developing a mastermind for doctors on debt repayment and wealth building. So far, I have a 3 month coaching package for doctors where they can: Find out why they should get out of debt so you can create true generational wealth · The importance of the debt strategy insurance · Get clarity about their next career and financial steps · Determine which strategy might be the best for you to pay off debt . Get rid of limiting beliefs about money for good . Get a solid plan to go from six figure debt to generational wealth · Find out where they could be re-allocating your money to acquire real wealth . Become confident about making financial decisions . Know how to diversify their income and investment portfolio . Understand when to start saving for retirement, and much more! Here's what a few doctors who have worked with me during the pandemic had to say: "I paid off 11 credit cards in 3 months and paid \$ 40,000 towards my student loans". Dr. Robinson (dentist) "[FOR-PROFIT COMPANY OWNER] has been giving me advice on how to pay back my student loans, well I decided to take it a step farther and use her services....Her plan for me gave me the push I needed and allowed me to look at repayment

Appendix C (Task Force to Study Alternate Student Loan Repayment Strategies)
 Ideas Gathered During Discovery

No.	Idea
	<p>in a different way. Because of her, I will be all paid off by mid 2020 after only 2 years of repayment post grad. I highly recommend you schedule a call with [FOR-PROFIT COMPANY OWNER]." Dr. B (pharmacist) "My credit score went from 764 to 804." Dr. Uwa (pediatrician) 'Since I started working with [FOR-PROFIT COMPANY OWNER], I better understand my financial portfolio. In less than 4 months I would have paid close to 15,000 on my existing debt. I have always had a great credit score but now it's almost 800. I paid an \$ 11,000 down payment on my youngest son's car. I feel financial freedom is right around the corner. Thank you [FOR-PROFIT COMPANY OWNER]. As you can see I am an obedient student". Dr. Hazel Glasper (dentist) " I feel empowered. I had a lot of money saved in the bank but now I know how to invest and grow my money. I also have a plan for retirement and for the children's future." Dr. Person (dentist) "Officially student loan debt free!! Paid off 115k in 29 months. Words can't describe the amount of joy and relief I feel. Special thank you to [FOR-PROFIT COMPANY OWNER] for guiding me in the right direction and creating a plan for me to follow in order to pay them off so quickly!!" Dr. Yancey (pharmacist) Best, [FOR-PROFIT COMPANY OWNER]</p>
51	<p>How about just lowering the interest rate or making them interest free?? My federal student loans carry ~7% interest rate which makes it hard to put a dent in them. Most of payment goes towards interest... I think lowering or eliminating the interest would be much smarter than any overall forgiveness...</p>
52	<p>The source of mitigating student loans is to prevent dental schools from charging and exorbitant amount in the first place. There needs to be a cap on what schools can charge, instead schools are using the premise that by providing the latest technology somehow that justifies an extremely steep tuition.</p>
53	<p>IRS has special loan repayment for health care professionals</p>
54	<p>Does the ADA endorse financial advisors for younger dentists? In looking - I was not able to find any. Matching new dentists to financial advisors that are knowledgeable and up to date on the latest federal and private student loan processes would also be very helpful.</p>
55	<p>I need a solution that can help me understand different Federal Repayment options such as Income Driven Repayment and help me enroll in Public Service Loan Forgiveness. I have two friends, one a teacher and the other a nurse, who are both members of the AFT and have access to a Student Loan Technology company called [COMPANY].</p>
56	<p>A more aggressive approach to creating a common fundraising effort for scholarships involving the ADA, ADEA, specialty organizations, and others (similar to OLOF in the early 2000s).</p>
57	<p>Lobby for stopping federal supports for student loans. The current federal loan guarantees enable universities to ask students for basically a blank check for educational costs.</p>
58	<p>Reduce the number of administrators in dental schools. The school bureaucracy is overwhelming and impedes efficiency.</p>
59	<p>Consider attending a less expensive school or work as a chairside assistant in a nearby, low income dental clinic.</p>

Appendix C (Task Force to Study Alternate Student Loan Repayment Strategies)
 Ideas Gathered During Discovery

No.	Idea
60	100% of student loan to be deductible regardless of income or amount of debt
61	Pay deans and the highest paid instructors less. When I went to dental school 30 years ago, most instructors were part-time working on their days off. It is ridiculous to pay the Deans and department heads way more than the average dentist makes in private practice. Especially when they get a retirement pension!
62	Allow employers to make tax-free contributions of up to \$5,250 a year to their employees' education debt.
63	Make all interest paid on student loans deductible.
64	The ADA could help develop a program where there are existing public health or private free clinics, and loan forgiveness can be given for a young dentist to rotate through the clinic a solid week at a time. If the amount was enough it would be one way to take a week "off" and pay down debt, and again help address access to care.
65	Give the option to refinance to a significantly lower interest rate through the federal student loan program after making a certain number of consecutive student loan payments.
66	Bolster the loan forgiveness programs (working at FQHC, IHS, Public health)
67	No interest for the new student loan. The old ones who are graduated and have been paying for years (existing student loans). Turn the years of interest that they have paid as a credit toward the initial principal of the loan. Keep in mind that these loans have been sold and bought few times from different lenders. They need to go back and check with every one them to see how much was the initial principal and how much the student has paid interest toward that loan from day one of paying.
68	Allow parents Or students the ability to have a tax write off on educational expenses regardless of their tax bracket
69	Same concept incentivize new grads to work with a mentor office for eventual ownership by giving tax breaks to the mentor and loan forgiveness for the new grad to work in mentoring program to help advance new grads skills and give benefit to mentors to work with new grads!
70	Know the difference between needs and wants. Dentist do not need a lease on an expensive car, or a brand new home fresh out of school or anytime
71	Abolish Private School Dental Fees. I would have saved so much money had I gone to Minnesota. Since I was from Wisconsin, Marquette's fee were astronomical. As a D1 Athlete coming in with ZERO debt, it was disgusting to come out with 262,000.00 after 4 years.
72	Supplement tuition with private clinic or hospital setting assisting. Increase interaction as a dental team in the real world.

Appendix C (Task Force to Study Alternate Student Loan Repayment Strategies)
 Ideas Gathered During Discovery

No.	Idea
73	Dental Colleges work with universities to provide post grad dental school academics requirements in the undergrad platform. Again the idea is to condense the time for a future dentist to complete the academic work. Look at the academic prowess of the dental student..... they are academically highly qualified and can handle the condensing .
74	No interest
75	Include all federal loans in the pause of payments and interest rates, not just direct federal loans (i.e. loans from the last 10 years or so). Thirteen of my 16 student loans (all federal) are not affected by the current pause because they were issued between 1997 and 2010.
76	Related to first in terms of funding such policies
77	Reduce federal loan rates to be on par with private loans. Many of us opt to refinance because of the vast difference in interest rate. I refinanced for 7.8% fed rate down to 2.95% private rate, which makes my payments more affordable on the same term. However, I lost the ability to defer without interest, a benefit afforded to federal loans but not private. During the pandemic, I had to dip significantly into my savings to not 1) put myself behind on payments, 2) pay additional compound interest if I deferred, or 3) void my consecutive payment bonus.
78	10% of profit or income goes toward the debt every year for 10 years. This money would not count as income toward the persons taxes. After 10 years, any outstanding balance is forgiven.
79	One of my goals is to coach and help as many dentists as possible to understand their debt, the purpose of debt, their debt to income ratio and understand when or if to refinance their student loans.
80	Make student loan interest tax deductible. Or lower student interest rates to rates similar to home mortgages.
81	Practices hiring associates pay towards loan re-payment and pay more if production is good.
82	Refinancing doesnt help me right now. It may in the future but Refinancing my Federal loans right now is the worst thing I can do since it will entail losing the federal payment pause in the future.
83	Pursue new and expanded partnerships with the dental trade and DSOs to provide support for scholarships.
84	study as to why state sponsored schools are so much less expensive than private schools. Their costs should be the same. Is the overall price tag the same and the states are just funding the difference? Set up programs with all schools where instead of 8 years of schooling ie 4 undergraduate and 4 graduate, make it a total of 6 years 2/4
85	Once you have a certain amount of your student loan debt paid off, open the option to pay off the remainder in a lump sum, but reduce the balance by a significant amount, i.e., 50%. Ex, paid off \$100,000 of a \$200,000 loan over 5 years. The remainder can be "paid off" in one final

Appendix C (Task Force to Study Alternate Student Loan Repayment Strategies)
 Ideas Gathered During Discovery

No.	Idea
	payment if you pay \$50,000. For the remainder of the loan life, at any point, you can pay off your balance at a rate of 50% if you pay one lump sum.
86	No more student loan. Designate places of need for them that government knows and send them to work. .
87	Work on making the cost of dental education more affordable by using technology (virtual standardized education)
88	Help new grads with ownership by giving a percentage of Medicaid and underserved patient encounters with a % of student loan forgiveness....so if you see 20% of your patient pool as underserved then you get an option to apply that percentage discount to loan payments for the year.. so if provider sees 20% of their patient pool in Medicaid pts and their student loan payment for the year is \$20,000 then they get to add an additional 20% on that toward the loans! So if you see a higher percentage of underserved you get a higher percentage of reimbursement on loans for faster payoff which will save on interest and help get grads into ownership faster.
89	There should be a standard fixed rate of no more than 3% to make payments manageable. If student loans are going to be forgiven by the government, maybe they should not back them in the first place
90	Encourage a roommate situation for Dental students especially 1-2 years. So many of us were paying +1000.00/month to live alone.
91	continue to work very hard at loan repayment programs that will help generate income for the dentist , while it takes advantage of have dental care in areas where there is definite inequities. " two birds with one stone". This is not reinventing the wheel, but placing many more wheels on the system. It requires a commitment to funding, which ADA continues to be a lead advocate.
92	Less expensive education
93	Lower interest rates. They are fixed rates that are artificially high relative to the market.
94	I am not in favor of a blanket loan forgiveness or partial/generalized loan forgiveness as this is an affront to those who made sacrifices such as military, HRSA service or other sacrifices to pay off their student loans. It also draws ire from folks who say that if you make the choice to take out student loans, they are your responsibility and not taxpayers (although arguably society benefits from having the professionally educated labor force that requires these high loans for training). This is again were I feel a better structured tax break would serve better, with higher max amounts allowed for student-loan tax deductions.
95	volunteering time at a dental clinic - time which is "paid" at \$100/hr that goes directly into paying down the debt and is not counted as income because they are not getting paid directly. If Volunteer x amount of hours per year, any remaining debt is forgiven after 10 years.

Appendix C (Task Force to Study Alternate Student Loan Repayment Strategies)
 Ideas Gathered During Discovery

<i>No.</i>	<i>Idea</i>
96	I am on a mission to have as many dental students as possible be financially literate, and aware that there are several scholarships, grants, and repayment programs to help mitigate the burden of student debt.
97	Don't go to dental school. Most practitioners become a slave to their student debt. Working as a dentist as just a means to pay off their loan with no end in sight
98	Make it a goal of the practice to pay off new associates loans in 5 years.
99	Advocate for private loans to qualify for all federal repayment and forgiveness programs, and then allow private lenders to compete with federal lenders to offer the best rates/terms to incoming professional students.
100	Modify/update application cycle for federal student loans. Application cycle usually starts in Jan - March, closes in May, and you don't find out if you receive it until late September. In other words, if you graduate in May, you have to work for a FQHC for 1 year and 4 months before you even know if you will get loan repayment or not. This happened to me my first time around, then had to wait an entire year before finding out I received the part-time portion, then had to work 2 more years. So I essentially worked over 4 years even though I only received loan repayment credit for 2 years, and was at the same site the entire time. Therefore I think modifications should be made to the application cycle to sync up with the graduation of dental students/residents.
101	Increase the loan repayment rewards. It has remained stagnant for years even though the average debt load has increased dramatically.
102	Expand the program in a way to include private practice dentists. Is there some way where a private practice dentist agrees to treat Medicaid/underserved population a certain number of days or encounters a year and receives federal help to be used solely towards student loans.
103	Work with DSOs and community health organizations to create a loan repayment benefit plan to attract dentists. Almost like a 401K solely for student loans, where the employer will match a certain percentage of what employees put into that and the employer facilitates the payment at the end of the year. Another benefit could be that if the employee doesn't take vacation that year, they could elect to use that PTO pay towards their loans, and the employer could make the deal even better by offering 1.5x the pay if the employee uses it towards their loans.
104	Would there ever be a way to create a new tax advantaged entity similar to a 401k where an employee could contribute money into it, place it into investments and allow it to grow tax free, and then use it towards their loans totally tax free? Could this be some sort of addition added onto existing 401k or 403b accounts? Where the same contribution rules apply (but maybe increase the limits) but you have the option to use the money towards your student loans penalty-free and tax-free.
105	Hiring a financial professional (potentially one with expertise in high student debt such as Student Loan Planner) to be available for free consultation to any ADA member. The ADA could

Appendix C (Task Force to Study Alternate Student Loan Repayment Strategies)
 Ideas Gathered During Discovery

No.	Idea
	offer up to 2 or 3 free sessions per member. We would really need to make sure they are providing quality and thorough advice.
106	Work with federal lenders to offer a low, competitive interest rate to dentists who work in public health situations. As long as they work in public health (or other qualifying situation), they receive an interest rate of 3%. If they move to private practice, the rate goes back to what it was originally.
107	Advocate for federal legislation to support direct payments: if there is a record of private student loans it could be submitted to a federal agency for direct reimbursement in the amount they are forgiving federal loans
108	Idea was suggested regarding ADA starting its own financial subsidiary to internalize student debt refinancing. (benefits: New ADA revenue source, Addresses one of our Lobby Day issues, Valuable Member benefit, Membership retention)*
109	Lobbying for tax credits for student loan payments.
110	Advocate for Student Loan Interest Deduction for dentists / high income earners (opportunity to reintroduce this in current environment)*
111	What is happening with privately refinanced loans? Any opportunities?
112	Partner with the Public Health Service Corps to work together on loan repayment programs for dentists, emphasize that you can have ownership and repayment.
113	Re-negotiate exclusive vendor relationship with Laurel Road - Reach out to additional vendors (online refinance companies, large banks, regional banks etc.) to establish a better member benefit. Currently Laurel Road is granted an exclusive contract with ADA and provides a 0.25% discount to ADA members. This same discount can be achieved online for free by signing up for Juno student loan refinancing. Thus, we are granted this company exclusive rights to our members, with no actual benefit in return. (Benefits: Addresses one of our Lobby Day issues, Valuable Member benefit, Membership retention)*
114	Advocate to include graduate student debt in debt relief/forgiveness programs
115	Educate dental students (or even earlier) about the reality of student loans
116	Student loan debt and how to best address the COVID forbearance period
117	Reduce student loan interest rates.
118	Provide refinancing opportunities to borrowers.
119	Provide opportunities for loan forgiveness, scholarships, grants and tax deductibility.

