

# 2010

## Annual Reports and Resolutions

151<sup>th</sup> Annual Session

Orlando, Florida

October 9 – 13, 2010







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American Dental Association  
211 East Chicago Avenue  
Chicago, Illinois 60611

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## **Councils and Commissions**

# Notes

# Council on Access, Prevention and Interprofessional Relations

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**Crabtree, Mark A.**, Virginia, 2010, chair  
**Davis, Gary S.**, Pennsylvania, 2011, vice chair  
**Allen, Nolan W.**, Florida, 2012  
**Baber, Greg L.**, Texas, 2010, American Hospital Association  
**Ciebien, Gerald J.**, Illinois, 2012  
**Flaherty, Kevin T.**, Wisconsin, 2010, American Medical Association  
**Gill, Eleanor A.**, Mississippi, 2012  
**Hanck, John J.**, Colorado, 2013  
**Hebl, Monica**, Wisconsin, 2013  
**Heddens, Heather B.**, Iowa, 2013  
**Holwager, David R.**, Indiana, 2012  
**Homicz, A.J.**, New Hampshire, 2011  
**Lang, Melanie S.**, Washington, 2011  
**Miller, David J.**, New York, 2011  
**Oneacre, Lee P.**, Texas, 2010  
**Ruskin, Danielle**, Michigan, *ex officio* \*  
**Scott, Brian E.**, California, 2013  
**Stanislav, Leon E.**, Tennessee, 2010  
**Stasch, Jeffrey J.**, Kansas, 2010  
**Whitman, Sidney A.**, New Jersey, 2012  
**Lampiris, Lewis N.**, director  
**Geiermann, Steven P.**, senior manager  
**Strock, Sheila A.**, senior manager  
**McGinley, Jane S.**, manager  
**Podschun, Gary D.**, manager  
**Smith, Barbara J.**, manager  
**Stoufflet, Nicole M.**, manager  
**Sweis, Luciana**, project manager

**The Strategic Plan of the American Dental Association:** The Council on Access, Prevention and Interprofessional Relations' (CAPIR) programs and activities support objectives in each of the five goals of the *ADA Strategic Plan: 2007-2010*. CAPIR facilitates collaboration and promotes dialogue between the ADA and a broad array of communities of interest and assists members position themselves as community leaders on issues related to oral health and the relationship between dentistry and medicine. CAPIR continues to be positioned as an advocacy leader for the ADA and external stakeholders in the areas of interprofessional relations, the prevention of oral disease and access to care.

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\* Committee on the New Dentist member without the power to vote.

The Council's main purpose is to broaden the scope of oral health care within the total health care system, promote preventive dentistry as a cornerstone of oral health care, and provide leadership, vision and coordination of the ADA's activities in the areas of access to dental care for specific population groups. The Council offers assistance in many areas that are tied to the ADA's strategic goals, including medical-dental collaboration, community water fluoridation, oral health literacy, public health outreach, tobacco use and oral cancer prevention, access to care for underserved populations and community oral health infrastructure and capacity building. CAPIR supports the American Indian/Alaska Native Dental Placement Program, the Give Kids A Smile<sup>®</sup> Program, OralLongevity<sup>™</sup> and other initiatives focused on the oral health needs of the growing vulnerable elderly population, National Children's Dental Health Month and the Community Dental Health Coordinator Pilot Program.

CAPIR supports efforts to improve oral health throughout various lifecycles and targeted populations and encourages collaboration with a broad array of communities to promote oral health as integral to overall health. Along with the Council on Government Affairs (CGA), CAPIR continues to explore ways to position the ADA as the nation's trusted oral health authority and to advocate at the federal and state levels for greater public/private collaboration to prevent dental disease and increase access.

Demands on Council volunteers and staff have grown exponentially over the past year.

In support of the Strategic Plan, CAPIR is now being directed to facilitate collaborative activities and promote dialogue between the ADA and a broad array of communities including but not limited to, the dental family, other professional health care organizations, the public health community, foundations and corporate America.

These activities are bearing appreciable results, including but not limited to: 1) garnering financial and in-kind resources to support programmatic activities; 2) being invited to participate in symposia and conferences, to serve on advisory committees and to interact with various communities of interest with costs for such activity being born by these external entities; 3) strengthening the reputation of the ADA and the Council as trusted sources of information; and 4) decreasing potential financial and reputational risk through active engagement.

## **Interprofessional Relations Activities and Trends**

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**Interprofessional Relations:** Interprofessional Relations activities fulfill the Council's *Bylaws* responsibilities to recommend policies and formulate programs on issues pertaining to the relationship of dentistry to medicine. These activities include interdisciplinary patient management, dentist-physician relations, oral health needs of patients with complex medical conditions, evaluating health outcomes of patients requiring cooperative dental-medical management in hospitals, and analysis of active medical and staff membership and clinical privileges in ambulatory care centers, long-term care facilities and other interdisciplinary health care settings. The Interprofessional

Relations program area of CAPIR facilitates collaboration and promotes dialogue between the ADA and a broad array of communities of interest in three major areas: accreditation, the dental-medical interface and interprofessional relations.

Value to the profession includes disseminating information on emerging topics of interest to the membership about the medical-dental connection, impacting areas of interest to the dental profession that relate oral health to overall health and expanding the scope of oral health care within the total health care system. Program initiatives build relationships with external stakeholders and promote collaborative activities to support the dental profession. The program further assists members position themselves as community leaders on issues related to oral health and the relationship between dentistry and medicine.

**The National Roundtable for Dental Collaboration:** In collaboration with the ADA Department of Dental Society Services, CAPIR staff assisted with planning and convening the first National Roundtable for Dental Collaboration. The ADA brought together presidents and executive directors from 15 recognized specialty associations and other dental organizations on January 9-10, 2010. The purpose of the meeting was to find common ground for joint action, foster routine and effective communication, identify and assess common challenges, and work collaboratively to address challenges to improve oral and overall health. The Roundtable is scheduled to reconvene in 2011 with four added organizations: the Hispanic Dental Association, the National Dental Association, the American Association of Women Dentists and the National Network for Oral Health Access.

**Use of the Emergency Room (ER) for Dental Treatment Efforts:** In conjunction with the ADA Department of State Government Affairs and representatives of U.S. Centers for Disease Control and Prevention (CDC), CAPIR has participated in a project to address utilization of ERs for oral health care. The first phase of the project is gathering existing data, investigating data sources and conducting a literature review. The CDC has agreed to fund the scientific literature search through Oak Ridge Institute for Science and Education (ORISE) and will announce the opportunity later in 2010 to select a researcher to publish the literature review.

**American Medical Association (AMA):** Dr. David Whiston, ADA past president, was an official observer to the AMA's 2009 annual and interim meetings. The AMA's annual meeting traditionally encompasses a broad agenda and the interim meeting focuses on advocacy issues. Topics of interest to dentistry at the 2009 AMA meetings included the sustainable growth rate (SGR) as it pertains to Medicare reimbursement, employer mandates for insurance coverage, comparative effectiveness research (CER), the Medical Home, tort reform and malpractice implications, the definition of physician and The Joint Commission's Center for Transforming Healthcare.

*The Medical Home.* The AMA continues to call for implementation of a health system infrastructure that would support a medical home for each patient, encourage more continuous contact with patients, coordinate care across the health system and use

more evidence-based medicine to guide clinical decision-making. The Centers for Medicare and Medicaid Services (CMS) released information about a demonstration project in eight states that will pay higher rates to selected practices that serve as medical homes. Concern was voiced in the medical community that “any additional payments that are made to primary care physicians are not budget neutral within the physician payment pool.” Dentistry, as a primary care driven profession, has much to offer as the debates regarding these potentially divisive issues move forward and as it relates to the concept of the dental home.

*Definition of a Physician.* The AMA House of Delegates asked that the AMA commissioners to The Joint Commission (TJC) request, and continue to work, to have TJC’s definition of physician limited to doctors of medicine and osteopathy. They also directed the AMA to “aggressively pursue revision of the Social Security Act (SSA) and, also, state law definitions of physician to be limited to doctors of medicine and osteopathy.” The ADA representatives to TJC and AMA will remain vigilant on this topic and will submit additional information as it becomes available.

**The Joint Commission (TJC):** Dr. David Whiston continues to serve as the ADA commissioner on The Joint Commission’s Board of Commissioners. He also serves as Chair of The Joint Commission Board and as a member of the Board of Joint Commission Resources. CAPIR staff and volunteers attended TJC meetings, including several Physician and Technical Advisory Committee (PTACs) and TJC Board meetings. There are six PTACs that function to provide technical support to TJC. The ADA has representation on five of the six committees and is seeking representation on the Laboratory PTAC. The focus of the PTAC meetings in the first quarter of 2010 was to discuss proposed standards changes to medication reconciliation. TJC-proposed revisions are designed to help patients provide more accurate medication information when receiving medical care.

*2010 National Patient Safety Goals (NPSGs).* The changes to the NPSGs reflect TJC’s continuing efforts to focus on topics that are of highest priority to patient safety and quality care. TJC has revised the Universal Protocol and some changes are effective immediately. The intent of the revisions is to address patient safety issues while allowing organizations flexibility in applying the requirements within existing work processes. Affected organizations include hospitals, critical access hospitals, ambulatory care facilities and office-based surgical practices.

*MS.01.01.01.* TJC Board of Commissioners approved changes to hospital medical staff standard MS.01.01.01. The standard supports patient safety and quality of care by ensuring that physicians and other licensed independent practitioners in the hospital form an organized medical staff that will provide oversight to clinical care and performance of those with clinical privileges.

*Center for Transforming Healthcare.* TJC launched the [Center for Transforming Healthcare](http://www.centerfortransforminghealthcare.org/) (<http://www.centerfortransforminghealthcare.org/>) that uses a new approach to systematically measure the magnitude of serious quality and safety problems,

pinpoint their underlying causes, and develop and test targeted long-lasting solutions. The Center's first initiative is hand washing failures that contribute to health care-associated infections that kill nearly 100,000 Americans each year and cost U.S. hospitals \$4 billion to \$29 billion annually to combat. Eight leading hospitals and health systems volunteered to address hand washing failures as a critical patient safety problem. The Center receives leadership and support from the American Hospital Association, Becton, Dickinson and Company (BD), Ecolab, GE Healthcare, Johnson & Johnson, Federation of American Hospitals and Hospira.

**Organization for Safety and Asepsis Procedures (OSAP) Committee on Infection Control for Mobile Units:** CAPIR represents the ADA on this committee which is developing an Infection Control Site Assessment and Checklist for settings that use portable equipment or mobile vans without operatories. The final draft and supporting documents were completed in February 2010 and sent to the field for testing. Further collaborative activities with OSAP are being pursued.

**The National Diabetes Education Program (NDEP) and the American Diabetes Association:** The CDC's Pharmacy, Podiatry, Optometry and Dentistry (PPOD) workgroup met in October 2009, in Washington, D.C., in conjunction with the Medical workgroup, for a two day meeting. The ADA was represented through CAPIR. The emphasis of this meeting was increasing the public's awareness of diabetes through educational activities in the media, through NDEP available publications and the use of the Internet. The number of type 2 diabetes patients diagnosed every year is rapidly increasing and could be reduced with proper diet, exercise and overall lifestyle management. The predisposition of certain ethnic populations to all types of diabetes is also well documented.

The PPOD group asked the ADA to post a link on the "public" and "member" sections of the ADA Web site directing individuals to the NDEP Web sites for additional information about diabetes. Video and written materials are available for the dental profession and the public about diabetes and its relationship to oral health. Further collaborative activities are being explored.

CAPIR is also communicating with the American Diabetes Association to investigate collaborative opportunities. These include the ADA participating at regional American Diabetes Association expos, providing continuing education at ADA annual session, and giving presentations at the scientific session of the American Diabetes Association.

**Alternative Dental Careers Program:** CAPIR staff continues to collaborate with the Hillenbrand fellow to update and revise the Alternative Dental Careers Packet into an electronic format. A project plan and timeline have been developed. A request for Web site development was accepted. Preliminary design and development began in April 2010. The Web site should be launched by August 2010.

**Oral Health Care Series:** CAPIR continues to work with the ADA Department of Product Development and Sales to publish a text on oral health care and other health

conditions. A project plan and timeline have been developed. CAPIR will have several areas of responsibility in the project including submitting recommendations for the position of editor of the Oral Health Care Series. CAPIR will also consult on the content and format of the textbook. CAPIR's Interprofessional Relations Subcommittee is in the process of reviewing the bios on possible candidates for editor. It is anticipated that the editor will be appointed and a contract signed by the end of May 2010.

## **Preventive Health and Fluoridation Activities and Trends**

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**Preventive Health and Fluoridation Activities:** Prevention is the cornerstone of oral health. The purpose of CAPIR's focus on fluoridation and preventive health is to conduct activities and recommend policies related to population-based preventive oral health measures. CAPIR provides advice and technical assistance to constituent societies and members on measures such as community water fluoridation, school-based oral health programs (including school-based sealant programs), tobacco use prevention and cessation, oral cancer awareness and nutrition/obesity/school food policies and assists members to position themselves as community leaders on issues related to oral health.

CAPIR's prevention focus area fosters and maintains liaison and collaborative relationships with a number of external stakeholders who also support or are involved in the delivery of population-based interventions. Additionally, these relationships are made possible in part by the prevention focus area's strong commitment to successful collaboration with internal ADA agencies such as the Division of Science, Department of State Government Affairs, Public Affairs, Membership, Tripartite Relations and Marketing, Communications and Marketing, Electronic Media and *ADA News*.

Community water fluoridation is the centerpiece of CAPIR's preventive health efforts. The Council serves as the focal point for fluoridation technical assistance and acts as a resource to the profession, public health officials and other external organizations.

**Community Water Fluoridation:** Water fluoridation celebrated its 65<sup>th</sup> anniversary in January 2010. The U.S. Centers for Disease Control and Prevention (CDC) has released numbers from the national 2008 Fluoridation Census indicating that 72.4% of the U.S. population (up from 65% in 2000) is served by water supplies in which the fluoride concentration has been adjusted to an optimal level or the natural fluoride content is sufficient to prevent tooth decay. The *Healthy People 2010* target of 75% appears obtainable in the future. *Healthy People 2020* has established the same goal.

*Technical Assistance.* The number of phone and e-mail requests for fluoridation technical assistance from members, constituent and component societies, and state and local governments continues to rise. While members seek assistance in initiating fluoridation in their communities, challenges to long-standing, successful fluoridation programs have increased significantly over the last several years, even in communities which have been fluoridated for 60 years or more. In analyzing the fluoridation awards presented jointly by the ADA, Association of State and Territorial Dental Directors and

the CDC in April 2010 at the National Oral Health Conference, it is interesting to note that 15 communities were recognized for the initiation of fluoridation while 25 were given awards for efforts to successfully retain existing fluoridation programs in 2009.

*Public and Professional Education.* Driven by a strong recommendation from its National Fluoridation Advisory Committee, CAPIR is working with ADA's Department of Electronic Communications to revise the fluoridation content on ADA.org and enhance search engine optimization to provide better search results for individuals seeking fluoridation information on the Web. However, a number of ADA fluoridation technical resources have been discontinued due to an inability to keep them current and meaningful for the profession and public. Additionally, the planned five-year revision of the ADA's premier resource, *Fluoridation Facts*, is currently in progress but behind schedule.

*State Public Affairs.* In the past year, fluoridation technical assistance has been provided to the Florida, Louisiana, Maine and Nebraska Dental Associations through CAPIR's participation in the ADA Public Affairs Initiative. Additionally, fluoridation assistance has been provided to societies and members in states including, but not limited to, Alaska, California, Florida, Georgia, Michigan, Missouri, Montana, New Jersey, Texas and Wisconsin. On November 20, 2009, CAPIR staff joined ADA staff, Mr. Dick Green, in facilitating a one-day Fluoridation Spokesperson Training for the Texas Dental Association. On April 16, 2010, CAPIR staff presented a continuing education fluoridation program for the Virginia Dental Hygienists' Association.

A new fluoridation opposition tactic was noted this year beginning in Louisiana. A bill was introduced that included a number of provisions including a requirement for customer notification of the name of the chemicals used and their countries of origin. Additionally the bill prohibited the use of any chemical or chemical compound in which any chemical process, manufacturing, packaging, or any other type of manipulation took place within the People's Republic of China. This appeared to be an attempt to tie fluoride to concerns about other potentially unsafe products from China. CAPIR collaborated with the Department of State Government Affairs to ensure that constituent societies were made aware of this legislation and its possible introduction in other state legislatures.

*Pew Charitable Trust.* Following a presentation by staff from the Advancing Children's Dental Health Initiative of The Pew Charitable Trusts to CAPIR in January 2010, efforts are on going to establish a collaborative relationship on fluoridation efforts.

*California Environmental Protection Agency.* Under the authority of California Proposition 65, the California Environmental Protection Agency's Office of Environmental Health Hazard Assessment (OEHHA) gave priority rankings for 38 chemicals assigned to them for review of possible carcinogenicity. The OEHHA chose nine, including fluoride, and assigned it a high priority status for a review that will most likely take place sometime over the next two years. CAPIR staff attended a strategy meeting sponsored by the California Dental Association on October 21, 2009,

and continues to monitor the progress of the review including the release of the Hazard Identification Document which is anticipated to occur in 2010.

*U.S. Environmental Protection Agency (EPA).* The EPA is charged with reviewing safe levels of natural-occurring fluoride in water. In March 2010, the EPA issued a press release stating they continue to work on the recommendations contained in the National Academies' 2006 report, *Fluoride in Drinking Water: A Scientific Review of EPA's Standards*. No future date has been given for the completion of their review.

*National Fluoridation Advisory Committee (NFAC).* The NFAC meets annually and is composed of a Council member and consultants to the Council. This Committee continues to serve the important role of assisting the Council with proactive community water fluoridation activities. In this regard, NFAC helps the Council monitor scientific and community-based trends associated with state and local water fluoridation initiatives and provides the Council with valuable input for development and/or revision of fluoridation education materials. The NFAC meeting was held June 21-22, 2010. The following members are serving one-year terms on the NFAC: Dr. Leon Stanislav, TN, chair (CAPIR member); Dr. Robert Crawford, Jr., FL; Dr. Jayanth Kumar, NY; Dr. Steven Levy, IA; Dr. Howard Pollick, CA; and Mr. Thomas Reeves, GA.

**Evidence-Based Dentistry (EBD):** CAPIR is participating in two EBD panels currently being conducted by the Division of Scientific Affairs related to fluoride issues. CAPIR is represented by Dr. Howard Pollick on the review concerning dietary fluoride supplements and by Dr. Rebecca King on the review related to infant fluoride intake. While not officially representing the National Fluoridation Advisory Committee (NFAC), a number of NFAC members are also active members for both panels. Additionally, CAPIR was represented by Dr. William Carpenter on the EBD panel on oral cancer screenings that was published in 2010.

**Partnerships to Promote Children's Oral Health through Health Education and Health Promotion:** The 2010 observance of National Children's Dental Health Month (NCDHM) featured a poster with new characters, The McGrinn Twins, Flossy and her brother Buck with the message, "For a sparkly smile The McGrinn Twins say: Remember to Brush & Floss Everyday!" The other side of the poster featured a healthy smile message for tweens with the slogan, "Rock Your Smile!" The poster was translated in English and Spanish and so was the program planning guide, poster insert and activity sheets. The ADA produced 210,000 posters (175,000 English and 35,000 Spanish). Program materials were made available to state and local dental societies, the Alliance of the ADA, public health departments and armed forces dental clinics in their local health campaign efforts. Additional information appeared on the ADA's Web site, <http://www.ada.org/2714.aspx> (Dentist version), visited by thousands of people who downloaded activity sheets, presentation ideas and other NCDHM content.

*Preferred Meal Systems.* The ADA again collaborated with Preferred Meal Systems on educational outreach to elementary school children, most in inner-city schools. Preferred Meal Systems provides meals and tray liners to elementary school cafeterias.

For the 2010 observance of NCDHM, the ADA prepared a tray liner featuring oral health puzzles and word games, resulting in oral health messages appearing on 2.5 million tray liners in school cafeterias in 21 states.

**Sports Dentistry:** The Council collaborated with the Department of Standards Administration to seek recommendations from the Academy for Sports Dentistry for possible candidates to participate on the ADA Standards Committee on Dental Products Working Group to update the American National Standard/American Dental Association Specification No. 99, "Athletic Mouth Protectors and Materials." This particular standard was reaffirmed in 2007 and needs to have revisions completed by the end of 2012. The Department of Standards Administration is in the process of selecting candidates for the review committee.

**Tobacco/Oral Cancer:** CAPIR continued its collaboration with the Department of State Government Affairs as the Federal Family Smoking Prevention and Tobacco Control Act was passed into law and implementation began. In October 2009, the ADA wrote to the FDA providing comments on approaches and actions that should initially be considered during the implementation of the Family Smoking Prevention and Tobacco Control Act. The ADA also nominated two dentist members for appointment to the FDA's Tobacco Products Scientific Advisory Committee. While neither of the two nominees were appointed to the Committee, in the coming months and years as portions of the Act are implemented, there will be numerous additional opportunities for the ADA to play a meaningful public role in protecting the public's health from the death and disease caused by the use of tobacco products.

*National Smokeless and Spit Tobacco Summit.* ADA co-sponsored the 5<sup>th</sup> National Smokeless and Spit Tobacco Summit in Madison, WI, on September 21-23, 2009. The theme, "New Products, New Challenges, and a New Generation of Advocacy" was inspired by the Summit goals to provide a learning forum centered in best practices for professionals working in the field of tobacco use prevention and cessation. Summit topics included new information on tobacco cessation, taxation, new products, priority populations and candy flavored tobacco. ADA was identified as the exclusive sponsor of the keynote speaker. Dr. Gerald Ciebien, CAPIR member, and a staff member attended the Summit.

*National Consortium on Tobacco Use Prevention through Schools.* On May 4, 2010, CAPIR staff participated in the annual meeting of the National Consortium on Tobacco Use Prevention through Schools. The Consortium, which is comprised of national organizations with state level affiliates, along with state school boards association representatives, is working to identify and implement joint strategies for collaboration in tobacco use prevention among health advocates and school boards in states. The Consortium is part of the National School Boards Association's work under a cooperative agreement with the Centers for Disease Control and Prevention, Division of Adolescent and School Health. Staff highlighted the 2009 ADA policy on tobacco free schools (*Trans.*2009:415; 419).

**ADA National Cancer Institute (NCI) Oral Cancer Grant:** Dr. Sol Silverman, principal investigator for ADA's NCI five-year grant on the early detection of oral cancer, and the grant's collaborators, have completed manuscripts regarding the grant's outcomes. Publication is anticipated in the *Journal of Cancer Education* in spring 2010.

**National Coordinating Committee on School Health and Safety (NCCSHS):** NCCSHS's annual meeting was held June 3, 2010, with a theme of "School Climate: Building a Shared Understanding." CAPIR staff provided information on the school-based sealant EBD review and the new ADA policy on tobacco free schools.

**American Academy of Pediatrics Chapter Advocate Training on Oral Health:** Following the second training session in November 2009, the final Chapter Advocate Training on Oral Health (CATOOH) is scheduled for November 5-6, 2010. This will be the third planned training event at which pediatricians will learn to conduct oral health risk assessments (including oral screening exams), teach families about oral health and prevention and refer children to a dental home. Over three years, all 66 AAP chapters will have the opportunity to send representatives, who will return home to be advocates for oral health and lead training in their home states. The ADA continues to be represented by Dr. Leon Stanislav, CAPIR member and NFAC chair, who provides a session on the use of fluorides for trainees. Funding for this project is through an American Dental Association Foundation grant.

### **Access, Community Outreach and Capacity Development, Volunteer Efforts and Trends**

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**Access, Community Outreach and Capacity Development and Volunteer Efforts:** These programs and activities assist in developing policies, plans and programs that support diverse community efforts to link people to needed oral health services, which emphasize increasing access to oral health care all within the context of population-based interventions, volunteer efforts and interdisciplinary patient management. These programs are focused on helping people be good stewards and advocates for their own oral health, including managing disease by providing advice and technical assistance to constituencies and communities in the core public health competencies of assessing community oral health need; in the design, implementation and evaluation of programs to meet identified need; and in building community oral health infrastructure and capacity to address access to dental care and prevention needs at the community level. Similar technical assistance is offered to strengthen the public health infrastructure at the state and national levels as well. The program area targets vulnerable populations, particularly low-income children and families, Native American and Alaska Native populations and the vulnerable elderly.

**Access to Dental Care Summit Follow-Up:** Working over the last year, the post-Summit Coordination and Communication (C&C) Workgroup has developed a framework for action, which includes operating and process principles for all of the Summit workgroups, a case statement to solicit fiscal resources in support of a sustainable infrastructure and an outline for re-engaging the original Summit

participants and developing an inventory of access efforts undertaken thus far. The initial re-engagement of the planning representatives of the 12 original Summit stakeholder groups with the C&C Workgroup was accomplished in March 2010. The remaining Summit participants will be invited to re-establish their membership within one of the seven topical workgroups, as outlined in the *Proceedings of the Access to Dental Care Summit*. Additional information regarding post Summit activities will be provided in a supplemental report to the 2010 House of Delegates.

**Healthcare Reform:** CAPIR continues to provide input to best frame the ADA's response to the ongoing development of healthcare reform implementation, especially with regard to enhancing the federal dental public health infrastructure and emphasizing greater support for community-based prevention efforts.

#### **ADA Liaison Committee to the Institute of Medicine's (IOM) Oral Health**

**Committees:** Under the direction of Dr. Raymond Gist, ADA president-elect, CAPIR serves as the liaison to the IOM and leads an intra-agency workgroup to provide pertinent and up-to-date oral health information to two IOM committees. ADA volunteer leaders and CAPIR staff were present at testimony hearings before both committees. Additional information regarding progress made by the IOM's Oral Health Committees will be provided in a supplemental report to the 2010 House of Delegates.

**Healthy People 2020:** "Healthy People" is a decennial campaign to identify the most significant preventable threats to health and to establish national goals to reduce those threats. Public and private entities will use the objectives that are developed to prioritize their investments in oral health and dental care projects over the coming decade. The ADA and CAPIR provided written comments on the oral health focus area and continue to monitor the development of HP2020.

**National Primary Oral Health Conference (NPOHC):** A CAPIR volunteer and staff continue to serve on the Board of Directors for the National Network for Oral Health Access (NNOHA) and helped plan the 2009 NPOHC. Dr. Ronald Tankersley, ADA president, addressed the oral health professionals during the opening plenary session. The NNOHA Board has declined to consider a trial co-location of the NPOHC with a future ADA annual session in 2010 or 2011, but there appears to be increasing Board support for such a venture in the future.

**National Oral Health Conference (NOHC):** CAPIR and ADA Department of State Government Affairs (DSGA) staff participated in the planning of the 2010 NOHC, "Pursuing Excellence in Dental Public Health," held in St. Louis on April 24-28. Several ADA-sponsored sessions included: 1) "What you need to know about fluorides and fluoridation," 2) "Demystifying organized dentistry," 3) "The next crisis: Elder oral health care," 4) "National plans to improve health literacy" and 5) "FUTURE SEARCH: Finding common ground while honoring our differences."

There was a roundtable presented on Give Kids A Smile Day activities and expansion plans. Dr. Tankersley addressed the Conference participants before the

third day's opening plenary. CAPIR contributed \$5,000 towards sponsorship of this conference. Additional information regarding the 2010 NOHC will be provided in a supplemental report to the 2010 House of Delegates.

**2010 President-Elect's Conference:** CAPIR participated on an Access to Care panel presentation that provided an "Update on ADA Access" activities, including guest presentations by Dr. Lee Francis, executive director and physician, Erie Family Health Center in Chicago, and Capt. Arlene Lester, regional minority health consultant, Office of Minority Health, Atlanta.

**Supporting Dental Public Health Infrastructure:** CAPIR sponsored the "ABCs of FQHCs," which was a continuing education session presented at the 2009 ADA annual sessions. The program was well received by over 200 audience members and CAPIR will be presenting the course again at both the 2010 and 2011 annual session. The course, "Demystifying Organized Dentistry," was presented at the National Oral Health Conference in April 2010. This session is intended to increase awareness of dental public health professionals about the practical reality of working with and within organized dentistry.

CAPIR provides leadership to the Dental Public Health Workforce Task Force, which is a joint effort among the ADA, the Association of State and Territorial Dental Directors (ASTDD) and the American Association of Public Health Dentistry (AAPHD). This group advocates for greater communication and coordination of efforts in order to enhance the dental public health infrastructure. CAPIR continues to actively participate on ASTDD Leadership and Professional Development, Best Practices, Healthy Aging and Mentoring Committees.

**Public Health Advisory Committee (PHAC):** This newly formed Advisory Committee met for the first time in early fall 2009 and made 13 recommendations to CAPIR which were accepted unanimously by the Council at its January 2010 meeting. The recommendations included: offering educational forums to increase the familiarity of dental public health (DPH) professionals with organized dentistry, working with the Council on Dental Education and Licensure to more fully integrate DPH into all dental school curricula, surveying state entities about successful public health projects, especially those highlighting public/private collaboration, developing talking points about improving the DPH infrastructure to enhance ADA advocacy efforts, appointing a PHAC member to serve on the CDHC evaluation workgroup, developing a DPH orientation for ADA trustees and CAPIR volunteers, working with the Center for Continuing Education and Lifelong Learning to create DPH CE courses, recommending a PHAC member to serve on the ADA Dental Economics Advisory Group, working to ensure that ADA EBD resources are cross-linked with other professional organizations' Web sites, reviewing current ADA policies specific to DPH and making recommendations to create, update or revise as appropriate, and examining the evaluation protocols for other proposed new dental team members and consider whether any design elements should be integrated into the CDHC Pilot Program.

**Cooperative Agreement to Provide Continuing Dental Education Courses:** The ADA and the American Public Health Association (APHA) Oral Health Section (OHS) entered into a three-year agreement to jointly sponsor continuing dental education courses during the APHA annual meeting, with Council representation on the APHA/OHS program planning committee.

**Technical Assistance and Public Outreach:** CAPIR provides technical assistance to diverse audiences (public and private sectors) on a multitude of issues, including: alternative careers, sustainability within dental safety net clinics, federal and state loan repayment options, U.S. Public Health Service Commissioned Corps, accessing dental care, dental practice-based research networks, collaborative practice, health advocacy and policy development, encouraging the adoption of a dental version of the Preventive Medicine Curriculum within U.S. dental and dental hygiene schools and utilizing EFDAs. Presentations specific to issues surrounding access to care and public health infrastructure needs were delivered to the 2009 Lobbyist Conference, the 2010 President-Elect's Conference, the 2010 National Rural Health Association Policy Institute, and HRSA's Bureau of Health Profession's Dimension of Diversity in the Health Professions Regional Meeting.

**American Indian/Alaska Native (AI/AN) Strategic Workgroup:** The AI/AN Strategic Workgroup, authorized by Resolution 27H-2008 (*Trans.*2008:456), met in November 2009, at the headquarters of the Inter Tribal Council of Arizona in Phoenix. The Workgroup adopted the following statement: "The AI/AN Strategic Workgroup recognizes that early childhood caries (ECC) disproportionately and more severely affects American Indian/Alaska Native children. The Workgroup urges the exploration of innovative methods that address ECC as an infectious, communicable disease and acknowledges the need to intervene throughout the age spectrum to eliminate ECC in American Indian/Alaska Native children." The Workgroup recommended that the ADA and AI/AN organizations advocate to health officials to sponsor a multi-federal agency (e.g., IHS, NIH, CDC, OMH, MCHB) workshop to create a coordinated and concerted strategy to eliminate ECC in AI/AN children. Dr. Ruth Bol, secretary/treasurer, Society of American Indian Dentists, also gave a presentation, requesting assistance with membership and resource development.

**Symposium on Early Childhood Caries in American Indian and Alaska Native Children:** CAPIR sponsored this November 2009 Symposium to advance ECC research in Native communities. The proceedings and an accompanying *ADA News* article were released in January 2010. A 2010 Symposium is planned to develop a research agenda to address ECC in Native American children. A core planning group was formed after the 2009 Symposium in response to participants' recommendations that the ADA host a follow-up meeting to allow more time for others to explore in greater detail the many important aspects of ECC in Native American children.

**American Indian/Alaska Native Dental Placement Program:** CAPIR continues to recruit and assign volunteer dentists and dental students to Indian Health Service (IHS) and tribal clinics, including a team of prosthodontists and dental students participating in

the IHS extern program. For summer 2010, students are assigned to White Earth Health Center (MN) and Cass Lake Hospital (MN). Each year, participation in the volunteer dental placement program has increased. In 2009, there were 29 volunteers. The dental clinics that host ADA-sponsored volunteers continue to report favorable experiences with the program.

**Give Kids A Smile:** The Eighth Annual Give Kids A Smile (GKAS) Day took place February 5, 2010. GKAS has become the ADA's signature access to care program with participation this year of nearly 50,000 volunteers, including more than 12,000 dentists and delivering care to approximately 325,000 underserved children. A satellite media tour was broadcast from Nashville. The event received radio and TV coverage in media markets across the country which included 540 radio stations and 169 TV airings to an estimated audience of 19.8 million people. Additionally, hundreds of GKAS news stories appeared in local outlets. The GKAS team continues to work with staff from the Health Policy Resources Center to improve data collection and analysis. Part of the plan to improve the data includes increasing the number of events returning to the GKAS site to input actual event data after the event is completed. As the data is studied, the results will enable the GKAS team to make data driven decisions, which in turn will improve the quality of the program delivery.

A CAPIR representative serves on the GKAS National Advisory Board, which continues to move ahead with taking the program to "More Than Just A Day." A major accomplishment this year has been the development of a plan for a National Oral Health Education Campaign between GKAS and *Scholastic Magazine*. The Campaign includes a multi-year plan to reach and provide oral health education to underserved children in elementary schools, with a primary focus on Title I schools, through book fairs and the Scholastic Read & Rise Program. It has a potential to reach over 70 million students and their families. Other expansion activities will be reported by the ADA Foundation, which oversees the GKAS National Advisory Board.

**Geriatrics and Special Needs Populations:** In response to Resolution 5H-2006 (*Trans.*2006:317) and to advise the Council, three ad hoc advisory committees on elder care advocacy, research, and education were established. In January 2010, the three committees were combined into one Council subcommittee, the National Elder Care Advisory Committee (NECAC) that will serve as a standing committee to CAPIR to provide guidance. NECAC met for the first time April 8-9, 2010, and drafted the following goals: equip dentists with the funding, education and delivery systems necessary to meet the needs of the elderly; enable elders and/or their caregivers to be good stewards and advocates for their own health, including managing disease; improve elder oral health outcomes by building national coalitions and promoting legislative and regulatory reform; and build and transfer the knowledge base needed to improve the oral health of elders.

*Education.* Funding is being sought to support the pilot testing of *Overcoming Obstacles to Oral Health: A Training Program for Caregivers of Adults with Disabilities and Frail Elders*, as CAPIR considers this curriculum to be an appropriate resource to

address Resolution 5H-2006 initiatives. Elder Care Education Committee members provided editorial comment and suggestions to be incorporated into all aspects of the program. Plans are to make these materials available to member dentists as well as other constituencies that seek to improve the oral health of nursing home residents through systematic facility-driven preventive programs. The program must be compatible to various state dental practice configurations for it to be useful to the membership.

*OralLongevity.* Working collaboratively with the Middle East Section of the International College of Dentists, an Arabic translation of the OralLongevity DVD/brochure has been completed for distribution to dental associations in the Arab East and through them to dental schools, social welfare groups, non government organizations, etc. The National Institute of Health has requested the use of footage from the OralLongevity videos for the upcoming periodontal disease topic on the NIHSeniorHealth Web site, NIH's senior-friendly health and wellness Web site. Discussions continue regarding the creation of a new collaborative agreement with GlaxoSmithKline and continuation of the OralLongevity program.

*Advocacy.* Resolution 5H-2006 underscores the importance of persuading legislators and regulators at all levels of government to make vulnerable elders' oral health a priority through increased funded legislation for care, education and research. The Special Care Dentistry Act, which mandates dental coverage of Medicaid-eligible persons who are aged, blind or disabled, has sponsorship and will be introduced into the 111<sup>th</sup> Congress. CAPIR will host "Oral Health of Vulnerable Older Adults and Persons with Disabilities: A National Coalition Consensus Conference" in November 2010 to establish a broad and sustainable coalition of stakeholders committed to improving oral health of older adults and persons with disabilities.

Elder Care Advocacy Committee volunteers, Drs. Paul Glassman and Mike Helgeson, presented at the October 5, 2009, American Health Care Association (AHCA) annual session. AHCA represents the professionals serving 11,000 long-term care facilities in the nation.

*Research.* The goal of Resolution 5H-2006 is to build and transfer the knowledge base needed to improve the oral health of vulnerable elders by generating, funding and supporting studies. Four manuscripts are being developed at dental schools at the University of Iowa, Boston University, New York University, and University of Texas, on root caries treatment, salivary dysfunction, root caries epidemiology, and elder care access, respectively. This effort was initiated by reaching out to training programs in geriatric dentistry, oral epidemiology and public health dentistry. Program directors were asked to consider working with one of their fellows/residents to perform and publish a critical review of the literature in one of the areas specified above. Targeted, comprehensive literature searches were provided to academic teams at these institutions by the Elder Care Research Committee to foster the development of publications on elder care oral health issues to benefit dentists providing care to older adults. Support of scholarly activity is expected from faculty at the academic institution

with the offer of additional guidance from ADA volunteer experts. This mechanism was chosen to foster scholarly research and publication, as well as develop dentists with in-depth knowledge of vulnerable elderly that are critically needed in the workforce to assist dentists in succeeding throughout their careers. Furthermore these manuscripts will help inform and educate members on issues related to managing disease in the vulnerable elderly.

*National Foundation of Dentistry for the Handicapped (NFDH).* The NFDH is a charitable affiliate of the ADA and is committed, through collaboration, to arrange comprehensive dental treatment and long-term preventive services to needy disabled, elderly or medically compromised individuals through a national network of direct service programs that involve more than 14,000 volunteer dentists and 2,800 volunteer laboratories. CAPIR provides liaison to NFDH, attending semi-annual board meetings and providing technical assistance regarding promotion of the Donated Dental Services (DDS) program through the Council's Geriatric and Special Needs Population program area.

**National Advisory Committee on Health Literacy in Dentistry:** The 2009 House of Delegates reauthorized the Council's Ad Hoc Advisory Committee on Health Literacy in Dentistry (*Trans.*2009:415; 419). The Committee met in April 2010 to continue its development of the action plan to improve health literacy, recommending goals and objectives related to five focus areas: 1) Training and Education, 2) Advocacy, 3) Research, 4) Dental Practice and 5) Build and Maintain Coalitions. Specific activities will be developed and implemented during the course of the plan, with major support coming from external sources. In 2010, the ADA President appointed two new members to the committee, Capt. Arlene Lester and Linda Neuhauser, Dr.P.H. The Advisory Committee will meet again in autumn 2010.

*Education and Outreach.* Council staff gave a presentation about CAPIR's 2010-2015 health literacy in dentistry action plan and the U.S. Department of Health and Human Services' draft "National Action Plan to Improve Health Literacy" during the March 2010 Council on Adult Basic Education (COABE) and ProLiteracy National Conference in Chicago. The CAPIR Vice Chair, Ad Hoc Advisory Committee members and staff gave a panel presentation during the November 2009 APHA annual meeting about the Council's health literacy survey of dental team members and CAPIR's 2010-2015 health literacy in dentistry action plan. Council staff was invited to give a poster presentation during the May 2010 Institute for Healthcare Advancement (IHA) National Health Literacy Conference about CAPIR's 2010-2015 health literacy in dentistry action plan. CAPIR consulted with the American Medical Association Foundation (AMAF) regarding the development, implementation and evaluation of the AMAF's health literacy toolkit to determine whether any of the AMAF's strategies might be replicated in the ADA's efforts to improve health literacy. CAPIR is invited to participate in the 2010 American College of Physicians' stakeholder meeting, an invitational conference to address the impact of low health literacy on health care quality. The meeting is co-sponsored by the Agency for Healthcare Research and Quality and the National Quality Forum.

Additional information regarding oral health literacy activities will be provided in a supplemental report to the 2010 House of Delegates.

### **Community Dental Health Coordinator (CDHC) Activities and Trends**

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**CDHC Update:** The rural and Native American CDHC pilot training programs at the University of Oklahoma School of Dentistry and the University of California Los Angeles were launched in March 2009 with 12 trainees beginning their online training. These trainees have completed their didactic portion of the curriculum and are entering their six-month internship phase of their training. In March 2010, a second cohort of 18 students (six per site) commenced their training; this group includes six new students from Temple University in Philadelphia, the urban pilot site selected for the project.

Work continues on the design of the Pilot Program's evaluation component. Efforts to identify companies and foundations that potentially could provide support for the CDHC project also continue. A supplemental report regarding the CDHC project, including a response to Resolution 39H-2008 (*Trans.*2008:429), Financial Support for CDHC Model, will be prepared for the 2010 House of Delegates.

### **Response to Assignments from the 2009 House of Delegates**

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**Tobacco Free Schools:** Resolution 13H-2009 (*Trans.*2009:415; 419) calls for the ADA to support the adoption of tobacco-free school laws or policies that incorporate the guidelines developed by the Centers for Disease Control and Prevention for school-based health programs to prevent tobacco use and addiction. Implementation of this policy is ongoing and has been partially accomplished through several venues. A Web page containing resources related to Tobacco Free Schools was established on ADA's Web site. This new policy was promoted via stories in *ADA News* and at the National Consortium on Tobacco Use Prevention through Schools and National Coordinating Committee on School Health and Safety annual meetings. Staff also participated in a continuing education program at the 2010 Chicago Midwinter Meeting which highlighted this policy.

**2010 Follow-up Medicaid Provider Symposium:** Resolution 42H-2009 (*Trans.*2009:415; 419) calls for a follow-up symposium to explore various business models and existing best practices for successfully incorporating Medicaid and SCHIP patients into a private practice. CAPIR volunteers, in conjunction with their peers on the Council on Government Affairs and the Council on Dental Practice, identified one individual from each district to participate in the Symposium, which will identify common elements and best practices for successfully integrating Medicaid and SCHIP recipients into private dental practices, while maintaining fiscal viability. The ADA Health Policy Resources Center (HPRC) developed an electronic survey of quantitative and qualitative elements to gather information before the July 12-13 Symposium. Additional information regarding the Follow-up Medicaid Provider Symposium will be provided in a supplemental report to the 2010 House of Delegates.

**Ad Hoc Advisory Committee on Health Literacy in Dentistry:** Resolution 43H-2009 (*Trans.*2009:415; 419) reauthorized the ad hoc advisory committee on health literacy in dentistry to assist the Council on Access, Prevention and Interprofessional Relations in the implementation of its five-year strategic action plan, development of policy recommendations, targeted educational strategies and other health promotion programs and activities to improve health literacy. Please see the section of the Council's report titled, "National Advisory Committee on Health Literacy in Dentistry," on page 24.

**Policy on Obesity:** Resolution 47H-2009 (*Trans.*2009:415; 420) calls for the ADA to collaborate with other health professionals to combat the growing problems of overweight and obesity. Implementation of this policy is ongoing and largely accomplished in collaboration with the Department of State Government Affairs as the ADA works to support nutrition initiatives at the federal level, including but not limited to, support for the reauthorization of the Child Nutrition Act of 1966, which includes Women, Infants and Children; support for the Healthy, Hunger-Free Kids Act of 2010 and collaboration with the Interagency Working Group on Food Marketed to Children.

**Resolutions:** This report is informational and no resolutions are presented.

## Council on ADA Sessions

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**Carstensen, Stephen W.**, Washington, 2010, chair  
**Albert, Jeremy M.**, Florida, *ex officio*\*  
**Bertagni, Hugo F.**, Illinois, 2013  
**Blicher, Michael M.**, Washington, D.C., 2013  
**Dubin, Gary K.**, Connecticut, 2010  
**Dunn, Mary Beth**, New York, 2010  
**Fussell, Randy G.**, North Carolina, 2012  
**Heier, Ronald K.**, Pennsylvania, 2011  
**Hendrickson, Gregg C.**, Nevada, 2011, *ex officio*  
**Huberty, Mark C.**, Wisconsin, 2012  
**Laing, Kevin M.**, Ohio, 2011  
**Lee, William E.**, Kentucky, 2013  
**Martin, Risé L.**, Texas, 2010  
**McCorkle, Hutson E.**, Florida, 2011  
**Nofsinger, Roger B.**, Florida, 2010, *ex officio*  
**Okano, David K.**, Wyoming, 2012  
**Peppes, Gregory J.**, Kansas, 2013  
**Percy, Kent H.**, Georgia, 2012  
**Remes, Michael C.**, Minnesota, 2011  
**Rounsavalle, Richard K.**, California, 2012  
**Mills, Catherine H.**, director

**The Strategic Plan of the American Dental Association:** At the May 2007 Council on ADA Sessions meeting, the Council elected to update its Vision & Mission Statements to provide better direction and focus for the Council.

**Vision Statement:** The Council on ADA Sessions holds the primary responsibility to create and continuously improve every aspect of the ADA annual session, to attain and maintain the stature of being the premier meeting in the worldwide dental community.

**Mission Statement:** The Council on ADA Sessions (CAS) is the Association agency that serves ADA members and the worldwide dental community by providing valuable professional, educational and social experiences, ultimately to benefit the patients they serve.

The CAS provides recommendations to the ADA's policymaking bodies on ADA annual session programs and related activities. It oversees the development of programs and supports related efforts in the areas of community building, member recruitment and retention, continuing education, exhibits, logistics and local arrangements. The Council is also charged with maintaining the annual session as a

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\* Committee on the New Dentist member without the power to vote.

revenue source for the ADA in a manner consistent with the strategic plan of the organization.

The Council continues to identify action plans to connect with and support various goals and objectives of the ADA Strategic Plan, it has established criteria for measuring success and has evaluated the effectiveness of its activities using those criteria. The Council on ADA Sessions has reviewed and identified primary and secondary goals and objectives of the *ADA Strategic Plan: 2007-2010*. As a result of this review, the Council has also revised their “Guiding Principles, Values & Beliefs” statement as follows:

The Council on ADA Sessions believes that:

1. Attending the annual session provides a unique and rewarding experience that will increase the Association’s value to the profession.
2. Member involvement in ADA activities through service on this Council and/or the volunteer corps for the annual session will promote a positive view of the value of ADA membership. This will aid in improving market share through sharing between member and nonmember dentists.
3. Keeping the ADA annual session as the premier dental meeting sets the culture in the entire membership that lifelong learning and a continuous advancement of knowledge is a critical value.
4. The annual session provides the best opportunity for the dental profession to keep abreast of the latest advances in the science and practice of dentistry, the materials and equipment available, and the value of professional collaboration.
5. The annual session helps every member dentist by maximizing non-dues revenue in an appropriate manner.
6. Survey results and data mined from our work will assist ADA policy makers as they seek to maintain excellence in and improve all operations of the Association.
7. The Council strives to provide “Wow Customer Service” to all annual session attendees.

### **150th Annual Session, Honolulu, Hawaii, September 30-October 4, 2009**

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**ADA 09 Honolulu:** The ADA’s 150th Annual Session and Technical Exhibition was held at the Hawaii Convention Center under the direction of the Council on ADA Sessions. Registration for the meeting was 24,568 total attendees. There were 8,087 dentists at the meeting, totaling 33% of all meeting registrants. Attendees registered via the following methods: 85% pre-registered online; 1% pre-registered by mail; 3% pre-registered by fax and 5% registered on-site.

In an effort to attract nonmembers to the annual session, the one-time reduced registration fee was continued for nonmember attendees who did not take advantage of this offer from 2005-2008. This reduced registration fee was \$75 (regularly \$750). As a result of this reduced fee, 266 nonmembers attended the annual session. A workgroup made up of staff from the ADA’s Council on Membership and Council on ADA Sessions

worked to implement several unique membership recruitment and retention programs including follow up with these nonmembers during the annual session registration cycle.

The Honolulu annual session drew many first-time attendees and featured a First-Time Attendee Orientation Center, which provided concierge style service to nonmembers and first-time attendees at the meeting.

The Hawaii Dental Association was most helpful in making the meeting a success by hosting the 2009 CLA micro site, which helped the Committee on Local Arrangements in the recruitment and management of close to 450 volunteers. Of these volunteers 72% were local and 28% were from the mainland. Three hundred twenty-five volunteers were from Hawaii and of that number, 185 were Hawaii Dental Association dentists. One hundred twenty-five volunteers were from the mainland and of this number, 91 were ADA member dentists.

The American Dental Assistants Association (ADAA) again met in conjunction with the ADA annual session and over 2,523 dental assistants registered for the annual session. The Marriott Waikiki served as headquarters for the ADAA House of Delegates, which met October 1-3. Other highlights of the ADAA meeting included the ADAA Foundation's silent auction and the ADAA President's Gala.

## **2009 Education Overview:**

*Attendance Review.* There were 184 courses available to the 24,568 attendees of the meeting; 42 (23%) of the courses were hands-on workshops, 6 were live patient Education in the Round, and 136 were lectures. Specifically, details of attendance include:

- 32,584 CE seats were occupied during the week.
- Each dental professional took an average of 2.5 courses.
- Of the 32,584 reserved seats, 21,250 (65%) were for no-fee lectures, 10,153 (31%) were for fee courses, and 1,181 (4%) were for fee workshops.
- 85% of all seats in workshops were sold.

*Education in the Round.* This was the third year for the live-patient courses. New for 2009, a live Web cast was made available for free to all North American Dental Students and Faculty. Attendees could watch the courses and interact live with the speakers in Hawaii. Forty-three of the schools took advantage of this opportunity.

*Live Operatory Center.* Two thousand and nine was the second year of the ADA's Live Operatory Center (LOC), where attendees could earn up to ten hours of free continuing education (CE) on the exhibit floor. This high tech environment is the first of its kind in the dental meeting arena and allowed attendees to be exposed to the latest technology and products on the market. This cutting edge, live-patient center was divided into distinct educational disciplines, including: The CAD CAM Pavilion and the 150 Products Stage. In addition the Council on ADA Sessions launched two new

professional competitions in the LOC, the Adult Preventive Practice of the Year Competition, and the Education Exchange Competition.

*ADA 365.* The annual session online networking community, ADA 365, expanded opportunities for attendees of the 2009 meeting. New for 2009, attendees were able to earn pre-course self study CE for 40 of the in-person courses in Hawaii. Attendees read papers submitted by the speakers before arriving in at the meeting and completed an assessment online. In addition, on a course by course basis, attendees were able to:

- Network with fellow attendees
- Participate in online discussion forums and message boards
- Research dental procedures, products, and issues important to their practice
- Create personal profiles and upload their picture
- Share personal stories and experiences
- Access video lectures, additional readings, and other supplemental course materials

*Educational Tracks.* In 2009 educational tracks were developed specifically for new dentists and dental assistants. In addition, tracks were developed on topics including: esthetic dentistry; team building; and prevention.

*Programs.* Workshops on topics including pediatric dentistry, occlusion/TMD, dental assisting, endodontics, and prosthodontics. Practice management courses included career transitions, customer relations, e-mail and Web marketing, health and wellness, career/life planning and diet/fitness.

Courses were presented in collaboration with ADA divisions and councils including the Council on Access, Prevention and Interprofessional Relations, Council on Dental Benefit Programs, Council on Dental Practice, Council on Dental Education and Licensure, Continuing Education and Lifelong Learning, Committee on International Development and Affairs, Council on Members Insurance and Retirement Plans, Committee on the New Dentist, Council on Scientific Affairs, and ADA Insurance Plans.

In addition, courses were presented in cooperation with the following organizations: American Dental Assistants Association, American College of Prosthodontics, American Association of Orthodontics, American Academy of Periodontology, American Association of Oral and Maxillofacial Surgeons, Academy of Laser Dentistry, American Academy of Sleep Medicine, and the American College of Dentists.

**ADA/DENTSPLY Student Clinician Research Program:** The student clinician research program, which celebrated its 50th anniversary in Honolulu at the 2009 annual session, is conducted annually by the Council on ADA Sessions and is financially supported by DENTSPLY International, Inc., York, PA.

On Saturday, October 3, at the Hawaii Convention Center, the American Dental Association and DENTSPLY International hosted the 50<sup>th</sup> Annual Student Clinician Research Program. Fifty-four U.S. student clinicians representing 52 dental schools and 15 International student winners of the DENTSPLY International Program presented their poster presentations from 1:00-3:00 p.m. at the Hawaii Convention Center.

The winners of the 2009 ADA/DENTSPLY Student Clinician Research Competition were:

Winning students in Category I: Clinical Science / Public Health Research were: First place, Todd W. Walker, Tufts University School of Dental Medicine; Second place, Nicholas D. Wilson, University of Colorado Denver School of Dental Medicine; Third place, Casey Jones, Arizona School of Dentistry & Oral Health.

Winning students in Category II: Basic Science Research were: First place, Jeremy Zuniga, Columbia University College of Dental Medicine; Second place, Anna Kreymer, University of California at Los Angeles School of Dentistry; Third place, Neil Robertson, University of Pittsburgh School of Dental Medicine.

The judges of the 2009 ADA/DENTSPLY Student Clinician Research Competition were:

Judges for Category I: Clinical Science / Public Health Research were: Dr. Janet L. Harrison, Memphis, TN; Dr. Theresa E. Madden, Portland, OR; Dr. Dan G. Middaugh, Seattle, WA; Dr. O. Jack Penhall, Greensburg, PA, *Chair*; Dr. John S. Rutkauskas, Chicago, IL; Dr. Alex C. Salinas, San Antonio, TX; Dr. Arturo Santiago, Guaynabo, PR; Dr. Ole Marker, Denmark; Dr. David L. Vorherr, Cincinnati, OH

Judges for Category II: Basic Science Research were: Dr. Raymond A. Dionne, Jr., Bethesda, MD; Dr. Rekha C. Gehani, Jackson Heights, NY; Dr. Sharon M. Gordon, Baltimore, MD; Dr. Takashi Komabayashi, West Hartford, CT; Dr. Mirdza E. Neiders, Buffalo, NY; Dr. Rahele F. Rezai, Washington, DC; Dr. Rada Sumareva, New York, NY; Dr. Jon B. Suzuki, Philadelphia, PA; Dr. Richard Carlos Tatum, Columbia, MD, *chair*; Dr. Thomas Van Dyke, Boston, MA

**Exhibition:** The ADA Marketplace featured 881 booths from more than 374 companies during a three-day exhibition period. The exhibition took place in Halls I-III of the Hawaii Convention Center.

The exhibit hall schedule was revised from normal hours to accommodate the program schedule change. This was due to the time change issues. The hall was open between the hours of 7:30 a.m. to 3:30 p.m.

In addition to the exhibits, other ADA programs featured in the exhibition hall included:

- The Live Operatory Center which featured live CAD/CAM demos, High Tech Product Stage featuring 150 products, and the Competition Hub.
- The International Pavilion which clustered approximately 20 international manufacturers together into one area of the hall.
- The annual session tote bags sponsored by Novalar were distributed at stations located strategically around the exhibit hall.
- Super Sweepstakes, the most visible traffic building program, encouraged attendees to visit five participating exhibitors in order to enter the drawing for a daily trip for two to the 2010 annual session in Orlando. In addition, a grand prize of \$5,000 cash was awarded.
- The Exhibit Hall Closing Party was held in an effort to attract attendees back to the exhibition hall during the last three hours of the exhibition. The event celebrated the ADA 150<sup>th</sup> Anniversary with cake and champagne punch.
- The ADA Photo Souvenir Stage featured a green screen backdrop of a toothbrush surfboard and Hawaiian dancers. There were approximately 3,000 photos taken over three days.
- The ADA sold box lunches to attendees prior to the meeting and these were distributed from the restaurant areas in the exhibit hall. Almost 3,500 lunches were sold.

**Special Social and Entertainment Events:** Socializing and networking added to the excitement of this year's annual session.

*ADA General Sessions featuring the Johnson & Johnson Distinguished Speaker Series.* The 2009 general session and Distinguished Speaker Series (DSS) took place on Wednesday, September 30, 2009, at the Waikiki Shell. The Distinguished Speaker Series was underwritten in part by the ADA Foundation through a donation from Johnson & Johnson Oral Health Products.

The opening general session helped highlight the ADA's celebration of its 150<sup>th</sup> Anniversary. During the DSS, the ADA 2009 Humanitarian Award was presented to Robert N. Kinsaul, D.M.D., who has dedicated over 33 years of his life to serve the oral health needs of thousands of individuals without access to care in over 25 countries. The presentation of the award featured a video highlight of Dr. Kinsaul's work. The distinguished speaker was Mr. Sidney Poitier who delivered a truly inspirational message based on vignettes of his life starting as a poor boy from the Bahamas to the man he has become today. In life, said Mr. Poitier, "*it doesn't matter how many times you've been knocked down – it's how you spend your time when you get up.*" This presentation received some of the best feedback from attendees the DSS has ever had, it was one of the best attended general sessions with approximately 6,900 people in attendance who gave Mr. Poitier a standing ovation.

*Evening Entertainment /150<sup>th</sup> Celebration Event.* The featured entertainment for 2009 was the ADA's An Evening Under the Stars at the Waikiki Shell; an outdoor theater at the base of Diamond Head. The event took place on Friday, October 2, 2009, and it was a custom created, spectacular event featuring seven Polynesian cultures. The

evening included hands-on activities, entertainment, refreshments and plenty of live music. This event was the culmination of a year-long celebration of the ADA's 150th anniversary. The event featured over 100 local performers. Hawaii was tremendously thankful that so much local entertainment was utilized; which is not generally the case with visiting groups. The finale song was written especially for the ADA's 150th Anniversary and attendees were able to download it after the event on the ADA's Web site.

*ADA Presidential Gala.* The Presidential Gala honored ADA President Dr. John Findley. In addition to the dinner for 820 attendees, the event featured Paradise and Company, Oahu's premier entertainment band. Guests enjoyed the expansive repertoire of hits while dancing and visiting with friends and colleagues throughout the evening.

*ADA/AADA "Brunch at Sunset Station".* The annual AADA brunch was held at the Moana Surfrider Hotel. Proceeds subsidized the AADA's Foundation for Dental Health Education, which provides grants for community-based dental health education programs.

*Related Events.* Meetings and social events were sponsored by 22 dental school alumni groups, one dental fraternity, one military organization and 26 academies, specialty and allied organizations.

*Hospitality Lounges and Cocktail Parties.* Special lounges and cocktail parties were hosted for clinicians, exhibitors, international dentists, retired members and students.

*House of Delegates.* ADA's chief legislative body met on Friday October 2, Monday October 5, and Tuesday October 6, at the Hawaii Convention Center. The Reference Committees convened on Saturday, October 3, at the Hilton Hawaiian Village. Members had a chance to see how ADA policies and programs are all determined and participate in the democratic process.

*Housing, Registration and Transportation.* ADA selected 40 hotels as official meeting hotels. Shuttle bus transportation was provided from the ADA official hotels to the convention center.

**Additional Services:** The annual session offered additional services:

- Internet Café and Wi-Fi Lounge
- ADA Store – offering the Association's latest products and publications along with branded gift items
- Publicity for upcoming regional and national meetings
- ADA Pavilion to promote ADA benefits and services
- Four special *ADA News Convention Dailies* highlighting each day's events

Registration and housing for the 2010 annual session in Orlando was made available in Honolulu and over 896 people pre-registered. Dr. Roger Nofsinger, general chair, Committee on Local Arrangements, along with members of the 2010 Committee on Local Arrangements, was on hand to answer questions and promote the meeting in Orlando, Florida.

## **151<sup>st</sup> Annual Session, Orlando, Florida, October 9-12, 2010**

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**ADA10 Orlando:** The 151<sup>st</sup> Annual Session will take place at the Orange County Convention Center in Orlando. The schedule of events will be:

Opening General Session: October 9  
Continuing Education: October 9-12

World Marketplace Exhibition: October 9-11  
House of Delegates: October 9-13

The Orange County Convention Center will set the stage for what promises to be an exciting meeting. The convention center complex will house the entire scientific program, workshops and Marketplace Exhibition under one roof with the House of Delegates taking place in the Hilton Orlando, the ADA's headquarter hotel.

**ADA World Marketplace Exhibition:** At the conclusion of the 2009 annual session, 52% of the show floor for Orlando was rented. In the past the approximate amount sold onsite was 75% based on 650 appointments. Because of the reduced amount of exhibiting companies in Hawaii, there were only about 350 appointments scheduled. This 52% sold includes most of our larger companies that purchase multiple booths. The remainder of the space will need to be sold to companies who are purchasing smaller booths. Companies that downsized in 2009 are not returning to their 2008 booth size. This creates a challenge in continuing to increase space sales each year. The ADA needs to continue to concentrate on sales and services for the smaller exhibitors as well as market to new exhibitors.

**General Sessions and Distinguished Speaker Series:** One General Session and keynote addresses (ADA Distinguished Speaker Series) is scheduled for Saturday, October 9. The General Session is designed to update attendees on key ADA activities, increase members' sense of the dental community, and to help facilitate spending time socially with colleagues, staff and family. Included in the session will be the Distinguished Speaker Series featuring Malcolm Gladwell, acclaimed author of three #1 *New York Times* bestsellers including *Tipping Point*, *Blink* and *Outliers*.

**2010 Education Overview:** Over 245 courses will be a part of the 2010 Scientific Program. Some highlights include:

*Education in the Round.* This will be the fourth year for this educational format, a live patient demonstration that is an interactive, multimedia, learning experience, augmenting the need for hands-on workshops. New for 2010, all six of the EIR courses

will be available as a live Web cast to every ADA member who is unable to attend the annual session. Members will be able to watch and interact live with the courses for free and the courses will be available for 30 days after the meeting. In addition, participants will be able to log into the ADA's Online CE Web page and continuing education (CE) for these courses.

*Live Operatory Center.* For the third year, the annual session will feature free CE on the exhibit floor in the LOC. In 2008, this high tech environment was the first of its kind in the dental meeting arena and allowed attendees to earn up to 3.5 hours of CE credit for their attendance in three disciplines, while being exposed to the latest technology and products on the market. In Orlando, attendees will be able to earn up to 24 hours of free CE in the LOC. New features include live patient scans in the 3D Imaging Center and the Technology Expo.

In order to better encompass all that is taking place in the LOC this year and how it has evolved over the past few years, it will undergo a name change for the 2010 annual session – *Learn Optimize Connect* – still keeping with the acronym LOC.

*Competition Hub.* In 2010, the ADA will host four competitions on the exhibit floor, allowing attendees to earn free CE. The competitions include the Matsco Dental Office Design Competition; Education Exchange Competition and the Adult Preventive Care Practice of the Year Competition and the DENTSPLY Student Clinician Research Program.

*ADA 365 (The annual session online networking community).* In 2010, attendees will be able to earn an additional hour of self-study CE for 44 of the in-person courses. In addition, on a course by course basis, attendees will be able to:

- Network with fellow attendees
- Participate in online discussion forums and message boards
- Research dental procedures, products, and issues important to their practice
- Create personal profiles and upload their picture
- Share personal stories and experiences
- Access video lectures, additional readings, and other supplemental course materials

*Educational Tracks.* The 2010 Scientific Program will feature 12 educational tracks designed specifically to enhance the attendee experience. New tracks for this year include ones on geriatric dentistry, leadership, professional development, ones conducted in both Spanish and Portuguese for international attendees and the Open Science and Clinical Forums developed in collaboration with JADA and CSA. Additional tracks include: ones for new dentists, federal dentists and dental assistants; as well as tracks based on esthetic dentistry, team building, preventive care.

*Programs.* Special courses will be presented in cooperation with the American Dental Assistants Association, American Association of Endodontists, American Academy of

Pediatric Dentistry, the American College of Prosthodontics, the American Association of Orthodontics, the American Academy of Periodontology, the American Association of Oral and Maxillofacial Surgeons, the Academy of Laser Dentistry, and American Academy of Sleep Medicine. Courses presented in cooperation with other ADA divisions will include Council on Access, Prevention and Interprofessional Relations, Council on Dental Benefit Programs, Council on Dental Practice, Council on Dental Education and Licensure, Continuing Education and Lifelong Learning, Committee on International Development and Affairs, Council on Members Insurance and Retirement Programs, Committee on the New Dentist, Council on Scientific Affairs, and ADA Insurance Plans.

**ADA/DENTSPLY Student Clinician Research Program:** This year marks the 51<sup>st</sup> year of the program. In 2008, the program was reformatted to better mirror medical research presentations, in the format of the American Association of Dental Research. This year in Orlando, the students will make their poster presentations to the public on Saturday, October 9, 1:00 to 3:00 p.m. the first day of the annual session meeting.

Complete annual session information including continuing education, registration and housing, and entertainment is available online at <http://www.ada.org>

**Meetings:** The Council met at the Hilton Orlando in Orlando, February 18-20, 2010 and at the ADA Headquarters Building in Chicago, May 20-22, 2010.

**Personnel:** Dr. Stephen W. Carstensen has served as Council Chair for the 2009-2010 terms with Dr. Risé L. Martin serving as 2010 Program Chair.

**Acknowledgments:** The Council wishes to express its appreciation to Dr. Roger B. Nofsinger, general chair of the 2010 Committee on Local Arrangements for his assistance in the planning and production of the 2010 annual session meeting and for his many useful contributions to all of the Council's deliberations during his tenure. The Council also wishes to thank those who capably assisted the Committee's activities related to the 2010 annual session. Most importantly, the Council thanks the 2010 Committee on Local Arrangements for their valuable assistance in the production of the annual session and they were: Dr. Michael G. McCorkle, vice chair; Dr. Timothy M. Lane and Dr. Jeffrey J. Sevor, Program co-chairs; Dr. John G. Lee and Dr. Robert D. Pellarin, Registration co-chairs; Dr. Kathryn E. Miller and Dr. Charles H. Schmitt, Hospitality co-chairs.

The Council also expresses its sincere appreciation to the entire Florida Dental Association for their support of this year's ADA annual session. Without the assistance and cooperation of these individuals and organizations, the 2010 annual session would not have been possible.

The Council wishes to recognize those of its members who will be completing their terms on the Council at the conclusion of the 2010 annual session, they are: Dr. Stephen W. Carstensen, Dr. Gary K. Dubin, Dr. Mary Beth Dunn and Dr. Risé L. Martin.

The Council also would like to recognize the contributions made by Dr. R. Wayne Thompson, Board of Trustees liaison, Dr. Jeremy M. Albert, Committee on the New Dentist liaison and Dr. Michael C. Meru, ASDA liaison who served on the Council on ADA Sessions during 2010. The Council will miss all of them and wish them all the best in their future endeavors.

**Resolutions:** This report is informational in nature and no resolutions are presented.

## Council on Communications

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**Green, Edward J.**, Georgia, 2010, chair  
**Kolling, Josef N.**, Michigan, 2011, vice chair  
**Brown, W. Carter**, South Carolina, 2012  
**Elliott, Anita W.**, Arizona, 2012  
**Gellert, Jonathan R.**, New York, 2011  
**Giannini, Eugene T.**, District of Columbia, 2011  
**Johnson, J. Michael**, Kentucky, 2013  
**Jones, Krista M.**, Oklahoma, 2013  
**Nase, John B.**, Pennsylvania, 2013  
**Nielson, David L.**, Alaska, 2010  
**Olinger, Thomas J.**, California, 2012  
**Perrino, Thomas J.**, Ohio, 2010  
**Poteet, Sarah**, Texas, *ex officio*\*  
**Ray, Pamela S.**, Texas, 2012  
**Reardon, Gayle T.**, South Dakota, 2010  
**Shenkin, Jonathan D.**, Maine, 2013  
**Starsiak, Mary A.**, Illinois, 2011  
**Wunderlich, Hugh T.**, Florida, 2012  
**Williams, Leslee**, director  
**Hall, Lydia**, manager

**The Strategic Plan of the American Dental Association:** The Council on Communications (CC) continues to address the *ADA Strategic Plan: 2007-2010* Goal: Achieve Effective Advocacy, through its strategic communications activities. The Council is the primary agency dedicated to advising the ADA on the image and brand implications of ADA plans, programs, service and activities in order to preserve and enhance the trusted image of the ADA and the profession.

In accordance with the *ADA Bylaws*, the Council also maintains the strategic communications plan for the ADA and serves as a communications resource to other ADA agencies. As part of the Council's bylaws duties approved by the 2006 House, the Council developed the ADA Strategic Communications Plan, which the ADA Board approved in July 2007 and transmitted to the ADA House later that year (*Supplement 2007:3023*). The goals of the plan are closely tied to the *ADA Strategic Plan: 2007-2010* and, along with the ADA brand strategy, can be used as a resource to guide decision making and help guide the communications strategy of the ADA. In 2010, the Council chair appointed a workgroup to begin updating the ADA Strategic Communications Plan to align with the ADA's 2011-2014 Strategic Plan once it is finalized. The workgroup members are Council vice chair Dr. Josef Kolling and Dr. Jonathan Shenkin. The Council's 2010-11 vice chair, who will be elected at the Council's June meeting, will also serve on the workgroup.

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\*Committee on the New Dentist member without the power to vote.

In 2010, the ADA created a new centralized Division of Communications and Marketing that will provide the structure to better enable the Council to discharge its mission and bylaws. Departments in the new division are: Public and Professional Communications; Electronic Media; Marketing and Brand Management; and Public Affairs.

**Council on Communications Liaison Program:** The liaison program, which began as a two-year pilot with Resolution 27H-2006, (*Trans.*2006:309), and established as an ongoing program with Resolution 30H-2008 (*Trans.*2008:490), enables CC representatives to attend host council meetings in order to identify communications issues and provide input to the host councils on their projects, programs or issues that have the potential to impact the public image of the ADA.

At a January 2010 meeting preceding the full Council meeting, CC liaisons to the Council on Access, Prevention and Interprofessional Relations (CAPIR), the Council on Dental Practice, the Council on Government Affairs (CGA), the Council on Membership (CM) and the Council on Scientific Affairs (CSA) recommended that the CC consider focusing its communications efforts on the following issues most-often cited in the liaison reports: access to oral health care, which would include the Community Dental Health Coordinator pilot project, oral health literacy and health care reform; oral health initiatives such as Give Kids A Smile, National Children's Dental Health Month and oral health literacy; and programs and issues that affect the image of dentistry such as the Smile Healthy Program and evidence-based dentistry. After a strategic discussion at one of the CC's meetings, the Council agreed that those were the three communications priorities on which the ADA should focus in 2010 and that staff can implement on a tactical level.