Appendix C (Task Force to Study Alternate Student Loan Repayment Strategies)
Ideas Gathered During Discovery

**APPENDIX D
REPORT OF THE TASK FORCE TO STUDY
ALTERNATE STUDENT LOAN REPAYMENT STRATEGIES**

ANALYSIS OF INTRIGUING IDEAS

1 The Task Force received 119 responses to the question: “What innovative ideas do you have—or
2 creative twists on conventional ideas—to help mitigate the burden of student debt?”

3 After filtering out duplicates, editorials, and commercial advertisements, the Task Force screened 87 of
4 the 119 submissions and determined that the following eleven were intriguing enough to warrant a more
5 in-depth analysis.

6 **1. Provide concierge financial literacy and debt management program tailored to dental students and new
7 dentists, much like an employee assistance program..... 2**

8 **12. Not all medically underserved are being considered for loan repayment program. The special needs
9 population is vulnerable and is not included. Because it is not included, health centers with this focus do not
10 qualify for a loan repayment program. By adding this group to the Medicaid list, it could boost interest in serving
11 the population and help with loan repayment. 3**

12 **13. Allow those with private student loans to take advantage of federal student loan benefits and
13 protections. 5**

14 **14. Make federal student loan repayment programs accessible to those who want to self-determine their
15 level of public service (e.g., full-time vs. self-selected hours, two-year commitment vs. a self-selected
16 commitment, designated practice locations vs. self-selected practice locations, etc.). 7**

17 **38. Lower the student loan interest rate based on number of underserved patients seen. 9**

18 **47. Develop some type of whole life insurance policy that would pay dividends for outstanding student loans
19 while also creating a legacy program. 11**

20 **49. Establish turn-key dental practices where a new dentist would receive a certain amount of student loan
21 forgiveness in exchange for working at the location for a specified period of time. 13**

22 **95. Work with local stakeholders, such as the Chamber of Commerce, the United Way, and others, to
23 establish volunteer clinics where “payment” is solely or partially in the form of student loan forgiveness. 16**

24 **103. Allow employers to claim a tax deduction for paying down student loans with an employee’s unused paid
25 time off. 18**

26 **104. Create a tax-advantaged student loan repayment plan (similar to a 401k) where an employer and
27 employee contribute pre-tax dollars, allow investments to grow, and allow the employee to draw from the
28 account expressly for student loan repayment. Or simply allow existing retirement account funds to be
29 withdrawn early—penalty-free and tax-free—for the express purpose of paying down student loans. 19**

30 **106. Offer a lower interest rate to dentists who work in public health settings (in lieu of loan repayment). ... 20**

1. Provide concierge financial literacy and debt management program tailored to dental students and new dentists, much like an employee assistance program.

1.1. To what extent is this proposal original, or a creative twist on a conventional idea?

This proposal is not particularly new or original. In fact, the ADA will be rolling this out as an exclusive member benefit in 2021. The ADA-endorsed program, Equitable Financial Advisors, will offer financial planning and educational resources on a complimentary basis initially—with subsequent consultations and broader advisory services available at a substantial member discount. The program will include quarterly check-ins with established clients to course correct and adjust their financial plan as may be needed to effectively manage debt and achieve their savings goals.

Equitable’s financial advisors, in collaboration with ADA Business Enterprises banking partners, are knowledgeable about the latest public and commercial educational loan and loan repayment programs, and how to help dentists develop a solid financial plan to lessen the burden of debt after graduation.

1.2. To what extent will this lessen the burden of a new dentist’s educational debt? To what extent will it impact a large number of dentists (versus a handful)?

Expert financial advisory services and debt management resources can provide the educational foundation needed to inspire and motivate recent graduates and new dentists to get on the right path to managing debt and savings goals. These financial planning resources are likely to have broad appeal with new and established dentists and, therefore, have a positive impact on recruitment and retention efforts.

1.3. To what extent will this proposal impact the Association’s budget or require the ADA to divert significant resources from existing projects?

Through the ADA Council on Members Insurance and Retirement Programs, Equitable Financial Advisors is planning to launch and promote these new member financial advisor resources in 2021. This new offering has no impact on ADA’s budget or resources beyond generating royalty income to support the ADA financial goals through CMIRP.

1.4. To what extent will this proposal add value to ADA membership? To what extent will it inspire dentists to become ADA members, or to renew their membership?

This program is likely to create substantial member value. Based on the responses during the Task Force’s discovery process, and based on New Dentist Committee survey results and the Association’s experience with similar programs, the member benefit is likely to be in high demand.

A February 2021 survey of students and recent graduates asked what types of resources and information would be most beneficial. The top three responses (out of 10) expressed a desire for more direct financial advice and resources.¹

1.5. To what extent can this proposal be achieved in the next five years?

The new member benefit will be rolled out in 2021. Watch for updates on ADA.org and at ADA.equitable.com.

¹ ADA Dental Student Quantitative Survey, 2021.

1 **12. Not all medically underserved are being considered for loan repayment program. The**
2 **special needs population is vulnerable and is not included. Because it is not included,**
3 **health centers with this focus do not qualify for a loan repayment program. By adding this**
4 **group to the Medicaid list, it could boost interest in serving the population and help with**
5 **loan repayment.**

6 **12.1. To what extent is this proposal original, or a creative twist on a conventional idea?**

7 This proposal requires clarification. If the focus of this proposal is Medicaid, the ADA is not aware of any
8 federal student debt relief programs that condition eligibility on treating Medicaid patients, though some
9 state student loan repayment programs do.

10 If the proposal relates to the National Health Service Corps (NHSC) and the NHSC Loan Repayment
11 Program (NHSC LRP), special needs patients are not necessarily excluded from qualifying as a medically
12 underserved population (MUP). But like all other characterizable groups, the special needs population
13 would not automatically qualify as medically underserved just because it is special needs. The state
14 primary care officer must first submit an application for the Health Resources and Services Administration
15 (HRSA) to recognize the population as medically underserved. HRSA administers the NHSC program.

16 To be eligible for the MUP designation, the population must be located in a rational service area (e.g.,
17 county, zip code, census tract, etc.). The population is then subject to a formula weighing its provider
18 density (per 1,000 population), poverty status, age status, and infant mortality rate.

19 More important than the MUP designation: The individual seeking debt relief must be practicing at an
20 NHSC-approved facility. If the facility is not NHSC-approved *solely* because it does not treat all required
21 populations—as could be the case for a facility serving predominantly non-MUP patients—the facility
22 might consider affiliating with a NHSC-approved facility that *does* offer the required services and treats all
23 the required populations. Doing so might remove a barrier for the facility's dentists to qualify for the NHSC
24 Loan Repayment Program.

25 Another option is for the individual to pursue loan repayment through the NHSC State Loan Repayment
26 Program (SLRP). NHSC SLRP is a grant-sharing program between HRSA and the states. It offers student
27 loan repayment to individuals who work in HPSAs, but offers more flexibility about who can qualify, where
28 they can practice, and the groups they treat. Currently, 41 states, Washington D.C. and one U.S. territory
29 (the Northern Mariana Islands) participate in the NHSC SLRP program.

30 The Task Force recognizes that some dentists have strongly held opinions about the populations and
31 areas that should be considered medically underserved. The Task Force also appreciates the need for
32 objective criteria to make those decisions, especially for programs with limited funding.

33 **12.2. To what extent will this lessen the burden of a new dentist's educational debt? To what**
34 **extent will it impact a large number of dentists (versus a handful)?**

35 The ADA speculates that few dentists would benefit from a debt relief program for working at facilities that
36 treat predominantly special needs patients in areas where that population that would qualify as a
37 medically underserved population. Again, special needs patients are not necessarily excluded from
38 qualifying as a medically underserved population. But like all other characterizable groups, the special
39 needs population would not automatically qualify just because it is special needs.

40 Moreover, data from the American Dental Education Association suggest that only dentists who were
41 already planning to work in public health settings would benefit.

42 Only 18.7 percent of 2019 dental school graduates reported that educational debt had any influence over
43 their postgraduate career plans.¹ As a motivating factor for primary professional activity, educational debt
44 ranked seventh—behind opportunity for professional development (54.0 percent), influence of a mentor or

1 role model (32.0 percent), income expectations (30.6 percent), power over living location (30.0 percent),
2 autonomy (23.8 percent), and opportunity to work with other dentists (22.7 percent).¹

3 Few graduating seniors also reported being interested in seeking debt relief through the Public Service
4 Loan Forgiveness program (5.6 percent) or any other existing service payback program (e.g., National
5 Health Service Corps, Indian Health Service, armed forces, etc.) (3.1 percent).² The majority of
6 graduating seniors report that their educational debt repayment strategy is to aggressively pay/overpay
7 (52.3 percent) or minimize monthly payments (36.7 percent).²

8 To be clear, the majority of graduating seniors report that they will definitely (12.9 percent) or probably
9 (46.9 percent) work in an underserved area at some point in their career.³ Debt relief is simply not the
10 motivating factor.

11 To the individual taking advantage of such a program, the impact would depend on the amount of benefit
12 offered in exchange for the amount of time the dentist is willing to devote. The price point (e.g., hours
13 spent with special needs patients covered by Medicaid, the number of Medicaid-covered special needs
14 patients seen, etc.) would have to be attractive enough for the individual dentist to take time away from
15 their primary work activity.

16 Again, the majority of graduating seniors seem more interested in maximizing income and aggressively
17 repaying their student loans than receiving loan forgiveness through public service.

18 It is doubtful there would be much opposition to advocating for such a program. The question is whether it
19 is realizable and whether indebted dentists would actually use it. The data suggest the idea would be
20 more aspirational than impactful.

21 **12.3. To what extent will this proposal impact the Association's budget or require the ADA**
22 **to divert significant resources from existing projects?**

23 This proposal would divert significant time from existing projects. The ADA would have to thoroughly
24 research the history, benefits, drawbacks, and costs—and lay the advocacy groundwork from scratch.

25 Also, the ADA does not have policy on establishing special needs individuals as a medically underserved
26 class for health professional shortage area designations, or expanding Medicaid coverage to include
27 special needs patients as a covered class.

28 With respect to Medicaid, this proposal would involve the Herculean task of expanding federal Medicaid
29 eligibility to include special needs children as a protected class, which would ripple across medicine and
30 other health service sectors. It would require creating a new federal student loan repayment program that
31 conditions eligibility on treating Medicaid patients, or expanding an existing loan repayment program to do
32 the same. Both would require new appropriations.

33 Other items to consider are the tax treatment of the amounts forgiven (requiring a change in the tax code)
34 and cost offsets to pay for the program and its administration. The ADA is also aware of political
35 sensitivities surrounding this issue.

36 **12.4. To what extent will this proposal add value to ADA membership? To what extent will it**
37 **inspire dentists to become ADA members, or to renew their membership?**

38 This is a difficult question to answer. Non-members benefit from the ADA's legislative and regulatory
39 accomplishments as much as members. There are no data to indicate that these accomplishments would
40 convince a non-member to join.

41 **12.5. To what extent can this proposal be achieved in the next five years?**

42 As with most legislative proposals, it is highly unlikely that this proposal can be achieved in the next five
43 years. The ADA would have to thoroughly research the history, benefits, drawbacks, and costs—and lay

1 the advocacy groundwork from scratch. Policy would also be needed on establishing special needs
2 individuals as a medically underserved population in health professional shortage areas, and expanding
3 Medicaid coverage to include special needs patients as a covered class.

4 With respect to Medicaid, this proposal would involve the Herculean task of expanding federal Medicaid
5 eligibility to include special needs children as a protected class, which would ripple across medicine and
6 other health service sectors. It would require creating a new federal student loan repayment program that
7 conditions eligibility on treating Medicaid patients, or expanding an existing loan repayment program to do
8 the same. Both would require new appropriations.

9 Other items to consider are the tax treatment of the amounts forgiven (requiring a change in the tax code)
10 and cost offsets to pay for the program and its administration. The ADA is also aware of political
11 sensitivities surrounding this issue.

12 **12.6. Other Remarks**

13 The ADA does not have policy to guide its position on establishing special needs individuals as a
14 medically underserved population for in health professional shortage areas, or expanding Medicaid
15 coverage to include special needs patients as a covered class.

16 This proposal appears consistent with the public goal in the ADA's strategic plan: To "support the
17 advancement of the health of the public and the success of the profession."

¹ American Dental Education Association. (March 2020). ADEA Survey of Dental School Seniors, 2019 Graduating Class Tables Report Washington, DC. (Table 26. Factors and Ranking of What Influenced Respondents to Choose Their Primary Professional Activity).

² American Dental Education Association. (March 2020). ADEA Survey of Dental School Seniors, 2019 Graduating Class Tables Report Washington, DC. (Table 17. Respondents' Current Educational Debt Repayment Strategy, by Race/Ethnicity).

³ American Dental Education Association. (March 2020). ADEA Survey of Dental School Seniors, 2019 Graduating Class Tables Report Washington, DC. (Table 34. Respondents' Plans to Teach, Be Involved in Research and/or Work in an Underserved Area at Some Point after Graduation).

18 **13. Allow those with private student loans to take advantage of federal student loan benefits** 19 **and protections.**

20 **13.1. To what extent is this proposal original, or a creative twist on a conventional idea?**

21 *Note: It is critical to understand that the term "private student loans" can be used many ways. Private*
22 *student loans from commercial lenders may qualify for some federal student debt relief programs; private*
23 *loans from family and other non-commercial sources do not.*

24 This idea is not new. In fact, it was allowed by law prior to 2009 and has been ADA policy for many years.
25 But there are two areas that need clarification: (1) commercial borrower access to federal student debt
26 relief programs and (2) federal borrowing protections for commercial loan holders. The ADA has policy
27 supporting both.