**Community Dental Health Coordinator (CDHC) Communications Committee:** The CDHC Communications Committee was designed to create a communications strategy to raise awareness of the CDHC program and how the new dental team member, through a prevention model, can aid in improving access to oral health care in underserved areas. The communications strategy is aimed at multiple audiences, most notably to ADA members, industry leaders, policymakers, and, to a lesser extent, the general public. The communications efforts are designed to better position the ADA as a leader in advocating for the oral health of all Americans and as an innovator in helping deliver care to those who lack it and most need it. Since its creation, the CDHC Communications committee has overseen the creation of a CDHC Communications Plan, which includes a communications toolkit to facilitate educational presentations about the CDHC program to multiple audiences.

The Council strongly believes that access to oral health care is a significant issue that can affect the ADA's reputation with its members, legislators and the public at large. Access to oral health care is a complex, multi-faceted problem and the issues of inadequate funding of public programs, oral health literacy, health status, geography, health behaviors, and socioeconomic status are all access determinants that must be considered to adequately address the problem. Therefore, the Council welcomed the

invitation from the chair of CAPIR to nominate a CC member to serve on the CDHC Communications Committee, a subgroup of the CDHC Workgroup, which is under the purview of CAPIR. Dr. Mary Starsiak, current CC liaison to CAPIR, was nominated along with new CC member Dr. Krista Jones to serve on the CDHC Communications Committee. CAPIR accepted both nominations.

**Access Communications:** The CGA is one of five host councils with a CC liaison. Following the January CGA meeting, the Chair sent a letter to the CC Chair asking for the Council's assistance in developing an access to oral health care communications strategy. The idea is to educate lawmakers and other influentials about the great breadth of factors affecting access to care, to foster the understanding that changes in the dental workforce alone will not have a substantive effect.

The CC Chair welcomed the opportunity to collaborate, and noted the challenge involved in trying to focus policymakers on proven solutions, such as reforming and adequately funding programs such as Medicaid. The CC Chair noted that a large amount of focus group research on workforce proposals, conducted under the State Public Affairs program has shown that once people become interested in a midlevel provider concept, it is difficult to shift their attention to other access to care proposals. Developing and testing messages is important, however the messages must support a strategy that state dental societies believe will change the behavior of people who make and influence policy decisions. A number of state dental associations have utilized the public affairs resources available through the ADA's State Public Affairs program to develop such strategies.

The CC Chair noted that as the nation's leading advocate for oral health, it is important for the ADA to dispel myths and advocate for policy that will help improve access to oral health care. To organize and begin testing what the ADA believes are credible, effective messages on the issue, a brochure was created for the attendees of the 2010 Washington Leadership Conference to describe the multiple factors involved in improving access to oral health care. The Chair appointed a workgroup to address the CGA Chair's request for an access to oral health care communications strategy, and the full Council will consider this issue at their June 2010 meeting. The workgroup members are Dr. Krista Jones and Dr. Eugene Giannini.

**State Public Affairs Program (SPA) Oversight Committee:** Communications plays a critical role in the SPA Program, which was established by Resolution 41H-2006, and detailed in Board Report 14: Protecting and Advancing Dentistry: A Strategic Path to a Nationally-Coordinated, State-Targeted Integrated Public Affairs Plan (*Supplement* 2006:3052). The Council, along with the CGA, has been designated to provide volunteer oversight to the SPA program by having a representative chair the SPA Oversight Committee on a rotating basis with CGA. Among its responsibilities, the committee will create metrics to measure the effectiveness of the SPA program; review proposals from numerous national public affairs firms interested in working with the ADA on the SPA program and review dental society applications for the SPA program. The CC Chair served on the committee in 2010 and the Council nominated Dr. Anita Elliott

for consideration as the 2010-12 Council representative pending approval of the ADA president.

**Evidence-Based Dentistry (EBD) Advisory Committee:** Dr. Josef Kolling was reappointed to serve on the EBD Advisory Committee, which was created to ensure the entire spectrum of research, dental practice and education are taken into account as the ADA moves forward on any given activity related to EBD. Promoting EBD can help raise public awareness that dentistry is a science-based profession while simultaneously promoting the value of good oral health care. To assist the Center for EBD in communicating EBD research reviews to the public, the Council agreed to design and field a public survey on an EBD summary to 30 patients from each Council member (510 surveys total) as a cost-effective means of gathering public survey data from geographically diverse areas of the country. This survey will be fielded before the plain language summaries are posted for the general public. The data collected from the survey will be provided to the Center for Evidence-Based Dentistry to help refine and improve the plain language summaries.

**Give Kids A Smile (GKAS) and National Children’s Dental Health Month (NCDHM):** The ADA Board of Trustees appointed Council member Dr. Hugh Wunderlich to serve on the National GKAS Advisory Board, and Council member Dr. Starsiak continues to serve on the NCDHM Advisory Panel. The GKAS board is accountable to the ADA Foundation for adherence to the GKAS “More than Just a Day” mission and goals. As the GKAS program continues to expand, the Council representative provides communications input throughout the year. The Council representative to the NCDHM panel works with two representatives from CAPIR to review the program’s poster artwork and slogan each year.

**Smile Healthy Advisory Panel:** Council vice chair Dr. Kolling and Council member Dr. Elliott were reappointed and appointed, respectively, by the ADA president to serve on the Smile Healthy Advisory Panel. Due to the down economy, panel members in May 2010 decided to recommend to the Board of Trustees that Smile Healthy activities be suspended for a year pending reactivation at the Board’s discretion.

**Impact of Information Technology on the Profession or Practice of Dentistry—  
Development of an ADA Social Media Strategy:** The Council and a number of other ADA agencies have expressed interest in the use of social media as a means to deliver ADA messages and open two-way communications with a variety of audiences. Communicating in a Web 2.0 environment poses both opportunities and challenges, and the Council believes a social media strategy is needed to address: goals and target audiences (in addition to what is already achieved via traditional communication channels); previous social research conducted with ADA members and the public; feedback from state dental societies on their use of social media; an analysis of opportunities and challenges and the estimated resources and capacity needed for implementation. In 2010, the Chair appointed a social media workgroup composed of Council members Dr. W. Carter Brown, Dr. John Nase and Dr. Hugh Wunderlich, as

well as the Council's CND *ex officio* Dr. Sarah Poteet and the ASDA consultant Dr. Jim Heidenreich, to develop a framework for a social media strategy.

The ADA's 2009 pilot video podcast program, titled "Straight from the Mouth," is an example of a social media tactic to disseminate accurate and reliable oral health information online and promote a positive image of the ADA as a trusted resource of oral health information for the public. Funding for the pilot video podcast has expired. As the Council develops an overarching social media strategy, it will consider what future tactical elements may best achieve the goals related to that strategy.

**Council Meeting Evaluation Survey:** The Council Chair provided strategic input for the creation of a standardized meeting evaluation survey for ADA councils, commissions and committees to field to their members after each meeting. Council meeting survey results will be provided by the ADA Executive Director to the Board of Trustees. The Council survey was conducted in January 2010 to evaluate the meeting materials and support provided to the Council in order to improve the quality of future Council meetings. The response rate to the survey was 89.5%, with 15 Council members responding as well as the CND *ex officio* and the ASDA consultant.

Nearly all respondents reported being "very satisfied" with the "staff support," they received to help them prepare for the January meeting. Council members reported a high level of satisfaction for communications between the June 2009 and January 2010 Council meetings and high overall satisfaction with items related to the January 2010 meeting. Council members indicated that they would like to increase the amount of work conducted between the two meetings, and in 2010 several workgroups began meeting via conference call to seed discussion at the June 2010 meeting.

### **Response to Assignments from the 2009 House of Delegates**

*ADA.org "Find a Dentist" Search Engine Optimization Proposal.* The 2009 House of Delegates adopted Resolution 20H-2009 (*Trans.*2009:486) put forth by the CM and the CC regarding the search engine optimization of "Find a Dentist" on the revamped ADA.org. The adopted resolution states:

**Resolved,** that the "Find a Dentist" feature on ADA.org be promoted to the public via search engine optimization to increase the result in various related searches.

Since the adoption of this resolution, ADA Information Technology and Electronic Communications staff have updated the "Find a Dentist" feature, and it is now prominently located on the home page of ADA.org. In addition, internal search engine optimization has been completed, and the "Find a Dentist" portion of ADA.org is now listed among the top results when "Find a Dentist" is entered into major search engines, thus promoting the ADA as America's leading advocate for oral health. A request for proposal has been developed to gain assistance in generating a high search engine position for the "Find A Dentist" portion of the Web site within more granular geographic

searches (“Find A Dentist” in Chicago, Illinois). The proposal will be distributed to prospective vendors prior to the CC and CM’s meetings in June.

**Awards:** The Council selected the North Carolina Dental Society’s “NC Missions of Mercy Public Awareness” in the constituent category and the Livingston (Michigan) District Dental Society’s “VINA (Vision, Integrity, Need, Action) Dental Clinic” in the component category as winners of the 2009 Golden Apple Award for Excellence in Dental Health Promotion to the Public. Nominations for the 2010 awards will be considered at the Council’s June meeting.

The Council passed a motion to revise the award submission criteria to specify that only those programs that had already been completed and could include metrics related to their effectiveness would be considered by the Council for the Golden Apple Award for Excellence in Dental Health Promotion to the Public. The new award submission criteria will become effective with the 2011 Golden Apple award submissions.

**Meetings:** The Council met January 22-23, 2010, and will meet June 18-19, 2010, at the ADA Headquarters in Chicago.

**Personnel:** The Council expresses appreciation to retiring members Dr. David L. Nielsen, Dr. Thomas J. Perrino and Dr. Gayle T. Reardon. The Council is grateful to Dr. Edward J. Green for his thoughtful leadership as chair. The Council thanks Dr. Edward J. Vigna, Tenth District trustee, for his commitment and valuable input as the Board of Trustees’ liaison to the Council.

**Resolutions:** This report is informational and no resolutions are presented.

## Commission on Dental Accreditation

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**Edgar, Bryan**, Washington, 2010, chair, American Association of Dental Boards  
**Turner, Sharon**, Kentucky, 2011, vice chair, American Dental Education Association  
**Biermann, Michael E.**, Oregon, 2013, American Dental Association  
**Buchanan, Richard**, New York, 2012, American Dental Education Association  
**Carlson, Eric R.**, Tennessee, 2013, American Association of Oral and Maxillofacial Surgeons  
**Casamassimo, Paul S.**, Ohio, 2011, American Association of Pediatric Dentistry  
**Curran, Elizabeth**, Arizona, 2013, National Association of Dental Laboratories  
**Elliott, O. Andy II**, Kentucky, 2010, *ad interim*, American Dental Association  
**Hopke, Corwyn**, New York, 2011, American Dental Education Association and American Student Dental Association  
**Iacono, Vincent J.**, New York, 2010, American Academy of Periodontology  
**Joondeph, Donald R.**, Washington, 2011, American Academy of Orthodontists  
**Kantor, Mel L.**, New Jersey, 2011, American Academy of Oral and Maxillofacial Radiology  
**Kershenstein, Karen W.**, Virginia, 2011, Public Member  
**Knoernschild, Kent L.**, Illinois, 2013, American College of Prosthodontists  
**Koppelman, Lee**, New York, 2012, Public Member  
**Leonard, Kathleen**, Minnesota, 2011, American Dental Hygienists' Association  
**Marinelli, Charles**, Michigan, 2013, American Association of Dental Boards  
**Messura, Judith**, North Carolina, 2013, American Association of Hospital Dentists and American Dental Education Association  
**Nalley, Logan**, Georgia, 2011, American Association of Dental Boards  
**Nelson, Anna**, California, 2012, American Dental Assistants Association  
**Pelot, Reuben N., III**, Tennessee, 2011, American Dental Association  
**Ray, Robert G.**, Washington, D.C., 2012, American Association of Dental Boards  
**Reed, Michael J.**, Missouri, 2010, American Dental Education Association  
**Richter, Mary K.**, Illinois, 2010, Public Member  
**Rouse, Leo E.**, Washington, D.C., 2013, American Dental Education Association  
**Thomalla, Kenneth**, Illinois, 2010, Public Member  
**Tonelli, J. Steven**, Massachusetts, 2012, American Dental Association  
**Wenckus, Christopher**, Illinois, 2012, American Association of Endodontists  
**White, B. Alexander**, Massachusetts, 2012, American Association of Public Health Dentistry  
**Wright, John M.**, Texas, 2010, American Academy of Oral and Maxillofacial Pathology  
**Ziebert, Anthony J.**, director  
**Horan, Catherine A.**, manager  
**Lewis, Lorraine**, manager  
**Renfrow, Patrice**, manager  
**Soeldner, Peggy**, manager  
**Tooks, Sherin**, manager  
**Welling, Gwendolyn**, manager

**Strategic Planning and Assessing Outcomes:** The Commission has developed goals, objectives, action plans and evaluation mechanisms reflective of its mission statement.

**Summary of Accreditation Actions:** Accreditation actions of the Commission from July 2009 through February 2010 are summarized in Table 1. These actions were based on site visit reports, progress reports and other information submitted by educational programs and their sponsoring institutions, detailing the degree to which specific recommendations included in previous evaluation reports had been implemented. In addition, other actions (report of major change; change in sponsorship; etc.) were taken at the July 2009 and February 2010 meetings, for a total of 483 accreditation actions. Applications for initial accreditation of education programs were reviewed. During this time, 11 dental hygiene programs, seven advanced specialty programs and seven postdoctoral general dentistry programs were granted the accreditation status of "Initial Accreditation." As indicated in Table 2, the total number of educational programs accredited is 1,391. This represents an increase of 10 programs from the previous reporting period. Of the 1,391 accredited programs, 25 (1.8%) hold the status of "Initial Accreditation." One thousand two hundred and ninety-eight (1,298) programs (93.3%) are in compliance with all requirements and have been awarded "Approval *without* Reporting Requirements." During this reporting period, 47 programs (3.4%) were found to have deficiencies or areas of noncompliance and hold the status of "Approval *with* Reporting Requirements." Each of the 47 programs has been given a specified time period to demonstrate compliance with all accreditation standards. Failure to do so will result in accreditation being withdrawn. The Commission also investigated six complaints against programs during this time.

During this reporting period, no education programs had accreditation withdrawn. The Commission *Rules* stipulate that when the Commission takes action to deny or withdraw accreditation, it must inform the institution of that decision and its right to appeal the action. The Appeal Board is an appellate body which is convened to hear and make recommendations on accreditation conflicts that may arise between an educational program or institution and the accrediting agency. The Appeal Board is an autonomous body, separate from the Commission, and it may either sustain the decision of the Commission, or remand the matter to the Commission for reconsideration.

Because accreditation is voluntary, programs may also discontinue accreditation at any time during the process upon written notification by the sponsoring institution. During this time period, 12 programs voluntarily discontinued their participation in the Commission's accreditation program.

**Table 1**  
**Selected Accreditation Actions: Two Meetings – July 2009 and February 2010**

	Dental	Specialty	Advanced General Dental	Dental Assisting	Dental Hygiene	Dental Laboratory Technology	Total
Initial Accreditation	0	7	7	0	11	0	25
Approval without reporting requirements	12	107	65	57	58	4	303
Approval with reporting requirements	5	13	11	35	27	1	92
Accreditation Denied	0	0	0	0	0	0	0
Discontinued Programs	0	3	6	2	1	0	12
Intent to Withdraw	0	3	1	8	0	0	12
Accreditation Withdrawn	0	0	0	0	0	0	0
Decision Appealed	0	0	0	0	0	0	0
Number of Accreditation Actions	17	133	90	102	97	5	444

**Table 2**  
**Total Number of Accredited Programs as of 2010**

	Dental	Specialty	Advanced General Dental	Dental Assisting	Dental Hygiene	Dental Laboratory Technology	Total
Initial Accreditation	2	12	12	0	20	0	46
Approval without reporting requirements	54	417	268	258	281	20	1,298
Approval with reporting requirements	2	12	5	15	13	0	47
Number of Accredited Programs	58	441	285	273	314	20	1,391

**Trends:** To support informed decision-making, the Commission monitors trends in the dental education and practice arenas, as well as in higher education. During this reporting period, the Commission, the discipline-specific review committees, the Standing Committee on Outcomes Assessment, and ad hoc committees considered the following:

- Activities of the Commission on Dental Accreditation of Canada (CDAC)
- Reauthorization of the Higher Education Act of 1965 and United States Department of Education (USDE) negotiated rulemaking
- Trends in the National Advisory Committee on Institutional Quality and Integrity (NACIQI) evaluation of accreditors for USDE recognition
- Proposals by the Council for Higher Education Accreditation (CHEA) regarding the CHEA Initiative, which calls for a restructuring of the federal government-accreditation relationship
- Reports of accreditation standard frequency of citations for all disciplines

The remainder of this report highlights some of the important topics considered by the Commission this year.

**Proposed Revised Standards:** The Commission approved the circulation of proposed revised standards to the communities of interest in the following areas for review at the August 2010 Commission meeting:

- A comprehensive revision of the standards in Predoctoral Dental Education
- Two new proposed Accreditation Standards for Advanced Specialty Education Programs in Orthodontics and Dentofacial Orthopedics
- Revisions to the language common to all specialty education programs (specialty boilerplate language) including, but not limited to, revised wording of Standard 1, Institutional Commitment/Program Effectiveness; revised wording of Standard 5 and complementary statements of intent on evaluation of students/residents; and new “Definition of Terms”
- Proposed standard “Ethics and Professionalism,” which would be common to all disciplines under the Commission’s purview
- Proposed revised Accreditation Standard 3-2 of the Accreditation Standards for Advanced General Dentistry Education Programs in Dental Anesthesiology

The Commission held open hearings on the proposed revised standards at the October 2009 ADA annual session and the March 2010 American Dental Education Association annual session.

**Accreditation Standards:** The Commission adopted revised Accreditation Standards for the following:

- Advanced General Dentistry Education Programs in Dental Anesthesiology with immediate implementation

- Advanced General Dentistry Education Programs in Oral Medicine with immediate implementation
- Accreditation Standards for Advanced Specialty Education Programs in Endodontics (revised intent statement for Standard 2-4.1) with immediate implementation
- Dental Hygiene Education Programs (Standard 2-17 Dental Hygiene Process of Care), with a January 1, 2010, implementation date
- Advanced General Dentistry Education Programs in Orofacial Pain with an implementation date of January 1, 2010
- Advanced Specialty Education Programs in Oral and Maxillofacial Surgery with an implementation date of July 1, 2010

**Task Force on Alternative Site Visit Methods:** The Commission continues to investigate the potential for conducting site visits to extramural training sites via distance education technologies. Lutheran Medical Center (Brooklyn, NY) demonstrated the conduct of a site visit using distance education technology to the Task Force on Alternative Site Visit Methods prior to the July 2009 Commission meeting. The demonstration included a review of documentation; a tour of the facilities; and the conduct of interviews; all using real-time distance education technology (videoconference). Demonstration of other methods of video teleconferencing technologies were also provided, including a portable videoconference unit, which ultimately had to be disconnected due to interference with the Lutheran connection; a live stream on a personal computer; videotapes; and a Web-based application. Following the demonstration, the Task Force came to the conclusion that conducting site visits using alternative methods has potential and should be further pursued. Concerns still remain, including confidentiality of interviews and discussions, observing clinical activities, reading documents via videoconferencing technology, and the ability to interact with site visitors at other locations during the site visit. The Task Force concluded that, at this time, the potential and possibilities outweigh the negatives and further exploration in the form of a pilot project is warranted. In addition, the Task Force believed that the use of technology such as Web-based applications and videoconferencing should be considered more broadly in the accreditation process, including continuous monitoring of accredited programs' compliance with the Accreditation Standards. The Commission concurred with the Task Force recommendations.

**Task Force on Communication:** At its July 21, 2009, conference call, the Task Force reviewed the referrals from the CODA Subcommittee on the ADA Task Force on CODA Report and Recommendations and developed implementation strategies. The Task Force on Communication also reviewed the feedback from the participants in the first Community of Interest (COI) Informational Session held on August 19, 2008. The Task Force noted that the feedback was generally good, with most participants appreciating the willingness of the Commission to hold informational sessions. The August 21, 2009, COI Informational Session was offered in a webinar format, with Commission chair Dr. James Koelbl leading with discussion and presentations by the CODA director and managers. There were over 40 participants logged on at any one time and, once again,

the feedback from the participants was generally good. The Commission plans to hold the COI Informational Session again in August 2010. Finally, the Task Force on Communication reviewed the first two issues of the Commission's e-newsletter "CODA Communicator" and made several recommendations for improvements. The Communicator will now come out three times per year (February, August and November). In addition, the distribution list was reviewed and updated to ensure the broadest possible outreach to the communities of interest.

**The Task Force on Specialty Standards:** At the July 2007 meeting, the Commission established the Task Force on Specialty Standards: Proficiency/Competency and Boilerplate Consistency, to study how proficiency and competency are measured in advanced specialty education programs and to review results of the specialties' validity/reliability studies as they relate to the language common to all advanced specialty education programs (boilerplate language). At the January 26, 2010, meeting, the Task Force considered the need for and placement of a standard on the assessment of students/residents, common to all specialties. After lengthy discussion, the Task Force came to a consensus that if there were to be an assessment standard common to all the specialties, it should be placed in Standard 5.Evaluation, which requires a system of ongoing evaluation and advancement of students/residents through the program director and faculty. The Task Force also reviewed definitions of "formative" and "summative" evaluation and carefully considered their inclusion in the proposed revised language of the Standard. The Task Force chose this terminology over words such as "valid," "reliable," "objective" and "measurable." Finally, the Task Force discussed complementary wording to enhance the meaning and application of a common assessment standard, and recommend a proposed statement of intent.

**Revised Policies:** The Commission develops, publishes and periodically reviews policies and procedures that guide the accreditation process. The *Evaluation Policies and Procedures* manual is available on ADA.org. During this reporting period, the Commission revised the following policies: *Policy on Advertising; Policy on Reporting Major Changes; Policy on Third Party Comments; Required Notice of Opportunity and Procedures to File Complaints; Policy on Complaints Directed at CODA Accredited Educational Programs; Operational Policy on Complaints; Policy on Simultaneous Service; Policy Statement on Accreditation of Off-Campus Sites; Protocol for Review of "Report on Accreditation Status of Educational Programs" at Commission on Dental Accreditation Meetings; Conflict of Interest Policy*, (section on Commission/Committee Members); *Criteria for Advanced Specialty Consultants to the Commission*; the selection criteria for the *"Nomination of Allied Site Visitors, Dental Assisting Consultant Criteria, and Criteria for Predoctoral Dental Education Consultants/Site Visitors to the Commission; Policy on State Board Participation; Policy on State Board Participation on Site Visit Team; Sexual Harassment Policy; Policy on Transmittal of Accreditation Actions; and Policy on Proposed Changes in Highlighted Standards*. The Commission reaffirmed ten policies and rescinded one policy. In addition, The Commission completed a reorganization of the Operational Policies and Procedures (OPP) and Evaluation Policies and Procedures (EPP) manuals into a single manual. Currently, only the EPP is on the Commission Web site, and the Commission believes it would be

beneficial to have a combined manual where all Commission policies and procedures would be available to the public and communities of interest. There are numerous redundancies throughout the two manuals, and the current organization of the manuals makes it difficult to locate specific policies and/or procedures. In addition, policies and procedures were evaluated to determine whether they reflected established ADA policy and USDE requirements. The new combined manual, to be called, "Evaluation and Operational Policies and Procedures," was made available to Commissioners beginning March 1. Commissioners have been asked to provide comment until June 1, with the revised manual available for consideration at the August 2010 Commission meeting. The rationale for this timeline is to have a completed document available to be published on the ADA Web site prior to CODA's application for continued recognition with USDE.

*Operational Effectiveness Assessment Plan.* The Commission reviewed the Operational Assessment Effectiveness Plan (OEAP), and determined that all Commission goals had been met in 2009. The Commission adopted an updated OEAP for 2010.

**Request to Accredit Educational Programs for New Dental Team Members:** The Commission received requests to accredit the educational programs in Dental Therapy and Advanced Dental Therapy from the Minnesota Board of Dentistry, the Minnesota Dental Association, the University of Minnesota, and Metropolitan State University of the Minnesota and State Colleges and Universities System. Students are already enrolled in two programs in Minnesota and the statutory language addresses program accreditation by requiring that an applicant for licensure have "...graduated with a baccalaureate degree or a master's degree from a dental therapy education program that has been approved by the board or accredited by the ...Commission on Dental Accreditation or another board-approved national accreditation organization." In addition the Commission received a request from the Dental Quality Assurance Commission (DQAC) of the State of Washington Department of Health to accredit Expanded Function Dental Auxiliary (EFDA) programs in that state. There are currently three programs in Washington State that DQAC has approved, and each of those programs has a CODA-accredited dental assisting or hygiene program at its institution. The Commission has formed a Task Force to evaluate these requests and determine the feasibility and process of developing accreditation standards for these types of educational programs.

**HIPAA Compliance:** The Commission received a report on the passage last year of the Health Information Technology for Economic and Clinical Health Act. Changes in the law will impact Commission policy and procedure regarding site visitor review of patient charts during site visits, and patient information requested in progress reports. This new law expands on the Health Insurance Portability and Accountability Act (HIPAA) of 1996 and the new regulations went into effect February 17, 2010. Under the new law, business associates (i.e., the Commission) have the same responsibilities as the "covered entities" (i.e., the institutions/programs being site visited) when it comes to HIPAA policy and procedures regarding security, privacy, and breach notification. In the

past, business associates were not held to the same standards as the covered entities. In order to meet the new requirements of the law, ADA legal staff, ADA information technology staff, and the Commission staff conducted a risk analysis, which is an accurate and thorough assessment of the potential risks and vulnerabilities to the confidentiality, integrity and availability of the Electronic Protected Health Information (ePHI) that the Commission holds. The law also calls for annual training, and documentation of the training, of all consultants, review committee members, Commissioners, Commission staff, and IT staff who have access to ePHI.

**Responses to Assignments from the House of Delegates:** As directed by Resolution 37H-2008, the Commission provided a progress report to the 2009 House of Delegates on the implementation of recommendations from the 2008 Report of the Task Force on CODA. The Commission appointed an ad hoc Subcommittee on the ADA Task Force on CODA Report and Recommendations to conduct a complete and objective review of all ADA Task Force recommendations in an open and collaborative manner. In addition, this Subcommittee has been interacting directly with the ADA Committee on Implementation of CODA Task Force Recommendations (ADA Monitoring Committee). The Subcommittee met four times at ADA Headquarters during 2009-2010. At the first meeting on May 29, 2009, the prioritized table of recommendations developed by the ADA Monitoring Committee was used as a starting point for consideration of the recommendations. Some recommendations were referred to Standing Committees and Task Forces of the Commission for further evaluation and implementation strategies. Other recommendations were considered directly by the Subcommittee and were designated for further discussion with the ADA Monitoring Committee. At its second meeting, on July 29, 2009, the Subcommittee considered the implementation strategies for several of the recommendations developed by the Commission's Task Force on Communication. At its July 2009 meeting, the Commission directed that the implementation strategies proposed by the Task Force on Communication and the Subcommittee be adopted. The Subcommittee met jointly with the ADA Monitoring Committee following the July 31<sup>st</sup> Commission meeting, forming a Joint CODA-ADA Monitoring Committee Workgroup to do a detailed study of the structure and finances of the Commission (recommendations 1, 2 and 3). The fourth meeting of the Subcommittee was held February 4, 2010. The Subcommittee considered the preliminary report of the Joint Workgroup on the Commission structure and finances. To date, the Commission has implemented, or has begun implementation of, 18 out of the 34 recommendations. The remaining 16 recommendations are all in various stages of study by the Subcommittee, Standing Committees of the Commission, and/or the ADA Monitoring Committee.

**Meetings:** The Commission conducted meetings on July 30-31, 2009, and February 4-5, 2010, at ADA Headquarters. The Commission's discipline-specific review committees met prior to these meetings. Approximately 40% of the review committees conducted business via teleconferencing. Reports, meeting minutes and the Commission's communications to the communities of interest were disseminated via e-mail and online at [www.ada.org](http://www.ada.org).

Board of Trustees' liaisons Dr. Marie C. Schweinebraten, trustee, Fifth District and Dr. Russell I. Webb, trustee, Thirteenth District, attended the July 2009 and February 2010 meetings, respectively. The next meeting of the Commission is August 5-6, 2010.

**Acknowledgments:** The Commission acknowledges with appreciation the many significant contributions made by those members who will complete their terms in 2010: Dr. Bryan Edgar, Dr. O. Andy Elliott, Dr. Vincent J. Iacono, Dr. Michael J. Reed, Ms. Mary Kay Richter, Mr. Kenneth Thomalla, and Dr. John M. Wright. The Commission also acknowledges the service of Ms. Kathleen Leonard, Dr. Logan Nalley, and Dr. Leo Rouse, all of whom are unable to complete their full terms and resigned this past year from the Commission. In addition, the Commission sent a plaque of appreciation to Dr. Les Tarver, who resigned as chair of the Commission in December 2009 due to health reasons.

**Resolutions:** This report is informational and no resolutions are presented.

# Council on Dental Benefit Programs

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**Oettmeier, Bert W., Jr.**, Kansas, 2010, chair  
**Plage, Robert G.**, North Carolina, 2010, vice chair  
**Dycus, Richard W.**, Tennessee, 2013  
**Eversman, Philip J.**, Indiana, 2011  
**Futrell, Harry C.**, Florida, 2011  
**Jurkovich, Mark W.**, Minnesota, 2010  
**Klemmedson, Daniel J.**, Arizona, 2011  
**Machnowski, Thomas J.**, Illinois, 2013  
**May, A. David**, Texas, 2013  
**Passeri, Lauri A.**, Pennsylvania, 2012  
**Prator, D. Mark**, Alaska, 2012  
**Richeson, James G.**, Washington, D.C., 2012  
**Seiver, Jeffrey**, New York, 2010  
**Smiley, Christopher J.**, Michigan, 2011  
**Stadeker, Wilkie J.**, Georgia, 2012  
**Toy, Bruce G.**, California, 2013  
**Unkenholz, Eric G.**, South Dakota, *ex officio* \*  
**Ura, Stephen C.**, New Hampshire, 2012  
**Preble, David M.**, director  
**Avalos, Rocio**, manager  
**Ellek, Donalda**, manager  
**McHugh, Dennis**, manager  
**Pokorny, Frank**, senior manager

**The Strategic Plan of the American Dental Association:** The Council's activities are consistent with and continue to support the *ADA Strategic Plan: 2007-2010*, particularly with the following Goals: Achieve Effective Advocacy; Build Dynamic Communities; Create and Transfer Knowledge; and, Lead in the Advancement of Standards. The Council annually reviews the Strategic Plan to assure that its activities and programs remain effective and relevant.

**Council Self-Assessment:** The Council conducted a self-assessment to determine its relevancy and to address its efficiency, productivity and to examine its mission and duties in response to Resolution 119H-2002 (*Trans.2002:373*). At its April 2010 meeting, the Council reviewed and approved the report of its self-assessment for submission to the House of Delegates.

**Emerging Issues:** The Council continues to provide technical expertise to assist in legislative advocacy activities, notably on non-covered services legislation on both the state and national levels.

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\* Committee on the New Dentist member without the power to vote.

As the lead agency for the Dental Quality Alliance, the Council will continue to facilitate the work of developing dental quality measures with an emphasis on actual improvement of oral health outcomes in the population rather than cost containment.

### **Dental Codes Maintenance and Development:**

*Code Revision Committee (CRC)/Code on Dental Procedures and Nomenclature (Code)*. The Council is excited to report the results of the first ever utilization of the CRC Appeal Committee. Action taken by the Appeal Committee on May 24, 2010, raises the prospect for a significant increase in the responsiveness of the CRC to code change requests supported by the profession.

Requests for changes to the *Code* are addressed through the CRC, which has three scheduled meetings in the two-year review and revision cycle. The cycle leading to a new version of the *Code* effective on January 1, 2011, is complete. Eight new procedure codes are added, 19 are revised and none are deleted.

There is a continuing downward trend in the number of change requests submitted in each cycle and the number of requests accepted by the CRC. In the 2009-10 cycle just completed, the CRC considered 118 requests and accepted 27. This is in marked contrast to the 302 requests in the 2003-04 cycle where 91 were accepted, yielding 39 new procedure codes, 49 revisions and three deletions. The reason for this downward trend is not known. A Council hypothesis is that the apparent reluctance of the CRC to approve code change requests has had a chilling effect on submissions.

The Appeal Committee, as provided for in the CRC Meeting Protocol, convenes to address ADA or Payer appeals of change requests that were declined due to a tie CRC vote. Three such declined additions were appealed by the ADA's CRC representatives. All three appeals were decided in favor of the ADA on the grounds that the *Code* should have sufficient granularity to accurately document services provided and that payers must defer to dentists to make the critical decisions about what is a necessary procedure, requiring a code. Use of an "unspecified procedure by report" makes the *Code* less accurate and is inconsistent with electronic health records and data exchange. These decisions are final.

The Council hopes that the CRC process will become more responsive to the needs of the profession since the Appeal Committee decisions affirm the ADA's position that dentists need appropriate codes for every procedure they perform.

October 1, 2010, is the closing date for the first batch of requests to be considered for inclusion in the version of the *Code* that is effective January 1, 2013. The next review and revision timetable is posted on ADA.org and the next CRC meeting is in February 2011.

Technical content for the ADA's revenue generating *Code* and *CDT* manual licensing and publication activity was delivered to the Department of Product Development and Sales on schedule, July 1, 2010.

*CDT Manual.* The eighth and newest edition of the manual, titled "CDT 2011/2012," incorporates changes to the *Code* that become effective January 1, 2011. This edition also incorporates a revision to ADA Dental Claim Form completion instructions to reflect adoption of Resolution 44H-2009 (*Trans.*2009:415; 419), Statement on Reporting Fees on Dental Claims. The Council has also added technical content to the Questions & Answers and Glossary sections.

*CDT Companion.* The third edition of this publication contains updated and additional technical content prepared by the Council on Dental Benefit Programs. This edition includes new and updated coding exercises that incorporate changes to the *Code* effective January 1, 2011.

*Code Workshop—Presentation.* This workshop, "The Code: Your Gateway to Accuracy," is now in its sixth version. The Council has revised the program's structure and content to incorporate changes to the *Code* effective January 1, 2011, and to address participant feedback received by Council volunteers who deliver the program. Delivery of this workshop is a scheduled event on the 2010 ADA annual session program.

*Code Workshop—CE Online.* This new self-guided educational program, "Introducing the Code: What it is and How it Works for You," was created by the Council for two audiences. The primary audience is dental students so that they become familiar with basic *Code* concepts and their use, and the secondary audience is dentists who may desire to improve their *Code* familiarity and receive CE credit. This new program is delivered via the ADA's CE Online at no cost to students and at a fee for dentists in practice. The program content is derived from the half-day presentation delivered in-person by Council members.

*ADA Dental Claim Form.* The Council determined that there is no immediate need to revise the current version's content or format. Future changes are anticipated when the next version of the HIPAA standard electronic dental claim (837D) must be in use (January 1, 2012) in accordance with policy adopted by the House of Delegates, Proposal for the ADA Dental Claim Form to be Maintained in a Form that Coincides with the HIPAA Required ANSI X12 837—Dental Transaction Set (*Trans.*2001:434).