28 In most cases, loans that qualify for federal student loan forgiveness are limited those made through the
29 Higher Education Act (e.g., Direct Loans, Grad PLUS Loans, etc.) or the Public Health Service Act;
30 however, a *small number* of federal student loan repayment programs are available to commercial
31 borrowers, including (but not limited to):¹

- 1 • Indian Health Service Loan Repayment Program
- 2 • National Health Service Corps Loan Repayment Program
- 3 • National Health Service Corps State Loan Repayment Program (Dental Hygienists Only)
- 4 • National Health Service Corps Students to Service Loan Repayment Program
- 5 • Dental Faculty Loan Repayment Program (Institution-Based)
- 6 • Faculty Loan Repayment Program (Institution-Based)
- 7 • National Institutes of Health Extramural Loan Repayment Programs
- 8 • National Institutes of Health Intramural Loan Repayment Programs

9 Further, loans owned by the federal government generally have more favorable borrowing terms than
10 loans owned by commercial lenders (e.g., fixed interest rates, income-based repayment plans, etc.).
11 Federal loan holders have other benefits, as well, During the COVID-19 pandemic, for example,
12 commercial borrowers were not eligible for the interest- and penalty-free deferral that Congress
13 extended to federal student loan holders, or to have portions of their student loans forgiven by federal
14 administrative action.

15 Because some federal debt relief programs are already open to commercial borrowers, this proposal
16 should be narrowed to allowing commercial student loan holders to have the same borrowing terms and
17 conditions as federal borrowers. For the purpose of this report, however, the idea is not particularly new.

18 **13.2. To what extent will this lessen the burden of a new dentist’s educational debt? To what**
19 **extent will it impact a large number of dentists (versus a handful)?**

20 The ADA Health Policy Institute has not gathered comprehensive data showing how many dentists have
21 commercial student loans.

22 The American Dental Education Association reports that around 11.6 percent of dental school seniors
23 reported graduating with commercial loans.² And at least 4,300 ADA members have refinanced their
24 educational loans through the ADA’s Student Loan Refinancing Program with Laurel Road. Otherwise,
25 the ADA does not know how many dentists hold commercial student loans.

26 **13.3. To what extent will this proposal impact the Association’s budget or require the ADA**
27 **to divert significant resources from existing projects?**

28 This proposal would divert significant time from existing projects. It is not something other organizations
29 are pursuing, so the ADA would have to thoroughly research the history, benefits, drawbacks, and
30 costs—and lay the advocacy groundwork from scratch.

31 Note that changing federal banking laws to require commercial lenders to offer the same borrowing and
32 repayment terms and conditions as are afforded to federal student loan borrowers (e.g., fixed interest
33 rates, income-based repayment plans, interest-free deferral during public health emergencies, etc.) would
34 pit the ADA against the banking industry, which has significant lobbying clout. It is not an insurmountable
35 barrier, but it does mitigate the likelihood of success.

36 The proposal may also complicate the Association’s relationships with the banks and other financial
37 institutions through which it offers member benefits.

38 **13.4. To what extent will this proposal add value to ADA membership? To what extent will it**
39 **inspire dentists to become ADA members, or to renew their membership?**

40 This is a difficult question to answer. Non-members benefit from the ADA’s legislative and regulatory
41 accomplishments as much as members. There are no data to indicate that these accomplishments would
42 convince a non-member to join.

1 **13.5. To what extent can this proposal be achieved in the next five years?**

2 As with most legislative proposals, it is highly unlikely that this proposal can be achieved in the next five
3 years. The ADA would have to thoroughly research the history, benefits, drawbacks, and costs—and lay
4 the advocacy groundwork from scratch. It is not something that other organizations are pursuing.

5 Note that changing federal banking laws to require commercial lenders to offer the same borrowing and
6 repayment terms and conditions as are afforded to federal student loan borrowers (e.g., fixed interest
7 rates, income-based repayment plans, interest-free deferral during public health emergencies, etc.) would
8 pit the ADA against the banking industry, which has significant lobbying clout.

9 **13.6. Other Remarks**

10 This proposal appears consistent with the ADA policies titled Federal Student Loan Programs
11 (Trans.2020:293) and Federal Student Loan Repayment Incentives (Trans.2019:293).

12 This proposal does not appear to be directly supported by the ADA’s strategic plan. There is an
13 association with student debt holders, regardless of degree. But that association is not exclusive to
14 dentistry or even health care professionals broadly. It is not singularly associated with the public’s oral
15 health or the art and science of dentistry.

¹ Congressional Research Service. Federal Student Loan Forgiveness and Loan Repayment Programs. Report No. R43571 (Updated November 18, 2018).

² American Dental Education Association. (March 2020). ADEA Survey of Dental School Seniors, 2019 Graduating Class Tables Report Washington, DC. (Table 24. Type of Loans Reported by Respondents).

16 **14. Make federal student loan repayment programs accessible to those who want to self-**
17 **determine their level of public service (e.g., full-time vs. self-selected hours, two-year**
18 **commitment vs. a self-selected commitment, designated practice locations vs. self-selected**
19 **practice locations, etc.).**

20 **14.1. To what extent is this proposal original, or a creative twist on a conventional idea?**

21 The ADA has not seen lawmakers or any other groups propose to enabling private practitioners to self-
22 determine their level of public service in exchange for some type of federal student loan forgiveness. The
23 ADA is attempting to secure a Congressional Research Service report to determine if has ever been tried.

24 CRS Reports explore complex topics from many different angles. They typically include a thorough
25 analysis of current policies, a history of what projects have been tried, and an impact analysis of the
26 proposal being sought. The reports are used at every stage of the legislative process—from the early
27 considerations that precede bill drafting, through committee hearings and floor debate, to the oversight of
28 enacted laws and various agency activities.

29 CRS is a branch of the Library of Congress. Only members of Congress may request CRS reports.

30 If the intent of this proposal is to increase the number of dentists practicing in underserved areas, data
31 from the American Dental Education Association suggest that it would likely only impact dentists who
32 were already planning to work in underserved areas (see paragraph 14.2).

33 Graduating seniors are far more interested in maximizing income and aggressively repaying their student
34 loans than receiving debt relief through public service. The majority appear interested in treating the
35 underserved at some point in their career, but debt relief is not the motivating factor (see Appendix E).

1 **14.2. To what extent will this lessen the burden of a new dentist’s educational debt? To what**
2 **extent will it impact a large number of dentists (versus a handful)?**

3 There is no indication that a program enabling private practitioners to self-determine their level of public
4 service in exchange for some type of federal student loan forgiveness would be sought after by a large
5 number of dentists. Educational debt does not seem to be influencing decisions to practice in
6 underserved areas.¹⁻² Moreover, recent graduates generally do not seem interested in leveraging service
7 payback programs as a debt repayment strategy.

8 Only 18.7 percent of 2019 dental school graduates reported that educational debt had any influence over
9 their postgraduate career plans.³ As a motivating factor for primary professional activity, educational debt
10 ranked seventh—behind opportunity for professional development (54.0 percent), influence of a mentor or
11 role model (32.0 percent), income expectations (30.6 percent), power over living location (30.0 percent),
12 autonomy (23.8 percent), and opportunity to work with other dentists (22.7 percent).¹

13 Few graduating seniors also reported being interested in seeking debt relief through the Public Service
14 Loan Forgiveness program (5.6 percent) or any other existing service payback program (e.g., National
15 Health Service Corps, Indian Health Service, armed forces, etc.) (3.1 percent).⁴ The majority of
16 graduating seniors report that their educational debt repayment strategy is to aggressively pay/overpay
17 (52.3 percent) or minimize monthly payments (36.7 percent).²

18 To be clear, the majority of graduating seniors report that they will definitely (12.9 percent) or probably
19 (46.9 percent) work in an underserved area at some point in their career.⁵ Debt relief is simply not the
20 motivating factor.

21 To the individual taking advantage of such a program, the impact would depend on the amount of benefit
22 offered in exchange for the amount of time the dentist is willing to devote.

23 The price point (benefit per hour, benefit per patient, etc.) would have to be attractive enough for the
24 individual dentist to take time away from their primary work activity. Other items to consider are the tax
25 treatment of the amounts forgiven, mechanisms to prevent fraud and no-shows, and cost offsets to pay
26 for the program and its administration.

27 Again, the majority of graduating seniors seem more interested in maximizing income and aggressively
28 repaying their student loans than receiving loan forgiveness through public service.

29 It is doubtful there would be much opposition to advocating for such a program. The question is whether it
30 is realizable and whether indebted dentists would actually use it. The data suggest the idea would be
31 more aspirational than impactful.

32 **14.3. To what extent will this proposal impact the Association’s budget or require the ADA**
33 **to divert significant resources from existing projects?**

34 This proposal would divert significant time from existing projects. The ADA would have to thoroughly
35 research the history, benefits, drawbacks, and costs—and lay the advocacy groundwork from scratch. It is
36 not something that other organizations are pursuing.

37 **14.4. To what extent will this proposal add value to ADA membership? To what extent will it**
38 **inspire dentists to become ADA members, or to renew their membership?**

39 This is a difficult question to answer. Non-members benefit from the ADA’s legislative and regulatory
40 accomplishments as much as members. There are no data to indicate that these accomplishments would
41 convince a non-member to join.

1 **14.5. To what extent can this proposal be achieved in the next five years?**

2 As with most legislative proposals, it is highly unlikely that this proposal can be achieved in the next five
3 years. The ADA would have to thoroughly research the history, benefits, drawbacks, and costs—and lay
4 the advocacy groundwork from scratch. It is not something that other organizations are pursuing.

5 The ADA notes the complexity of administering such a program since the Department of Education, which
6 owns federal student loans, is not in the business of health care. Likely, the program would have to be
7 coordinated with (or administered by) federal health agencies (e.g., HRSA, IHS, etc.). It then becomes of
8 question of which agency’s budget will finance the benefit.

9 Another consideration is that the Department of Education’s only similar program, the Public Service Loan
10 Repayment Program, is in danger of being eliminated. The application process and qualification criteria
11 have been so poorly administered over the years that only about 4 percent of those who applied were
12 deemed eligible—and a sizable number of users discovered their public service did not qualify after
13 spending years believing they were participating in the program. It will be difficult to justify asking for more
14 flexibility and less oversight at a time when the program will be lucky to survive.

15 Additionally, there is no guarantee the idea will be well received. The groups that the ADA has spoken to
16 have been skeptical about the proposal’s impact and expressed concern about the likelihood of fraud.

17 **14.6. Other Remarks**

18 This proposal appears consistent with the ADA policy titled Federal Student Loan Repayment Incentives
19 (*Trans.2019:297*).

20 This proposal also appears consistent with the public goal in the ADA’s strategic plan: To “support the
21 advancement of the health of the public and the success of the profession.”

¹ Nicholson S, Vujicic M, Wanchek T, et al. The effect of education debt on dentists’ career decisions. *J Am Dent Assoc.* November 2015; 146(11):800-807.

² Kamyar N and Vujicic M. The relationship between education debt and career choices in professional programs: The case of dentistry. *J Am Dent Assoc.* November 2017; 148(11):825-833.

³ American Dental Education Association. (March 2020). ADEA Survey of Dental School Seniors, 2019 Graduating Class Tables Report Washington, DC. (Table 26. Factors and Ranking of What Influenced Respondents to Choose Their Primary Professional Activity).

⁴ American Dental Education Association. (March 2020). ADEA Survey of Dental School Seniors, 2019 Graduating Class Tables Report Washington, DC. (Table 17. Respondents’ Current Educational Debt Repayment Strategy, by Race/Ethnicity).

⁵ American Dental Education Association. (March 2020). ADEA Survey of Dental School Seniors, 2019 Graduating Class Tables Report Washington, DC. (Table 34. Respondents’ Plans to Teach, Be Involved in Research and/or Work in an Underserved Area at Some Point after Graduation).

22 **38. Lower the student loan interest rate based on number of underserved patients seen.**

23 **38.1. To what extent is this proposal original, or a creative twist on a conventional idea?**

24 The Task Force did not find evidence that lawmakers or any other groups have proposed a program that
25 would allow a borrower to qualify for a lower annual interest rate based on seeing a minimum number of
26 underserved patients.

27 The ADA notes the complexity of administering such a program since the Department of Education, which
28 owns most federal student loans, is not in the business of health care. Likely, the program would have to
29 be administered as health professions loans offered by federal health agencies (e.g., HRSA, IHS, etc.).

1 Doing so would require creating a brand new program. And unlike student loans from the Education
2 Department, funding would be provided through congressional appropriations.

3 **38.2. To what extent will this lessen the burden of a new dentist's educational debt? To what**
4 **extent will it impact a large number of dentists (versus a handful)?**

5 There is no indication that a program lowering a dentist's student loan interest rate based on number of
6 underserved patients seen would be sought after by a large number of dentists. Educational debt does
7 not seem to be influencing decisions to treat the underserved.¹⁻² The majority of graduating seniors seem
8 more interested in maximizing income and aggressively repaying their student loans than receiving loan
9 forgiveness through public service.

10 Data from the American Dental Education Association suggest that only dentists who were already
11 planning to work in public health settings would benefit.

12 Only 18.7 percent of 2019 dental school graduates reported that educational debt had any influence over
13 their postgraduate career plans.³ As a motivating factor for primary professional activity, educational debt
14 ranked seventh—behind opportunity for professional development (54.0 percent), influence of a mentor or
15 role model (32.0 percent), income expectations (30.6 percent), power over living location (30.0 percent),
16 autonomy (23.8 percent), and opportunity to work with other dentists (22.7 percent).¹

17 Few graduating seniors also reported being interested in seeking debt relief through the Public Service
18 Loan Forgiveness program (5.6 percent) or any other existing service payback program (e.g., National
19 Health Service Corps, Indian Health Service, armed forces, etc.) (3.1 percent).⁴ The majority of
20 graduating seniors report that their educational debt repayment strategy is to aggressively pay/overpay
21 (52.3 percent) or minimize monthly payments (36.7 percent).²

22 To be clear, the majority of graduating seniors report that they will definitely (12.9 percent) or probably
23 (46.9 percent) work in an underserved area at some point in their career.⁵ Debt relief is simply not the
24 motivating factor.

25 To the individual taking advantage of such a program, the impact would depend on the amount of benefit
26 offered in exchange for the amount of time the dentist is willing to devote. The price point (e.g., ratio of
27 interest points to the number of patients seen, etc.) would have to be attractive enough for the individual
28 dentist to take time away from their primary work activity. Other items to consider are the tax treatment of
29 the amounts forgiven, mechanisms to prevent fraud, and cost offsets to pay for the program and its
30 administration.

31 Again, the majority of graduating seniors seem more interested in maximizing income and aggressively
32 repaying their student loans than receiving loan forgiveness through public service.

33 It is doubtful there would be much opposition to advocating for such a program. The question is whether it
34 is realizable and whether indebted dentists would actually use it. The data suggest the idea would be
35 more aspirational than impactful.

36 **38.3. To what extent will this proposal impact the Association's budget or require the ADA**
37 **to divert significant resources from existing projects?**

38 This proposal would divert significant time from existing projects. It is not something other organizations
39 are pursuing, so the ADA would have to thoroughly research the history, benefits, drawbacks, and
40 costs—and lay the advocacy groundwork from scratch.

41 The ADA notes the complexity of administering such a program since the Department of Education, which
42 owns federal student loans, is not in the business of health care. Likely, the program would have to be
43 coordinated with other federal agencies (e.g., CMS, HRSA, etc.), which would oversee the public service
44 aspect of the program. The program would require a new congressional appropriation.

1 **38.4. To what extent will this proposal add value to ADA membership? To what extent will it**
2 **inspire dentists to become ADA members, or to renew their membership?**

3 This is a difficult question to answer. Non-members benefit from the ADA's legislative and regulatory
4 accomplishments as much as members. There are no data to indicate that these accomplishments would
5 convince a non-member to join.

6 **38.5. To what extent can this proposal be achieved in the next five years?**

7 As with most legislative proposals, it is highly unlikely that this proposal can be achieved in the next five
8 years. The ADA would have to thoroughly research the history, benefits, drawbacks, and costs—and lay
9 the advocacy groundwork from scratch. It is not something that other organizations are pursuing.

10 The ADA also notes the complexity of administering such a program since the Department of Education,
11 which owns federal student loans, is not in the business of health care. Likely, the program would have to
12 be coordinated with other federal agencies (e.g., CMS, HRSA, etc.), which would oversee the public
13 service aspect of the program. It then becomes of question of which agency's budget will finance the
14 benefit.

15 There is no guarantee the idea will be well received. The groups that the ADA has approached have been
16 skeptical about the proposal's impact and expressed concern about the likelihood of fraud.

17 **38.6. Other Remarks**

18 This proposal appears consistent with the ADA policy titled Federal Student Loan Repayment Incentives
19 (*Trans.2019:297*).

20 This proposal also appears consistent with the public goal in the ADA's strategic plan: To "support the
21 advancement of the health of the public and the success of the profession."

¹ Nicholson S, Vujicic M, Wanchek T, et al. The effect of education debt on dentists' career decisions. *J Am Dent Assoc*. November 2015; 146(11):800-807.

² Kamyar N and Vujicic M. The relationship between education debt and career choices in professional programs: The case of dentistry. *J Am Dent Assoc*. November 2017; 148(11):825-833.

³ American Dental Education Association. (March 2020). ADEA Survey of Dental School Seniors, 2019 Graduating Class Tables Report Washington, DC. (Table 26. Factors and Ranking of What Influenced Respondents to Choose Their Primary Professional Activity).

⁴ American Dental Education Association. (March 2020). ADEA Survey of Dental School Seniors, 2019 Graduating Class Tables Report Washington, DC. (Table 17. Respondents' Current Educational Debt Repayment Strategy, by Race/Ethnicity).

⁵ American Dental Education Association. (March 2020). ADEA Survey of Dental School Seniors, 2019 Graduating Class Tables Report Washington, DC. (Table 34. Respondents' Plans to Teach, Be Involved in Research and/or Work in an Underserved Area at Some Point after Graduation).

22 **47. Develop some type of whole life insurance policy that would pay dividends for outstanding**
23 **student loans while also creating a legacy program.**

24 **47.1. To what extent is this proposal original, or a creative twist on a conventional idea?**

25 The concept of borrowing against the cash value of a whole life insurance policy to pay down outstanding
26 student loan debt is not new or original. Insurance agents and advisors have shared opposing views on
27 this subject for years.

Appendix D (Task Force to Study Alternate Student Loan Repayment Strategies)
Analysis of Intriguing Ideas

1 Whole life insurance is specifically designed to provide lifetime insurance protection in the form of a
2 guaranteed death benefit and level premium payments, a portion of which earn tax-deferred cash value
3 based on a fixed interest rate from the carrier. It is most valuable if purchased at a younger age, to
4 maximize the number of years to make premium contributions and grow the policy cash value or
5 investment.

6 Protective Life Insurance Company, which underwrites the ADA Members Group Insurance Plans, does
7 not recommend using whole life insurance to help pay down outstanding student loans. Their lead actuary
8 and vice president points out that whole life, as a permanent form of life insurance protection, is meant to
9 be a long-term investment given its tax-advantaged *cash value* which increases the total policy value
10 overtime. It is commonly used as a risk-free component of a larger financial/estate planning and wealth
11 transfer strategy given that these products are designed to protect one's assets and build a tax-effective
12 legacy for their heirs.

13 Affordability would also be a strong consideration for new dentists since whole life insurance is inherently
14 more expensive (can be up to 10x) compared to annually renewable term life which ADA provides as a
15 benefit of membership through Protective Life at a substantial group rate discount. Purchasing (group)
16 term life at lower cost offers the new dentist an opportunity to apply the savings towards payment of debt
17 and begin to invest in other tax-advantage savings options for the future.

18 The ADA currently offers its members a broad portfolio of group-rated insurance plans including 3
19 different types of life insurance: (1) annually renewable term life; (2) level term life and (3) universal life
20 (permanent life) which has resembles whole life insurance with a cash value benefit. In addition, ADA
21 offers group disability income protection, group office overhead expense and supplemental medical plans.

22 **47.2. To what extent will this lessen the burden of a new dentist's educational debt? To what**
23 **extent will it impact a large number of dentists (versus a handful)?**

24 It is unclear whether a large number of new dentists would seek to borrow against the cash value of a
25 whole life insurance policy to pay down student loans. While whole life policies generally permit loans, the
26 amount must be paid back at an interest rate—which could have the appearance of trading one form of
27 debt for another. The difference being that with a whole life policy loan, the interest paid is credited back
28 to the policy's total value.

29 Aside from the higher cost of whole life insurance, another potential drawback is that depending upon
30 how the policy is written, the insured may have few options to modify their coverage or adjust the required
31 premium, if the need arose during the policy term. Both of these factors could challenge an early career
32 dentist who is trying to get established financially and balance life/career plans and goals.

33 As a practical matter, Protective Life insurance experts point out that given high cost of whole life
34 insurance, the more prudent financial strategy for new dentists is to "buy term life and invest the
35 difference" or more specifically, use the cost savings to pay down existing debt and invest any additional
36 savings in growth-oriented investments (e.g., stocks, bonds, real estate, etc.) or tax-advantaged savings
37 products for the future. Unlike whole life insurance, these types of investments can be more easily
38 liquidated, if needs change, and function more as a financial planning tool rather than a debt instrument.

39 **47.3. To what extent will this proposal impact the Association's budget or require the ADA**
40 **to divert significant resources from existing projects?**

41 Although not recommended, this proposal would have little (if any) impact on the Association's budget or
42 require a significant diversion of resources. As with the ADA members insurance and retirement plan
43 offerings (through CMIRP), the insurance company is responsible for all marketing and plan
44 administration functions as well as program costs. Whether such a plan could generate royalty for the
45 ADA long-term would depend on how it was structured and its financial strength and future stability.

1 **47.4. To what extent will this proposal add value to ADA membership? To what extent will it**
2 **inspire dentists to become ADA members, or to renew their membership?**

3 For reasons cited in this summary, this proposal is not being recommended by ADA's insurance carrier
4 experts. Rather, they recommend the promotion of the *existing* ADA Members Group Insurance Plans
5 portfolio of product options which includes annually renewable term life, level term life and universal life,
6 as well as disability and supplemental medical plans.

7 ADA's group insurance plans represent one of the most valued benefits of membership which also
8 support the ADA Common Ground 2025 Strategic Plan membership and financial goals. Moreover, since
9 the inception of the ADA Term Life Plan in 1934, ADA has through its insurer promoted the concept "buy
10 term and invest the difference" and this philosophy holds true even today. The ADA group plans also
11 serve as an important part of ADA's membership recruitment and retention efforts to inspire, attract and
12 retain dentists across all diverse market segments.

13 **47.5. To what extent can this proposal be achieved in the next five years?**

14 It is doubtful that this proposal could be achieved in the next five years.

15 Fundamentally, this product proposal is flawed. The ADA's insurance experts advise there is no added
16 value in attempting to use whole life insurance to manage or pay down student debt and therefore, would
17 not recommend it. Rather, ADA's carrier, in consultation with CMIRP, has for decades supported the
18 philosophy that new dentists are best advised to "buy term and invest" the cost savings difference to
19 manage their debt and begin as early as possible to save for retirement.

20 **49. Establish turn-key dental practices where a new dentist would receive a certain amount of**
21 **student loan forgiveness in exchange for working at the location for a specified period of**
22 **time.**

23 **49.1. To what extent is this proposal original, or a creative twist on a conventional idea?**

24 Programs like this already exist in some places. As a project, the question is what the ADA's role (or the
25 state dental society's role) would be.

26 A "turn-key" practice is an established site of dental care with an already established infrastructure (e.g.,
27 existing building, plumbing, equipment, etc.) that a dentist would join as an employee. They are typically
28 state-specific and state implemented. Iowa is one example.

29 The Primary Care Recruitment and Retention Endeavor (PRIMECARRE), a program of the Iowa
30 Department of Public Health, requires a two-year practice commitment in a public or non-profit site
31 located in a health professional shortage area. Candidate selection is based on a ranking of community
32 needs, the applicant's history of debt assistance and the applicant's evidence of community commitment
33 and personal experience in rural settings.

34 For dentists, the program provides up to \$50,000 for two years of full-time service and \$25,000 for two
35 years of part-time service. For hygienists, the program offers \$30,000 for two years of full-time service
36 and \$15,000 of part-time service.

37 Another program, Fulfilling Iowa's Need for Dentists (FIND), is operated by Delta Dental of Iowa. The
38 program collaborates with communities to recruit dentists and establish private practice dental offices
39 located in rural, underserved areas.

40 The FIND program offers up to \$125,000 over a five-year period for dentists who work in a priority county,
41 and up to \$200,000 over a five-year period for dentists who work in a high priority county. In return, each

1 selected dentist agrees to practice in one of Iowa's designated dental shortage areas and to allocate 35
2 percent of patient services to underserved populations.

3 Platforms to advertise these opportunities and provide connections already exist, as well. For example,
4 3RNet is a non-profit recruiter specializing in health care jobs in rural and underserved communities.
5 3RNet enables health care professionals to search for jobs in underserved areas across the country. This
6 includes opportunities at federally qualified health centers, where junior dental students might receive
7 stipends (while still in school) to help with expenses in exchange for the future obligation to work at that
8 health center after graduation. Those expenses might otherwise be financed with debt.

9 3RNet is supported by fees paid by participating state health departments. Employers who meet the
10 state's qualification criteria are permitted to advertise their positions on 3RNet's platform. Those
11 employers may (or may not) be asked to pay a usage fee to the state, depending on how the state
12 program is structured.

13 Health centers provide valuable community interaction, which can lead to the new graduate becoming
14 familiar with the health center (and the private practice community) prior to joining the staff.

15 **49.2. To what extent will this lessen the burden of a new dentist's educational debt? To what**
16 **extent will it impact a large number of dentists (versus a handful)?**

17 For the individual dentist, the student loan repayment benefit of a turn-key practice will vary by state and
18 by program. For example, Iowa's PRIMECARE program provides up to \$50,000 for two years of full-
19 time service in a "health professional shortage area". However, Delta Dental of Iowa's FIND program
20 would allow the same dentist to work in a "priority county" for the same period and receive up to
21 \$200,000. And the geographic areas served by the two programs may not necessarily be the same.

22 On spec, it is reasonable to think that a large number of dentists would use a free recruitment tool to
23 quickly identify dental practices offering student loan repayment opportunities. The question is whether
24 those opportunities would be limited to practicing in underserved areas, which is the foundation of
25 3RNet's recruitment model. Based on data from the American Dental Education Association, it is likely
26 that only dentists who were already planning to work in public health settings would benefit.

27 The majority of 2019 graduating seniors reported that they will definitely (12.9 percent) or probably (46.9
28 percent) work in an underserved area at some point in their career.¹ However, they also reported that
29 their educational debt repayment strategy is to aggressively pay/overpay (52.3 percent) or minimize
30 monthly payments (36.7 percent).² Less than 9 percent plan to use public service as a debt repayment
31 strategy (e.g., federally qualified health center, non-profit clinic, etc.).²

32 Only 18.7 percent of dental school graduates in 2019 reported that educational debt had any influence
33 over their postgraduate career plans.³ In fact, as a motivating factor for primary professional activity,
34 educational debt ranked seventh—behind opportunity for professional development (54.0 percent),
35 influence of a mentor or role model (32.0 percent), income expectations (30.6 percent), power over living
36 location (30.0 percent), autonomy (23.8 percent), and opportunity to work with other dentists (22.7
37 percent).³

38 To be clear, graduating dental students seem interested in treating the underserved at some point in their
39 career, but educational debt does not seem to be a motivating factor.⁴⁻⁵ It is therefore likely that this
40 proposal would benefit only those who were already planning to work in public health settings.