*Dental Content Committee.* The ADA's Dental Content Committee (DeCC), housed administratively within the Council, convened by conference call for all meetings, including its annual meeting on November 9, 2010. The DeCC has fully embraced electronic information exchange and telephonic meetings for efficiency and cost savings. All 2010 meetings are expected to again convene by conference call, including the DeCC's annual meeting on November 8, 2010. Beginning in 2011 this activity will be housed administratively in the Department of Dental Informatics.

*Membership Services.* The Council continues its support of the membership by addressing and resolving requests for assistance and information. There are approximately 7,500 telephone and electronic requests for code, claim form and third-party payer information annually.

### **Dental Benefit Information Service (DBIS):**

*Direct Reimbursement (DR) Promotional Co-op Program.* The DR Promotional Co-op Program is designed to augment the reach and impact of the ADA's National DR Marketing Campaign by making additional funds available to each participating constituent dental society for the purpose of promoting DR locally. In 2008, 12 state dental societies participated in the program and \$149,151 was spent by those dental societies to support local DR promotional efforts. In 2009, the number of states requesting funds increased to 13 (AL, CA, FL, GA, IN, IA, MN, NC, OH, TN, TX, VA and WI) and the number of dollars allocated remained high at \$140,045. The funding structure of the program includes an annual maximum of \$30,000 for mentoring states, \$15,000 for states willing to be mentored and \$5,000 for all others.

*Incentives for Companies Providing Goods and Services to the Dental Community.* The ADA recognized three exhibitors at the 2009 annual session in Hawaii for offering a direct reimbursement dental program to their employees. The recognition included special exhibit hall signage, customized booth signage, special badge ribbons, mention in the official program guide, recognition in "Shuttlelevision" programs on buses and hotel in-room messaging.

*National Dental Benefits Conference 2010.* The National Dental Benefits Conference 2010 is scheduled for August 20 at ADA Headquarters in Chicago. Dental benefit trends and issues continue to be the major theme and it is expected that over 120 people will participate in this year's Conference. Attendees typically include benefits brokers, consultants, third-party administrators, constituent and component dental society staff, and dentists and their staff. The length of this year's conference will be shortened to one full day in response to diminished attendance on the Saturday morning of the conference. A new \$35 registration fee will be utilized this year to help offset operating costs of the Conference and once again, continuing education credits will be available for this meeting.

*Dental Benefits 101.* The Council recognized the need to educate dentists and dental offices on the proper terminology that is being used today in the world of dental benefits. Therefore, the Council developed a primer course on dental benefits titled, "Dental Benefits 101," which is available for continuing education credits. The course is an online course, in conjunction with the ADA's Center for Continuing Education and Lifelong Learning (CELL).

*Meetings with Dental Benefit Carriers.* The DBIS Subcommittee met with representatives from United Concordia Companies, Inc. (UCCI) and Delta Dental Plans Association (DDPA) on August 27, 2009 (immediately preceding the National Dental

Benefits Conference). The purpose of the meetings was to meet with representatives from various dental insurance carriers to discuss issues of mutual concern and other matters as deemed appropriate.

The general consensus of the Subcommittee members was that the meetings were very productive. For these reasons, the Council approved the Subcommittee's recommendation that these meetings with dental benefit carriers continue, facilitated by the DBIS Subcommittee and held immediately before the National Dental Benefits Conference. This year's meeting is scheduled for August 19 with the carriers and topics of concern yet to be determined.

*Statement on Determination of Usual, Customary and Reasonable Fees.* The Council reviewed the Statement on Determination of Usual, Customary and Reasonable Fees (*Trans.*1991:633), and believes the words "Usual" "and Reasonable" should be deleted in the title of the Statement. Dentists determine their own usual or reasonable fees and insurance companies determine customary fees which may or may not accurately reflect the fees that area dentists charge. The Council, therefore, recommends adoption of the following resolution. This resolution supports the ADA Strategic Plan Goal of Advocacy.

**1. Resolved**, that the Statement on Determination of Usual, Customary and Reasonable Fees (*Trans.*1991:633) be amended by deleting the words "usual" and "reasonable" (deletions are shown by strikethroughs), and be it further **Resolved**, that appropriate agencies of the ADA take action to encourage the adoption of these guidelines at both the state and federal level.

#### **Statement on Determination of Usual, Customary and Reasonable Fees**

The legitimate interests of insured patients are best served by use of precise, accurate and publicly announced methodologies for determining ranges of fees for all dental services.

Therefore, policy makers should develop guidelines for regulations which:

- Establish standard terminology for identifying benefits in policies, Explanation of Benefits and other descriptive materials
- Establish a standard screen setting method (such as percentile) and/or require a policy statement, which describes the overall percentage of services (percentile) the policy should allow in full
- Require disclosure regarding the average percentage of claim dollars submitted anticipated to be allowed
- Require disclosure describing the frequency of updates and/or the basis for screen development
- Require disclosure describing how region and specialty were considered in setting the Customary Fee Screens

- Require carriers to use sufficient data when determining Customary Fee Screens (whether from claims experience or other sources)
- Require carriers to demonstrate how they have set their screens and how they have determined if sufficient data were employed.

*Definitions of Fraudulent and Abusive Practices in Dental Benefit Plans and Claims.* The Council reviewed the ADA policy on Definitions of Fraudulent and Abusive Practices in Dental Benefit Plans and Claims (*Trans.* 1998:701; 2001:428) with a goal of amending the policy to be consistent with other policies that contain language referencing usual, customary and reasonable fees and felt that there was no need to provide examples of inappropriate fee discounting practices as these practices can change frequently over time. The Council, therefore, recommends adoption of the following resolution. This resolution supports the ADA Strategic Plan Goal of Advocacy.

**2. Resolved**, that the Definitions of Fraudulent and Abusive Practices in Dental Benefit Plans and Claims (*Trans.* 1998:701; 2001:428) be amended by deletion of the second paragraph under the definition of “Inappropriate Fee Discounting Practices” (deletions are shown by strikethroughs):

**Inappropriate Fee Discounting Practices:**

Intentionally engaging in practices which would force a dentist, who does not have a participating provider agreement, to accept discounted fees or be bound by the terms and conditions set forth in the participating provider contract.

~~Some examples of inappropriate fee discounting practices include: issuing reimbursement checks which, upon signing, result in the dentist accepting the amount as payment in full; using claim forms which, upon signing, require the dentist to accept the terms of the plan’s contract; issuing insurance cards which state that the submittal of a claim by a dentist means that he or she accepts all terms and conditions set forth in the participating provider contract; and sending communications to patients of nonparticipating dentists which state that he or she is not responsible for any amount above usual, customary and reasonable fees as established by the plan.~~

*Standards for Dental Benefit Plans.* The Council reviewed the ADA policy on Standards for Dental Benefit Plans (*Trans.* 1988:478; 1989:547; 1993:696; 2000:458; 2001:428; 2008:453) with a goal of amending the policy to be consistent with other policies that contain language referencing usual, customary and reasonable fees and felt that the term “reimbursement schedules” would adequately suffice in this statement. The Council, therefore, recommends adoption of the following resolution. This resolution supports the ADA Strategic Plan Goal of Advocacy.

**3. Resolved**, that the Standards for Dental Benefit Plans (*Trans.* 1988:478; 1989:547; 1993:696; 2000:458; 2001:428; 2008:453), Paragraph 21, be amended as follows (deletions are shown by strikethroughs):

21. The methodology used by plan administrators to set reimbursement schedules ~~or percentiles, or for UCR and/or MAB determinations~~ should rely on current, geographic and other relevant data and be readily available to patients, plan purchasers and dentists.

*The American Dental Association Dental Health Program for Children.* The Council reviewed the ADA policy on American Dental Association Dental Health Program for Children (*Trans.*1966:179, 306; 1967:336) with a goal of amending the policy to be consistent with other policies that contain language referencing usual, customary and reasonable fees, and felt that it is important that reimbursement for this program be based on the dentist's full fee and not on the usual and customary basis per current policy. The Council, therefore, recommends adoption of the following resolution. This resolution supports the ADA Strategic Plan Goal of Advocacy.

**4. Resolved**, that the policy "American Dental Association Dental Health Program for Children" (*Trans.*1966:179, 306; 1967:336), Principle 16, be amended as follows (additions are shown by underscoring; deletions are shown by strikethroughs):

16. Priority consideration should be given to reimbursement for professional services on the "full ~~usual and customary~~ fee" basis.

*Statement on Dental Consultants.* The Council feels that the three current ADA policies on dental consultants, Disclosure of Dentist Consultants Upon Request (*Trans.*1985:583), Statement on Dental Consultants (*Trans.*1989:542), and Identifying Dental Consultants (*Trans.*2002:412), should be combined into one easy to locate policy with redundant statements deleted. Therefore, the Council recommends adoption of the following resolution. This resolution supports the ADA Strategic Plan Goal of Advocacy.

**5. Resolved**, that the following Statement on Dental Consultants be adopted.

#### **Statement on Dental Consultants**

Third-party payers and plan purchasers have used dental consultants in order to streamline the claims review process for many years.

The Council on Dental Benefit Programs initially applauded the use of dental consultants by third-party payers as a means of receiving professional advice on certain aspects of dental benefits plans. While the Council still believes that there is value to third-party payers' use of dental consultants, it also believes that some clear distinctions must be made between dental consultants and dental claims reviewers.

Dental claims reviewers work under supervision. They do not necessarily have, or need, clinical dental or dental practice background, and are trained specifically by the third-party payer to review dental claims that are uncomplicated and require straightforward processing.

Dental consultants are licensed dentists who, even if not currently practicing, have many years of experience in practice and can and should:

- Offer a professional opinion regarding complicated dental treatment
- Provide their name, degree, license number and direct phone number to the treating dental office
- Request consultations from specialists for certain specialty-related cases, when necessary
- Provide advice to third-party payers regarding the merit and value of dental benefits plan designs
- Educate plan purchasers regarding the impact alternative, less costly treatment may have on the life of a tooth, overall oral health, etc.
- Alert third-party payers when dentists' treatment patterns are changed by cost containment strategies to the detriment of the patients
- Provide guidance to third-party payers regarding the importance of the dentist/patient relationship
- Inform third-party payers, plan sponsors and subscribers about the availability and value of the profession's peer review system
- Initiate dialogue with organized dentistry regarding questionable treatment modalities
- Inform the dental profession of those treatment procedures on which questions of judgment between the dentist and the dental consultant are most likely to result in areas of disagreement
- Discuss treatment decisions with dentists on a professional level
- Explain clearly to practicing dentists the provisions of particular contracts and the benefit limitations of those contracts
- Demonstrate knowledge of contract interpretation, and laws and regulations governing dental practice in those jurisdictions affected by their consulting activities, as well as accepted standards of administrative procedure within the dental benefits industry
- Dentists reviewing claims submissions should be licensed in the United States, preferably within the jurisdiction of the dentist treating the patient in accordance with applicable state law

Dentists have a fundamental obligation to serve the best interests of the public and their profession. This obligation can never be abrogated for any reason. In order to maintain independent thought and judgment regarding dental matters, dental consultants should be practicing dentists for a minimum of 50% of their time, thus ensuring familiarity with current clinical procedures and practice through such mechanisms as continuing education, or have been in practice for a minimum of ten years immediately preceding employment as a dental consultant, and remain involved in the continuing dental education process in order to stay current with clinical procedures and changing technology.

It is strongly recommended that dental consultants be members of the American Dental Association.

and be it further

**Resolved**, that the Council on Dental Benefit Programs distribute copies of this Statement to all third-party payers, and be it further

**Resolved**, that third-party payers, including dental consultants to payers, should not exceed their legitimate role in the processing of dental benefit claims, and specifically, third-party payers and dental consultants should not:

- Change code numbers as submitted without written permission of the attending dentist
- Redefine code numbers without prior notification of the attending dentist
- Disapprove complex specialty cases without seeking the advice of appropriate specialist consultants

and be it further

**Resolved**, that the ADA urge third-party payers and administrators to identify dental consultants by name in any correspondence to attending dentists, and be it further

**Resolved**, that the policies on Disclosure of Dentist Consultants Upon Request (*Trans.*1985:583), Statement on Dental Consultants (*Trans.*1989:542) and Identifying Dental Consultants (*Trans.*2002:412) be rescinded.

*Legislation to Require Dental Benefit Plans to Provide Dental Consultant Information.*

With the emerging trend of dental benefit carriers sending claims adjudication jobs overseas and now even dental consulting positions, the Council felt it was important to reiterate that the identification and disclosure of dental consultants should be properly communicated in explanation of benefits language. Furthermore, the Council believes that dentists reviewing claims submissions should be licensed in the United States, preferably within the jurisdiction of the dentist treating the patient. Therefore, the Council recommends adoption of the following resolution. This resolution supports ADA Strategic Plan Goal of Advocacy.

**6. Resolved**, that the American Dental Association pursue federal legislation or regulation to require self-funded dental benefit plans to provide in the explanation of benefits the name, degree, license number, and direct phone number of the licensed dentist or of any other individual who makes the final decision involved in accepting or rejecting the dental claim, and be it further

**Resolved**, that the ADA request that constituent and component dental societies pursue state legislation or regulation to require insured dental benefit plans to provide in the explanation of benefits the name, degree, license number, and direct phone number of the licensed dentist or of any other individual who makes the final decision involved in accepting or rejecting the dental claim and that dentists reviewing claims submissions should be licensed in the United States, preferably within the jurisdiction of the dentist treating the patient in accordance with applicable state law.

**Office of Quality Assessment and Improvement:** The Council's Office on Quality Assessment and Improvement monitors and analyzes policy and initiatives that relate to

the concept, implementation or assessment of the quality of health care; and oversees the structure and function of the peer review system. The Council's Subcommittee on Quality Assessment and Improvement includes members of the Council on Dental Benefit Programs and, because the subject of quality of care intersects with the interests of many ADA agencies, also includes representatives from the Council on Dental Practice, the Council on Dental Education and Licensure, the Council on Government Affairs and the Council on Access, Prevention and Interprofessional Relations.

The Subcommittee met on February 4, 2010. The Subcommittee recommended several clarifications to the ADA policy presented in the *Peer Review Manual* and that the peer review PowerPoint presentation be revised to reflect the clarifications.

**Contract Analysis Service:** The ADA Contract Analysis Service was established in 1987 and is currently housed in the ADA Division of Legal Affairs.

This is a popular member service. Since its inception, the Service has analyzed over 4,345 contracts, 139 of those contracts in 2009 and, 34 contracts as of April 30, 2010.

The Service is authorized to analyze the following:

- dental provider contracts
- dental management service organizations contracts ("DMSO")
- contracts that offer dental school students scholarships or loans in exchange for commitments for future employment

The Service educates members, in clear language, on issues concerning contract provisions. It mainly focuses on aiding members in making informed decisions about participating provider contracts offered by dental benefit companies. The Service does not provide legal advice or recommend whether a contract should or should not be signed. Dentists are informed that they need to make an independent decision on whether to enter into a contract and are urged to seek the counsel of their personal advisors, including their personal attorney.

The Service is available at no charge to members who request a review through their state dental society. Dentists contacting the ADA directly are charged a \$50 fee.

The Service also provides free informational literature to members or state or local dental societies. Brochures currently available include:

- *What Every Dentist Should Know Before Signing a Dental Provider Agreement*
- *Considering a Dental Benefit Contract Brochure*
- [\*Model Contract For Third Party Dental Service Agreements\*](#)
- *What Every Dentist Should Know Before Affiliating With a DMSO: a Legal Perspective*

- *What Every Dental Student Should Know Before Signing an Agreement Offering a Scholarship or Loan in Exchange for a Work Commitment*

The Service remains committed to the following goals: meeting the current demand in a timely manner; developing new informational material regarding dental provider contracts; and working closely with state and local societies to address member dental provider contracting concerns.

The Service also presents seminars and workshops concerning the legal implications of dental contracts upon request. In addition, the Service responds to member inquiries via telephone. For more information, see the following ADA.org address at <http://www.ada.org/1308.aspx>.

**Dental Practice Parameters:** The Dental Practice Parameters Committee (DPPC), whose charge is to maintain the Dental Practice Parameters, held its yearly meeting via conference call on May 18, 2010. The DPPC commented that there is no plan to revise the Parameters, especially considering that evidence-based clinical recommendations and other resources, which serve as more current reference materials for dentists, are being developed. Thus the DPPC recommended that: 1) the Parameters remain on the ADA.org Web site as a resource and a statement be added to the Web site noting that the listed parameters are no longer being updated or maintained and are provided for reference. The statement further would direct users to the ADA Evidence Based Dentistry Web site for the most current information; 2) the DPPC be disbanded; and 3) the Council on Dental Benefit Programs be charged with the responsibility to monitor the Parameters and recommend removal if any become too outdated to be useful. Therefore, the Council recommends adoption of the following resolution. This resolution supports the ADA Strategic Plan Goal of Create and Transfer Knowledge.

**7. Resolved,** that the Dental Practice Parameters Committee be disbanded effective December 31, 2010, and be it further

**Resolved,** that the Council on Dental Benefit Programs be charged with the responsibility to monitor the Parameters and recommend removal of any Parameters that become too outdated to be useful.

**Dental Quality Alliance (DQA):** The Executive Committee of the DQA met on March 26-27, 2010. The members of the Executive Committee are Dr. R. Wayne Thompson, chair, (ADA Twelfth District trustee); Dr. Christopher J. Smiley (CDBP); Dr. Mark R. Züst (Council on Dental Practice); Dr. Joseph Crowley (Council on Government Affairs); Dr. Greg Baber (Council on Access, Prevention and Interprofessional Relations); Dr. Ralph Cooley (Academy of General Dentistry); Dr. W. Ken Rich (Medicaid SCHIP Dental Association); Dr. James J. Crall (American Association of Pediatric Dentistry); Dr. Ronald J. Hunt (American Dental Education Association); Dr. Craig Amundson (National Association of Dental Plans); and Dr. A. Conan Davis (Centers for Medicare and Medicaid Services). The Executive Committee developed a mission statement and objectives, operating rules, and an organizational structure; it also identified major stakeholders in oral health care that will be invited to become members of the DQA and

will be invited to attend a meeting of the DQA scheduled for October 28-29, 2010. It is expected that performance measurement development will begin in early 2011.

### **Response to Assignments from the 2009 House of Delegates:**

*Amendment of the Guidelines on Coordination of Benefits for Group Dental Plans.* Resolution 1H-2009 (*Trans.*2009:415; 422) directed that the Council on Dental Benefit Programs:

- Urge third-party payers, representing self-funded as well as insured plans, to adopt these guidelines as an industry-wide standard for coordination of benefits.
- Urge all third parties providing or administering dental benefits to adopt a unified standardized formula for determining primary or secondary coverage and that the formula should be readily applied by dental providers based on information easily obtained from the patient.
- Urge the National Association of Insurance Commissioners (NAIC) to amend their model legislation to conform with ADA policy.

In response to Resolution 1H-2009, the Council sent letters to the following organizations urging them to adopt the coordination of benefits guidelines and to adopt a unified standardized formula for determining primary or secondary coverage:

- National Association of Dental Plans
- Delta Dental Plans Association
- Blue Cross/Blue Shield Association
- America's Health Insurance Plans
- Centers for Medicare and Medicaid Services
- National Conference of Insurance Legislators

The Council sent a letter to the National Association of Insurance Commissioners urging them to amend their model legislation to conform to ADA policy.

In addition, the ADA Department of State Government Affairs sent letters to constituent societies encouraging them to seek enactment of legislation that would require all policies and contracts that provide benefits for dental care to use these guidelines to determine coordination of benefits.

*Amendment to the Policy, Reporting of Dental Procedures to Third Parties.* Resolution 2H-2009 (*Trans.*2009:415; 418) replaces the term "code system" with "code taxonomy" as the latter facilitates protection of ADA intellectual property, and specifically names the *Code on Dental Procedures and Nomenclature* as the code taxonomy for use in dental claim adjudication processes. The Council is continually consulted on questions concerning *Code/CDT* manual licensing by the ADA agencies responsible for that activity, and thereby works to ensure widespread adoption and use of the *Code* by third-party payers and claims administrators.

*Amendment of the Bylaws Duties of the Council on Dental Benefit Programs.* Resolution 3H-2009 (*Trans.*2009:415; 419) broadens the Council's responsibilities for dental coding taxonomies by eliminating language that previously limited the Council's interests to procedural and diagnostic coding as applicable to dental claims. The Council established the Subcommittee on SNODENT and EHR Vocabularies that addresses dental coding taxonomies other than the *Code on Dental Procedures and Nomenclature*.

*Principles for the Application of Risk Assessment in Dental Benefit Plans.* Resolution 14H-2009 (*Trans.*2009:415; 423) will be used by the Council when discussing risk assessment with third-party payers and other groups developing risk assessment for use in dental benefit plans.

*Statement on Reporting Fees on Dental Claims.* Resolution 44H-2009 (*Trans.*2009:415; 419) provides a definition for a dentist's full fee for a procedure and provides guidance on reporting this fee on dental claims, thereby resolving a gap in ADA policy. The Council has revised the ADA Dental Claim Form completion instructions to be published in the eighth edition of the ADA publication titled "CDT 2011/2012" to incorporate this policy statement. Council staff who are primary responders to member inquires concerning the *Code* and claim submission make reference to this policy statement when answering questions concerning reporting fees.

*Development of an "Employer Section" on ADA.org to Educate Employers on Evaluating Dental Insurance Plans.* Resolution 72-2009 (*Trans.*2009:406; 409) was referred to the Council on Dental Benefit Programs for implementation. The resolution directed that the appropriate ADA agency develop an "Employer Section" on ADA.org to educate employers on evaluating dental insurance plans, and that information about the existence and benefits of the "Employer Section" be communicated to employers and HR organizations.

In response to this resolution, the Council will place the ADA's *Understanding Your Dental Benefits* brochure, which is intended to educate employers on the variety of dental plan types in the market, in this "Employer Section" on ADA.org. This brochure offers specific questions to ask before changing or selecting a new dental plan and assists employers by identifying pertinent features to look for in a quality dental plan. In addition, the Council will work collaboratively with the new ADA communications department for innovative ways to drive human resources professionals to the ADA Web site for information on dental benefits.

Please refer to the section above regarding Resolution 78H-2009, Education of Human Resources Professionals on the Value of Dental Benefits, as these two resolutions are very closely linked together. Furthermore, staff will exhibit at the two largest human resources conferences to communicate this enhancement on ADA.org to HR professionals. Since the Council is already working toward the direction in the resolution, the Council recommends that 72-2009 not be adopted.

*Education of Human Resources Professionals on the Value of Dental Benefits.* Resolution 78H-2009 (*Trans.*2009:415; 420) directed the Council on Dental Benefit Programs to study the development of an aggressive national public relations program to educate human resource professionals on the value of dental coverage and the process of evaluating comprehensive dental insurance benefits and report to the 2010 House of Delegates.

The subject and intent of Resolution 78H has always been a responsibility of the Council and is reinforced by the ADA *Bylaws* duties of the Council which affirms this. Education of human resources professionals on the value of dental benefits has been accomplished by the ADA's promotion of direct reimbursement, which has been and continues to be the ADA's preferred method of financing dental treatment. The Council has noted that this resolution is very closely linked to Resolution 72-2009, Development of an "Employer Section" on ADA.org to Educate Employers on Evaluating Dental Insurance Plans, and believes that educating human resource professionals is very important in helping them make informed decisions regarding the purchase of comprehensive dental benefits coverage.

The Council asked the ADA Survey Center to conduct a comprehensive survey of human resources (HR) professionals on how they would like to receive information on the value of dental benefits coverage. In addition, the Council will exhibit at the two largest HR conferences in the country to educate and provide information on dental benefits to attendees. These conferences include:

- The Society for Human Resource Management (SHRM) Annual Conference and Exposition which typically attracts 12,000-14,000 HR professionals, including benefits managers and decision-makers, from across the country and is the largest HR conference in the United States.
- The HR Southwest, Human Resources Conference and Exposition, held annually in Fort Worth, TX, is the second largest HR conference in the country.

Trade shows give the ADA the opportunity to meet face-to-face with hundreds of HR professionals and to educate and provide them with information necessary to make informed decisions on the purchase of dental benefit programs. This includes referring these individuals to the new employer section on ADA.org for additional information. In addition, pre and post conference marketing lists of registered attendees can be purchased to contact attendees that did not have time to stop by the exhibit booth to receive information.

*Use of the Terms "Usual," "Reasonable" and "Customary."* Resolution 79-2009 (*Trans.*2009:415; 421) was referred to the Council on Dental Benefit Programs for study and report to the 2010 House of Delegates. The resolution reads as follows.

**79-2009. Resolved,** that the values of "usual," "reasonable" and "customary" fees are statistically derived from the historical data of fees actually charged by an

individual dentist or collectively charged by the dentists of a particular designated community, and be it further

**Resolved**, that the following definitions of usual, reasonable and customary fees be adopted:

*Usual fee* is the fee which an individual dentist most frequently charges for a specific dental procedure.

*Reasonable fee* is a value that falls within the range of fees charged by an individual dentist for a specific dental procedure which have been adjusted higher or lower than the dentist's usual fee to reasonably reflect unusual difficulty or circumstances in delivering a particular service.

*Customary fee* is an amount that has been designated by a single party from a range of values that reflect both the predominately reported charges of the dentists in a particular community for a specific dental procedure and the purposes of the party making the designation. The designated value of the *customary fee* for a particular community will vary greatly depending on the computational parameters selected and the intent of its use.

and be it further

**Resolved**, that it is inappropriate to assign or communicate values for "usual" and "reasonable" fees based on a sample of a dentist's charging history that is less than complete for a given period, and be it further

**Resolved**, that the use of the term "customary" or "UCR" to justify denial of a claim or communicate with patients or dental benefit plan purchasers is inappropriate due to the arbitrary and prejudicial manner in which it can be designated, and be it further

**Resolved**, that the ADA should communicate these definitions to insurance regulators, consumer advocacy groups, and dental benefits administrators to encourage the proper use of these terms, and be it further

**Resolved**, that the current policy on definitions of usual, customary and reasonable fees (*Trans.* 1987:501) be rescinded.

The Council on Dental Benefit Programs has reviewed Resolution 79-2009 and recommends that it not be adopted. The Council agrees that the terms "UCR" or "usual," "customary" and "reasonable" can be misleading and may have a negative impact on the doctor-patient relationship. A common misperception is that the terms usual, customary and reasonable are interchangeable; they are not and "UCR" is a misleading acronym.

Dentists determine their own usual fees. The insurance company's fee schedule is called customary, but it may or may not reflect the fees that area dentists charge. There is no universally accepted method for determining the customary fee schedule, which may vary a great deal among plans—even when those plans operate in the same area.

The fee the insurance company determines to be “customary” may be lower than the area dentists’ usual fee for the same service.

The term “reasonable” is actually a subset of the term “usual.” The Council believes that the public may interpret a fee that is not “reasonable” as being “unreasonable” and by eliminating this definition and including it in the definition of “usual” should help clarify these terms and may lessen any negative impact on the doctor-patient relationship due to EOB language that currently uses these terms. Therefore, the Council recommends adoption of the following resolution. This resolution supports the ADA Strategic Plan Goal of Advocacy.

**8. Resolved**, that the following definitions of “usual” and “customary” fees be adopted:

*Usual fee* is the fee which an individual dentist most frequently charges for a specific dental procedure independent of any contractual agreement.

It is always appropriate to modify this fee based on the nature and severity of the condition being treated and by any medical or dental complications or unusual circumstances.

*Customary fee* is the fee level determined by the administrator of a dental benefit plan for a specific dental procedure. This may vary widely by geographic region or by benefit plans within a region.

and be it further

**Resolved**, that the use of the terms “customary” or “UCR” to justify denial of a claim or communicate with patients or dental benefit plan purchasers is inappropriate due to the arbitrary and prejudicial manner in which it can be designated, and be it further

**Resolved**, that the ADA should communicate these definitions to insurance regulators, consumer advocacy groups, and dental benefits administrators to encourage the proper use of these terms, and be it further

**Resolved**, that the Definitions of Usual, Customary and Reasonable Fees (*Trans.*1987:501) be rescinded.

**Meetings:** The Council met in the ADA Headquarters Building on April 23-25, 2009, November 19-21, 2009, and April 22-24, 2010. The Council is scheduled to meet again on November 4-6, 2010. Dr. Kenneth J. Versman, Fourteenth District trustee, serves as the Board of Trustees’ liaison to the Council and Ms. Naomi S. Sever serves as the ASDA liaison to the Council.

**Chair and Vice Chair:** Dr. Christopher J. Smiley was nominated as chair of the Council for the 2010-2011 term at the April 2010 meeting. Dr. Daniel J. Klemmedson was elected vice chair of the Council for the 2010-2011 term at the April 2010 meeting.

**Personnel:** The close of the 2010 annual session brings to an end the terms of three valued members of the Council: Dr. Bert W. Oettmeier, Jr., Dr. Robert G. Plage and Dr. Jeffrey Seiver. These members have made great contributions to the work of the Council and have given unselfishly of their time and energy on behalf of the profession. Their efforts are acknowledged by the Council with great appreciation.

## Summary of Resolutions

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**1. Resolved**, that the Statement on Determination of Usual, Customary and Reasonable Fees (*Trans.*1991:633) be amended by deleting the words “usual” and “reasonable” (deletions are shown by strikethroughs), and be it further **Resolved**, that appropriate agencies of the ADA take action to encourage the adoption of these guidelines at both the state and federal level.

### **Statement on Determination of Usual, Customary and Reasonable Fees**

The legitimate interests of insured patients are best served by use of precise, accurate and publicly announced methodologies for determining ranges of fees for all dental services.

Therefore, policy makers should develop guidelines for regulations which:

- Establish standard terminology for identifying benefits in policies, Explanation of Benefits and other descriptive materials
- Establish a standard screen setting method (such as percentile) and/or require a policy statement, which describes the overall percentage of services (percentile) the policy should allow in full
- Require disclosure regarding the average percentage of claim dollars submitted anticipated to be allowed
- Require disclosure describing the frequency of updates and/or the basis for screen development
- Require disclosure describing how region and specialty were considered in setting the Customary Fee Screens
- Require carriers to use sufficient data when determining Customary Fee Screens (whether from claims experience or other sources)
- Require carriers to demonstrate how they have set their screens and how they have determined if sufficient data were employed.

**2. Resolved**, that the Definitions of Fraudulent and Abusive Practices in Dental Benefit Plans and Claims (*Trans.*1998:701; 2001:428) be amended by deletion of the second paragraph under the definition of “Inappropriate Fee Discounting Practices” (deletions are shown by strikethroughs):

#### **Inappropriate Fee Discounting Practices:**

Intentionally engaging in practices which would force a dentist, who does not

have a participating provider agreement, to accept discounted fees or be bound by the terms and conditions set forth in the participating provider contract.

~~Some examples of inappropriate fee discounting practices include: issuing reimbursement checks which, upon signing, result in the dentist accepting the amount as payment in full; using claim forms which, upon signing, require the dentist to accept the terms of the plan's contract; issuing insurance cards which state that the submittal of a claim by a dentist means that he or she accepts all terms and conditions set forth in the participating provider contract; and sending communications to patients of nonparticipating dentists which state that he or she is not responsible for any amount above usual, customary and reasonable fees as established by the plan.~~

**3. Resolved**, that the Standards for Dental Benefit Plans (*Trans.*1988:478; 1989:547; 1993:696; 2000:458; 2001:428; 2008:453), Paragraph 21, be amended as follows (deletions are shown by strikethroughs):

21. The methodology used by plan administrators to set reimbursement schedules ~~or percentiles, or for UCR and/or MAB determinations~~ should rely on current, geographic and other relevant data and be readily available to patients, plan purchasers and dentists.

**4. Resolved**, that the policy "American Dental Association Dental Health Program for Children" (*Trans.*1966:179, 306; 1967:336), Principle 16, be amended as follows (additions are shown by underscoring; deletions are shown by strikethroughs):

16. Priority consideration should be given to reimbursement for professional services on the "full ~~usual and customary~~ fee" basis.

**5. Resolved**, that the following Statement on Dental Consultants be adopted.

### **Statement on Dental Consultants**

Third-party payers and plan purchasers have used dental consultants in order to streamline the claims review process for many years.

The Council on Dental Benefit Programs initially applauded the use of dental consultants by third-party payers as a means of receiving professional advice on certain aspects of dental benefits plans. While the Council still believes that there is value to third-party payers' use of dental consultants, it also believes that some clear distinctions must be made between dental consultants and dental claims reviewers.

Dental claims reviewers work under supervision. They do not necessarily have, or need, clinical dental or dental practice background, and are trained specifically

by the third-party payer to review dental claims that are uncomplicated and require straightforward processing.

Dental consultants are licensed dentists who, even if not currently practicing, have many years of experience in practice and can and should:

- Offer a professional opinion regarding complicated dental treatment
- Provide their name, degree, license number and direct phone number to the treating dental office
- Request consultations from specialists for certain specialty-related cases, when necessary
- Provide advice to third-party payers regarding the merit and value of dental benefits plan designs
- Educate plan purchasers regarding the impact alternative, less costly treatment may have on the life of a tooth, overall oral health, etc.
- Alert third-party payers when dentists' treatment patterns are changed by cost containment strategies to the detriment of the patients
- Provide guidance to third-party payers regarding the importance of the dentist/patient relationship
- Inform third-party payers, plan sponsors and subscribers about the availability and value of the profession's peer review system
- Initiate dialogue with organized dentistry regarding questionable treatment modalities
- Inform the dental profession of those treatment procedures on which questions of judgment between the dentist and the dental consultant are most likely to result in areas of disagreement
- Discuss treatment decisions with dentists on a professional level
- Explain clearly to practicing dentists the provisions of particular contracts and the benefit limitations of those contracts
- Demonstrate knowledge of contract interpretation, and laws and regulations governing dental practice in those jurisdictions affected by their consulting activities, as well as accepted standards of administrative procedure within the dental benefits industry
- Dentists reviewing claims submissions should be licensed in the United States, preferably within the jurisdiction of the dentist treating the patient in accordance with applicable state law

Dentists have a fundamental obligation to serve the best interests of the public and their profession. This obligation can never be abrogated for any reason. In order to maintain independent thought and judgment regarding dental matters, dental consultants should be practicing dentists for a minimum of 50% of their time, thus ensuring familiarity with current clinical procedures and practice through such mechanisms as continuing education, or have been in practice for a minimum of ten years immediately preceding employment as a dental consultant, and remain involved in the continuing dental education process in order to stay current with clinical procedures and changing technology.

It is strongly recommended that dental consultants be members of the American Dental Association.

and be it further

**Resolved**, that the Council on Dental Benefit Programs distribute copies of this Statement to all third-party payers, and be it further

**Resolved**, that third-party payers, including dental consultants to payers, should not exceed their legitimate role in the processing of dental benefit claims, and specifically, third-party payers and dental consultants should not:

- Change code numbers as submitted without written permission of the attending dentist
- Redefine code numbers without prior notification of the attending dentist
- Disapprove complex specialty cases without seeking the advice of appropriate specialist consultants

and be it further

**Resolved**, that the ADA urge third-party payers and administrators to identify dental consultants by name in any correspondence to attending dentists, and be it further

**Resolved**, that the policies on Disclosure of Dentist Consultants Upon Request (*Trans.*1985:583), Statement on Dental Consultants (*Trans.*1989:542) and Identifying Dental Consultants (*Trans.*2002:412) be rescinded.