41 **49.3. To what extent will this proposal impact the Association's budget or require the ADA**
42 **to divert significant resources from existing projects?**

43 Since programs like this already exist, the budget and resource implication would depend on what the
44 ADA's role (or the state dental society's role) would be. Promoting turn-key programs that already exist—

1 and have a student loan repayment benefit—would not require a significant diversion of time and
2 resources.

3 Creating turn-key programs from scratch—in states where they do not already exist—would require a
4 significant demand on time and a redirection of resources. There would also be a budgetary implication if
5 a cost-sharing mechanism is required.

6 **49.4. To what extent will this proposal add value to ADA membership? To what extent will it**
7 **inspire dentists to become ADA members, or to renew their membership?**

8 A facilitative activity has the potential to add tremendous value to ADA membership, particularly to dental
9 students and new dentists. However, it would depend on the extent to which it is offered to non-members
10 (versus members-only), either freely or at a discount. There would be little (if any) added member value if
11 the resource is offered to non-members free of charge.

12 **49.5. To what extent can this proposal be achieved in the next five years?**

13 The time required to implement this proposal would depend on what the ADA's role (or the state dental
14 society's role) would be. Promoting turn-key programs that already exist—and have a student loan
15 repayment benefit—could be achieved in less than one or two years.

16 Creating turn-key programs from scratch—in states where they do not already exist—would require more
17 than five years to achieve. It would require significant project planning, examination of the budget
18 implication, and time to identify stakeholders and broker relationships. It would also require significant
19 redirection of time and possibly House approval of new monies for cost-sharing.

20 3RNet has stated that in five years it could report on the number of dentists who have had loan
21 repayment addressed through successful “matches” to turn-key practices rural areas. The company has
22 already shared that dentists have become the third most sought after health care professional being
23 recruited.

24 Matching new grads to existing sites of care that need a dentist could add a continuum of care for
25 underserved communities.

¹ American Dental Education Association. (March 2020). ADEA Survey of Dental School Seniors, 2019 Graduating Class Tables Report Washington, DC. (Table 34. Respondents' Plans to Teach, Be Involved in Research and/or Work in an Underserved Area at Some Point after Graduation).

² American Dental Education Association. (March 2020). ADEA Survey of Dental School Seniors, 2019 Graduating Class Tables Report Washington, DC. (Table 17. Respondents' Current Educational Debt Repayment Strategy, by Race/Ethnicity).

³ American Dental Education Association. (March 2020). ADEA Survey of Dental School Seniors, 2019 Graduating Class Tables Report Washington, DC. (Table 26. Factors and Ranking of What Influenced Respondents to Choose Their Primary Professional Activity).

⁴ Nicholson S, Vujicic M, Wanchek T, et al. The effect of education debt on dentists' career decisions. *J Am Dent Assoc.* November 2015; 146(11):800-807.

⁵ Kamyar N and Vujicic M. The relationship between education debt and career choices in professional programs: The case of dentistry. *J Am Dent Assoc.* November 2017; 148(11):825-833.

95. Work with local stakeholders, such as the Chamber of Commerce, the United Way, and others, to establish volunteer clinics where “payment” is solely or partially in the form of student loan forgiveness.

95.1. To what extent is this proposal original, or a creative twist on a conventional idea?

The ADA is not aware of any free and charitable clinics that offer a student loan repayment benefit to dentists who devote their time with no other compensation. If the clinics are interested in financing a student loan repayment with no outside assistance, it would certainly add to their fundraising burden. They would also have to do so through a properly designed educational assistance program that meets Internal Revenue Service regulations.

Programs do exist where well-financed third parties (e.g., federal student loan repayment programs, etc.), offer student loan repayment in exchange for a time commitment to practice in underserved areas. The clinics themselves may or may not share in the cost. However, the dentist would be a direct employee of the clinic, not a volunteer.

If the expectation is for the ADA, dental societies, and other third parties—such as local Chamber of Commerce and United Way affiliates—to directly finance such a benefit, those organizations would have to make a serious financial investment to ensure the benefit could be sustained. They would have to create an IRS-approved educational assistance program, and the financial investment would have to be significant to make a lasting and notable impact. And they would likely need to create some sort of trust to administer the program.

A question arises of why a free and charitable clinic would want to administer such a complex benefit themselves instead of offering the clinician a straightforward stipend. The dentist could then use the stipend however they want, including as a payment toward their outstanding loans. The downside is that a stipend would not be a tax-free benefit under a qualifying educational assistance program.

Note that any form of remuneration would make the dentist an employee or contractor (not a volunteer).

95.2. To what extent will this lessen the burden of a new dentist’s educational debt? To what extent will it impact a large number of dentists (versus a handful)?

The extent to which this proposal would lessen the individual dentist’s outstanding debt will vary.

Federal student loan repayment programs, such as the National Health Service Corps Loan Repayment Program, provide enough of a repayment benefit that there are often more applications than the programs are able to accommodate (due to congressional appropriations). However, the programs are financed on a much larger scale than an individual clinic or a coalition of local third party financiers would likely be able to accommodate.

There is no indication that a large number of dentists would spend time working at a non-profit clinic (without pay) in exchange for remuneration through a student loan repayment benefit alone. Almost 90 percent of dental school seniors who graduated in 2019 reported being more interested in maximizing income and aggressively repaying their student loans than receiving student loan debt relief through “volunteerism” or public service.^{1,2,3}

Only 18.7 percent of 2019 dental school graduates reported that educational debt had any influence over their postgraduate career plans.⁴ As a motivating factor for primary professional activity, educational debt ranked seventh—behind opportunity for professional development (54.0 percent), influence of a mentor or role model (32.0 percent), income expectations (30.6 percent), power over living location (30.0 percent), autonomy (23.8 percent), and opportunity to work with other dentists (22.7 percent).¹

Few graduating seniors also reported being interested in seeking debt relief through the Public Service Loan Forgiveness program (5.6 percent) or any other existing service payback program (e.g., National

1 Health Service Corps, Indian Health Service, armed forces, etc.) (3.1 percent).¹ The majority of
2 graduating seniors report that their educational debt repayment strategy is to aggressively pay/overpay
3 (52.3 percent) or minimize monthly payments (36.7 percent).¹

4 To be clear, the majority of graduating seniors report that they will definitely (12.9 percent) or probably
5 (46.9 percent) work in an underserved area at some point in their career.⁵ Debt relief is simply not the
6 motivating factor.

7 To the individual taking advantage of such a program, the impact would depend on the amount of benefit
8 offered in exchange for the amount of time the dentist is willing to devote with no direct pay. The annual
9 benefit would have to be attractive enough for the individual dentist to take time away from their primary
10 work activity (where they may also be receiving a student loan repayment benefit).

11 Again, the majority of graduating seniors seem more interested in maximizing income and aggressively
12 repaying their student loans than receiving loan forgiveness through forms of public service. As a matter
13 of devoting Association resources to the endeavor, the data suggest the idea would be more aspirational
14 than impactful.

15 **95.3. To what extent will this proposal impact the Association's budget or require the ADA**
16 **to divert significant resources from existing projects?**

17 If the intent is to encourage dental societies to directly finance a student loan benefit at a free and
18 charitable clinic, or help them cultivate local partnerships to jointly finance such a benefit, there would be
19 a low to moderate redirection of time, and possibly a modest budget implication. The ADA would need to
20 prepare guidance materials and possibly host webinars to help dental societies do this. (It is possible that
21 these technical assistance materials have already been developed, but not necessarily with a dental
22 society focus.)

23 If the intent is for the ADA, dental societies, and other third parties—such as the local Chamber of
24 Commerce and United Way affiliates—to directly finance such a benefit, those organizations would have
25 to make a serious financial investment to ensure the benefit could be sustained. The commitment would
26 have to be significant to make a lasting and notable impact. There would be a serious redirection of time
27 and a significant budget implication. Alignment with their priorities would be crucial, and the program
28 would likely require a dues increase.

29 If the intent is to help free and charitable clinics find dentists to work for them in exchange for a student
30 loan repayment benefit, the ADA Practice Transitions program already enables them to do this. Dental
31 societies could simply promote ADAPT to the non-profit clinics in their area. Learn more at
32 ADA.org/adapt.

33 **95.4. To what extent will this proposal add value to ADA membership? To what extent will it**
34 **inspire dentists to become ADA members, or to renew their membership?**

35 It is possible that non-members might join ADA to take advantage of ADAPT, or that existing members
36 will renew because they benefitted from ADAPT.

37 It is also possible that non-members would join if the ADA and/or dental societies directly financed their
38 student loan repayment benefit, regardless of the setting. Doing so would require a significant redirection
39 of time and would have a serious budget implication, which would likely involve a dues increase.

40 Otherwise, the dental societies would be working mostly behind the scenes with various third parties.
41 They would have to actively market their involvement to ensure a joint effort is noticed by the non-
42 member.

1 **95.5. To what extent can this proposal be achieved in the next five years?**

2 It is highly unlikely that this proposal can be achieved in the next five years. If the free and charitable
3 clinics were willing to finance a student loan repayment benefit on their own, it would certainly add to their
4 fundraising burden. If the expectation is for the ADA, dental societies, and other third parties to finance
5 such a benefit, those organizations would have to make a serious commitment of dollars to ensure the
6 benefit could be sustained. Financing and administering an IRS-approved educational assistance
7 program would likely require a dues increase.

8 It may be a better use of time to let the organizations representing free and charitable clinics take the lead
9 on this proposal. Their member clinics are best positioned to identify their most critical needs. They stand
10 to gain the most from receiving outside resources, determining how those resources align with their
11 needs, and deciding whether a targeted student loan repayment program is in their best interest.

12 The ADA has been trying to connect with the National Association of Free and Charitable Clinics;
13 however, the organization has been slow to respond.

¹ American Dental Education Association. (March 2020). ADEA Survey of Dental School Seniors, 2019 Graduating Class Tables Report Washington, DC. (Table 17. Respondents' Current Educational Debt Repayment Strategy, by Race/Ethnicity).

² Nicholson S, Vujicic M, Wanchek T, et al. The effect of education debt on dentists' career decisions. *J Am Dent Assoc.* November 2015; 146(11):800-807.

³ Kamyar N and Vujicic M. The relationship between education debt and career choices in professional programs: The case of dentistry. *J Am Dent Assoc.* November 2017; 148(11):825-833.

⁴ American Dental Education Association. (March 2020). ADEA Survey of Dental School Seniors, 2019 Graduating Class Tables Report Washington, DC. (Table 26. Factors and Ranking of What Influenced Respondents to Choose Their Primary Professional Activity).

⁵ American Dental Education Association. (March 2020). ADEA Survey of Dental School Seniors, 2019 Graduating Class Tables Report Washington, DC. (Table 34. Respondents' Plans to Teach, Be Involved in Research and/or Work in an Underserved Area at Some Point after Graduation).

14 **103. Allow employers to claim a tax deduction for paying down student loans with an**
15 **employee's unused paid time off.**

16 **103.1. To what extent is this proposal original, or a creative twist on a conventional idea?**

17 Around 8 percent of companies already offer such a benefit, according to the Society for Human
18 Resource Management. The ADA would only be advocating for an employer tax deduction.

19 **103.2. To what extent will this lessen the burden of a new dentist's educational debt? To what**
20 **extent will it impact a large number of dentists (versus a handful)?**

21 The decision to offer this benefit rests with employers. Since it is already permitted, the end goal would
22 not be to permit employers to offer such a benefit, but to enable them to claim a tax deduction for doing
23 so.

24 **103.3. To what extent will this proposal impact the Association's budget or require the ADA**
25 **to divert significant resources from existing projects?**

26 This proposal would divert significant time from existing projects. This is not something that other
27 organizations are pursuing, so the ADA would have to lay the advocacy groundwork from scratch.
28 Changing the tax code is notoriously difficult and would require a revenue offset.

1 **103.4. To what extent will this proposal add value to ADA membership? To what extent will it**
2 **inspire dentists to become ADA members, or to renew their membership?**

3 This is a difficult question to answer. Non-members benefit from the ADA's legislative and regulatory
4 accomplishments as much as members. There are no data to indicate that these accomplishments would
5 convince a non-member to join.

6 **103.5. To what extent can this proposal be achieved in the next five years?**

7 As with most legislative proposals, it is highly unlikely that this proposal can be achieved in the next five
8 years. This is not something that other organizations are pursuing, so the ADA would have to lay the
9 advocacy groundwork from scratch. Changing the tax code is notoriously difficult and would require a
10 revenue offset.

11 **103.6. Other Remarks**

12 The ADA does not have any policy governing the use of salary, paid time off, or employer-provided fringe
13 benefits as a means of paying down an employee's student debt.

14 This proposal does not appear to be directly supported by the ADA's strategic plan. There is a tie to being
15 an employer, but there is no exclusivity to the business being a dental practice or a health care employer
16 of any kind. It is not associated with the public's oral health or the art and science of dentistry.

17 **104. Create a tax-advantaged student loan repayment plan (similar to a 401k) where an employer**
18 **and employee contribute pre-tax dollars, allow investments to grow, and allow the**
19 **employee to draw from the account expressly for student loan repayment. Or simply allow**
20 **existing retirement account funds to be withdrawn early—penalty-free and tax-free—for the**
21 **express purpose of paying down student loans.**

22 **104.1. To what extent is this proposal original, or a creative twist on a conventional idea?**

23 This idea was proposed by Sen. Rand Paul in 2019 as S. 2962, the Higher Education Loan Payment and
24 Enhanced Retirement Act of 2019 (HELPER Act). The bill would have permitted withdrawals from certain
25 retirement plans for repayment of student loan debt. The bill secured two cosponsors and did not
26 advance out of the Senate Finance Committee.

27 Interestingly enough, the IRS issued Private Letter Ruling in 2018 that effectively allows employers to
28 make 401(k) plan contribution matches when an employee makes payments toward their student loan
29 debt. The current Congress is considering several bills that would codify the IRS' administrative ruling
30 (e.g., H.R. 2917, S. 1443, Secures Act 2.0, etc.).

31 Also note that the Consolidated Appropriations Act (CAA) signed into law in December 2020, allows
32 employers to offer student loan repayment (up to \$5,250 per employee) as a tax-free benefit under a
33 qualified educational assistance program. The tax benefit remains in effect through the end of 2025, with
34 the potential to be renewed thereafter.