**6. Resolved**, that the American Dental Association pursue federal legislation or regulation to require self-funded dental benefit plans to provide in the explanation of benefits the name, degree, license number, and direct phone number of the licensed dentist or of any other individual who makes the final decision involved in accepting or rejecting the dental claim, and be it further

**Resolved**, that the ADA request that constituent and component dental societies pursue state legislation or regulation to require insured dental benefit plans to provide in the explanation of benefits the name, degree, license number, and direct phone number of the licensed dentist or of any other individual who makes the final decision involved in accepting or rejecting the dental claim and that dentists reviewing claims submissions should be licensed in the United States, preferably within the jurisdiction of the dentist treating the patient in accordance with applicable state law.

**7. Resolved**, that the Dental Practice Parameters Committee be disbanded effective December 31, 2010, and be it further

**Resolved**, that the Council on Dental Benefit Programs be charged with the responsibility to monitor the Parameters and recommend removal of any Parameters that become too outdated to be useful.

**8. Resolved**, that the following definitions of “usual” and “customary” fees be adopted:

*Usual fee* is the fee which an individual dentist most frequently charges for a specific dental procedure independent of any contractual agreement.

It is always appropriate to modify this fee based on the nature and severity of the condition being treated and by any medical or dental complications or unusual circumstances.

*Customary fee* is the fee level determined by the administrator of a dental benefit plan for a specific dental procedure. This may vary widely by geographic region or by benefit plans within a region.

and be it further

**Resolved**, that the use of the terms “customary” or “UCR” to justify denial of a claim or communicate with patients or dental benefit plan purchasers is inappropriate due to the arbitrary and prejudicial manner in which it can be designated, and be it further

**Resolved**, that the ADA should communicate these definitions to insurance regulators, consumer advocacy groups, and dental benefits administrators to encourage the proper use of these terms, and be it further

**Resolved**, that the Definitions of Usual, Customary and Reasonable Fees (*Trans.*1987:501) be rescinded.

## Council on Dental Education and Licensure

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**Meyerowitz, Cyril**, New York, 2011, chair, American Dental Education Association  
**Perkins, David**, Connecticut, 2011, vice chair, American Association of Dental Boards  
**Antoon, James W.**, Florida, 2012, American Dental Association  
**Davis, Jennifer**, Pennsylvania, *ex officio* \*  
**Edwards, Michael D.**, Alabama, 2013, American Dental Association  
**Hupp, James R.**, North Carolina, 2010, American Dental Education Association  
**Israelson, Hilton**, Texas, 2013, American Dental Association  
**Javed, Tariq**, South Carolina, 2013, American Dental Education Association  
**Johnson, Charles E.**, Illinois, 2012, American Dental Association  
**Kanna, Stanwood H.**, Hawaii, 2010, American Association of Dental Boards  
**Kennedy, Brian T.**, New York, 2011, American Dental Association  
**Kinney, George J., Jr.**, Minnesota, 2012, American Association of Dental Boards  
**Lloyd, Patrick M.**, Minnesota, 2012, American Dental Education Association  
**Moore, David T.**, New Mexico, 2010, American Dental Association  
**Rich, Barbara A.**, New Jersey, 2010, American Dental Association  
**Robinson, William F.**, Florida, 2013, American Association of Dental Boards  
**Schmidt, James L.**, Maine, 2011, American Dental Association  
**Hart, Karen M.**, director  
**Borysewicz, Mary**, manager  
**Haglund, Lois J.**, manager  
**Yokom, Nanci G.**, manager

**Meetings:** The Council on Dental Education and Licensure (CDEL) met in the ADA Headquarters Building on November 5-6, 2009, and April 29-30, 2010. Dr. Samuel B. Low, Seventeenth District, served as the Board of Trustees' liaison to the Council. The Council is supported by the following Subcommittees:

- Committee on Dental Education
- Committee on Licensure
- Continuing Education Recognition Program Committee
- Committee on Career Guidance and Diversity Activities
- Committee on Continuing Education
- Committee on Educational Measurements and Testing
- Committee on Specialty Recognition
- Committee on Anesthesiology
- The ADA/ADEA/CODA Liaison Committee

**Strategic Planning and Self-Assessment:** The Council continued to develop and implement action plans and strategies which complement the *ADA Strategic Plan: 2007-*

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\*Committee on the New Dentist member without the power to vote.

2010 and are relevant to its mission and duties. The Council's strategic priorities for 2009-2010 were:

- 1) Work with CODA in the development of accreditation standards for training programs for new allied dental team member categories.
- 2) Work with the communities of interest to achieve acceptance of a national licensure examination.
- 3) Work with the communities of interest to address the faculty recruitment and retention challenges facing dental, advanced dental and allied dental education
- 4) Work with communities of interest in addressing concerns related to conflict of interest and commercialism in dental and continuing dental education.
- 5) Support ADA CE Online.
- 6) Promote continuing education offerings in sedation, particularly the two-part Recognition and Management of Complications during Minimal and Moderate Sedation course.
- 7) Support the ADA's diversity activities.
- 8) Support the Association's promotion of the dental laboratory technology industry.

In November 2009, the Council's Mega Issue Discussion focused on the education of new allied dental team members. The Council conducted a periodic self-assessment in April 2010, confirming that its current membership composition is appropriate and its activities are relevant to grass roots members. A detailed report is provided to the House of Delegates elsewhere by the ADA Board of Trustees. During this self-assessment process, the Council reviewed the ADA *Bylaws*, Chapter X. Councils, carefully examining Section 20. MEMBERS, SELECTION, NOMINATION AND ELECTIONS and Section 120. DUTIES. The Council determined that Section 20 related to Committees of the Council on Dental Education and Licensure should be amended to change the name of the Committee on Dental Education and Educational Measurements to its accurate name, i.e., the Committee on Dental Education. In regard to Section 120. DUTIES, the Council concluded that some terminology should be updated. For example, "dental auxiliary" should be changed to "allied dental personnel" and "special areas of practice" should be changed to "dental specialties." In addition, the Council believed that its responsibility for providing information on dental careers and recommending policy on continuing dental education should be clearly noted in its duties. Accordingly, the Council forwards to the House of Delegates the following resolutions proposing amendments to correct the name of the Council's Committee on Dental Education and update the Council's duties.

**9. Resolved**, that Chapter X. COUNCILS, Section 20. MEMBERS, SELECTION, NOMINATION AND ELECTIONS, Subsection A. regarding the Council on Dental Education and Licensure, Subsection a.(3) c. Committees of the ADA *Bylaws* be amended as follows (strikethrough = deletion):

- c. Committees. The Council on Dental Education and Licensure shall establish a standing Committee on Dental Education and ~~Educational Measurements~~ and a standing Committee on Licensure, each consisting of eight (8) members selected

by the Council. The Council may establish additional committees when they are deemed essential to carry out the duties of this Council.

**10. Resolved**, that Chapter X. COUNCILS, Section 120. DUTIES, Subsection E. COUNCIL ON DENTAL EDUCATION AND LICENSURE, subsections a., b. and c. of the ADA *Bylaws*, be amended and subsection e. be added as follows (strikethrough = deletion; underscore = additions):

*Section 120. DUTIES:*

E. COUNCIL ON DENTAL EDUCATION AND LICENSURE. The duties of the Council shall be:

- a. To act as the agency of the Association in matters related to the evaluation and accreditation of all dental educational, allied dental ~~auxiliary~~ educational and associated subjects.
- b. To study and make recommendations including the formulation and recommendation of policy on:
  - (1) Dental education, continuing dental education and allied dental ~~auxiliary~~ education.
  - (2) The recognition of dental specialties.
  - (3) The recognition of categories of allied dental personnel ~~auxiliaries~~.
  - (4) The approval or disapproval of national certifying boards for dental specialties ~~special areas of dental practice~~ and for allied dental personnel auxiliaries.
  - (5) The educational and administrative standards of the certifying boards for ~~special areas of dental practice~~ dental specialties and for allied dental personnel auxiliaries.
  - (6) Associated subjects that affect all dental, allied dental ~~auxiliary~~ and related education.
  - (7) Dental licensure and allied dental personnel auxiliary credentialing.
- c. To act on behalf of this Association in maintaining effective liaison with certifying boards and related agencies for ~~special areas of dental practice~~ dental specialties and for allied dental personnel auxiliaries.
- d. To monitor and disseminate information on continuing dental education and to encourage the provision of and participation in continuing dental education.
- e. To monitor and disseminate information on careers in dentistry.

**Collaborating with Councils, Agencies and Associations:** Members of the Council served on a number of interagency committees and subcommittees in 2009-2010, including the Dental Practice Parameters Committee, Council on Dental Benefit Program's Subcommittee on Quality Assessment and Improvement, Advisory Committee on Evidence-Based Dentistry, SNODENT Editorial Panel, Elder Care Education Committee, CDHC National Advisory Board, ADA National Dental Diversity Summit, Dental Lab Summit, Board Workgroup to Study Resolution 26S-1-2009, (a national clinical exam), Board Workgroup to Study Admission Examination for Advanced Dental Education Programs (Resolution 56H-2009), CODA/CDEL/CEBJA Ad

Hoc Committee to Develop Definitions for Recognition, Accreditation and Certification, and the ADA/ADEA Workgroup on the Education of New Allied Dental Team Members.

CDEL and the American Dental Education Association (ADEA) co-sponsored the American Association of Dental Boards' (AADB) April 2010 Mid-Year Meeting. CDEL, with the Council on Ethics, Bylaws and Judicial Affairs (CEBJA) and the Council on Dental Practice (CDP) continued the work of the Joint Subcommittee on Ethics and Integrity in Dental Education and Practice. Other organizations collaborating in this effort include the American College of Dentists, (ACD), American Student Dental Association (ASDA), American Dental Education Association (ADEA), American Association of Dental Boards (AADB), Commission on Dental Accreditation (CODA), Joint Commission on National Dental Examinations (JCNDE) and the American Society of Dental Ethics (ASDE).

During the ADA 2009 annual session, CDEL and ADEA co-sponsored workshops for practitioners interested in becoming dental faculty and members interested in mentoring dental students.

## **Dental Education**

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**Faculty Recruitment and Retention:** The Council continues to support several initiatives aimed at recruiting dental students/dentists into careers in dental education. A top priority is the development of a DVD promoting careers in academic dentistry, an initiative approved by the Council at its May 2009 meeting. The Council also approved the recommendation of its Subcommittee on Faculty Recruitment and Retention to seek financial support from the dental specialty organizations to develop the video. The Council proposed the joint effort to the dental specialty organizations and certifying boards at its August 2009 meeting with those groups; representatives were receptive to the idea and indicated their interest in and willingness to contribute to the project.

In November 2009, the Council directed the appointment of an ad hoc committee to oversee the development, production and distribution of a DVD positioning academia as an attractive career choice and directed that the proposed schedule for development, production and distribution of the DVD be accelerated and completed as soon as possible. Letters were sent in March 2010 to each dental specialty organization and its foundation as well as the ADA Foundation requesting financial support for the development and production of the DVD.

**Golden Apple Awards:** The ADA's Golden Apple Awards Program is a unique opportunity for constituent and component dental societies to gain valuable recognition for their leaders, members and staff. Since 2003, the Council has sponsored a Golden Apple Award to recognize individuals for outstanding mentoring of students interested in academic careers. The award, "Inspiring Careers in Dental Education," is open to nominations from not only constituents and components, but other dental organizations and members at large.

At its April 2010 meeting, the Council chose Dr. Joseph Paul Connor, assistant professor, Department of Restorative Dentistry, University of Texas Health Science Center at San Antonio, as the 2010 recipient of the award. Dr. Connor will receive the prestigious Golden Apple Trophy along with funding to attend ADA's 2010 annual session.

**Matters Relating to Accreditation:** A duty of the Council is to review matters related to the accreditation of dental and allied dental education programs. Accordingly, the Council reviewed and made comments regarding the following proposed changes to Commission on Dental Accreditation standards:

*Proposed Revisions to the Accreditation Standards for Advanced General Dentistry Education Programs in Dental Anesthesiology.* The Council members agreed that the changes to Standard 3-2, Faculty and Staff, regarding the educational and training requirements of dental anesthesiology program directors, were appropriate and believed that the proposed changes provide more flexibility in finding individuals to serve as program directors who meet the accreditation standards.

*Proposed Revisions to the Accreditation Standards Common to All Advanced Education Programs Related to Standard 5, Advanced Education Students/Residents Evaluation.* The Council noted that the requirements for ongoing student evaluation and advancement have not changed *per se*. However, the terminology and processes for evaluation and advancement have been changed to reflect the educational protocols and practices related to competency-based education. Specifically, student/resident assessment must be ongoing and use multiple methods (process and end-product) of evaluation.

*Proposed Revisions to the Accreditation Standards for Dental Education Programs.* The Council noted that the term, "community-based experiences," and its definition have been added to the standards and includes dental offices as a location where students can provide patient care. The Council expressed its concerns about the use of private practice facilities for instruction, e.g., student/resident supervision, calibration of teaching staff and patient fees. The Council noted that other proposed changes to Standards 1, 2, 3, 4 and 5 are editorial in nature and do not change the intent of the standards.

*Proposed Revisions to the Accreditation Standards for Advanced Specialty Education Programs in Orthodontics and Dentofacial Orthopedics.* The Council noted the changes in Standard 2.2 and Standard 4, requiring programs to prepare students for and to monitor their success in achieving certification by the American Board of Orthodontics.

*Proposed Ethics and Professional Standard for All Disciplines under CODA's Purview.* The Council strongly supported the addition of the proposed ethics and professionalism standard to the accreditation standards for all programs.

*Proposed Revisions to the Accreditation Standards for Advanced Specialty Education Programs in Oral and Maxillofacial Surgery.* The Council noted three proposed changes to Standards 4.15 and 4.16 to: 1) expand the scope of orthognathic surgery by the addition of “treatment of obstructive sleep apnea” to its definition; 2) add consultation with “sleep medicine team” to the definition of comprehensive care for sleep apnea patients and 3) limit the types of cosmetic surgery experiences students should have to only three procedures.

*Proposed Revisions to Language Common to the Accreditation Standards for All Advanced Specialty Education Programs.* Three references permitting the use of private office facilities for providing clinical experiences for students/residents were noted in the revised language. The Council expressed its concerns about the use of private practice facilities for instruction in regards to student/resident supervision, calibration of teaching staff, and patient fees. Other changes were considered to be editorial in nature and do not change the intent of the standards.

## **Allied Dental Education**

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In April 2010, the Council received a report summarizing the establishment of the Oral Preventive Assistant curriculum, as requested by the 2006 ADA House of Delegates (*Trans.2006:307*) and reported to the 2008 House of Delegates (*Supplement 2008:4063*).

The OPA curriculum modules were developed under the assumption that enrollees will be graduates of CODA-accredited dental assisting programs or dental assistants certified by the Dental Assisting National Board, Inc. (DANB). Many of the skill sets for the OPA already are incorporated in CODA-accredited dental assisting programs, e.g., application of fluoride, placement of sealants and oral hygiene instruction. The OPA program will expand in those areas, and include select clinical instruction for competency in scaling for patients with plaque-induced gingivitis. The main focus of this new category of allied dental personnel is to provide the dentist and dental team an expanded preventive capability and flexibility to increase access to care. The highly trained and licensed hygienist can focus on the more involved patients while the OPA treats the less complex gingivitis cases. The design of the OPA curriculum permits several options for delivery, including online (as appropriate), classroom and clinical settings. Ultimately, state dental boards will determine eligibility, training, and certification and/or licensure requirements specific for their states. Each state has the prerogative to determine if and how to implement an OPA training program.

In accord with Resolution 48H-2008 (*Trans.2008:495*) which established the protocol requiring appropriate councils to be involved in the Association’s intellectual property licensing grants, the Council reviewed and approved the terms for use of the OPA curriculum and the Board of Trustees approved the elements of the draft agreement template for licensing oral preventive assistant curriculum modules for non-exclusive use by ADA constituent dental societies and accredited dental assisting programs. Subsequently, state dental societies were notified of the availability of licenses for the

oral preventive assistant curriculum modules. To date, the Missouri Dental Association and Illinois State Dental Society have contacted the ADA for more information about the OPA modules.

### **Trends in Dental Licensure and Clinical Licensing Examinations**

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Each year, the Council reviews an update on the status of clinical licensure examinations and related issues. As appropriate, the Council provides current information to the dental school deans about each state's membership in the clinical testing agencies and contact information for the state boards of dentistry and the clinical testing agencies. The Council periodically contacts the constituent dental societies, encouraging them to undertake initiatives to implement ADA policies related to licensure and freedom of movement.

**Dental Licensure via PGY-1:** New York continues to be the only state that requires initial licensure applicants to complete an advanced education residency program of at least one year in length (PGY-1) that is accredited by the ADA Commission on Dental Accreditation. California, Connecticut, Minnesota and Washington offer candidates the option of completing a residency or taking a clinical examination. Delaware is the only state that requires both the one-year residency and a clinical examination.

**Minnesota's Use of the Canadian NDEB's Exam:** In June 2009, the Minnesota Board of Dentistry voted unanimously to approve use of the National Dental Examining Board (NDEB) of Canada's two part exam, which includes both a written and a non-patient-based Objective Structured Clinical Examination (OSCE), for testing competence of University of Minnesota graduates applying for licensure to practice in the state. To date, Minnesota is the only state to approve this alternative to the traditional clinical licensure examination. The examination was administered for the first time at the University of Minnesota in March 2010.

**Licensure by Credentials:** There have been no changes in state laws regarding licensure by credentials since the Council's 2009 annual report. Dental boards in 46 states plus the District of Columbia and Puerto Rico have authority to grant licensure by credentials. Only Delaware, Florida, Hawaii, Nevada and the Virgin Islands do not.

Hawaii has a community service law that allows dentists with certain credentials to work *only* in federally qualified health centers, native Hawaiian health centers and postsecondary dental training programs. Florida adopted a law in May 2008 that allows dentists who have been in practice for five years and licensed in another state to obtain a "health access" dental license without taking the clinical examination; practice under that license is limited to health access settings such as community health centers and Head Start centers.

**Volunteer Licensure:** Approximately half of all state dental boards may grant volunteer licenses to dentists who agree to donate their services to underserved populations. Volunteer licenses are most often granted to retired dentists. More states

are expected to enact this type of legislation in an effort to address access to care issues.

**Clinical Licensure Examinations:** There are five regional testing agencies and four independent states that administer a clinical licensure examination. The five regional clinical testing agencies include the Central Regional Dental Testing Service (CRDTS), Council of Interstate Testing Agencies, Inc. (CITA), North East Regional Board of Dental Examiners, Inc. (NERB), Southern Regional Testing Agency (SRTA), and Western Regional Examining Board (WREB). The four independent/state testing agencies are Delaware, Florida, Nevada and the Virgin Islands.

Nevada is not a member of any particular testing agency, but is a member of ADEX and accepts WREB examination results. California administers its own examination and also is a WREB member for the dental examination only. Approximately six state dental licensing agencies accept successful completion of a clinical licensure examination administered by any recognized individual state or regional/national testing agency for the purpose of licensure in their state.

The American Board of Dental Examiners (ADEX) continues to operate as an examination development agency. The Council continues to monitor the ramifications of the decision by CRDTS to discontinue the use of the examination developed by ADEX. In early 2009, approximately 40 states accepted the results of the ADEX examination. In 2010 the number of state boards participating as members of ADEX decreased from approximately 31 to approximately 22.

### **ADA-Recognized Dental Specialties and ADA-Recognized Specialty Certifying Boards**

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**Annual Meeting with Dental Specialty Certifying Boards and Organizations:** In August 2009, the Council hosted its annual meeting with the ADA-recognized dental specialty certifying boards and sponsoring organizations at ADA Headquarters in Chicago. The meeting agenda included updates on ADA activities and the proposed resolutions to the 2009 House of Delegates, a report from the Royal College of Dentists of Canada, a presentation about the ADA Course on Recognition and Management of Complications during Minimal and Moderate Sedation, updates from the dental specialty boards and organizations, a discussion on an alternative to the National Board Dental Examination scores for evaluation of candidates for advanced dental education programs, a proposal from CDEL for collaboration on activities to promote academic careers and an update on ADA Evidence-Based Dentistry activities. The 2010 meeting is scheduled for Monday, August 16.

**Report of the ADA Recognized Dental Specialty Certifying Boards:** As part of its *Bylaws* responsibilities the Council annually surveys the recognized dental specialty certifying boards. The 2010 *Report of the ADA Recognized Dental Specialty Certifying Boards* is available on ADA.org at <http://www.ada.org/494.aspx>. The 2010 report shows that during this period, all nine specialty certifying boards certified diplomates and six

recertified diplomates. The report also reflects changes that some boards made to the eligibility requirements, application and registration procedures, reexamination policies, recertification policies or *Bylaws*. Four certifying boards (dental public health, oral and maxillofacial pathology, oral and maxillofacial surgery and pediatric dentistry) reported offering an alternate pathway to certification for internationally trained dental specialists; none of the boards reported certifying individuals through this pathway in 2009.

### **2011 Periodic Review of Dental Specialty Education and Practice**

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In 1992 the Council proposed and the ADA House of Delegates directed that a review of specialty education and practice should be conducted at 10-year intervals beginning in 2001 (*Trans.*1992:620). The purpose of these studies is to gather strategic information that will be of value to the profession. Factors such as changes in technology, changes in enrollment patterns, changes in dental disease patterns, changing demographics, epidemiological studies, shifts in scope of practice of all specialties and changes in the general and specialty practice environments are considered.

In preparation for the 2011 Periodic Review, the Council reviewed the format of the report during its August 2008 meeting with the dental specialty organizations and certifying boards. Following the established timetable, the Council disseminated the Report Form for the 2011 Periodic Review of Dental Specialty Education and Practice to each of the dental specialty organizations in July 2009, requesting that completed reports be submitted to CDEL by May 1, 2010. All reports have been received. The Council's Committee on Specialty Recognition will review the completed reports and forward a summary report to the Council for review at its November 2010 meeting. The Council will then forward its final report to the 2011 House of Delegates.

### **Recognition of Interest Areas in General Dentistry**

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The ADA 2009 House of Delegates referred Resolution 52-2009, CDEL *Bylaws* Amendment Regarding Recognition of Non-Specialty Interest Areas in General Dentistry (*Trans.*2009:442; 445), to the Council on Dental Education and Licensure for further study.

Since 1975, the ADA House of Delegates and the Board of Trustees have been discussing issues related to the recognition of non-specialty interest areas in general dentistry. The Council reviewed this history, including Board Report 12-2006 (*Supplement* 2006:5057) as well as Board Report 13-2009 (*Supplement* 2009:4016), and concluded that a recognition program would be beneficial to members and the public. The Council believes that the ADA is the appropriate organization to recognize interest areas in general dentistry and CDEL is the appropriate Council to conduct such a recognition program. Therefore, the Council recommends that its *Bylaws* duties be amended to include this new responsibility.

The Council also concurred with the Board's 2006 recommendation that general dentistry interest areas should first seek recognition by the ADA House of Delegates

before seeking accreditation by CODA. This sequence will be helpful to CODA in determining whether the interest area is a *bona fide* practice area with focused training programs and has the profession's support.

The Council then considered the name given to the program in Resolution 52 and the discussion regarding the name of the program found in Board Report 12-2006, page 5059. Report 12-2006 acknowledges that the program name, Non-specialty Interest Areas in General Dentistry, is consistent with the *ADA Code*. However, the Council believes that the term, "non-specialty interest areas" may be confusing and misunderstood by the public and recommends that the new recognition program be named, "The Recognition of Interest Areas in General Dentistry."

To manage this new responsibility, the Council determined that its Standing Committee on Specialty Recognition could conduct the preliminary reviews of applications for recognition of general dentistry interest areas, mirroring its process for the recognition of dental specialties:

- 1) An application for Recognition as an Interest Area in General Dentistry is submitted to the Council on Dental Education and Licensure by June 1 along with the appropriate documentation and application fee (current fee for Specialty Recognition is \$3,000).
- 2) Receipt of the application is announced by CDEL and made available to all communities of interest for review and comment.
- 3) At the end of the comment period, CDEL considers the application along with the comments and determines whether to recommend recognition by the House of Delegates.
- 4) CDEL forwards the application and its recommendation to the House of Delegates for consideration.
- 5) If the application for recognition is approved by the House of Delegates, the House urges CODA to initiate an accreditation process for advanced education programs in the general dentistry interest area.

The Council supports the recognition criteria as first proposed by the Board of Trustees in 2006 with one addition to include the term "evidence-based" in Requirement 1 and recommends that the proposed "Criteria for Recognition of Interest Areas in General Dentistry" be adopted by the 2010 House of Delegates.

Accordingly, in response to Resolution 52-2009, the Council transmits the following resolutions to the 2010 ADA House of Delegates:

**11. Resolved**, that Chapter X. COUNCILS, Section 120. DUTIES, Subsection E. COUNCIL ON DENTAL EDUCATION AND LICENSURE, subsection b, of the *ADA Bylaws*, be amended by addition of the following new paragraph:

- (3) The recognition of interest areas in general dentistry.

and be it further

**Resolved**, that existing paragraphs “3” through “7” be renumbered as “4” through “8,” respectively.

**12. Resolved**, that the following proposed “Criteria for Recognition of Interest Areas in General Dentistry” be adopted.

### **Criteria for Recognition of Interest Areas in General Dentistry**

1. The existence of a well-defined body of established evidence-based scientific and clinical dental knowledge underlying the general dentistry area - knowledge that is in large part distinct from, or more detailed than, that of other areas of general dentistry education and practice.

#### Elements to be addressed:

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

#### Elements to be addressed:

- Identification of distinct components of biomedical, behavioral and clinical science in the advanced education area
  - Description of why this area of knowledge is a distinct education area of general dentistry, rather than a series of just one or more techniques
  - Documentation demonstrating that the body of knowledge is unique and distinct from that in other education areas accredited by the Commission on Dental Accreditation
  - Documentation of the complexity of the body of knowledge of the general dentistry area by identifying specific advanced techniques and procedures, representative samples of curricula from existing programs, textbooks and journals
3. The existence of established advanced educational programs with structured curricula, qualified faculty and enrolled individuals for which accreditation by the Commission on Dental Accreditation can be a viable method of quality assurance.

Elements to be addressed:

- Description of the historical development and evolution of educational programs in the area of advanced training in general dentistry
- A listing of the current operational programs in the advanced general dentistry training area, identifying for each, the:
  - a. Sponsoring institution;
  - b. Name and qualifications of the program director;
  - c. number of full-time and part-time faculty (define part-time for each program);
  - d. Curriculum (course outlines, student competencies, class schedules);
  - e. Outcomes assessment method;
  - f. Minimum length of the program;
  - g. Certificate and/or degree awarded upon completion;
  - h. Number of enrolled individuals per year for at least the past five years\*; and
  - i. Number of graduates per year for at least the past five years.\*

\*If the established education programs have been in existence less than five years, provide information since their founding.

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

Elements to be addressed:

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

5. The competence of the graduates of the advanced education programs is important to the health care of the general public.

Elements to be addressed:

- Description of the need for appropriately trained individuals in the general dentistry area to ensure quality health care for the public
- Description of current and emerging trends in the general dentistry education area
- Documentation that dental health care professionals currently provide health care services in the identified area
- Evidence that the area of knowledge is important and significant to patient care and dentistry

### **ADA-Recognized Certification Boards for Dental Laboratory Technology and Dental Assisting**

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One of the duties of the Council is to approve or disapprove national certifying boards for dental auxiliaries. In accordance with the *Criteria for Approval of a Certification Board for Dental Laboratory Technicians*, the National Board for Certification in Dental Laboratory Technology (NBC) submits an annual report on its program to the Council to determine if the Board continues to meet the *Criteria*. The report includes information on major changes in policies or procedures related to board organization, operation and certification requirements and *Bylaws* changes. A financial statement is provided, as well as a list of current directors serving on the Board. NBC's 2009 Annual Report was presented to the Council for consideration at its November 2009 meeting. NBC's Report was complete and provided the required information.

The Dental Assisting National Board (DANB), as the recognized certifying board for dental assistants, also is required to submit an annual report on its program to the Council to ensure that the Board continues to meet the *Criteria for Recognition of a Certification Board for Dental Assistants* as approved by the 1989 ADA House of Delegates. DANB presented a complete report to the Council at its November 2009 meeting.

In a separate but related matter, the Council continues to discuss DANB's plans to create a certification program for the ADA's new proposed workforce model—the Oral Preventive Assistant. DANB announced at the Council's April 2010 meeting that it has no plans to develop a certification program for the Community Dental Health Coordinator workforce model. The Council has monitored DANB's efforts to federally register as certification marks the terms "Oral Preventive/Prevention Assistant" and "Community Dental Health Coordinator" both alone and preceded by the word "certified," and to federally register the acronyms "COPA" and "CCDHC." DANB has abandoned all those efforts to obtain federal certification mark registrations except as to "COPA." The Council believes that DANB should also abandon its application for registration of COPA and has urged DANB to continue to work with representatives of

the ADA to find a mutually agreeable solution for the COPA trademark certification issues.

### **Anesthesiology and the Emergency Airway Management Course**

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During the 2006-2007 comprehensive review and update of the ADA's anesthesia guidelines documents, the Council recommended that a course be developed specifically for dentists, which concentrates on the emergency management situations faced by dentists administering sedation or general anesthesia in the dental office. Existing courses, such as Advanced Cardiac Life Support (ACLS), focus on interventions concentrating on cardiac arrhythmias, which are not early presentations of airway-related emergencies most commonly faced by dentists administering sedation. The Council worked with the American Dental Association Foundation to develop a Request for Proposal (RFP) for the Foundation's 2008 Education Grant Program. The Grant Review Committee composed of ADAF and CDEL representatives selected the Anesthesia Research Foundation of the American Dental Society of Anesthesiology (ADSA) as the grant recipient.

The Council's Committee on Anesthesiology worked closely with the ADSA during the course development process. The new course, Recognition and Management of Complications during Minimal and Moderate Sedation, has been licensed by the ADA from the ADA Foundation. It contains an online didactic component and examination (Part I) that must be completed prior to taking a hands-on workshop portion of the course (Part II). The Part II workshop consists of a pre-assessment, task training, high fidelity learning experiences and a post course assessment. The task training portion includes oxygen/ventilation, airway adjuncts, monitoring/vital signs and drugs. The high fidelity learning experiences use a simulated patient manikin programmed with several scenarios on hypoventilation/apnea and obstruction (allergy/asthma). The participants work first as a team and are then assessed individually in "rescuing" their "patients." The course will be offered to the general membership for the first time on Thursday-Friday, October 28-29, 2010, at the ADA Headquarters Building.

### **ADA Continuing Education Recognition Program (CERP)**

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The ADA CERP assists members and the broader dental profession in identifying and participating in quality continuing dental education (CE). The ADA CERP promotes continuous quality improvement of CE and assists dental regulatory agencies in establishing a sound basis for increasing their uniform acceptance of CE credits earned by dentists to meet the CE relicensure requirements currently mandated by 49 licensing jurisdictions. At the time this report was prepared, there were 411 ADA CERP nationally recognized providers. Providers are distributed in the following self-reported categories: 23% dental education companies; 17% dental/medical schools, universities and colleges in the United States and Canada; 14% dental specialty organizations or societies; 9% constituent dental societies; 9% pharmaceutical/dental equipment companies; 4% study clubs; 3% hospitals; 3% component dental societies; 3%

communications/publishing companies; 3% consulting companies; 2% federal agencies; 2% insurance companies; and 9% identified as “other.”

**The Extended Approval Process (EAP):** The ADA CERP includes an extended approval process (EAP) through which ADA CERP recognized constituent dental societies and recognized dental specialty organizations can extend approval to their component societies and local affiliates. The state or specialty society submits the application to ADA CERP and, after gaining approval, can extend its ADA CERP recognition to its local groups. Currently, 14 constituent dental societies (Illinois, Indiana, Louisiana, Maryland, Massachusetts, Michigan, Missouri, Nevada, New York, Ohio, Pennsylvania, Tennessee, Virginia and Washington) have been granted the authority to extend their ADA CERP approval to their local societies. The American Academy of Oral and Maxillofacial Pathology, the American Association of Endodontists and the American Association of Orthodontists also use the extended approval process. A total of 136 component dental societies and specialty component organizations have ADA CERP recognition through the EAP. (These are in addition to the 411 providers profiled above.)

**Continuing Education Course Listing:** ADA CERP-recognized providers have the ability to list their CE course offerings on <http://www.ada.org/377.aspx>. This information is available to members and nonmembers.

**Outcomes Assessment for ADA CERP Process:** ADA CERP routinely conducts a survey to collect feedback from the CE providers that have recently completed the application process. Results from providers surveyed in the spring 2010 decision cycle indicate that overall respondents found the application instructions clear and complete, the organization of the application appropriate and logical and the questions clear. Approximately two-thirds of the survey respondents indicated that they had submitted the Abbreviated Application, the shorter version of the application available to providers that demonstrated substantial compliance with recognition standards at the time of their previous review. The Abbreviated Application was first made available in fall 2007. Forty percent of the survey respondents also indicated that this was the first time they had completed an ADA CERP application. This is comparable to the proportion of new provider administrators in previous surveys, indicating a continuing need for information and education for ADA CERP providers. Results from applicant surveys are used to develop instructional programs for providers such as the “Basics of ADA CERP Recognition,” a workshop held during the 2008 ADA annual session, which will be offered again during the 2010 ADA annual session, as well as checklists and additional information for applicants posted online. Provider feedback was also considered when revising the Standard Application for Recognition in 2008-2009.

**Activities Related to Commercialism and Conflicts of Interest in Continuing Education:** The Council and the CERP Committee have been monitoring developments related to management of commercial conflicts of interest in continuing education for healthcare professionals. Concerns have been raised by a variety of professional organizations, regulatory agencies, state and federal governments and the

public regarding financial relationships between industry and healthcare professionals that may create conflicts of interest which can adversely affect professionals' objectivity. The Council reviewed policy statements issued by the Association of American Medical Colleges in 2008, the Institute of Medicine in 2009, and the Council of Medical Specialty Societies in 2010, calling for stronger firewalls between industry and healthcare professionals so that medical education is conducted independent of commercial interests. The Council also noted legislation passed in 2009 in the states of Massachusetts and Vermont regulating interactions between healthcare professionals and industry representatives, and the Physicians Payments Sunshine Act of 2010 which mandates a national database of payments from industry to healthcare providers. In light of the increased emphasis on transparency and independence in continuing education for healthcare providers, the Council directed the CERP Committee to assess whether existing ADA CERP standards and policies effectively promote independence from commercial influence in continuing dental education. Revisions to the ADA CERP Recognition Standards that have been made to help continuing education providers develop appropriate policies and procedures with respect to commercial funding and managing conflicts of interest are described in the next section, in addition to measures that are currently under consideration.