35 **104.2. To what extent will this lessen the burden of a new dentist's educational debt? To what**
36 **extent will it impact a large number of dentists (versus a handful)?**

37 It is likely there would be some demand for leveraging a tax benefit and an employer match for student
38 loan payments. The benefit to the individual dentist would depend on (1) whether their employer offers
39 such a benefit and (2) whether the dentist's compensation is high enough for them to make discretionary
40 pre-tax contribution(s).

1 **104.3. To what extent will this proposal impact the Association’s budget or require the ADA**
2 **to divert significant resources from existing projects?**

3 If the ADA has to lay the advocacy groundwork from scratch, the proposal will divert significant time from
4 existing projects. However, if the ADA is able to identify a coalition already leading the effort, it would take
5 very little time to join the coalition.

6 **104.4. To what extent will this proposal add value to ADA membership? To what extent will it**
7 **inspire dentists to become ADA members, or to renew their membership?**

8 This is a difficult question to answer. Non-members benefit from the ADA’s legislative and regulatory
9 accomplishments as much as members. There are no data to indicate that these accomplishments would
10 entice a non-member to join.

11 **104.5. To what extent can this proposal be achieved in the next five years?**

12 As with most legislative proposals, it is highly unlikely that this proposal can be achieved in the next five
13 years. The media spotlight on student debt will continue for some time; however, the immediacy in the
14 current news cycle has waned following President Biden’s announcement that he will forgive \$10,000 in
15 student debt per person. It may return as the 2022 elections draw closer, though it is likely that
16 Republicans will make deficit spending a campaign issue.

17 As of this writing, there are only five cosponsors for S. 1443 and seven cosponsors for H.R. 2917. No
18 hearings have been scheduled and no Republicans have registered their support. There is also no
19 indication that Sen. Rand Paul will be reintroducing his 2019 bill, and none of these bills garnered much
20 support in the 116th Congress.

21 The extent to which this proposal is impacted by the Employee Retirement Income Security Act would
22 also have to be studied. ERISA is a federal law that sets minimum standards for most voluntarily
23 established retirement and health plans in private industry to provide protection for individuals in these
24 plans.

25 **104.6. Other Remarks**

26 The ADA does not have policy governing the use of 401(k) or other employer-sponsored retirement plans
27 as a means to pay down student debt.

28 This proposal does not appear to be directly supported by the ADA’s strategic plan. There is a tie to being
29 a student borrower, but there is no exclusivity about the borrower being a dental student or someone
30 seeking a health professions degree of any kind. It is not associated with the public’s oral health or the art
31 and science of dentistry. The only association is to the financial stability and success of the individual
32 practitioner.

33 **106. Offer a lower interest rate to dentists who work in public health settings (in lieu of loan**
34 **repayment).**

35 **106.1. To what extent is this proposal original, or a creative twist on a conventional idea?**

36 Programs like this exist, but they are not administered through the Department of Education. The Health
37 Resources and Services Administration, for example, administers the Health Professions Student Loan
38 Program. It offers lower interest health professions student loans to help those pursuing specific health
39 professional degrees, including dentistry. The interest rate is typically lower than for Department of
40 Education loans. The intent is to encourage health care professionals to practice in underserved
41 communities.

Appendix D (Task Force to Study Alternate Student Loan Repayment Strategies)
Analysis of Intriguing Ideas

1 Some benefits of these health professions student loans are lower interest rates, longer grace periods,
2 and subsidized interest (meaning the borrower would not pay interest until the grace period ends).
3 Deferment is also available for qualified activities, such as advanced professional training (e.g., pursuing
4 a medical or dental residency). Borrowers may also renegotiate the terms of their outstanding loans
5 during times of financial difficulty.

6 There are drawbacks, however. The loans come with service requirements—meaning the borrower may
7 be required to work in an underserved area or practice in a particular field until the loan is paid in full—
8 and the interest rate may increase if the borrower does not comply. The loans are also administered
9 through academic institutions, and not all schools participate. Further, applicants must usually
10 demonstrate a financial need.

11 **106.2. To what extent will this lessen the burden of a new dentist’s educational debt? To what**
12 **extent will it impact a large number of dentists (versus a handful)?**

13 It is unclear whether a program offering lower interest rates to dentists who work in a public health
14 settings (in lieu of loan repayment) would be sought after by a large number of dentists who were not
15 already planning to work in public health settings. Educational debt does not seem to be influencing
16 decisions to practice in underserved areas.¹⁻² Moreover, recent graduates generally do not seem
17 interested in leveraging service payback programs as a debt repayment strategy.

18 Based on data from the American Dental Education Association, it is likely that only dentists who were
19 already planning to work in public health settings would benefit.

20 The majority of 2019 graduating seniors reported that they will definitely (12.9 percent) or probably (46.9
21 percent) work in an underserved area at some point in their career.³ However, they also reported that
22 their educational debt repayment strategy is to aggressively pay/overpay (52.3 percent) or minimize
23 monthly payments (36.7 percent).⁴ Less than 9 percent plan to use public service as a debt repayment
24 strategy (e.g., federally qualified health center, non-profit clinic, etc.).²

25 Only 18.7 percent of dental school graduates in 2019 reported that educational debt had any influence
26 over their postgraduate career plans.⁵ In fact, as a motivating factor for primary professional activity,
27 educational debt ranked seventh—behind opportunity for professional development (54.0 percent),
28 influence of a mentor or role model (32.0 percent), income expectations (30.6 percent), power over living
29 location (30.0 percent), autonomy (23.8 percent), and opportunity to work with other dentists (22.7
30 percent).³

31 To be clear, the majority of graduating seniors report that they will definitely (12.9 percent) or probably
32 (46.9 percent) work in an underserved area at some point in their career.⁶ Debt relief is simply not the
33 motivating factor.⁷⁻⁸

34 To the individual not already planning to work in a public health setting, the impact would depend on the
35 amount of benefit offered in exchange for the amount of time the dentist is willing to devote. It is still a
36 form of student loan forgiveness, but the benefit would be in the form of interest saved instead of a
37 specified amount forgiven. It would still require some type of service quota (e.g., number of patients seen,
38 number of hours worked, number of years worked, etc.).

39 The price point (e.g., benefit per hour, benefit per patient, per year, etc.) would have to be attractive
40 enough for private practice dentists to take time away from their primary work activity. Other items to
41 consider are the tax treatment of the interest forgiven, mechanisms to prevent fraud and no-shows, and
42 cost offsets to pay for the program and its administration.

43 Again, the majority of graduating seniors seem more interested in maximizing income and aggressively
44 repaying their student loans than receiving loan forgiveness through public service.

1 It is doubtful there would be much opposition to advocating for such a program. The question is whether it
2 is realizable and whether indebted dentists would actually use it. As a matter of devoting Association
3 resources to the endeavor, the data suggest the idea would be more aspirational than impactful.

4 **106.3. To what extent will this proposal impact the Association’s budget or require the ADA**
5 **to divert significant resources from existing projects?**

6 This proposal would divert significant time from existing projects. The ADA would have to thoroughly
7 research the history, benefits, drawbacks, and costs—and lay the advocacy groundwork from scratch. It is
8 not something that other organizations are pursuing.

9 **106.4. To what extent will this proposal add value to ADA membership? To what extent will it**
10 **inspire dentists to become ADA members, or to renew their membership?**

11 This is a difficult question to answer. Non-members benefit from the ADA’s legislative and regulatory
12 accomplishments as much as members. There are no data to indicate that these accomplishments would
13 entice a non-member to join.

14 **106.5. To what extent can this proposal be achieved in the next five years?**

15 As with most legislative proposals, it is highly unlikely that this proposal can be achieved in the next five
16 years. The ADA would have to thoroughly research the history, benefits, drawbacks, and costs—and lay
17 the advocacy groundwork from scratch. It is not something that other organizations are pursuing.

18 The ADA also notes the complexity of administering such a program, since the Department of Education,
19 which owns federal student loans, is not in the business of health care. Likely, the program would have to
20 be coordinated with other federal agencies (e.g., HRSA, CMS, etc.), which would oversee the public
21 service aspect of the program. It then becomes of question of which agency’s budget will finance the
22 benefit. Loans from the Education Department are self-sustaining; loans from federal health agencies are
23 subject to congressional appropriations.

24 **106.6. Other Remarks**

25 The proposal appears consistent with a number of ADA policies that support unspecified “incentives” to
26 treat the underserved.

27 The proposal also appears consistent with the public goal in the ADA’s strategic plan: To “support the
28 advancement of the health of the public and the success of the profession.”

¹ Nicholson S, Vujicic M, Wanchek T, et al. The effect of education debt on dentists’ career decisions. *J Am Dent Assoc.* November 2015; 146(11):800-807.

² Kamyar N and Vujicic M. The relationship between education debt and career choices in professional programs: The case of dentistry. *J Am Dent Assoc.* November 2017; 148(11):825-833.

³ American Dental Education Association. (March 2020). ADEA Survey of Dental School Seniors, 2019 Graduating Class Tables Report Washington, DC. (Table 34. Respondents’ Plans to Teach, Be Involved in Research and/or Work in an Underserved Area at Some Point after Graduation).

⁴ American Dental Education Association. (March 2020). ADEA Survey of Dental School Seniors, 2019 Graduating Class Tables Report Washington, DC. (Table 17. Respondents’ Current Educational Debt Repayment Strategy, by Race/Ethnicity).

⁵ American Dental Education Association. (March 2020). ADEA Survey of Dental School Seniors, 2019 Graduating Class Tables Report Washington, DC. (Table 26. Factors and Ranking of What Influenced Respondents to Choose Their Primary Professional Activity).

⁶ American Dental Education Association. (March 2020). ADEA Survey of Dental School Seniors, 2019 Graduating Class Tables Report Washington, DC. (Table 34. Respondents’ Plans to Teach, Be Involved in Research and/or Work in an Underserved Area at Some Point after Graduation).

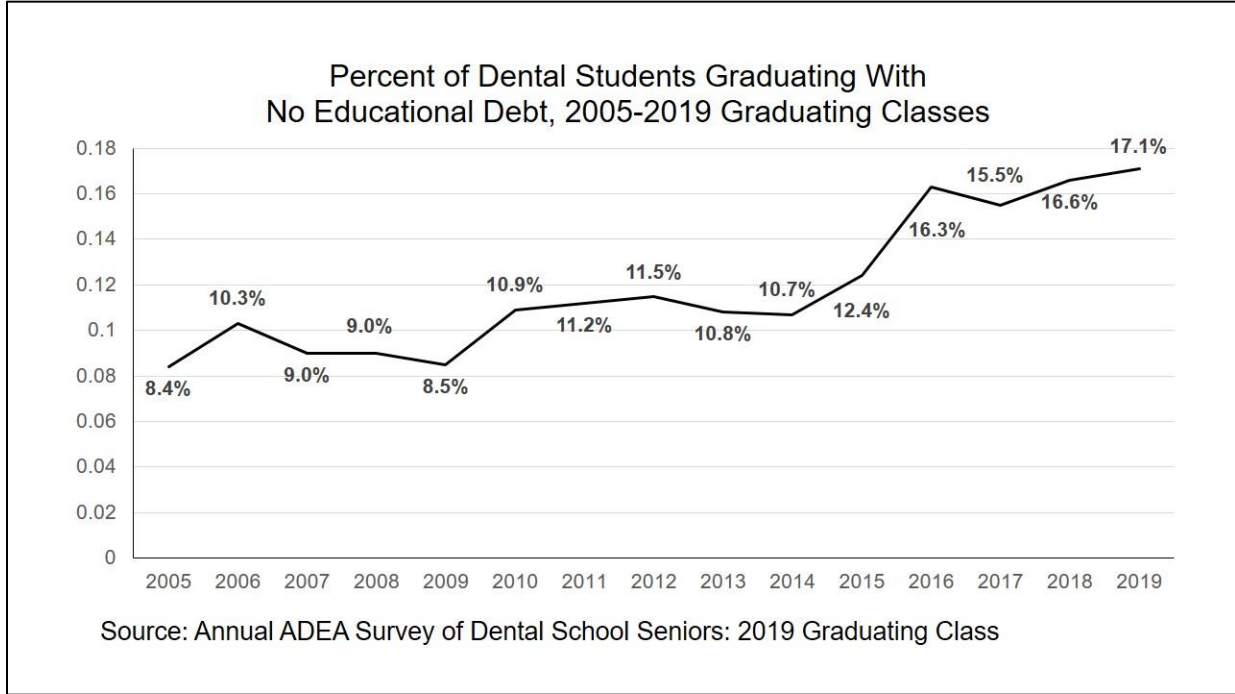
⁷ Nicholson S, Vujicic M, Wanchek T, et al. The effect of education debt on dentists’ career decisions. *J Am Dent Assoc.* November 2015; 146(11):800-807.

Appendix D (Task Force to Study Alternate Student Loan Repayment Strategies)
Analysis of Intriguing Ideas

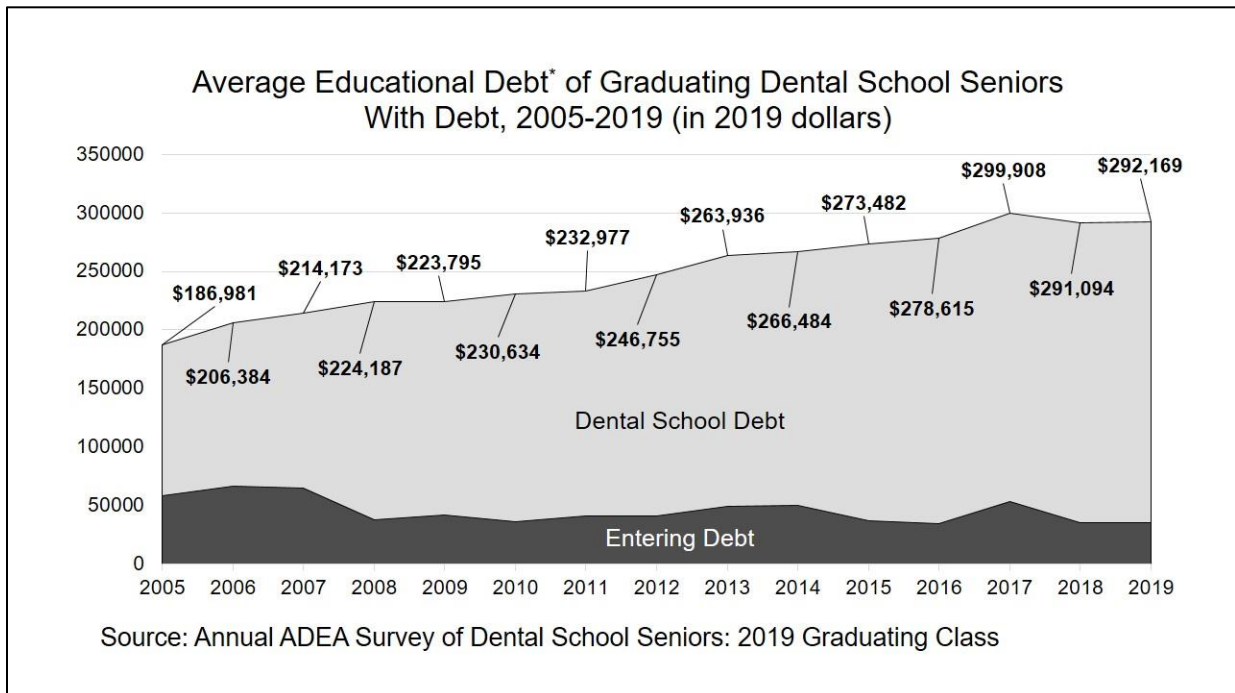
⁸ Kamyar N and Vujcic M. The relationship between education debt and career choices in professional programs: The case of dentistry. *J Am Dent Assoc.* November 2017; 148(11):825-833.

APPENDIX E
REPORT OF THE TASK FORCE TO STUDY
ALTERNATE STUDENT LOAN REPAYMENT STRATEGIES

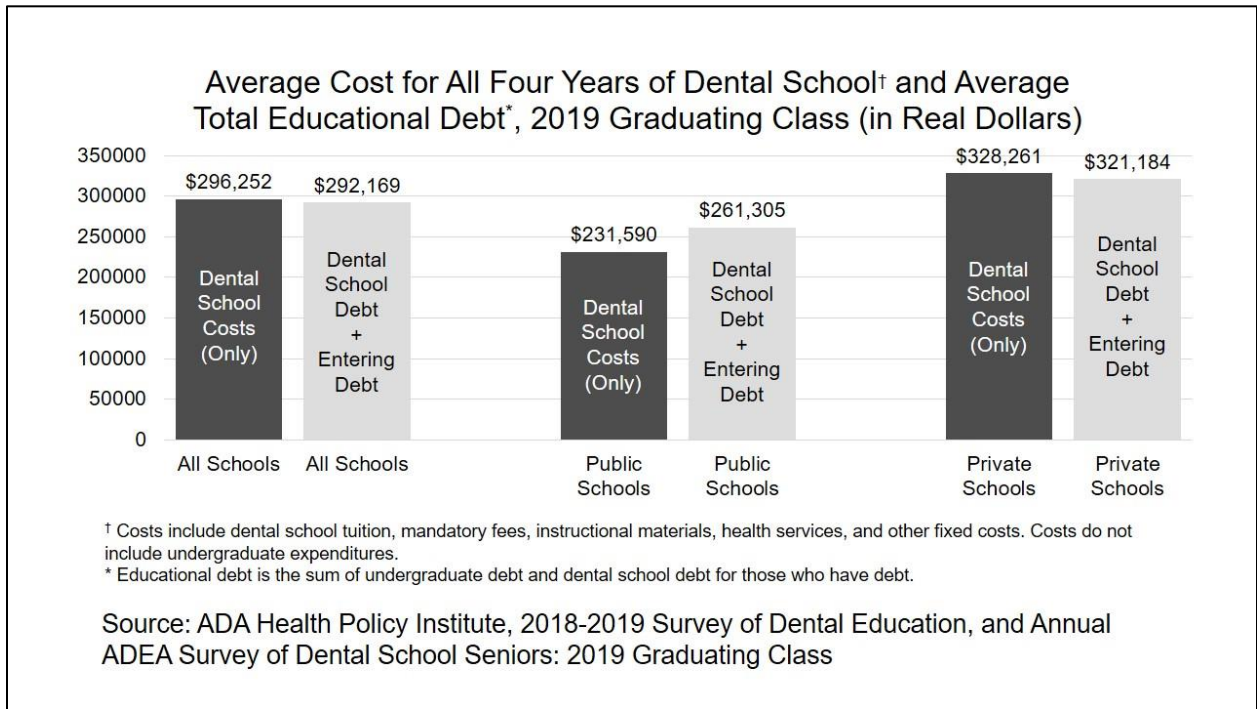
DATA AND TRENDS



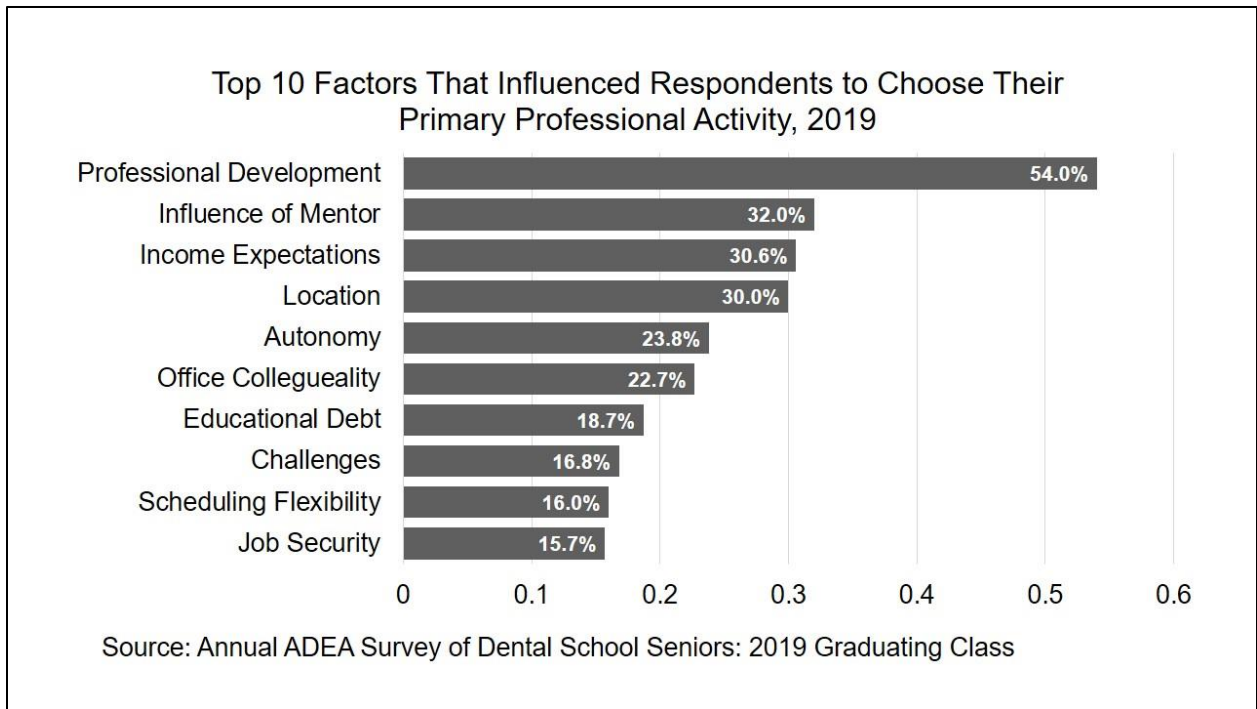
1 **Insight:** An increasing number of dental students are graduating with no debt.



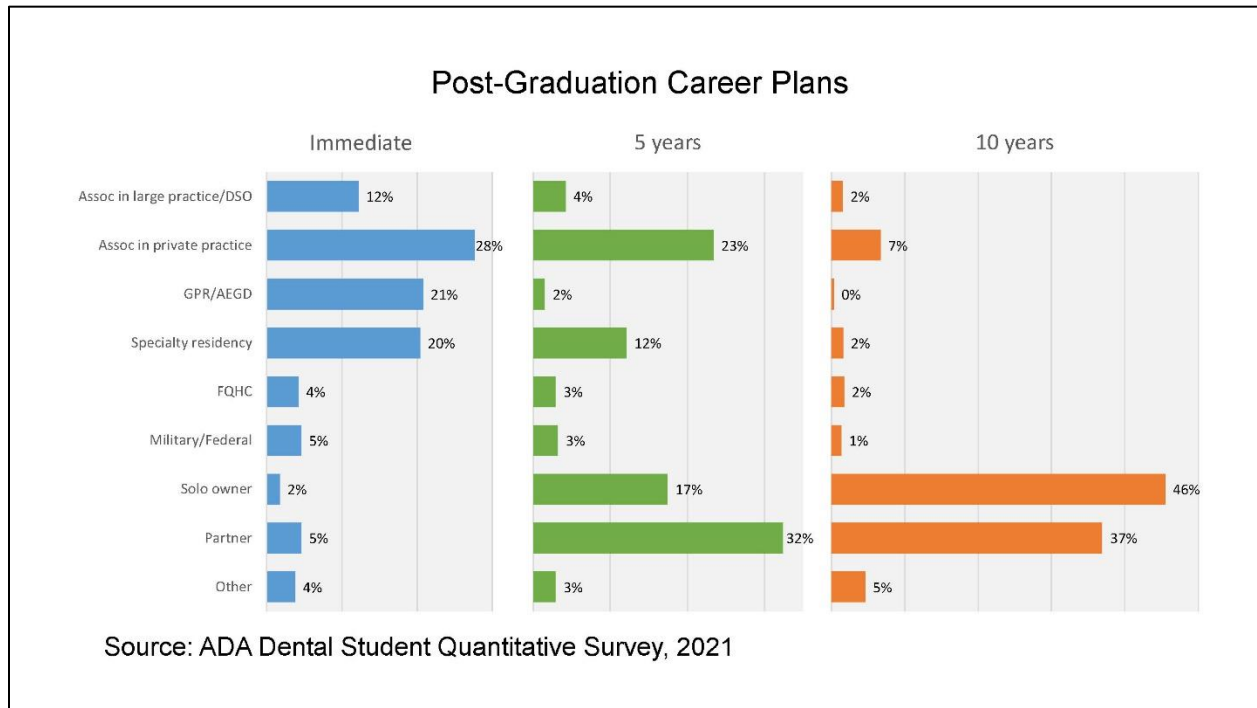
2 **Insight:** The debt burden is growing for those graduating with educational debt.



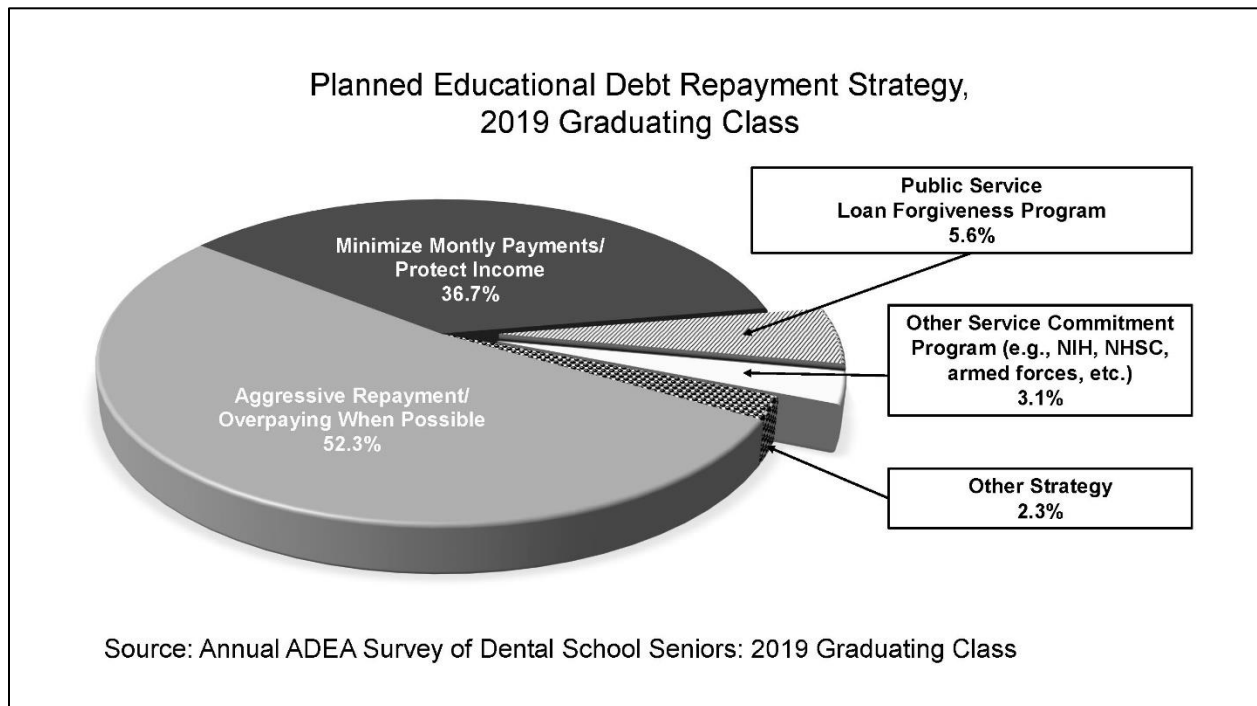
1 **Insight:** Educational debt is generally in line with the cost of attending dental school.



2 **Insight:** Educational debt is not significantly influencing graduating seniors' practice choices.



- 1 **Insight:** There is a noticeable shift from associate toward owner/partner. Associate drops from 40% to
- 2 9% by year ten. Owner/partner shifts from 7% to 83%.



- 3 **Insight:** Graduating seniors are overwhelmingly more interested in maximizing income and aggressively
- 4 repaying their student loans than in receiving debt relief through public service.