**Changes to ADA CERP Recognition Standards and Policies:** The ADA CERP Recognition Standards and Procedures (Standards and Procedures) undergo review on a periodic basis to ensure currency. In addition, changes may be proposed by ADA CERP's communities of interest. In turn, the Council solicits feedback from the communities of interest prior to adopting substantive proposed changes. In November 2007, at the recommendation of the Board of Trustees, the Council approved revising the CERP Eligibility criteria to permit individual continuing education providers to apply for recognition through the program. Prior to implementing this change, the Council directed the CERP Committee to conduct a thorough review of the Standards to identify any corollary changes needed to make certain that all providers, including individuals, demonstrate compliance with the guidelines for offering credible, unbiased, non-promotional continuing education. The CERP Committee subsequently proposed revisions to the ADA CERP Eligibility Criteria, Recognition Standards, Regulations Governing the Recognition Process, Joint Sponsorship Policy and the Lexicon of Terms (*Reports 2009:78*). A call for comments was circulated to the communities of interest. During the current reporting period, the Council considered feedback from the communities of interest regarding the proposed revisions, and at its November 2009 meeting, the Council approved the revisions. Major revisions are summarized below:

*Eligibility Criteria.* Individual or "sole" providers will be eligible to apply for ADA CERP recognition beginning in January 2011. In addition, it will no longer be required that a provider's continuing education program consist of more than a single course.

To support these measures and enhance providers' abilities to offer continuing education based on identified professional needs and sound content, the Council approved revisions to the Standards detailing the composition and responsibilities of the

independent CE advisory committee that all providers, including “sole” providers, are required to establish.

*Joint Sponsorship.* The Council also approved revisions to the ADA CERP Joint Sponsorship Policy to clarify the responsibilities of an approved provider when partnering with another provider for the purpose of offering credits for specific CE activities. Providers will be required to use a standard statement in all publicity and course materials informing participants when an activity is jointly sponsored, and clearly identifying the organization that is responsible for issuing the CE credits.

*Minimizing Opportunities for Commercial Conflicts of Interest.* The Council approved measures for increasing transparency and minimizing commercial conflicts of interest in continuing dental education, including new requirements for full disclosure of any relevant financial relationships that instructors and planners may have. The revised Standards also include additional guidelines for providers regarding appropriate management of commercial support, advertising and exhibits in conjunction with continuing education activities. The Academy of General Dentistry’s Council on Program Approval for Continuing Education (AGD PACE) has approved similar revisions to the PACE Guidelines.

The Council and the CERP Committee also have considered the potential for conflicts of interest and bias in continuing dental education when companies that manufacture or distribute proprietary dental products or services are approved as providers of continuing education. In reviewing the policies of other organizations that approve or accredit providers of continuing education, the Council noted that the Accreditation Council for Continuing Medical Education (ACCME), Accreditation Council for Pharmacy Education (ACPE), and the American Nurses Credentialing Center (ANCC) do not consider companies that manufacture or market healthcare products eligible for accreditation. The Council believes that collaboration between healthcare professionals and industry can provide many benefits, and that commercial support of continuing education, if managed appropriately by an independent educational provider, may be appropriate. However, the Council believes that approving CE providers that also manufacture or market dental products is inconsistent with the ADA CERP Standards that require providers to develop CE content and select speakers independent of commercial influence. The Council therefore has approved in concept revising the ADA CERP Eligibility criteria to stipulate that companies that manufacture or distribute proprietary products or services will no longer be considered eligible to participate in the program. The Council has directed the CERP Committee to draft revisions to the Eligibility criteria and develop a detailed proposal and time line for implementing this change for the Council’s consideration at its November 2010 meeting.

*Review and Validation of CE Content.* During this reporting period the Council issued a call for comments regarding periodic review of the content of continuing education activities. At its April 2010 meeting, the Council approved new criteria requiring CE providers that offer self-instructional activities to publish the release date and the expiration date for each self-instructional activity in order to better ensure that the

content of self-instructional activities remains current. The expiration date may be a maximum of three years from the release date. Providers may review an activity and release it again if the content is determined valid. The Council also considered a proposal requiring providers to develop and operate in accordance with written policies ensuring that the content of clinical CE courses is grounded in a sound scientific basis. Based on feedback from the communities of interest, including the ADA's Council on Scientific Affairs (CSA), the Council determined that additional clarification of the proposed requirement is needed and directed the CERP Committee to work with CSA to develop guidelines for providers regarding scientifically sound CE.

**ADA CERP and AGD PACE Mutual Recognition:** Since 2003 the CERP Committee and the Council have been working with AGD PACE to achieve mutual recognition between the programs. In 2009, the two groups considered a side-by-side comparison of the CERP and PACE recognition standards and proposed revisions to bring them into closer alignment. Representatives from both organizations have agreed that the revised CERP and PACE standards will, when fully implemented, establish consistent guidelines for quality continuing dental education. However, at a joint meeting of the CERP Committee and PACE Council in 2009, differences in the administration and oversight of the CERP Extended Approval Process (EAP) and the PACE local approval process were identified as significant barriers to mutual recognition. The CERP Committee stated its commitment to maintaining consistent standards for continuing dental education among all approved providers, whether at the national or the local level. The CERP and PACE committees therefore agreed to separately review their processes and identify possible improvements before resuming discussions of mutual recognition. The Council deferred further discussion of mutual recognition until substantive differences between the AGD PACE local approval process and the ADA CERP Extended Approval Processes (EAP) can be resolved.

The chairs of the AGD PACE Council and the ADA CERP Committee continue to update each other on developments within their respective programs. The AGD PACE has reported on several planned changes to the process whereby AGD constituent societies review and approve local CE providers. The ADA CERP Committee conducted a review of the CERP Extended Approval Process, and the Council has concurred with the CERP Committee's recommendation to require the organizations that extend approval to their component societies to periodically submit information to CERP about their approval practices. The Council will monitor progress and consider recommendations from the CERP Committee regarding the Extended Approval Process and discussions with the AGD PACE at future meetings.

**ADA CERP Provider Workshop at 2010 ADA Annual Session:** Based on information obtained from regular surveys of ADA CERP applicants, roughly half of the applications submitted are prepared by staff members who have never previously prepared an application. Recognizing the need for ongoing education about the ADA CERP recognition program, members of the ADA CERP Committee will present a workshop for providers of continuing dental education during the 2010 ADA annual session. The workshop will focus on the ADA CERP Recognition Standards, including new and

revised criteria, and discuss ways in which providers can demonstrate compliance with the Standards. A similar workshop offered in 2008 was well received.

**Consideration of Resolution 50H-2009 Continuing Education Approval:** The Council and the CERP Committee carefully considered Resolution 50H from the 2009 House of Delegates regarding the possibility of joint approval by the ADA CERP and the Accreditation Council for Continuing Medical Education (ACCME) of CE courses that meet both programs' certification requirements.

The Council and CERP Committee reviewed the ACCME accreditation criteria, standards for commercial support and application processes. They noted that the ACCME, like the ADA CERP, approves *providers* of continuing education, but does not approve individual continuing education *courses*. The ACCME defines the content of continuing medical education (CME) as "that body of knowledge and skills generally recognized and accepted by the profession as within the basic medical sciences, the discipline of clinical medicine, and the provision of health care to the public." Based on these findings, the Council believes that the ACCME accreditation standards and processes are comparable to the ADA CERP Recognition Standards and Procedures, and providers of CME accredited by the ACCME meet or exceed comparable standards established by ADA CERP. As neither the ACCME nor the ADA CERP approve individual continuing education activities, the Council concluded that establishing a joint approval process for designating courses that meet both programs' requirements is beyond the current scope of the ACCME's or the ADA CERP's missions. However, because the ACCME and ADA CERP processes are designed to approve providers that offer CE courses with a sound scientific basis, independent of commercial bias, etc., the Council believes that credits earned from courses offered by ACCME accredited providers should be considered by state dental boards as comparable to credits earned from courses offered by ADA CERP recognized providers. The Council directed that its conclusions be reported to the ADA Board of Trustees and recommended that the following proposed policy statement be forwarded to the House of Delegates for consideration:

**13. Resolved**, that the American Dental Association urges state boards of dentistry to accept for licensure renewal purposes dentists' participation in formal continuing medical education courses offered by continuing education providers accredited by the Accreditation Council for Continuing Medical Education (ACCME).

## ADA CE Online

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In June 2009, the Board of Trustees assigned oversight of ADA CE Online to the Council on Dental Education and Licensure. The Council established the Committee on Continuing Education to fulfill this responsibility. Chaired by CDEL member Dr. Tariq Javed, it includes representatives from the Council on Scientific Affairs, Council on ADA Sessions, Council on Dental Practice, Council on Membership and Committee on the New Dentist.

**The Current State of ADA CE Online:** ADA CE Online, now in its fourth year, is delivered by a vendor through a revenue sharing model. The number of registered users increased in 2009 by more than 50%.

**Members' Needs Assessment:** The 2010 member survey indicates that 93.4% agree that CE is an important member benefit; and 73.4% are likely to take an ADA CE Online course.

**Course Fees:** CE Online course fees have not increased since 2006. At its April 2010 meeting, the Council raised the course fees for each hour of credit from \$28 to \$35 for members, from \$42 to \$53 for nonmembers, and from \$15 to \$20 for dental team members.

**Library of Courses and Content Development:** The current library includes 115 courses; 21 have been developed by the ADA. The Association's online courses do not encompass all areas of the ADA. ADA CE Online should feature additional offerings from existing programs such as *Journal of the American Dental Association*, *Professional Product Review*, annual session and other ADA initiatives and programs.

The peer review process, a strength of the program, is overseen by the editor-in-chief, Dr. Jeffrey Sameroff. Existing courses are reviewed periodically.

To attract new and repeat users, new courses need to be developed. To encourage content experts to write new online courses for the ADA, a 2011 budget decision package was submitted for CE course content development. The Council was supportive, urging the Association to commit \$49,000 in 2011 to develop new content for ADA CE Online.

**Future of the ADA CE Online:** The Council supports the continued development of ADA CE Online. If the ADA seeks to be a leader in online continuing dental education, it should invest in learning management system (LMS) software. Otherwise, it will remain dependent on outside businesses. Therefore, the Council supported in principle including funds in the 2011 budget for research to assess the need for an ADA-hosted learning management system.

## **Career Recruitment, Resources and Related Activities**

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**Career Resource Events:** During this past year, dental and allied dental career resources were exhibited at several national conferences/events including the:

- 2009 Hispanic Dental Association (HDA) annual meeting, Houston, TX
- 2009 Society of American Indian Dentists (SAID) Annual Conference, Los Angeles, CA
- 2009 Learning for Life, National Health Careers Exposition, Bethesda, MA
- 2010 Give Kids a Smile Events (Sullivan-Schein Dental supported the inclusion of 2,500 dentistry career posters in the promotional kits)

- 2010 UIC Pre-dental Consortium Conference, Chicago, IL
- 2010 ADA Take Our Sons and Daughters to Work Day

**Student Ambassador Program:** The 2009 Student Ambassador Program, *Joining Forces to Advance Diversity*, was held on October 21, 2009, at the Anatole Hilton Hotel, Dallas, TX in conjunction with the fall meetings of the American Dental Education Association (ADEA). The program was planned by the Committee's Student Ambassador Planning Team consisting of representatives from the National Association of Advisors to the Health Professions (NAAHP), the American Student Dental Association (ASDA), the Student National Dental Association (SNDA), the Hispanic Student Dental Association (HSDA), ADEA's Council of Students and the Society of American Indian Dentists (SAID) Student Chapter. The 2009 program exemplified the focus and spirit in reaching out to partner with admissions offices, creating communication tools to follow up with all ambassadors and strategies to initiate and expand student-to-student recruitment activities across the country.

Thirty-eight dental schools again showed their support for the program, sponsoring a total of 55 students. The Committee and Council are grateful to GlaxoSmithKline (GSK) for generously contributing funding for the 2009 event.

The centerpiece of this year's program was the opportunity for ambassadors to partner with admissions offices and build on the awareness that both groups share similar goals and values in promoting dentistry as a profession, especially to students from underrepresented groups. New activities this year included grouping the ambassadors into four regions utilizing the National Association of Advisors to the Health Professions (NAAHP) regional breakdown and selecting an Ambassador Regional Coordinator (ARC) for each region. An Ambassador Award Program was initiated with the first award to be given at the 2011 Program.

In follow up to the 2009 program, the new student ambassadors received a resource kit, *Joining Forces to Advance Diversity*, containing information on student recruitment "Best Practices," outreach marketing strategies, resource Web sites and more. Student ambassadors also received a follow-up questionnaire to gather information for evaluation of the program. An Ambassador Program page has been established on Facebook.

**ADA Recipient of Career Guidance Award:** Learning for Life, a national career guidance organization, bestowed the organization's highest honor, the William Spurgeon III Award to the ADA, CDEL and CDEL staff member Ms. Beverly Skoog for close association and collaboration with its Health Careers Exploring Program at the 2009 National Learning for Life meeting in San Diego, CA. The Learning for Life, Health Careers Exploring organization, provides a variety of programs for youth to explore dentistry and health careers.

**Mentoring for Admission to Dental School—A Prescription for Success Workshop:** The session, co-sponsored by ADEA and held during the 2009 ADA

annual session in Hawaii, highlighted the dentist's unique role as a career mentor and offered strategies to effectively coach the millennial generation interested in dentistry as well as students from diverse backgrounds. The workshop's focus, to stimulate interest in mentoring and increase the skills of mentors, was co-facilitated by Dr. Dave Brunson, ADEA, associate executive director, Center for Equity and Diversity, and Dr. Anne Wells, ADEA, associate executive director, Educational Pathways. Participants included ADA mentor coordinators, member dentists, dental school faculty and students interested in learning about the mentoring process.

### **Dental Admission Testing Program (DAT)**

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The DAT continues to be administered exclusively on computer at Prometric Testing Centers throughout the United States and its territories. Survey findings indicate that examinees are satisfied with the performance of the testing system, the testing center surroundings, and the total experience of taking the DAT on computer. DAT score information is provided to dental school admission chairs in an electronic format through a secure Web site. Examinees continue to receive an unofficial report of scores upon completing the DAT at a Prometric Testing Center. Prehealth advisors receive printed score listings. Beginning in 2010, DAT score information was reported electronically to schools through the American Dental Education Association's (ADEA) Associated American Dental Schools Application Services (AADSAS) and the Texas Medical and Dental School Application Service (TMDSAS). AADSAS and TMDSAS include the scores on the electronic applications for distribution to dental school admission offices. This facilitates the application process for admission committees.

The Commission on Dental Accreditation, Joint Commission on National Dental Examinations, ADEA, and the American Dental Association collaborated during 2009 on the implementation of a unique identification number known as the DENTPIN™ for applicants and students in pre-doctoral and post-doctoral/advanced dental education programs and for candidates for National Board Dental/Dental Hygiene Examination (NBDE/NBDHE) certification. The DENTPIN™ enhances the privacy of applicants and students by eliminating the use of Social Security and Reference Numbers to identify them.

The Council on Dental Education and Licensure, through its Committee on Educational Measurements and Testing, is in the process of determining whether to modify the DAT to include a critical thinking test. If included on the DAT battery, this critical thinking test would either be added as an additional subtest or replace an existing one. During 2009, a basic calculator was added for use on the Quantitative Reasoning Test so that higher level items could replace lower-level computational items.

The number of administrations of the DAT increased by 1,466 or an increase of 11.7% from 2005 to 2009. The gender ratios have changed since 2005; i.e., percentages of administrations of the DAT to males declined from 52% to 51% while the percentage of females taking the DAT increased from 48% to 49%. Concerning ethnicity for the same period, less than 2% of the administrations of the DAT were to

American Indian examinees; between 5% and 8% of the administrations were to Black and Hispanic examinees; between 22% and 27% of the administrations were to Asian examinees; and between 55% and 58% were to White examinees. For Asian and Hispanic examinees, the numbers were higher in 2009 when compared to 2005 through 2008. For White examinees, the number was the lowest in 2009. The percentage of examinees taking the DAT more than once was the highest at 37.6% in 2009. During 2005 and 2009, there were 8,711 and 8,737 first-time examinees, respectively; this represents an overall increase of 26 examinees.

## Review of Association Policies

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In accord with Resolution 15H-1995 (*Trans.*1995:660), the Council reviewed nine ADA policies to determine whether any were redundant, irrelevant, or needing revision. Based on this review, the Council concluded that the following policies should be retained as written:

- Dentistry (1997:687)
- Policy on Dental Licensure (1998:720; 2003:341)
- Policy on Dual-Degreed Dentists (2003:367)
- Clinical Licensure Examinations in Dental Schools (2003:368)
- State Board Support for CDA as Responsible to Evaluate Dental Education Programs (2003:367)
- Policy on One Standard of Competency: State Boards Review Limited Licensure Graduates on Nonaccredited Dental Schools for Providing Access to Care for Underserved Populations (2003:369)
- Guidelines for Licensure (1976:919; 1977:923; 1989:529; 1992:632; 1999:938; 2000:401; 2003:340)
- Policy Statement on Federal Intervention in Licensure (1975:187, 718)

In an effort to stimulate change that will reflect greater teaching emphasis on ethics in professional marketing and management techniques, the Council believes that the policy, Recommended Curricula Changes (1983:555), should be amended by adding the word “ethical” after the word “skills” and before the word “professional and presents the following resolution to the House of Delegates for consideration:

**14. Resolved**, that the policy Recommended Curricula Changes (*Trans.*1983:555) be amended by adding the word “ethical” before the word “professional,” so the amended policy would read (underscore = addition):

**Resolved**, that the ADA urge the Commission on Dental Accreditation, in cooperation with the American Dental Education Association and individual dental schools, to stimulate curricular changes that will reflect greater teaching emphasis on interpersonal skills, ethical professional marketing strategies and management techniques.

## **Response to Assignments from the 2009 House of Delegates**

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**Rescission of Endorsement of Recommendations of the Joint ADA/AADE Guidelines for Valid and Reliable Dental Licensure Clinical Examinations and Utilization of the ADA Guidelines of Licensure by Credentials:** Resolution 4aH-2009 (*Trans.*2009:446) amended Resolution 93H-1992 (*Trans.*1992:628) by deleting the first resolving clause which referenced an outdated document known as the Joint ADA/AADE Guidelines for Valid and Reliable Dental Licensure Clinical Examinations. The amended policy will appear in the ADA *Current Policies*.

**Amendment of the Requirements for Recognition of Dental Specialties and National Certifying Boards for Dental Specialists:** Resolution 5H-2009 (*Trans.*2009:415; 442) amended the Association's Requirements for Specialty Recognition and National Certifying Boards. The amended requirements will appear in ADA *Current Policies* and have been posted on ADA.org. The Council also notified the communities of interest about the amended policy.

**Amendment to the Policy, Dentist Administered Dental Assisting and Dental Hygiene Education Program:** Resolution 28-2009 (*Trans.*2009:415; 431) was referred to the Council on Dental Practice (CDP). At its April 2010 meeting, CDEL received general information about the management of the resolution, noting that CDP will consider the resolution at its May 13-14 meeting. CDEL expressed its willingness to assist CDP, as appropriate.

**ADA Specialty Logo:** Resolution 32H-2009 (*Trans.*2009:486) was managed by the Council on Membership; CDEL and CEBJA staff representatives served as resources.

**Continuing Education Approval:** As directed by Resolution 50H-2009 (*Trans.* 2009:442), the Council on Dental Education and Licensure and its Committee on the Continuing Education Recognition Program (CERP Committee) considered the possible joint approval of ADA CERP and the Accreditation Council for Continuing Medical Education (ACCME) courses. As neither the ACCME nor the ADA CERP approve individual continuing education *courses*, the Council believes that establishing a joint approval process for designating courses that meet both programs' requirements is beyond the current scope of the ACCME's or the ADA CERP's missions. However, because the ACCME and ADA CERP processes are designed to approve *providers* that offer CE courses with a sound scientific basis, independent of commercial bias, etc., the Council believes that credits earned from courses offered by ACCME accredited providers should be considered comparable to credits earned from courses offered by ADA CERP recognized providers. The Council therefore proposes the adoption of a new ADA policy stating this, in order to encourage greater acceptance of relevant CME courses by state dental boards and transmits Resolution 13 to the Board of Trustees and the 2010 House of Delegates for consideration, as presented previously in this report.

**CDEL Bylaws Amendment Regarding Recognition of Non-Specialty Interest Areas in General Dentistry:** Resolution 52-2009 (*Trans.*2009:442; 444) was referred to and considered by CDEL. As noted previously in this report, the Council supported the intent of the resolution, concluding that the Association should establish criteria and a process for the recognition of general dentistry interest areas and transmitting Resolution 12 to the 2010 House of Delegates for consideration.

**Amendments to the ADA Bylaws: Composition of the Council on Dental Education and Licensure:** Resolution 58H-2009 (*Trans.*2009:442; 455) changed the composition of the Council, effective with the 2010 term, by requiring that the eight members appointed by the House of Delegates not be current dental examiners or members of a state or regional testing agency, state dental board or jurisdictional dental licensing agency. *ADA Bylaws* and other appropriate ADA documents have been updated to reflect this change.

**Chair and Vice Chair for 2010-2011:** The Council forwarded the name of Dr. Brian T. Kennedy to the Board of Trustees for approval as the Council's chair for the upcoming term. Dr. George J. Kinney was elected vice chair for the 2010-2011 term.

**Personnel:** At the 2010 annual session, Dr. James R. Hupp, Dr. Stanwood H. Kanna, Dr. David Moore, Dr. Barbara A. Rich and Dr. Jennifer Davis complete their terms as Council members. Dr. Tim Moriarty completes his term as the American Student Dental Association's representative to the Council. The Council wishes to express deep appreciation to these individuals for exemplary leadership and contributions during their tenure. The Council also acknowledges the guidance and valuable input provided by its trustee liaison, Dr. Samuel B. Low.

## Summary of Resolutions

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**9. Resolved**, that Chapter X. COUNCILS, Section 20. MEMBERS, SELECTION, NOMINATION AND ELECTIONS, Subsection A. regarding the Council on Dental Education and Licensure, Subsection a.(3) c. Committees of the *ADA Bylaws* be amended as follows (strikethrough = deletion):

c. Committees. The Council on Dental Education and Licensure shall establish a standing Committee on Dental Education and ~~Educational Measurements~~ and a standing Committee on Licensure, each consisting of eight (8) members selected by the Council. The Council may establish additional committees when they are deemed essential to carry out the duties of this Council.

**10. Resolved**, that Chapter X. COUNCILS, Section 120. DUTIES, Subsection E. COUNCIL ON DENTAL EDUCATION AND LICENSURE, subsections a., b. and c. of the *ADA Bylaws*, be amended and subsection e. be added as follows (strikethrough = deletion; underscore = additions):

*Section 120. DUTIES:*

E. COUNCIL ON DENTAL EDUCATION AND LICENSURE. The duties of the Council shall be:

- a. To act as the agency of the Association in matters related to the evaluation and accreditation of all dental educational, allied dental auxiliary educational and associated subjects.
- b. To study and make recommendations including the formulation and recommendation of policy on:
  - (1) Dental education, continuing dental education and allied dental auxiliary education.
  - (2) The recognition of dental specialties.
  - (3) The recognition of categories of allied dental personnel auxiliaries.
  - (4) The approval or disapproval of national certifying boards for dental specialties ~~special areas of dental practice~~ and for allied dental personnel auxiliaries.
  - (5) The educational and administrative standards of the certifying boards for ~~special areas of dental practice~~ dental specialties and for allied dental personnel auxiliaries.
  - (6) Associated subjects that affect all dental, allied dental auxiliary and related education.
  - (7) Dental licensure and allied dental personnel auxiliary credentialing.
- c. To act on behalf of this Association in maintaining effective liaison with certifying boards and related agencies for ~~special areas of dental practice~~ dental specialties and for allied dental personnel auxiliaries.
- d. To monitor and disseminate information on continuing dental education and to encourage the provision of and participation in continuing dental education.
- e. To monitor and disseminate information on careers in dentistry.

**11. Resolved**, that Chapter X. COUNCILS, Section 120. DUTIES, Subsection E. COUNCIL ON DENTAL EDUCATION AND LICENSURE, subsection b, of the ADA *Bylaws*, be amended by addition of the following new paragraph:

- (3) The recognition of interest areas in general dentistry.

and be it further

**Resolved**, that existing paragraphs “3” through “7” be renumbered as “4” through “8,” respectively.

**12. Resolved**, that the following proposed “Criteria for Recognition of Interest Areas in General Dentistry” be adopted.

**Criteria for Recognition of Interest Areas in General Dentistry**

1. The existence of a well-defined body of established evidence-based scientific and clinical dental knowledge underlying the general dentistry area -

knowledge that is in large part distinct from, or more detailed than, that of other areas of general dentistry education and practice.

Elements to be addressed:

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

Elements to be addressed:

- Identification of distinct components of biomedical, behavioral and clinical science in the advanced education area
  - Description of why this area of knowledge is a distinct education area of general dentistry, rather than a series of just one or more techniques
  - Documentation demonstrating that the body of knowledge is unique and distinct from that in other education areas accredited by the Commission on Dental Accreditation
  - Documentation of the complexity of the body of knowledge of the general dentistry area by identifying specific advanced techniques and procedures, representative samples of curricula from existing programs, textbooks and journals
3. The existence of established advanced educational programs with structured curricula, qualified faculty and enrolled individuals for which accreditation by the Commission on Dental Accreditation can be a viable method of quality assurance.

Elements to be addressed:

- Description of the historical development and evolution of educational programs in the area of advanced training in general dentistry
- A listing of the current operational programs in the advanced general dentistry training area, identifying for each, the:
  - a. Sponsoring institution;
  - b. Name and qualifications of the program director;
  - c. number of full-time and part-time faculty (define part-time for each program);

- d. Curriculum (course outlines, student competencies, class schedules);
- e. Outcomes assessment method;
- f. Minimum length of the program;
- g. Certificate and/or degree awarded upon completion;
- h. Number of enrolled individuals per year for at least the past five years\*; and
- i. Number of graduates per year for at least the past five years.\*

\*If the established education programs have been in existence less than five years, provide information since their founding.

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

Elements to be addressed:

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

Elements to be addressed:

- Description of the need for appropriately trained individuals in the general dentistry area to ensure quality health care for the public
- Description of current and emerging trends in the general dentistry education area

- Documentation that dental health care professionals currently provide health care services in the identified area
- Evidence that the area of knowledge is important and significant to patient care and dentistry

**13. Resolved**, that the American Dental Association urges state boards of dentistry to accept for licensure renewal purposes dentists' participation in formal continuing medical education courses offered by continuing education providers accredited by the Accreditation Council for Continuing Medical Education (ACCME).

**14. Resolved**, that the policy Recommended Curricula Changes (*Trans.*1983:555) be amended by adding the word "ethical" before the word "professional," so the amended policy would read (underscore = addition):

**Resolved**, that the ADA urge the Commission on Dental Accreditation, in cooperation with the American Dental Education Association and individual dental schools, to stimulate curricular changes that will reflect greater teaching emphasis on interpersonal skills, ethical professional marketing strategies and management techniques.

## Council on Dental Practice

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**DeSnyder, Jerome**, New York, 2010, chair  
**Glenn, Stephen O.**, Oklahoma, 2011, vice chair  
**Ahlstrom, Robert H.**, Nevada, 2010  
**Armstrong, Craig S.**, Texas, 2013  
**Cole, Jeffrey M.**, Delaware, 2013  
**D'Aiuto, Charles W.**, Florida, 2012  
**Gardner, H. Lee, Jr.**, South Carolina, 2011  
**Halasz, Michael H.**, Ohio, 2011  
**Johnston, Jon J.**, Pennsylvania, 2013  
**Knapp, Jonathan B.**, Connecticut, 2013  
**Larsen, Christopher C.**, Illinois, 2011  
**Liang, Christopher G.**, Maryland, *ex officio*\*  
**Newman, Roger K.**, Montana, 2012  
**Sledd, Jamie L.**, Minnesota, 2012  
**Tippett-Whyte, Judee**, California, 2012  
**Torbush, Douglas B.**, Georgia, 2010, *ad interim*  
**Vandehaar, Kent L.**, Wisconsin, 2010  
**Zust, Mark R.**, Missouri, 2012  
**Willey, James L.**, director  
**Poremski, Pamela M.**, senior manager  
**Furlong, Arlene M.**, manager  
**Siwek, Alison M.**, manager

**The Strategic Plan of the American Dental Association:** The activities of the Council on Dental Practice (CDP) are consistent with and continue to support the ADA *Strategic Plan: 2007-2010*. In keeping with Goal: Achieve Effective Advocacy, Objectives 1 and 5, the Council is involved with the Team Building Series held during the ADA annual session. Further, the CDP formed a Subcommittee on Workforce Issues (SWI) to review and draft ADA policy regarding issues relating to dental workforce as assigned by the 2009 House of Delegates. For Goal: Build Dynamic Communities, Objective 2, the Council maintains liaison relationships with the American Dental Hygienists' Association (ADHA), the American Dental Assistants Association (ADAA), the Dental Assisting National Board, Inc. (DANB), the National Association of Dental Laboratories (NADL), the University of Utah School on Alcoholism and other Drug Dependencies, the Tufts Health Care Institute and the National Disaster Life Support Education Consortium™ (NDLSEC™) of the American Medical Association (AMA). The CDP updated several practice management resources and created a practice management Web site on ADA.org called the Dental Practice Hub. These projects meet the criteria for Goal: Create and Transfer Knowledge, Objective 3. In addition, the convening of a Future of Dental Laboratory Technology Conference and subsequent formation of the Subcommittee on the Future of Dental Laboratory Technology (SFDLT); the activities of

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\* Committee on the New Dentist member without the power to vote.

the Council's Electronic Health Record Members Advisory Group (EHR MAG); the Council's efforts to educate dentist/members on the Payment Card Industry Data Service Standard (PCI DSS); the Council's participation in the Joint Subcommittee on Ethics and Integrity in Dental Education and the Profession; the CDP's representation on Evidence-Based Dentistry (EBD) Advisory Committee and the Dental Quality Alliance (DQA) Steering Committee, are each linked to Goal: Lead in the Advancement of Standards, Objectives 3 and 5. Finally, the Council supports Goal: Attain Excellence in Operations, Objective 3, by participating in the development of a survey measuring the effectiveness of biannual Council meetings and also by taking the lead on Comparative Effectiveness Research (CER) by forming a Subcommittee on CER (SCER).

### **Emerging Issues and Trends**

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**Subcommittee on Economic Issues (SEI):** The new Dental Practice Hub, Thriving in Today's Economy Web site on ADA.org, went live on September 10, 2009, in order to assist ADA members with issues related to the then weak economy. Quarterly Surveys on Economic Confidence can be accessed through the Hub. The SEI reviews content that is posted to this Web site. As the economy improves, the SEI intends to develop the Web site to include more practice management content.

**Clinical Risk Assessment in Dentistry:** At its June 2008 meeting, the Board of Trustees directed that the ADA Councils on Scientific Affairs (CSA) and Dental Practice consider convening a conference/workshop on risk assessment in dental practice, including communicating risk assessment information to patients. The Council recommended that the Subcommittee on Caries Risk Assessment collaborate with the CSA and other appropriate ADA agencies in planning a conference on clinical risk assessment in dental practice in 2011, contingent upon funding. The Division of Science has placed risk assessment on the 2010-2011 ADA Research Agenda and the CSA and the CDP plan to revisit the concept of a conference during 2012 budget planning process.

**Trends in Dental Group Practice:** The CDP staff attended the American Academy of Dental Group Practice Conference January 28-30, 2010, to learn more about emerging trends toward group practice. The CDP staff monitors dental group practice models and scouts for possible contributors to the CDP's Dental Practice Hub Web site, to upcoming ADA conferences and for potential *ADA News* articles. The CDP participated in a meeting with Mr. Greg Serrao, American Dental Partners, to learn more about very large group practices on March 24, 2010, at the ADA Headquarters Building in Chicago.

**Dental Team Workforce Issues:** In response to an assignment from the 2009 House of Delegates, the Council's Subcommittee on Workforce Issues (SWI) conducted ten conference calls occurring November 2009 through May 2010 and met in person on February 26, 2010, to discuss the referred workforce amendments. The Council provided an update report to the Board of Trustees in December 2009 and circulated this report to members of the House of Delegates.

The CDP collaborated with the Councils on Membership and Communications to create a communications plan related to workforce issues, which was implemented in the summer of 2010. The basic plan, written at the request of the American Society of Constituent Dental Executives (ASCDE), included a conference call and a webinar in June, a 2010 Conference on Workforce Issues to be held on Sunday, July 18, 2010, at the ADA Headquarters Building in Chicago and a follow-up webinar and conference call to be held in August 2010.

The purpose of the 2010 Conference on Workforce Issues is to engage volunteer leaders in a facilitated information-based dialogue related to workforce issues. It is hoped this Conference will lead to a better understanding of workforce models, a better appreciation of regional differences and perspectives on workforce issues, and a better understanding of the role that national foundations play regarding new dental team members.

**Going Green in the Dental Office:** The 2009 House of Delegates directed the CDP to continue with the development of the “Going Green” initiative and provide members with additional content and information in 2010. The Subcommittee on Going Green developed a “Going Green in the Dental Practice” landing page for ADA.org. The Council approved the Department of Dental Society Services draft entry guidelines for a new award category for the Golden Apple Awards called the Green Apple—Excellence in Environmentally Sustainable Programs and Education, that was implemented and judged by CDP in 2010.

**Impact of Information Technology on Dentistry:** Six members of the CDP serve on the Electronic Health Record Members Advisory Group (EHR MAG). The EHR MAG reviewed and offered comments on the Notice of Potential Rule Making (NPRM) entitled “Medicare and Medicaid Programs; Electronic Health Record Incentive Program; Proposed Rule,” published on January 13, 2010, and the Interim Final Rule on the Health Information Technology: Initial Set of Standards, Implementation Specifications, and Certification Criteria for Electronic Health Record Technology. The EHR MAG participated in a conference call convened on March 23 to discuss the scope of this group and another on March 30 with the EHR Workgroup. The EHR MAG will collaborate with the Council on Dental Benefit Programs (CDBP) Vocabulary Committee on an *ADA News* article on SNODENT.

**Payment Card Industry Data Service Standard:** The PCI DSS is a set of security standards developed by the major credit card issuers (American Express, Discover Financial Services, JCB International, MasterCard Worldwide and Visa Inc. International) to assure consistent data security measures and its effects on merchants, including dentists, who handle credit information related to cards issued by any of the founder brands. The CDP researched the issue and advised educating ADA members of the impact of this industry standard on dental practices. The *ADA News* published an article explaining the standard in its May 3, 2010, issue.

**Dental Quality Alliance:** In 2008, the Centers for Medicare and Medicaid Services (CMS) proposed to the ADA that a DQA be established to develop performance measures for oral health care and that the Association should take a leadership role in its formation. Pursuant to Resolution B-120-2008 (*Trans.*2008:398), Participation in Dental Quality Alliance, the DQA Steering Committee was formed and has ten members including a representative from the CDP. The Steering Committee met on December 4-5, 2009, and March 26-27, 2010, at the ADA Headquarters Building in Chicago. The Committee plans to develop work product and education measures.

**Comparative Effectiveness Research:** The American Recovery and Reinvestment Act of 2009 (ARRA), Public Law 111-5, established the Federal Coordinating Council for CER. The purpose of CER is to provide information for clinicians and patients to use to choose the treatment options that fit the individual patient's condition, needs and preferences. The Council reviewed a draft Report of the Chief Policy Advisor and the Senior Vice President, Dental Practice/Professional Affairs on CER and offered its comments in January 2010. The CDP was assigned the lead on CER by the ADA Board of Trustees in April 2010 and intends to collaborate with the Council on Government Affairs (CGA), the Council on Access, Prevention and Interprofessional Relations (CAPIR), CDBP and CSA. At its May 2010 meeting, the CDP formed a Subcommittee on Comparative Effectiveness Research.

### **Response to Assignments from the 2009 House of Delegates**

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**Amendment to the “Comprehensive Policy Statement on Allied Dental Personnel”:** Resolution 27-2009 (*Trans.*2009:415; 425) was referred to the CDP. The House of Delegates directed that the Council review the ADA Policy on the Comprehensive Policy Statement on Allied Dental Personnel (*Trans.*1996:699; 1997:691; 1998:713; 2001:467; 2002:400; 2006:307). The Council formed the SWI, which discussed this policy during ten conference calls and an in person meeting held at the ADA Headquarters Building in Chicago on February 26, 2010. A supplemental report on Resolution 27-2009 will be submitted to the 2010 House of Delegates.

**Amendment to the Policy, “Dentist Administered Dental Assisting and Dental Hygiene Education Programs”:** Resolution 28-2009 (*Trans.*2009:415; 431) was referred to the CDP. The House of Delegates directed that the Council review the ADA Policy on Dentist Administered Dental Assisting and Dental Hygiene Education Programs (*Trans.*1992:616). The Council directed its SWI to draft an amendment to the policy at its meeting in February. The CDP staff attended the CDEL meeting held on April 30 to discuss this resolution. A supplemental report on Resolution 28-2009 will be submitted to the 2010 House of Delegates.

**Amendment to the Policy, “Opposition to Pilot Programs Which Allow Nondentists to Diagnose Dental Needs or Perform Irreversible Procedures”:** Resolution 29-2009 (*Trans.*2009:415; 432) was referred to the CDP. The House of Delegates directed that the Council review the ADA Policy on Opposition to Pilot Programs Which Allow Nondentists to Diagnose Dental Needs or Perform Irreversible

Procedures (*Trans.*2005:343). The Council directed its SWI to draft an amendment to this policy. This was done during the SWI's May 10 conference call. A supplemental report on Resolution 29-2009 will be submitted to the 2010 House of Delegates.

**Amendment to the Policy, “Diagnosis or Performance of Irreversible Dental Procedures by Nondentists”:** Resolution 30-2009 (*Trans.*2009:415; 433) was referred to CDP. The House of Delegates directed that the Council review the ADA Policy on Diagnosis or Performance of Irreversible Dental Procedures by Nondentists (*Trans.*2004:328). The Council directed its SWI to draft an amendment to this policy. This was done during its May 10 conference call. A supplemental report on Resolution 30-2009 will be submitted to the 2010 House of Delegates.

**Amendment to the Policy, “ADA’s Position on New Dental Team Members”:** Resolution 31H-2009 (*Trans.*2009:415) was adopted by the 2009 House of Delegates. The Council reviewed this policy and considered it when reviewing the workforce policies assigned to it by the 2009 House of Delegates.

**Action Plan to Enhance Professionalism in Dentistry:** Resolution 39H-2009 (*Trans.*2009:461; 475) directed that the Joint Subcommittee on Ethics and Integrity in Dental Education and the Profession continue its activities in 2010. Two CDP members serve on the Joint Subcommittee and attended the meetings held in Chicago on February 11-12 and May 21, 2010.

**Promoting Wellness for the Profession:** Resolution 41-2009 (*Trans.*2009:415; 421) was assigned to the CDP. This resolution directed that the ADA identify and promote a wellness program to promote healthy diet, exercise and lifestyle for the dental team. The CDP developed a health and well-being newsletter that is distributed quarterly to constituent wellness programs to share with their members. The CDP also developed specific story ideas related to wellness for the *ADA News*. The CDP intends to incorporate programs on healthy diet, lifestyle and exercise into the 2011 Conference on Dentist Health and Wellness. A supplemental report on Resolution 41-2009 will be submitted to the 2010 House of Delegates.

**Collaboration with Specialty Organizations on Workforce:** Resolution 46H-2009 (*Trans.*2009:415; 420) was assigned to the CDP and the Council on Government Affairs. This resolution directed that the ADA and its constituents be urged to notify and collaborate with appropriate specialty and other dental organizations for comment and assistance when strategizing advocacy efforts relating to legislative and regulatory proposals regarding dental team members. The Council's SWI sought to learn the positions of specialty organizations while reviewing the workforce resolutions referred by the 2009 House of Delegates. The CDP will collaborate with the CGA to submit a supplemental report to the 2010 House of Delegates.

**Development of a Standard for Secure Electronic Transmission of Digital Radiographs:** Resolution 83H (*Trans.*2009:415; 420) was assigned to the ADA Standards Committee on Dental Informatics (SCDI). This resolution directed the SCDI

to develop a standard for the secure electronic transmission of digital radiographs and photographs, to promote this standard for use by practitioners as well as third-party payers and to provide a status report to the 2010 House of Delegates. The CDP provides standards oversight to the SCDI related to dental informatics. The Council, at its May 2010 meeting, approved Proposed ADA Technical Report No. 1060 for the Secure Exchange and Utilization of Digital Images in Dentistry for circulation to all interested parties. The CDP continues to consider what the ADA can do to facilitate the adoption of these standards by practitioners and third-party payers.

**Health Credit Cards/Patient Financing Programs:** Resolution 84H-2009 (*Trans.*2009:406; 413) was assigned to the ADA Business Enterprises, Inc. (ADABEI) and to the CDP. This resolution directed that the ADA review its endorsement of patient financing vendors and provide information about patient financing programs that members may utilize in determining whether to offer a financing program to patients. The CDP and ADABEI collaborated to create a three-part practice management series which was published in the *ADA News*.

## Council Activities

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**Dental Team Advisory Panel (DTAP):** The Council's DTAP met on March 19, 2010, at the ADA Headquarters Building in Chicago. The Panel discussions included program and promotional ideas for the dental team's involvement in the 2011 Conference on Dentist Health and Wellness, general perceptions about workforce issues, ADA.org topics of interest to the dental team and patients, ADA publications and continuing education. At its May 2010 meeting, the Council considered DTAP discussions and approved its recommendations.

**Team Building Series:** The 15th Annual Team Building Series, jointly sponsored by the CDP and the Council on ADA Sessions (CAS), will be held Saturday through Monday, October 9-11, during the 2010 ADA annual session in Orlando. CAS collaborated with the CDP and the Disney Institute to develop team building opportunities for attendees at the 2010 ADA annual session. The Council suggested potential speakers and topics for CAS to include in the 16<sup>th</sup> Annual Team Building Series, which will be held at the 2011 annual session.

**Liaison with the American Dental Hygienists' Association (ADHA):** Council staff met with representatives from the ADHA on October 19, 2009, in order to identify collaborative projects of mutual interest. The ADHA President and Executive Director attended the Council meeting held October 29-31, 2009, and gave an overview of education, workforce and the current economy as it relates to dental hygienists. The ADHA is not interested in participating in additional collaborative projects with the CDP at this time, due to its commitment to recently realigned strategic priorities. ADHA representatives met with the Council on Access, Prevention and Interprofessional Relations and CDP in February 2010 to learn more about the ADA's Community Dental Health Coordinator (CDHC) model. Scaling and licensure issues were reported as

primary concerns to the ADHA membership. The Council Director also attended the ADHA's 87<sup>th</sup> Annual Session held in Las Vegas on June 26-29, 2010.

**Liaison with the American Dental Assistants Association (ADAA) and the Dental Assisting National Board, Inc. (DANB):** Staff met with ADAA representatives on a quarterly basis in 2009-10 to share information and discuss collaborative projects. One of these projects includes a continuing education course on "going green" in the dental office, which will be jointly published in *The Dental Assistant*. The ADAA President met with CDP at its May 2010 meeting and reported on the ADAA's new e-membership category. The President also reported that ADAA's highest membership rates are located in states where certification is required.

The CDP staff joined other interested stakeholders at the DANB Headquarters in May 2010 to learn of its plans to develop a certification program to support the ADA's Oral Preventive Assistant workforce model. DANB representatives presented its plan at the CDP's May 2010 meeting.

**Dental Laboratory Industry Activities:** The CDP formed the Subcommittee on the Future of Dental Laboratory Technology to draft Council resolutions to the 2010 House of Delegates. The Subcommittee reported its findings from the ADA's 2009 Future of Dental Laboratory Technology Conference to participants of the 2010 Dental Lab Summit. The 2009 ADA Conference was held in response to Resolution 62H-2008 (*Trans.2008:475*), calling for discussion on the problems facing the dental laboratory industry. The CDP, at its May 2010 meeting, drafted an amendment to existing ADA policy (*Trans.1997:682*) and a new resolution related to dental laboratory industry activities. A supplemental report on dental laboratory issues will be submitted to the 2010 House of Delegates.

The National Association of Dental Laboratories Co Executive Director attended the CDP's May meeting and reiterated the importance of the ADA Future of Dental Laboratory Technology Conference and Lab Summit findings, lauded progress made by NADL, ADA and other allied organizations in addressing critical issues facing the dental laboratory industry and highlighted news from the ADA's 2008 Survey on the Use of Dental Laboratories.

**Liaison with the National Board of Certification in Dental Laboratory Technology (NBC):** Dr. Jerome DeSnyder concludes his term as trustee of the National Board of Certification in Dental Laboratory Technology in 2010. Dr. DeSnyder's successor will be appointed by the incoming chair of the Council at the October 2010 ADA annual session in Orlando.

**Council Publications:** The Council is working with the Department of Product Development and Sales (PDS) to update the *Employee Office Manual* and *Internal Marketing* publications for 2010, as well as approximately 25 patient brochures. Publications slated for revision in 2011 include *Dental Office Design*, *Associateships* and *Valuing a Practice*. A recently updated publication *The ADA Practical Guide to*

*HIPAA Compliance: Privacy and Security Kit* is now available in the *ADA Catalog*. The *HIPAA Guide* addresses regulations and requirements introduced by the federal government in 2009.

**Dentist Health and Wellness:** The biennial Conference on Dentist Health and Wellness: Body, Mind & Soul: Thriving in a Chaotic World took place on September 9-11, 2009, at the ADA Headquarters in Chicago, including a pre-conference meeting that was held with state well-being program directors. Staff developed and circulated a quarterly health and wellness newsletter for state well-being directors, commencing in 2010. Staff and two members of the Dentist Well-Being Advisory Committee (DWAC) attended the 2010 University of Utah School on Alcoholism and Other Drug Dependencies meeting which took place on June 20-25, 2010, in Salt Lake City.

Staff and a DWAC member attended the Tufts Health Care Institute Steering Committee meeting in Boston on November 19, 2009. Tufts sought input on the dental professionals' role in preventing opioid abuse and diversion. Staff and a DWAC member also participated in a collaborative conference call with Tufts on January 6 regarding its Conference agenda. Staff and a DWAC member attended the Tufts Opioid Risk Management Conference held on March 11-12, 2010, in Boston, to discuss efforts to educate dentists and dental team members about opioid prescribing and their role in prevention and management of prescription opioid abuse and diversion for patients.

The DWAC and the Ergonomic Disability and Support Advisory Committees (EDSAC) held a joint meeting March 26, 2010, at the ADA Headquarters Building in Chicago. The Committees discussed the 2011 Conference on Dentist Health and Wellness, Resolution 41-2009 (*Trans.*2009:415; 421), Promoting Wellness for the Profession, and viewed a presentation on noise-induced hearing loss by the ADA Hillenbrand Fellow.

OSHA informed the ADA on December 11, 2009, that they had decided not to renew the ADA-OSHA Alliance agreement due to shifting priorities. OSHA was satisfied with the ADA performance related to the agreement prior to their decision not to renew. Tip sheets on safe patient transfers, an upper back pain and back pain success story were developed and reviewed by OSHA and these documents were posted to ADA.org. The CDP participated in a conference call on February 15 with the ADA Washington Office to discuss the feasibility of establishing an ergonomic partnership with other agencies. The final ADA-OSHA Alliance Implementation Team Meeting took place via conference call on March 30.

**Developing ADA Policy on Hearing Loss:** The Council, at its May 2010 meeting, formed a workgroup to draft a resolution related to hearing loss prevention and education for submission to the 2010 House of Delegates. The DWAC and the EDSAC are developing resources to prevent noise-induced hearing loss that will be posted on ADA.org. A supplemental report will be submitted to the 2010 House of Delegates.

**Dentistry's Role in Emergency Preparedness and Disaster Response:** The ADA serves as a voting member of the NDLSEC™. The CDP will attend the annual NDLSEC™ meeting held in Chicago on July 29. The meeting agenda includes information on course revisions related to the Core Disaster Life Support™ and Advanced Disaster Life Support™ courses.

**ADA Response to the H1N1 Pandemic:** The CDP monitored the H1N1 pandemic throughout the fall of 2009 and spring of 2010 and provided information to members and staff. The CDP staff piloted CitizenReady™-Pandemic Flu, an AMA 90-minute program geared toward educating the public on September 23 and October 14, 2009, at the ADA Headquarters Building in Chicago.

**Proposed Bylaws Changes:** The Council approved an addition to its *Bylaws* duties at its May 2010 meeting to address its role of standards oversight in dental informatics. A supplemental report will be submitted to the 2010 House of Delegates.

**Council Self-Assessment:** The Council completed its self-assessment assignment pursuant to Board Report 22 to the 2003 House of Delegates: Response to Resolution 118H-2002 (*Trans.2002:418*), Development of a Review Process of Councils and Commissions and Resolution 119H-2002 (*Trans.2002:373*), Council and Commission Self-Study whereby the Board of Trustees established a five-year cycle for agencies to conduct a review of their relevancy, productivity, efficiency, mission and duties.

**Meetings:** The Council met at the ADA Headquarters Building in Chicago on October 29-31, 2009, and May 13-15, 2010. Dr. Robert A. Faiella, First District trustee, serves as the Board of Trustees' liaison to the Council.

**Personnel:** At the October 2009 meeting of the Council, Dr. Jerome DeSnyder was unanimously nominated as chair for 2009-10 to replace Dr. Mark S. Ritz, who resigned from the CDP due to illness in October 2009. Dr. Tankersley, ADA president, appointed Dr. DeSnyder as chair in December 2009. Dr. Tankersley approved Dr. Ritz to serve as a CDP consultant for 2009-10 in November 2009. Dr. Ritz passed away on January 31, 2010. Dr. Douglas Torbush of Conyers, GA was appointed to complete the balance of Dr. Ritz's term. At the May 2010 meeting of the Council, Dr. Stephen O. Glenn was unanimously nominated as chair for 2010-11 and Dr. Mark R. Zust was elected vice chair for 2010-11. The 2010 ADA annual session will mark the retirement from the Council of Dr. Jerome DeSnyder, chair, Dr. Robert Ahlstrom and Dr. Kent L. Vandehaar. The Council wishes to express its appreciation to these individuals for their thoughtful, determined leadership and for the many contributions during their tenure. The Council takes special note of Dr. Mark Ritz's leadership and significant contribution to the CDP and expresses its deepest sympathy to his wife and family.

**Resolutions:** This report is informational and no resolutions are presented.

## Council on Ethics, Bylaws and Judicial Affairs

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**Boden, David F.**, Florida, 2010, chair  
**Wentworth, Rodney B.**, Washington, 2011, vice chair  
**Brooks, Dwyte E.**, Nevada, 2013  
**Chinoy, Walter I.**, New Jersey, 2013  
**Esterburg, Jeffrey C.**, Ohio, 2013  
**Fisch, Judith M.**, Vermont, 2010  
**Foy, Patrick J.**, Minnesota, 2012  
**Gamba, Thomas W.**, Pennsylvania, 2011  
**Henner, Kevin A.**, New York, 2013  
**Kosel, Eric B.**, Illinois, *ex officio*\*  
**Lantz, Marilyn S.**, Michigan, 2012  
**McCarley, David H.**, Texas, 2012  
**Norbo, Kirk M.**, Virginia, 2010  
**Ortego, L. Stephen**, Louisiana, 2012  
**Palcanis, Kent G.**, Alabama, 2012  
**Sebelius, Carl L., Jr.**, Tennessee, 2011  
**Stein, Alan R.**, California, 2010  
**Tiersky, Terri S.**, Illinois, 2011  
**Elliott, Thomas C., Jr.**, director  
**Sweeney, Karen J.**, manager

**Meetings:** The Council on Ethics, Bylaws and Judicial Affairs (the Council) met on November 13-14, 2009, and April 8-9, 2010, at the ADA's Headquarters in Chicago. Dr. W. Ken Rich, trustee of the Sixth District, served as the Board of Trustees' liaison to the Council. Ms. Tiffany Manzo, a student at the University of Colorado Denver School of Dental Medicine, served as the American Student Dental Association's consultant to the Council.

**The Strategic Plan of the American Dental Association:** To ensure on an ongoing basis that the activities of the Council are current and consistent with the ADA Strategic Plan, the Council's subcommittee on Visionary and Strategic Planning reviewed current events and print media for issues that could have corollaries to dentistry. Members of the Council have been and are involved in the planning and preparations for the Mega Topic Discussion that will take place at the 2010 House of Delegates. That discussion, entitled "ADA Strategic Priority: Make dentists successful throughout their careers. Success At What Cost?," is aligned with Goal One of the ADA 2011-14 Strategic Plan, "Provide support to dentists so they may succeed and excel throughout their careers," and supports the goal's objective and desired outcome of professional competency and ethical standards. Council members have also been involved in other activities throughout the year in furtherance and support of the ADA's current Strategic Plan,

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\* Committee on the New Dentist member without the power to vote.

including continued work in developing a survey tool that will be periodically used to assess the professional ethical climate in dentistry. Such a survey supports the Strategic Plan Goal of Building Dynamic Communities as it is anticipated that survey results will benefit not only the Council but various agencies throughout the Association. A subcommittee of the Council and a Council consultant who formulated the concept of such a survey while serving on the Council finalized the survey instrument, and the survey launched in mid-May and closed in mid-July 2010. Once the data resulting from the survey is received from the ADA Survey Center, the subcommittee will then analyze that data collected and report on that analysis to the Council at an upcoming Council meeting.

The Council also continues to be sensitive to the need to provide members with mechanisms to address the need for lifelong learning and to provide a robust collection of professional ethics resources in support of Strategic Plan Goal to Create and Transfer Knowledge. The Ethics Resources Web page sponsored by the Council launched in May 2010, following the advent of the redesigned ADA.org. The Ethics Resources section of ADA.org includes, among other resources, the *ADA Principles of Ethics and Code of Professional Conduct (ADA Code)*, ethics-related statements promulgated by the Council, and links to *Ethical Moment* articles written by Council members and appearing in *The Journal of the American Dental Association*, conveniently indexed to the *ADA Code* sections to which the articles pertain. The Ethics Resources section of ADA.org also includes links to CERP-approved online ethics courses offered by the American College of Dentists (ACD) and a collection of ethical scenarios and commentary originally published in the *Texas Dental Journal* and authored by the late Dr. Thomas K. Hasegawa and others and now available on the ACD Web site. The Council acknowledges with thanks the cooperation of the ACD in making this ethics material available.

The development of the Ethics Resources section of ADA.org was undertaken by the Council to promote knowledge of and adherence to ethical principles (Strategic Goal – Lead in Advancement of Standards) and maintain the trusted professional image of the dentist among the top three professionals (Strategic Goal-Advocacy). These efforts will also support the ADA 2011-14 Strategic Plan, and in particular Goal One, “Provide support to dentists so they may succeed and excel throughout their careers.”

## **Emerging Issues and Trends**

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The Council’s mission is to enhance the ethical conscience of dentists by promoting the highest moral, ethical and professional standards in the provision of dental care to the public. Pursuit of this mission includes monitoring trends and emerging issues in professionalism and ethical conduct.

**Joint Subcommittee on Ethics and Integrity in Dental Education and the Profession:** The joint subcommittee, originally made up of members from the Council on Dental Education and Licensure (CDEL) and the Council, was established in 2008 to develop actions and long term strategies to advance ethics and professionalism in

dental schools. The subcommittee developed numerous recommendations for addressing dental educational ethics issues and collaborated with representatives from the American College of Dentists, American Dental Education Association, Commission on Dental Accreditation, American Society for Dental Ethics, Joint Commission on National Dental Examinations, American Association of Dental Boards, and American Student Dental Association.

In the course of the work of the joint subcommittee it was determined that many of the issues examined also exist within the professional dental community. With the approval of the 2008 Board of Trustees, the scope of the joint subcommittee was expanded to include activities designed to strengthen dental professionals' awareness of and commitment to ethics and professionalism and representation from the Council on Dental Practice (CDP) was added. The subcommittee met in February 2010 and is scheduled to again meet for a one day meeting on May 21, 2010.

The joint subcommittee requested the Council to assume the further development of a program for ethics assessment and development by individual professionals and in dental practices. At its April 2010 meeting, the Council formed a subcommittee tasked with undertaking this project and requested a report on the progress made at the November 2010 Council meeting. The joint subcommittee also requested the Council to examine a proposal to develop a structured analysis of resolutions having ethical implications for the purpose of raising awareness of those implications among the decision making bodies of the ADA. A Council workgroup was appointed to develop a pilot test of such a procedure working with a group of resolutions to the 2010 House of Delegates selected by the workgroup and to report on its work and the pilot test at the November 2010 Council meeting.

### **Response to Assignments from the 2009 House of Delegates**

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**Annual Revision of the ADA *Constitution and Bylaws*:** The current edition of the *ADA Constitution and Bylaws (ADA Bylaws)*, revised to January 1, 2010, reflects amendments that were approved by the 2009 House of Delegates. A current electronic version of this document is available on ADA.org.

**Annual Revision of the ADA *Principles of Ethics and Code of Professional Conduct (ADA Code)*:** The current edition of the *ADA Code*, revised to January 1, 2010, reflects amendments that were approved by the 2009 House of Delegates. A current electronic version of this document is available on ADA.org.

## **Report on Resolutions Referred by 2009 House of Delegates**

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The ADA Council on Ethics, Bylaws and Judicial Affairs (the Council) was charged by the 2009 House of Delegates with reviewing the following resolutions:

Resolution 15—Amendment of the ADA *Bylaws*, Chapter V, Section 100, Quorum of the House of Delegates

Resolution 16—Amendment of the ADA *Bylaws*, Chapter V, Section 90B, Official Call for Special Session of the House of Delegates

Resolution 17—Amendment of the ADA *Bylaws*, Chapter V, Section 60, Transfer of Powers and Duties of the House of Delegates

Resolution 65H—Dentists Rights and Responsibilities

Resolutions 67 and 67RC—Qualifications for Candidates for Elective or Appointive Officers

Resolution 68—Development of Enabling Language to Define Mechanisms for Sanctions and Hearings

Resolutions 70 and 70RC—Consequences for Violation of Attorney-Client Privilege or Executive Session

Resolution 82—Member Code of Conduct

Resolution 102H—Tenure of the House of Delegates

At the Council's November 2009 meeting, each member was assigned to one or more subcommittees formed to conduct reviews of the resolutions referred to the Council by the 2009 House of Delegates and to report their recommendations to the Council at its April 2010 meeting. Each of the subcommittees did so; the results and recommendations resulting from the Council's deliberations are set forth below. Following consideration and action by the 2010 House of Delegates with respect to these recommendations the Council will, upon request, draft any appropriate *Bylaws* amendments necessary to effectuate those actions for submission to the 2011 House of Delegates.

**Amendment of the ADA *Bylaws* Chapter V, Section 100, Quorum of the House of Delegates:** The referral of Resolution 15-2009 (*Trans.*2009:461; 475) calls for the Council to evaluate the need to increase the quorum required for transacting business at the House of Delegates from  $\frac{1}{4}$  to  $\frac{1}{2}$  the number of voting members of the House. The Council considered the historical record within ADA *Transactions* to gain insight into the original intent of the drafters of this section of the ADA *Bylaws*. The earliest record found, from 1912, set the quorum to transact business at one-fifth ( $\frac{1}{5}$ ) of the voting members of the House of Delegates. The quorum definition was amended in 1948 to the current definition found in Chapter V, Section 100 of the *Bylaws*. No rationale for either the establishment of  $\frac{1}{5}$  of the voting members constituting a quorum or the change to  $\frac{1}{4}$  of the voting members could be found in the Association's historical governance records.

The Council also reviewed quorum requirements described in the fourth edition of *The Standard Code of Parliamentary Procedure* by Alice Sturgis. Sturgis discourages a simple majority and advises that a quorum should be set low enough for a sufficient number of those charged with transacting the business of the group to be present to conduct the organization's business yet high enough to preclude minority control. However, Sturgis also recognizes that where the business of an organization is transacted by delegates, a quorum may be set at a higher level.

Following its research and discussions respecting the information consulted as applied to the ADA's method of conducting business, it is the view of the Council that the definition of a quorum as  $\frac{1}{4}$  of the voting members of the House of Delegates, representing at least  $\frac{1}{4}$  of the constituent societies and the federal dental services, is low enough to ensure sufficient delegate representation (both numerically and geographically) yet high enough to prevent minority control and allows the Association to be responsive enough to conduct business in the event of a special session called under extraordinary circumstances.

*Recommendation.* For the reasons stated, the Council finds no compelling reason to change the definition of a quorum from  $\frac{1}{4}$  of the voting members of the House presently found in the *Bylaws* to  $\frac{1}{2}$  the voting members, for either regular meetings or special sessions. The Council, therefore, recommends that Resolution 15-2009 not be adopted.\*

**Amendment of the ADA *Bylaws* Chapter V, Section 90B, Official Call for Special Session of the House of Delegates:** The referral of Resolution 16-2009 (*Trans.* 2009:461; 475) calls for the Council to deliberate on the advisability of revising the number of days required for official notice of a special session of the House of Delegates from not less than 15 days to not less than 30 days prior to the special session.

In considering this referral, the Council appreciated the desire for as much notice as possible for the calling of a special session of the House of Delegates, inasmuch as attending such a meeting will involve setting aside the normal and scheduled activities of each of the delegates to the House of Delegates for multiple days. However, it is the Council's judgment that special sessions are called most infrequently and only for the consideration of issues of an immediate or extraordinary nature requiring prompt consideration and action. Instituting a 30 day notice provision for special sessions of the House of Delegates would diminish the House of Delegates' adaptability and flexibility in making timely decisions in dealing with an extraordinary situation. Although any detrimental impact on the affairs of the Association might be mitigated by the Board of Trustees' ability to set *ad interim* policies under Chapter VII, Section 90E of the *Bylaws*, the Council foresees potential situations where extending the notice provision from 15 to 30 days could severely impair the Association's responsiveness to extraordinary or catastrophic events.

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\* The Council separately considered the inclusion of delegates from ASDA in the calculation of a quorum. Please see pages 128-129, *infra*, for a discussion of that topic.

*Recommendation.* The Council finds no compelling reason to lengthen the 15 day notice provision for calls for special sessions of the House to conduct business of an immediate or extraordinary nature. The Council therefore agrees with the Board of Trustees' assessment that the 15-day period is an appropriate notice provision and recommends against amending ADA *Bylaws* Chapter V, Section 90 as suggested by Resolution 16-2009.

**Amendment of the ADA *Bylaws* Chapter V, Section 60, Transfer of Powers During Extraordinary Emergency of the House of Delegates:** The referral of Resolution 17-2009 (*Trans.*2009:461; 475) calls for the Council to evaluate the need to amend the ADA *Bylaws* to increase the number of ballots required for a valid vote from  $\frac{1}{4}$  to  $\frac{1}{2}$  of members of the last House of Delegates and to allow for electronic voting. The Council agrees that the addition of the ability to cast ballots electronically is appropriate in that it would allow the Association to use current technology in order to expedite its actions in times of perceived extraordinary emergency. However, before that change is implemented, the Council believes it to be appropriate to consult with the appropriate ADA agency regarding the technology to be used for such activity and the procedures to undertake in casting of ballots electronically to develop a voting system and procedure that is secure and can reliably authenticate the ballots of delegates being cast.

For the same reasons stated with respect to Resolution 15-2009, the Council finds no compelling reason to increase the number of ballots required to constitute a valid vote of the House.

*Recommendation.* The Council recommends that Chapter V, Section 60 of the *Bylaws* be amended to allow for electronic voting on the question of declaring the existence of an extraordinary emergency. It is suggested that the appropriate agency within the Association be first consulted respecting the procedures and technology to be used to ascertain that proper levels of authentication and security are present and can be maintained. For the same reasons as stated in its discussion of Resolution 15-2009, above, the Council recommends against any increase in the number of ballots required to constitute a valid vote.\*

**Dentists Rights and Responsibilities:** By the referral of Resolution 65-2009 (*Trans.*2009:461; 475), the Council was requested to prepare a Dentists' Rights and Responsibilities statement. The basis for that resolution, as stated in the report to the 2009 House of Delegates, was that it was believed that dentists' rights and responsibilities are interspersed throughout the ADA *Code* and other Association policy manuals (*Supplement* 2009:5060). The resolution envisions that with the rights and responsibilities of member dentists summarized into one document, it would be an easily accessible member tool to "guide the members of the profession in an ethical and practical manner."

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\* The Council also recommends an additional change to Chapter V, Section 60 to make the Section consistent with the Council's recommendation respecting Resolution 102—Tenure of the House of Delegates. That recommended amendment to Chapter V, Section 60 of the *Bylaws* is set forth with the discussion of Resolution 102, *infra*, pages 126-127.

The Council has developed a draft Dentist's Rights and Responsibilities Statement as requested by the House; it is presented below. However, as indicated in response to a suggestion by a delegate from the 2008 House of Delegates (*Reports.2009:99*), the Council firmly believes that the *ADA Code* sufficiently delineates the rights' and responsibilities of dentists. As reported in the Council's 2009 Annual Report, in deliberating on that suggestion, the Council, made a considered determination that any attempt to prepare a list of dentists' rights and responsibilities could potentially do a disservice to the Association and its members by diminishing the importance and value of the *ADA Code*.

In its effort to construct the requested document, the Council reviewed the *ADA Code* and the recently adopted Dental Patient's Rights and Responsibilities statement, as well as several other non-ADA resources, including the American Medical Association (AMA) Code of Ethics and the dentist's rights and responsibilities statement developed by the Fédération Dentaire Internationale (FDI). It should be noted that *ADA Current Policies* were not considered as part of this review as the Council determined that the Association policies related more to the rights and responsibilities of membership in the Association than to the relationship of dentists and the profession to patients. The Council therefore gave primary consideration to dentists' rights and responsibilities with respect to patients and society.

The introductory statement of the *ADA Code* states that the privileges afforded to the dental profession require that dentists accept a number of obligations in exchange for being granted these privileges by society, and that the obligations imposed on dentists by the *ADA Code* are more stringent than "responsibilities." The Council understood that while dentists do have rights, the focus of the *ADA Code* is mainly on the member dentist's professional obligations owed to patients. This same opinion is shared by the FDI, where it states in its rights and responsibilities document that there are "situations where professional responsibilities should take precedence over [dentists'] professional rights."

With the sole objective of satisfying the request of the 2009 House of Delegates, the Council prepared the draft statement below:

### **Draft ADA Dentists Rights and Responsibilities Statement**

#### **Dentist's Rights**

1. Dentists have the right to exercise their professional autonomy and judgment for the benefit of the patient and the public.
2. Dentists have the right to ask patients questions about their health and social and family history as needed for the purpose of assessing the patient's oral health status and treatment needs.
3. Dentists have a right to expect patients to communicate honestly in providing personal health information for the purpose of assessing the patient's oral health status and treatment needs.

4. Dentists have the right to expect mutual respect in dentist-patient interactions.
5. Dentists have the right to expect patients to participate in making decisions about their oral health care.

#### Dentist's Responsibilities

1. Member dentists have the responsibility to abide by the ADA *Principles of Ethics and Code of Professional Conduct*.
2. Member dentists have the responsibility to abide by the Codes of Ethics of the constituent and component societies within whose jurisdiction the member practices or conducts other professional dental activities.
3. Dentists must abide by their state's dental practice act and other applicable state laws.

*Recommendation.* The Council maintains its original position that the existing framework of the ADA Code adequately addresses the dentists' rights and responsibilities, and respectfully does not recommend adoption of any other statement designed for that purpose.

**Governance Issues:** The House of Delegates requested the Council to consider Resolutions 67, 67RC, 68, 70 and 70RC (*Trans.*2009: 378; 380) and report to the 2010 House of Delegates. The Council considered these resolutions together as they were viewed as addressing intertwined and complementary issues. By way of background and for ease of reference, the resolutions are reproduced below.

*Resolution 67-2009—Qualifications for Candidates for Elective or Appointive Office.*

**Resolved**, that candidates for elective or appointive officers may not have had any sanctions bestowed upon them by the Association.

*Resolution 67RC-2009—Qualifications for Candidates for Elective or Appointive Officers.*

**Resolved**, that anyone found by the Committee on Credentials, Rules and Order to have violated his or her duties to the Association shall be disqualified from holding elective or appointive office.

*Resolution 68-2009—Development of Enabling Language to Define Mechanisms for Sanctions and Hearings.*

**Resolved**, that the current ADA *Bylaws* be reviewed by the Council on Ethics, Bylaws and Judicial Affairs and enabling language crafted that would define the mechanism for sanctions up to and including removal from office of a delegation member or Board of Trustee member if the member is found to have cause for removal as shall be defined, and be it further

**Resolved**, that cause, at a minimum, should include those causes as delineated currently for council members, and be it further

**Resolved**, that a method for fair and impartial hearings be recommended. It shall be established as an authorized committee of the House that can be held on an ad interim basis between annual sessions of the House of Delegates with authority to determine and impose any such sanctions which are deemed appropriate, and be it further

**Resolved**, that a report to the 2010 House of Delegates be presented with bylaw language changes for consideration by the House.

*Resolution 70-2009—Consequences for Violation of Attorney-Client Privilege or Executive Session.*

**Resolved**, that if any member of the ADA, including delegation member, council, committee or task force member, or Board of Trustees member has been acknowledged as breaking the attorney-client privilege or executive session, that member is, at a minimum, barred from ever again participating in an attorney-client or executive session within the ADA. This shall include such acts which have been acknowledged as occurring prior to the enactment of this resolution.

*Resolution 70RC-2009—Consequences for Violation of Attorney-Client Privilege or Executive Session.*

**Resolved**, that violation of attorney-client privileged communication is considered a breach of ethical behavior, professional conduct, and a failure to comply with the duties of one's position, and be it further

**Resolved**, that if any member of the ADA, including delegation member, council, committee or task force member, or Board of Trustees member has been acknowledged as breaking the attorney-client privilege or executive session, that member is, at a minimum, barred from ever again participating in an attorney-client or executive session within the ADA. This shall include such acts which have been acknowledged as occurring prior to the enactment of this resolution.

The Council conducted a critical review of the governance issues addressed by these referred resolutions. Among the information reviewed was an overview of candidate credentialing procedures, procedures for nominating candidates and examining their eligibility from the floor of the House of Delegates, the legal definition of "due process" and the concepts of "for cause," "without cause," "fiduciary duty" and "duty of loyalty." The Council also discussed the fundamental question of whether the Council was the appropriate entity to develop candidate qualification or selection procedures. The meaning of attorney-client privilege, its importance to the ADA and the potential consequences flowing from a breach of such privilege were addressed and clarified.