APPENDIX F
REPORT OF THE TASK FORCE TO STUDY
ALTERNATE STUDENT LOAN REPAYMENT STRATEGIES

ADA MEMBER OFFERINGS AND ONGOING ACTIVITIES

1 The ADA has invested in a host of exclusive and non-exclusive programs to help dental students finance
2 their dental education responsibly, and help new dentists manage their outstanding educational debt
3 effectively. Many of these resources are accessible through two of the ADA’s online portals:
4 ADA.org/money and ADA.org/mydebt.

5 **MEMBER-ONLY BENEFITS**

6 **ADA Student Loan Refinancing Program (Laurel Road).** The ADA offers student loan refinancing as
7 an exclusive member benefit through Laurel Road, a subsidiary of the 13th largest bank in the country,
8 KeyBank. The program enables ADA members to refinance their existing federal and private
9 undergraduate and graduate school loans at a 0.25 percent discount off of Laurel Road’s already low
10 interest rates. Laurel Road offers ADA members a 0.25 refinancing discount off of their already low
11 interest rates. And student loan borrowers receive an additional 0.50 percent rate discount just for being a
12 dentist.

13 Over 4,300 ADA members have refinanced their loans with Laurel Road, which translates to
14 approximately \$88,000,000 in total student loan savings to ADA members. Learn more at ADA.org/money
15 or ADA.org/mydebt.

16 **ADA/Equitable Financial Advisors.** New in 2021, the ADA will be offering an endorsed program of in-
17 person consultative financial advisor services to ADA members and their employees. The new program,
18 Equitable Financial Advisors, will offer financial planning and educational resources on complimentary
19 basis initially—with subsequent consultations and broader advisory services available at a substantial
20 member discount. The program includes quarterly check-ins with established clients to course correct and
21 adjust their financial plan as may be needed to effectively manage debt and achieve their savings goals.

22 Equitable’s financial advisors are knowledgeable about the latest public and private educational loan and
23 loan repayment programs, and how to assist dentists in developing a solid financial plan to lessen the
24 financial burden of debt after graduation.

25 Equitable Financial Advisors complements the ADA Members Retirement Program, also provided through
26 Equitable Financial and Equitable Investment Management Group. The program offers an array of
27 investment and retirement products, including 401(k), IRA, defined contribution pension, profit sharing,
28 defined benefit, and cash balanced retirement savings plans. Learn more at ADA.equitable.com.

29 **NON-EXCLUSIVE PROGRAMS**

30 **Plan Your Financial Journey: A Series for Dental Students and New Dentists.** The ADA is producing
31 a series of both live and on-demand webinars to help recent graduates and those practicing less than five
32 years plan their financial journey—early in their dental career, when educational debt is at its highest.
33 Additional webinars are planned for dentists who have been practicing five to ten years.

34 The webinar series is produced jointly with ADA-endorsed companies following a February 2021 survey
35 of students and recent graduates asking what types of resources and information would be most
36 beneficial. The top three responses (out of 10) expressed a desire for more direct financial advice and
37 resources.¹ Learn more at ADA.org/money.

38 **ADA Accelerator Series.** The ADA offers online, on-demand program to provide information tailored to
39 the early-career dentist’s unique financial, leadership and work-life balance. These resources help
40 dentists navigate and thrive through life’s changes, according to the Association. Learn more at
41 ADA.org/accelerator.

1 **Laurel Road student loan refinancing webinars.** Upon request, the ADA's student loan refinancing
2 partner, Laurel Road, will produce customized student loan refinancing webinars for both the ADA and
3 individual dental societies. Laurel Road also authors and provide critical expertise for content in various
4 ADA publications. One such webinar is titled Student Loan Repayment During Uncertain Times. Learn
5 more at [ADA.org/money](https://ada.org/money).

6 **Dental Practice Success.** Financial foundations for the new dentist was the focus of a 12-page special
7 edition of Dental Practice Success, the ADA's quarterly, magazine-style supplement to ADA News. The
8 January 2021 edition highlights methods to achieve financial independence and career success while
9 continuing to pay down outstanding student loans.

10 **New Dentist Now Blog.** The ADA hosts an online platform, New Dentist Now, for new dentists and
11 dental students share best practices and lessons learned about their experiences as new dentists,
12 including insights about student loan repayment. Learn more at [ADA.org/money](https://ada.org/money) or [ADA.org/mydebt](https://ada.org/mydebt).

13 **Compilation of Federal and State Student Loan Repayment Programs.** The ADA, in collaboration
14 with the American Dental Education Association and the American Academy of Pediatric Dentistry, offers
15 a comprehensive list of federal and state student loan repayment programs available to dentists. Learn
16 more at [ADA.org/money](https://ada.org/money) or [ADA.org/mydebt](https://ada.org/mydebt).

17 **ADVOCACY**

18 **ADA Dentist and Student Lobby Day.** More than 1,000 dentists, dental students, state association staff,
19 and other dental leaders gather in Washington every year for the Association's second largest
20 conference: the ADA Dentist and Student Lobby Day. As a critical stakeholder, the American Student
21 Dental Association has routinely identified student debt as their number one issue. ASDA leaders have
22 historically identified and advocated for student loan bills that emphasize:

- 23 • Lowering federal student loan interest rates.
- 24 • Allowing federal student loans to be refinanced more than once.
- 25 • Halting interest and deferring payments for those completing a medical or dental residency.

26 **In Congress.** The ADA routinely lobbies Congress for new appropriations to support federal student loan
27 and loan repayment programs, such as the Health Professions Student Loan Program, the National
28 Health Service Corps Student Loan Repayment Program, the Indian Health Service Student Loan
29 Repayment Program, the National Institutes of Health Extramural Loan Repayment Program, and others.

30 The ADA also routinely lobbies for stand-alone bills to advance the Association's education priorities. In
31 the current Congress, for example, the ADA is lobbying on the following bills. Some have been formally
32 introduced; others are expected.

- 33 • *H.R. 4122, the Resident Education Deferred Interest Act (or REDI Act),* would allow medical and
34 dental residents to defer payments on their federal student loans—and delay the point at which
35 interest begins to accrue—until after completing their residency.
- 36 • *H.R. 2160, the Student Loan Refinancing Act,* would enable borrowers to refinance their federal
37 student loans on multiple occasions to take advantage of lower interest rates. (This was one of
38 the bills selected for the 2021 ADA Dentist and Student Lobby Day.)
- 39 • *H.R. 1918, the Student Loan Refinancing and Recalculation Act,* would provide a chance for
40 borrowers to refinance their federal student loans when interest rates are lower. It would also
41 eliminate loan origination fees and allow medical and dental residents to defer payments until
42 after completing their residency programs. Additionally, it would delay the accrual of interest for
43 many low- and middle-income borrowers while they are in school. (This was one of the bills
44 selected for the 2021 ADA Dentist and Student Lobby Day.)

- 1 • *H.R. 1285, the Dental Loan Repayment Assistance Act*, would allow full-time faculty members
2 participating in the Dental Faculty Loan Repayment Program (DFLRP) to exclude the amount of
3 the loan forgiveness from their federal income taxes. The Senate companion bill is S. 449.
- 4 • *Protecting Our Students by Terminating Graduate Rates that Add to Debt Act (or POST GRAD*
5 *Act)*, would reinstate eligibility for graduate and professional students with financial need to
6 receive Direct Subsidized Stafford Loans, which are now only available to undergraduate
7 students.

8 As is common, many of these stand-alone bills are intended to be absorbed into more comprehensive
9 legislation reauthorizing the Higher Education Act of 1965, which provides the statutory authority for most
10 federal student loan programs to operate. The HEA is more than six years overdue for a major overhaul
11 and its reauthorization has been a priority for the ADA and a focus of the ADA Dentist and Student Lobby
12 Day for years.

13 These are merely the latest examples of the Association’s advocacy on student loans and postgraduate
14 educational debt. The ADA was also instrumental in securing the student loan interest deduction in 1997
15 and tying student loan interest rates to market rates (rather than being fixed by law at 6.8 percent) in
16 2013. Learn more at ADA.org/advocacy.

17 ACCREDITATION

18 ***CODA Accreditation Standard for Debt Management and Financial Planning.*** The ADA Council on
19 Dental Education and Licensure urged the Commission on Dental Accreditation to adopt the now-codified
20 standard for dental education programs that states, “Student Services must include...appropriate
21 information about the availability of financial aid...and instruction on personal debt management and
22 financial planning”, as well as the standard that “students must be advised of the total expected cost of
23 their dental education” at the time of acceptance.²

¹ ADA Dental Student Quantitative Survey, 2021.

² Commission on Dental Accreditation, Accreditation Standards for Dental Education Programs, 2020.

NEW BUSINESS-MAJORITY VOTE RECEIVED FOR CONSIDERATION

Resolution No. 106 New

Report: N/A Date Submitted: October 2021

Submitted By: Fourth Trustee District

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

Total Net Financial Implication: None Net Dues Impact: None

Amount One-time _____ Amount On-going _____

ADA Strategic Plan Objective: None

How does this resolution increase member value: Not Applicable

1 **FAIR DELEGATE ALLOCATION FOR FEDERAL DENTAL SERVICES**

2 The following resolution was submitted by the Fourth Trustee District and transmitted on October 6, 2021,
 3 by Dr. George Shepley, Fourth District Trustee, American Dental Association.

4 **Background:** The joint mission of the ADA and federal dental programs is to improve the public's oral
 5 and general health, and this is facilitated by ongoing and timely exchanges about common challenges
 6 and collaborative solutions. It is critical that there be a capacity for federal dentists to educate key people
 7 in federal programs about ADA policies and priorities, as well as to maintain an effective information
 8 pipeline from federal dental programs into organized dentistry.

9 The Federal Dental Services (Air Force, Army, Navy, U.S. Public Health Service, and VA) have
 10 traditionally been represented at the ADA by two Delegates, usually the chief dental officer or director of
 11 each branch as well as one appointed Delegate. Unlike other ADA constituencies, the Federal Dental
 12 Services have little control over ADA membership and are placed at a distinct disadvantage due to the
 13 following reasons:

- 14 • Force strength in each service is determined by statutory authority and Congressional
- 15 appropriations.
- 16 • Federal employees aren't allowed to promote membership in any one organization as it would
- 17 infer bias toward that organization.
- 18 • Many Federal Dental Services dentists join through state dental associations, either unaware of
- 19 the FDS membership route or because they value the tripartite opportunities available; and
- 20 • Some states encourage FDS dentists to join through their state dental associations, even offering
- 21 incentives/reduced rates to join/renew ADA membership.

22 For the above reasons, the Federal Dental Services are often under threat of losing ADA representation.
 23 In the 2014-17 delegate allocation, the Navy Dental Corps was under threat of losing one of two
 24 Delegates but was able to maintain both. In the 2022-25 delegate allocation (reference: Resolution 73-
 25 2021), Public Health will lose one Delegate. In the future, as the military undergoes transformation
 26 through realignment within the Defense Health Agency, there is even greater potential for the FDS to lose
 27 representation due to the current ADA delegate allocation methodology.

28 Another issue affecting membership, especially in Public Health, is identity of its member dentists. Due to
 29 decentralization of public health budgets, many public health dentists are unaware that they are part of
 30 the Public Health constituency. The Public Health constituency consists of dentists not only in the
 31 uniformed branch of the U.S. Public Health Service Commissioned Corps, but also federal Civil Service

NEW BUSINESS-MAJORITY VOTE RECEIVED FOR CONSIDERATION

1 dentists, tribal dentists, and other dentists working in federally funded facilities. Current public health
2 membership includes a total of 7,307 dentists. This includes 1,100 in the Indian Health Service, 486 in
3 the Federal Bureau of Prisons, 61 in the U.S. Coast Guard, 5,324 in the Health Resources and Services
4 Administration (working in federally qualified health centers), 3 in the Food and Drug Administration, 32 in
5 the Immigration and Customs Enforcement Health Service Corps, 7 in the National Institutes of Health, 5
6 in the Centers for Disease Control and Prevention, and 1 in the Centers for Medicare and Medicaid
7 Services. ADA records only count a total of 482 dentists in the Public Health constituency, of which 135
8 are direct members through the FDS membership. This is a significant undercount of public health
9 dentists. The dentists who have played a significant role in serving underserved and vulnerable
10 populations for the past century, especially during the current COVID-19 pandemic, the largest public
11 health emergency ever in the U.S.

12 This resolution proposes that the ADA revise the delegate allocation methodology to restore and maintain
13 two Delegates for each of the Federal Dental Services, regardless of the membership size of each of the
14 Services. This resolution would not result in a loss or change of delegates for any of the other ADA
15 constituencies. It would reinforce the ADA's longstanding support of the Federal Dental Services by re-
16 establishing the parity between the representation of the Federal Dental Services and small state
17 constituencies by allocating a minimum of two delegates for each of the Federal Dental Services.

18

Resolution

19 **106. Resolved**, that the appropriate agency revise the delegate allocation methodology found in the
20 Manual of the House of Delegates so that a minimum of two delegates is allocated to each of the
21 Federal Dental Services, and be it further

22 **Resolved**, that a report on the requested revisions be provided to the 2022 House of Delegates.

23 **BOARD COMMENT: Received after the deadline for New Business submission of September 28.**

24

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Res. 5	5015	Council on Government Affairs Rescission of the Policy, Advocating for ERISA Reform
Res. 6	5018	Council on Government Affairs Amendment of the Policy, Use of Expert Witnesses in Liability Cases
Res. 7	5021	Council on Government Affairs Rescission of the Policy, Professional Liability Insurance Legislation
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Res. 29	5170	Council on Government Affairs Rescission of the Policy, Adding the ADA Definition of Dentistry to Existing Dental Regulatory Provisions
Res. 30	5094	Council on Government Affairs Amendment of the Policy, Antitrust Reform
Res. 31	4001	Commission for Continuing Education Provider Recognition Amendment of Chapter IX, Section A of the Governance and Organizational Manual of the American Dental Association
Res. 32	4005	Council on Education and Licensure Amendment of the Policy: Review of ADA Definition: Continuing Competency
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Res. 34	5102	Council on Ethics, Bylaws and Judicial Affairs Amendment and Simplification of Bylaws Chapter I., Section 20.B.
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