During its deliberations, the Council determined that it would be more appropriate to use the word “discipline” rather than “sanction” since, as indicated in *Bylaws* Chapter XII, the word “discipline” is the customary language of the Association. With respect to general topics considered, the Council concluded as follows:

*Candidate Review.* The Council concluded that it would be appropriate to specify that one of the qualifications for elective or appointive office should be that a candidate must not be under active discipline for violating duties owed to the Association or to the constituent society within whose jurisdiction the candidate practices. It was noted that procedures would need to be in place to coordinate the reporting of constituent society discipline for this purpose. The Council further noted that, in the case of a member announcing his/her candidacy for elective office from the floor of the House, any alleged discipline would need to be disclosed during debate.

After considerable debate and consideration, the Council originally decided that the duties of the Committee on Credentials, Rules and Order (CCRO), currently responsible for reviewing the eligibility of a candidate for delegate or alternate delegate positions, should be expanded to include reviewing candidates for all elective or appointive Association offices or positions. Thereafter, the Council was contacted by the Speaker of the House of Delegates, who expressed reservations concerning the CCRO assuming that responsibility given that it is a body with parliamentary responsibilities. After conferring with the Speaker through the Council chair, the Council agreed to revise its recommendation to suggest that the Election Commission conduct the contemplated candidate review. The Election Commission would not be required to investigate allegations or conduct hearings, but would review a candidate’s disciplinary record to verify whether he/she is under active discipline, and, if so, rule the candidate ineligible. The Election Commission would also need to be available to conduct those reviews throughout the year rather than just 60 days prior to annual session.\*

A flow chart, attached as Appendix 1, depicts in graphical form the Council’s recommended steps in the candidate review process.

*Hearing Entity.* The Council began deliberations on the question of a system for addressing the issue of disciplining a current holder of an elected or appointed office or position by considering what person or agency of the Association would be appropriate for conducting hearings on allegations of impropriety. The Council determined that, because the resolutions under consideration each call for the potential imposition of discipline, it is imperative that the entity or entities charged with deciding whether such discipline is warranted be capable of addressing pertinent issues in a fair, impartial and judicious manner and should have knowledge or experience in processes employed in making such determinations.

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\* The Election Commission would not, however, have any role in any review of candidates for the appointive office of Executive Director, as that responsibility for appointments for that office rests with the Board of Trustees pursuant to Chapter IX, Section 20 of the *Bylaws*.

The Council was unanimous in its support of its subcommittee's recommendation that the Council itself was the appropriate ADA agency to conduct hearings of allegations that Association delegates or elected or appointed office or position holders have violated duties owed to the Association (including alleged breaches of the attorney-client privilege and/or improperly divulging ADA confidential information). The Council based this determination on its responsibility under the ADA *Bylaws*, as set forth in Chapter XII, Section 20A, for hearing appeals arising from decisions of constituent societies and the Council's extensive experience in conducting those hearings. It was further agreed that all members of the Council should sit on the hearing panel with the exception of any member from the trustee district or districts of the delegate or office or position holder involved.

*Hearing Procedure.* A flow chart, attached as Appendix 2, illustrates the sequence and steps the Council recommends should comprise a judicial hearing process. Under the proposed process, 1) charges are submitted to Council director, 2) the Council conducts hearing and renders a decision, to include whether a violation has occurred and what type of discipline, if any, is warranted, and 4) Council reports its determinations to the Election Commission.

While the Council deliberated at length on whether it would be necessary for the Council to investigate the merits of a charge prior to convening a hearing, it determined that such a procedure should not be adopted in light of the time and expense such a procedure would involve. Moreover, given the nature of the alleged misconduct that would be subject to a hearing, the Council believes that a full and complete understanding of the events involved can be arrived at by reading submissions from the complaining party and accused and the opportunity to question the parties at a hearing. During the hearing, the Council would serve in an adjudicatory capacity and the Legal Division would appoint an attorney (from within or outside the Association) to serve in a prosecutorial role. Depending on the circumstances of the case and its impact on the Association's ability to function without interruption, the Council could convene to conduct a disciplinary hearing at times other than its regularly scheduled meetings.

The Council also debated whether the Executive Director should be subject to the outlined disciplinary process. The Council concluded that the Executive Director should not be included as the power to appoint (and thus inherently to remove) the Executive Director is vested in the Board of Trustees under Chapter IX, Section 20 of the ADA *Bylaws*.\*

*Opportunity for Appeal.* The Council considered the advisability of incorporating an appeal to the House of Delegates into the proposed hearing process. The Council expressed concern that having the House of Delegates as a whole consider appeals would be impractical and that even if a smaller ad hoc committee of the House of Delegates were formed for this purpose, such an appeals process would present practical difficulties associated with, among other things, transmitting case records to

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\* The Council also noted that the Board of Trustees can request that the Council review any allegations of wrongdoing made against the Executive Director, and report in an advisory capacity to the Board with its findings.

each member, protecting against the inadvertent disclosure of confidential information, filtering out political considerations and the considerable financial costs involved in coordinating the deliberation of an appeal. Bearing these issues in mind, the Council felt it appropriate that the judicial decisions made by the Council should be considered final.

*Disciplinary Penalties.* The Council also discussed the need to list with specificity the offenses that could warrant the imposition of discipline. It was felt that any list would be unlikely to cover every possible situation but that it would be appropriate to provide examples of offenses within the official judicial procedures. Attached as Appendix 3 is a list of potential grounds for the imposition of discipline as adapted from the *Standing Rules for Councils and Commissions* as requested in the original resolution from the House of Delegates. The Council also addressed the impact of disciplinary penalties that do not have specific end dates or are simply a matter of record such as letters of reprimand, censure and stayed suspensions, on a member's qualifications to hold elective or appointive office. The Council concurred that the definition of each type of discipline would have to be carefully crafted, mindful of the possible consequences to a member's ability to qualify as a candidate for office. Council members also agreed that all hearings and decisions would have to be made public and reported to the Election Commission so that those responsible for making appointments and for judging the qualifications for elective or appointive would have access to this information.

*Recommendation.* Based upon the discussions and deliberations of the Council and its subcommittee respecting the matters raised by Resolutions 67, 67RC, 68, 70 and 70RC as summarized in this report, the Council recommends the adoption of the following resolution:

**15. Resolved**, that anyone identified by the Election Commission to be under active discipline for violating his or her duties to the constituent society within whose jurisdiction the member practices or of this Association shall be disqualified from seeking elective or appointive office while under that active discipline, and be it further

**Resolved**, that any member holding an elective or appointive position, but excluding the Executive Director, charged with violating his or her fiduciary or legal duties to the Association shall be afforded a fair and impartial hearing conducted according to existing judicial procedures of the Council on Ethics, Bylaws and Judicial Affairs. The Council on Ethics, Bylaws and Judicial Affairs shall be the disciplinary body whose actions shall be final and not appealable, and may include, but are not limited to: censure, suspension, probation or expulsion, and be it further

**Resolved**, that the final results of such hearing process shall be a public record and shall be reported to the Election Commission, and be it further

**Resolved**, that the appropriate amendments the ADA *Bylaws* to effectuate the matters set forth in this resolution shall be prepared by the Council on Ethics, Bylaws and Judicial Affairs and submitted to the 2011 House of Delegates, and be it further

**Resolved**, that the financial implications, if any, of this resolution shall be investigated by the Council on Ethics, Bylaws and Judicial Affairs and reported to the 2011 House of Delegates with the suggested *Bylaws* revisions.

**Member Code of Conduct:** By referral of Resolution 82-2009, the Council was asked to develop a Member Code of Conduct, including investigation and enforcement procedures, using the principles outlined in the resolution as a guide. The Council members present during the discussion of the resolution at the House briefed the Council on the intent behind the proposed Member Code of Conduct and advised that the Member Code of Conduct is intended to serve as a guide for members of the Association in their interactions with other dentists, dentist members, and Association officers, trustees and staff that occur in the course of conducting the business of the Association. The Council is also cognizant that any procedures that are developed and adopted by the Association on this topic may serve as a template for the development of similar processes by constituent and component societies.

The Council considered suggesting that a Member Code of Conduct be appended to the *ADA Code* so that members would have a single reference source for their ethical and professional duties and obligations. However, since the strength of the *ADA Code* is its focus on the dentist-patient relationship resulting from the clinical practice of dentistry the Council believes this distinctive focus of the *ADA Code* should be maintained.

In addition, the Council discussed the possibility that confusion would result between the *ADA Code* and an intra-Association conduct code if the latter were called a “code,” and determined that such confusion would be a distinct possibility. To guard against possible confusion, the Council recommends that the word “Code” be removed from the title and that the title be revised to “ADA Member Conduct Policy.”

The Council recommends that the judicial procedures described in the *ADA Bylaws*, Chapter XII, Section 20C should be used to enforce the proposed policy. Section 20A of the same chapter, detailing conduct subject to discipline, should also be amended to include violations of the proposed conduct policy.

The Council agreed that such a policy merits consideration. It used the template provided in Resolution 82-2009 to formulate language, revised the sentence structure to adhere to phrasing commonly used in professional conduct documents, and proposes the following specific changes to the ADA Member Code of Conduct put forth in House Resolution 82-2009 (additions underlined; deletions stricken):

#### ADA Member ~~Code~~ of Conduct Policy

~~Members will maintain high standards of integrity and conduct their dealings as members of the Association in a professional manner.~~

1. Members should communicate respectfully in all interactions with ~~will treat~~ other members and Association officers, trustees and staff. ~~with courtesy and respect, and shall refrain from conduct that is unreasonably disruptive or is harassing.~~
2. Members ~~will~~ should respect the decisions and polices of the Association and ~~will~~ must not engage in conduct that is disruptive to behavior in interactions with

~~other members, Association officers, trustees, or staff, or causes the Association to expend an unreasonable amount of time or effort to address.~~

3. ~~Members have an obligation to be informed about and use are encouraged to use proper Association policies for channels of communication and dispute resolution to address differences.~~
4. Members ~~will~~ must comply with all applicable laws and regulations, including but not limited to antitrust laws and regulations.
5. Members ~~will~~ must respect and protect the intellectual property rights of the Association, including any trademarks, logos, and copyrights.
6. Members ~~will~~ must not use Association membership lists, on-line member listings, or attendee lists from Association-sponsored conferences or CE courses for personal or commercial gain, such as selling products or services, prospecting, or creating databases for these solicitation purposes.

~~Members will not use all or part of Association lists, including membership directory, online member listings, conference attendees, and education course participants for selling, prospecting or creating a directory or database.~~

7. Members ~~will~~ must treat all information furnished by the Association as confidential and ~~will~~ must not reproduce materials without the Association's written approval.
8. Members must not violate the confidentiality of attorney-client sessions conducted within the Association's tripartite. Members will must make every effort to avoid conflicts of interest and the appearance of conflicts of interest.

*Recommendation.* Based on its consideration of Resolution 82-2009, the Council recommends adoption the following resolution:

**16. Resolved,** that the ADA Member Conduct Policy set forth below be adopted as policy of the Association, effective at the close of the 2011 House of Delegates:

#### **ADA Member Conduct Policy**

1. Members should communicate respectfully in all interactions with other dentists, dentist members, Association officers, trustees and staff.
2. Members should respect the decisions and policies of the Association and must not engage in disruptive behavior in interactions with other members, Association officers, trustees, or staff.
3. Members have an obligation to be informed about and use Association policies for communication and dispute resolution.

4. Members must comply with all applicable laws and regulations, including but not limited to antitrust laws and regulations.
5. Members must respect and protect the intellectual property rights of the Association, including any trademarks, logos, and copyrights.
6. Members must not use Association membership directories, on-line member listings, or attendee records from Association-sponsored conferences or CE courses for personal or commercial gain, such as selling products or services, prospecting, or creating directories or databases for these purposes.
7. Members must treat all confidential information furnished by the Association as such and must not reproduce materials without the Association's written approval.
8. Members must not violate the confidentiality of attorney-client and executive sessions conducted at any level within the Association.
9. Members must fully disclose conflicts, or potential conflicts, of interest and make every effort to avoid the appearance of conflicts of interest.

and be it further

**Resolved**, that this resolution be referred to the Council on Ethics, Bylaws and Judicial Affairs for the purpose of developing an enforcement procedure for the ADA Member Conduct Policy by modifying the judicial procedures described in Chapter XII, Section 20C of the ADA *Bylaws* as appropriate to harmonize with ADA Member Conduct Policy, and be it further

**Resolved**, that the resulting enforcement procedures for the ADA Member Code of Conduct be presented for consideration to the 2011 House of Delegates.

**Tenure of the House of Delegates:** In its referral of Resolution 102H-2009 (*Trans.*2009:494), the House of Delegates requested the Council to evaluate a proposed delineation of the tenure of members of the House of Delegates. The Council agreed that there is a need to address this issue and concurs with the intent of the resolution in its attempt to clarify the point at which delegates' duties and rights to confidential business and financial information between sessions of the House commence and conclude. In its deliberations, the Council recognized that the schedules used by constituent societies to select delegates and alternate delegates vary from state to state and contribute to the difficulty of defining specific tenure. As a consequence, the Council extensively discussed a number of possible options and their impact on the constituent societies' current procedures, including alternative tenure cycles, requiring every state society to utilize identical calendars for selecting delegates and alternate delegates, and the creation of a delegate-elect position.

As a result of its deliberations, the Council believes it appropriate that the term of a delegate or alternate delegate commence when such delegate or alternate delegate is

certified and that such term run until a duly elected or appointed replacement delegate or alternate delegate is certified by the Association. To effectuate that recommendation, Chapter V, Section 10 of the *ADA Bylaws* should be amended by addition to define delegate tenure and Chapter V, Section 60 of the *ADA Bylaws* should be amended so that references to members of the House of Delegates are consistent with the proposed amendments to Section 10G.

The Council recommends adoption of the following resolution:

**17. Resolved**, that the *ADA Bylaws*, Chapter V, be amended to include a Section 10G, which shall read as follows (new language underscored):

G. TERM OF DELEGATES AND ALTERNATE DELEGATES. The term of a delegate or alternate delegate elected or selected pursuant to Section 20 of this Chapter commences from the time such delegate or alternate delegate is certified pursuant to Section 30 of this Chapter until another delegate or alternate delegate elected or selected in place of such delegate or alternate delegate is so certified.

and be it further

**Resolved**, that the *ADA Bylaws*, Chapter V, Section 60 be amended as follows (new language underscored, deleted language stricken).

*Section 60. TRANSFER OF POWERS AND DUTIES OF THE HOUSE OF DELEGATES:* The powers and duties of the House of Delegates, except the power to amend, enact and repeal the *Constitution and Bylaws*, and the duty of electing the elective officers and the members of the Board of Trustees, may be transferred to the Board of Trustees of this Association in time of extraordinary emergency. The existence of a time of extraordinary emergency may be determined by unanimous consent of the members of the Board of Trustees present and voting at a regular or special session. Such extraordinary emergency may also be determined by mail vote of the last House of Delegates on recommendation of at least four (4) of the elective officers. A mail vote to be valid shall consist of ballots received from not less than one-fourth (1/4) of the current members of the ~~last~~ House of Delegates. A majority of the votes cast within thirty (30) days after the mailing of the ballot shall decide the vote.

## Judicial Affairs

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**Appeals from Disciplinary Hearings:** One of the Council's *Bylaws* duties is to sit as an appellate body to review decisions of the constituent and component societies in disciplinary matters. The Council is to determine whether the evidence before the society that preferred charges against the accused member supports the decision or warrants the penalty imposed. The Council also reviews the disciplinary procedures used to render the decision to make sure such procedures are fair and in accordance with the *Bylaws*. Since its last report, the Council has not rendered any decisions. One

appeal has been submitted and is presently being briefed. A hearing on that appeal is scheduled to be held during the Council's November 2010 meeting.

**Survey of Constituent Judicial Procedures:** The Council has begun a survey of constituent dental societies to ascertain the procedures used in acting on complaints of ethics violations received by the constituent societies. Such a survey was previously conducted in 1998. The Council believes updating the information in its possession will assist it in updating and revising the template manual of judicial procedures the Council maintains and provides to constituent and component organizations upon request.

### **Review of the ADA Constitution and Bylaws**

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**Editorial Review of the ADA Bylaws:** Pursuant to the Council's *Bylaws* duties (Chapter X. COUNCILS, Section 120. DUTIES, G. COUNCIL ON ETHICS, BYLAWS AND JUDICIAL AFFAIRS, Subsection h), the Council considered and unanimously passed a resolution to amend the ADA *Bylaws* to reflect the name change of the American Association of Dental Examiners to the American Association of Dental Boards. The sections of the ADA *Bylaws* affected by the revision are: Chapter X. COUNCILS, Section 30. ELIGIBILITY, Subsection C; Chapter XIV. COMMISSIONS, Section 20. MEMBERS, SELECTIONS, NOMINATIONS AND ELECTIONS, Subsection A. COMMISSION ON DENTAL ACCREDITATION, member selection method (2) and Subsection B. JOINT COMMISSION ON NATIONAL DENTAL EXAMINATIONS; and Chapter XIV. COMMISSIONS, Section 40. ELIGIBILITY, Subsection B. The revisions are reflected in the January 2010 edition of the ADA *Constitution and Bylaws*.

**Review of ADA Bylaws Relating to the Nomination of Treasurer:** In December 2010, the Board of Trustees requested the Council to review the ADA *Bylaws* and the *Organization and Rules of the Board of Trustees* regarding the treasurer nomination process and report the conclusions of the Council resulting from that review to the Board at a future meeting. A workgroup was appointed by the Council chair to conduct a review of the nomination procedures and to report to the Council at its April 2010 meeting. Following the workgroup's report to the Council, the Council determined that further consideration of the issues raised by the workgroup was warranted. The Council approved an expansion of the workgroup and requested that additional review of the procedures for nomination of Treasurer be conducted with a report to the Council on that additional work to be given in November 2010.

**Addition of American Student Dental Association (ASDA) Delegates in Determining a Quorum:** During the Council's discussions and consideration of Resolution 15-2009 referred by the House of Delegates, it was noted that the ASDA delegation of five delegates specified in Chapter V. HOUSE OF DELEGATES, Section 10. COMPOSITION, A. VOTING MEMBERS and D. DELEGATE ALLOCATION are not included in the calculation of a quorum set forth in Chapter V. HOUSE OF DELEGATES, Section 100. QUORUM. The Council believes that this apparent discrepancy should be rectified by an amendment to the ADA *Bylaws* and that the ASDA delegation should be included as a part of the calculation of a quorum of the

House of Delegates, just as are the delegates from the constituent societies and the federal dental services. Therefore, the Council recommends adoption of the following resolution:

**18. Resolved**, that ADA *Bylaws* Chapter V. HOUSE OF DELEGATES, Section 100. QUORUM, be amended by the addition by the addition of the following language (additions underscored):

*Section 100. QUORUM:* One-fourth (1/4) of the voting members of the House of Delegates, representing at least one-fourth (1/4) of the constituent societies, the American Student Dental Association and the federal dental services, shall constitute a quorum for the transaction of business at any meeting.

### **Review of the ADA Code**

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**Advisory Opinion 5.B.3. Revision:** At the 2009 House of Delegates, the House adopted Resolution 44H (*Trans.*2009:415; 419) presented by the Council on Dental Benefits Programs (CDBP). The resolution called for a statement on reporting fees on dental claims, and provides a definition of the term “full fee.” The Council reviewed Advisory Opinion 5.B.3. of the ADA *Code* to ascertain whether an amendment to the Advisory Opinion was required in light of the adoption of the resolution. As a result of that deliberation, the Council unanimously voted to amend Advisory Opinion 5.B.3 as shown below (additions underlined; deletions stricken):

5.B.3. Fee Differential. The fee for a patient without dental benefits shall be considered a dentist’s full fee.\* This is the fee that should be represented to all benefit carriers regardless of any negotiated fee discount. Payments accepted by a dentist under a governmentally funded program, a component or constituent dental society-sponsored access program, or a participating agreement entered into under a program ~~of~~ with a third party shall not be considered or construed as evidence of overbilling in determining whether a charge to a patient, or to another third party in behalf of a patient not covered under any of the aforementioned programs constitutes overbilling under this section of the Code.

\* A full fee is the fee for a service that is set by the dentist, which reflects the costs of providing the procedure and the value of the dentist’s professional judgment.

The amendment to Advisory Opinion 5.B.3. will appear in the next edition of the ADA *Code*.

**Proposed ADA Code Addition Section 3.F. Professional Demeanor in the Workplace:** In response to a recent report from The Joint Commission, the Council investigated the issue of intimidating and disruptive behavior among health care professionals, particularly with respect to the potential effect that such behavior may have upon the care received by patients. The Council, in considering the report of a subcommittee convened to investigate the issue, felt strongly that instances of

intimidating, disruptive and/or abusive behavior in the workplace could negatively affect care given patients by dental professionals. Consequently, the Council adopted the recommendation of the subcommittee that the ADA Code be amended by addition to include a section setting forth the obligation to provide a workplace environment conducive to providing professional care to patients, and recommends adoption of the following resolution:

**19. Resolved**, that the ADA *Principles of Ethics and Code of Professional Conduct* be amended by the addition of the following code section, 3.F. Professional Demeanor in the Workplace (additions underlined):

3.F. PROFESSIONAL DEMEANOR IN THE WORKPLACE.  
Dentists have the obligation to provide a workplace environment that supports respectful and collaborative relationships for all those involved in oral health care.

### **Council Activities**

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**ADA Current Policy Review:** As required by Resolution 15H-1995 (*Trans.*1995:660), a subcommittee of the Council was charged with review of the *Current Policies* to identify those policies that impact the Council's duties under the *ADA Bylaws*. In reporting to the Council on that undertaking, the subcommittee reported that the task was found to be quite cumbersome in that the *Current Policies* contain policy statements in language that is outdated or no longer accurate. It was reported to the Council that numerous policy statements were found that had seemingly outlived their relevance or value. Finally, the report indicated that the process of merely identifying the policies relevant to the Council was unnecessarily tedious because there are no official indicators of which agency is responsible for each policy. As a result of the report, the Council deliberated on an approach that would keep *ADA Current Policies* relevant and consistently stated. As a result, the Council recommends the adoption of the following resolution to achieve that goal:

**20. Resolved**, that the Association Board of Trustees appoint a task force charged with reviewing *ADA Current Policies* and, after consulting with Association councils, commissions and committees, or appropriate ADA entity assign each existing policy to a council, commission or committee or appropriate ADA entity for purposes of conducting periodic reviews of Association policies, and be it further

**Resolved**, that the task force report back to the Board of Trustees on the policy assignments, and be it further

**Resolved**, that each council, commission and committee or appropriate ADA entity to which a policy or policies are assigned by the task force review all policies assigned to it and determine if each policy should remain unchanged, be revised or rescinded or new policy submitted in resolution form to the House of Delegates, and be it further

**Resolved**, that each council, commission and committee or appropriate ADA entity to which a policy or policies are assigned by the task force report back to the Board of Trustees on its review of policies to it by June 2011, and be it further

**Resolved**, that any new Association policy proposed to the House of Delegates include a designation of the council, commission or committee or ADA entity responsible for the periodic review of that policy, and be it further

**Resolved**, that Resolution 15H-1995 be amended as follows (insertions underlined and deletions stricken):

**Resolved**, that commencing as of June 2011, each council, commission and committee or appropriate ADA entity of the Association review all policies assigned to it at least as often as every seven-three years after the adoption of a policy, ~~that policy shall be reviewed by the appropriate ADA agency;~~ if ~~modification~~ revision or rescission is suggested, it shall be submitted to the House of Delegates for action.

so that the amended Resolution 15H-1995 reads as follows:

**Resolved**, that commencing as of June 2011, each council, commission and committee or appropriate ADA entity of the Association review all policies assigned to it at least as often as every three years; if revision or rescission is suggested, it shall be submitted to the House of Delegates for action.

**Golden Apple Award for Outstanding Achievement in the Promotion of Dental Ethics:**

The Council serves as the sole judge for the *Golden Apple Award for Outstanding Achievement in the Promotion of Dental Ethics*. The award recognizes a component or constituent dental society for outstanding efforts in the promotion of dental ethics through workshops, articles or other scholarly activities. The deadline for submissions this year is Tuesday, June 1, 2010. The Council will vote upon nominations submitted for the 2010 award by confidential mail ballot.

**Ethical Moment Feature in JADA:** The Council continued its contributions to the *Journal of the American Dental Association (JADA)* feature entitled "Ethical Moment." This monthly feature provides practical answers to everyday dental practice dilemmas based on the *ADA Principles of Ethics and Code of Professional Conduct*. This year, subjects addressed included consent and confidentiality issues when treating elderly patients, Web site ethics, ethical considerations of continuing education and use of the words "specializes" and "specialist" by general dentists. Because the "Ethical Moment" feature first appeared over five years ago, this year the Council requested that one of its subcommittees begin looking at the treatment of ethical issues in early "Ethical Moment" articles to ascertain if those issues need to be revisited. The Council welcomes questions from members. Suggestions should be sent to [ethics@ada.org](mailto:ethics@ada.org).

**Subcommittee on Advertising:** The subcommittee on advertising is a standing Council subcommittee composed of the senior members of the Council. Its role is to provide advisory letters in response to requests for advice from constituent societies on compliance of dental advertisements with the *ADA Code*. Constituent societies may forward questionable advertisements to the subcommittee for review. The subcommittee responds with an opinion letter that is strictly advisory and not binding on

either the Council or the society that requests the opinion. The opinion letter is confidential between the subcommittee and the constituent. The Council is not informed of its contents. Should the matter proceed to a disciplinary hearing that results in an appeal to the Council, members of the subcommittee who participated in the advisory opinion will have ceased to be Council members by the time the appeal is heard, thus preserving the Council's impartiality. Constituent societies are encouraged to contact the Council staff for further information.

**Student Ethics Video Contest:** The Council's student ethics video contest is in its third year this reporting period. The contest is intended to encourage student review and study of the *ADA Code*. With the cooperation of the American Student Dental Association (ASDA), ASDA members have been invited to create video presentations on common ethical situations demonstrating one of the principles, codes or advisory opinions found in the *ADA Code*. To be eligible, videos must be submitted by July 31, 2010. Winners will be selected by the Council through mail ballot. Depending on the quality of submissions received, it is intended that the top videos will be aired at the 2010 annual session in Orlando, Florida. Monetary prizes will be awarded including \$2,000 to the first place winner. Numerous inquiries have been received from students requesting more details about the 2010 contest.

**Council Self-Assessment:** The Council conducted a periodic self-assessment in the spring of 2010, confirming that its activities continue to be relevant and valuable to individual members of the Association. A detailed report on the self-assessment is provided to the House of Delegates elsewhere by the ADA Board of Trustees.

**Council Satisfaction Survey:** Staff for the Council, with the assistance of the ADA Survey Center, created a short survey instrument that will be sent to the Council members following each meeting to assist the staff in assessing its performance and that of the processes and procedures used in fulfilling the Council's responsibilities under the *ADA Bylaws*. The first survey was distributed to the Council following the April 2010 meeting of the Council. The Council staff will evaluate the results and report to the Council at its November 2010 meeting.

**Council Procedure for Handling Republication Requests:** The Council receives multiple requests each year for permission to reproduce, either in whole or in part, the *ADA Constitution and Bylaws*, the *ADA Code* and the Council's template manual of judicial procedures. These requests usually involve the reprinting of the desired material as an appendix to other original material prepared by or on behalf of the requesting party or the reprinting of excerpts of the *ADA Bylaws* or the *ADA Code* in a newsletter or an article in a periodical. These requests are typically viewed with favor by the Council, because the reprinting or quoting of the requested material serves to call attention to that material. The Council has also begun to receive multiple requests for copies of the videos submitted pursuant to the Student Ethics Video Contest. Copyright in these videos is assigned to the ADA as a part of the submission process. These permission requests for videos normally come from dental schools or dental societies and indicate that the requesting party desires to show the video to its members over a

short period of time. ASDA has also requested to post the winning student video on its Web site.

To expedite these routine, non-controversial and beneficial requests, the Council has approved a template granting permission for one-time reproduction of ADA copyrighted material consisting of all or portions of the *ADA Constitution and Bylaws*, the *ADA Code* or the Council's template of manual of judicial procedures and for limited viewing rights to entries in the Council's Student Ethics Video Contest. A report seeking the approval of the Board of Trustees to the Council's approved procedure is scheduled to be submitted for consideration at the Board's June 2010 meeting.

**Chair and Vice Chair for 2009-2010:** The Council forwarded the name of Dr. Rodney B. Wentworth to the Board of Trustees for approval as the Council's chair for the upcoming term. Dr. Marilyn S. Lantz was elected as vice chair for the upcoming term.

**Personnel:** The Council welcomed three new members this term: Dr. Dwyte E. Brooks, Dr. Walter I. Chinoy and Dr. Jeffrey C. Esterburg. In addition, Dr. Kevin A. Henner was reappointed to a full term on the Council after serving one year in completion of the term of Dr. Joseph F. Cipollina. The 2010 annual session will mark the completion of the terms of service of four Council members: Dr. David F. Boden, Dr. Judith M. Fisch, Dr. Kirk M. Norbo and Dr. Alan R. Stein. The Council expresses its gratitude to each of the retiring members for the exemplary manner in which they performed their duties in furthering the interests of the profession.

## Summary of Resolutions

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**15. Resolved**, that anyone identified by the Election Commission to be under active discipline for violating his or her duties to the constituent society within whose jurisdiction the member practices or of this Association shall be disqualified from seeking elective or appointive office while under that active discipline, and be it further

**Resolved**, that any member holding an elective or appointive position, but excluding the Executive Director, charged with violating his or her fiduciary or legal duties to the Association shall be afforded a fair and impartial hearing conducted according to existing judicial procedures of the Council on Ethics, Bylaws and Judicial Affairs. The Council on Ethics, Bylaws and Judicial Affairs shall be the disciplinary body whose actions shall be final and not appealable, and may include, but are not limited to: censure, suspension, probation or expulsion, and be it further

**Resolved**, that the final results of such hearing process shall be a public record and shall be reported to the Election Commission, and be it further

**Resolved**, that the appropriate amendments the *ADA Bylaws* to effectuate the matters set forth in this resolution shall be prepared by the Council on Ethics, Bylaws and Judicial Affairs and submitted to the 2011 House of Delegates, and be it further

**Resolved**, that the financial implications, if any, of this resolution shall be investigated by the Council on Ethics, Bylaws and Judicial Affairs and reported to the 2011 House of Delegates with the suggested *Bylaws* revisions.

**16. Resolved**, that the ADA Member Conduct Policy set forth below be adopted as policy of the Association, effective at the close of the 2011 House of Delegates:

### **ADA Member Conduct Policy**

1. Members should communicate respectfully in all interactions with other dentists, dentist members, Association officers, trustees and staff.
2. Members should respect the decisions and policies of the Association and must not engage in disruptive behavior in interactions with other members, Association officers, trustees, or staff.
3. Members have an obligation to be informed about and use Association policies for communication and dispute resolution.
4. Members must comply with all applicable laws and regulations, including but not limited to antitrust laws and regulations.
5. Members must respect and protect the intellectual property rights of the Association, including any trademarks, logos, and copyrights.
6. Members must not use Association membership directories, on-line member listings, or attendee records from Association-sponsored conferences or CE courses for personal or commercial gain, such as selling products or services, prospecting, or creating directories or databases for these purposes.
7. Members must treat all confidential information furnished by the Association as such and must not reproduce materials without the Association's written approval.
8. Members must not violate the confidentiality of attorney-client and executive sessions conducted at any level within the Association.
9. Members must fully disclose conflicts, or potential conflicts, of interest and make every effort to avoid the appearance of conflicts of interest.

and be it further

**Resolved**, that this resolution be referred to the Council on Ethics, Bylaws and Judicial Affairs for the purpose of developing an enforcement procedure for the ADA Member Conduct Policy by modifying the judicial procedures described in Chapter XII, Section 20C of the ADA *Bylaws* as appropriate to harmonize with ADA Member Conduct Policy, and be it further

**Resolved**, that the resulting enforcement procedures for the ADA Member Code of Conduct be presented for consideration to the 2011 House of Delegates.

**17. Resolved**, that the ADA *Bylaws*, Chapter V, be amended to include a Section 10G, which shall read as follows (new language underscored):

G. TERM OF DELEGATES AND ALTERNATE DELEGATES. The term of a delegate or alternate delegate elected or selected pursuant to Section 20 of this Chapter commences from the time such delegate or alternate delegate is certified pursuant to Section 30 of this Chapter until another delegate or alternate delegate elected or selected in place of such delegate or alternate delegate is so certified.

and be it further

**Resolved**, that the ADA *Bylaws*, Chapter V, Section 60 be amended as follows (new language underscored, deleted language stricken).

*Section 60. TRANSFER OF POWERS AND DUTIES OF THE HOUSE OF DELEGATES:* The powers and duties of the House of Delegates, except the power to amend, enact and repeal the *Constitution and Bylaws*, and the duty of electing the elective officers and the members of the Board of Trustees, may be transferred to the Board of Trustees of this Association in time of extraordinary emergency. The existence of a time of extraordinary emergency may be determined by unanimous consent of the members of the Board of Trustees present and voting at a regular or special session. Such extraordinary emergency may also be determined by mail vote of the last House of Delegates on recommendation of at least four (4) of the elective officers. A mail vote to be valid shall consist of ballots received from not less than one-fourth (1/4) of the current members of the ~~last~~ House of Delegates. A majority of the votes cast within thirty (30) days after the mailing of the ballot shall decide the vote.

**18. Resolved**, that ADA *Bylaws*, Chapter V. HOUSE OF DELEGATES, Section 100. QUORUM, be amended by the addition by the addition of the following language (additions underscored):

*Section 100. QUORUM:* One-fourth (1/4) of the voting members of the House of Delegates, representing at least one-fourth (1/4) of the constituent societies, the American Student Dental Association and the federal dental services, shall constitute a quorum for the transaction of business at any meeting.

**19. Resolved**, that the ADA *Principles of Ethics and Code of Professional Conduct* be amended by the addition of the following code section, 3.F. Professional Demeanor in the Workplace (additions underlined):

3.F. PROFESSIONAL DEMEANOR IN THE WORKPLACE.  
Dentists have the obligation to provide a workplace environment that supports respectful and collaborative relationships for all those involved in oral health care.

**20. Resolved**, that the Association Board of Trustees appoint a task force charged with reviewing ADA *Current Policies* and, after consulting with Association councils, commissions and committees, or appropriate ADA entity assign each existing policy to a council, commission or committee or appropriate ADA entity for purposes of conducting periodic reviews of Association policies, and be it further

**Resolved**, that the task force report back to the Board of Trustees on the policy assignments by December 2010, and be it further

**Resolved**, that each council, commission and committee or appropriate ADA entity to which a policy or policies are assigned by the task force review all policies assigned to it and determine if each policy should remain unchanged, be revised or rescinded or new policy submitted in resolution form to the House of Delegates, and be it further

**Resolved**, that each council, commission and committee or appropriate ADA entity to which a policy or policies are assigned by the task force report back to the Board of Trustees on its review of policies to it by June 2011, and be it further

**Resolved**, that any new Association policy proposed to the House of Delegates include a designation of the council, commission or committee or ADA entity responsible for the periodic review of that policy, and be it further

**Resolved**, that the Resolution 15H 1995 be amended as follows (deletions stricken and insertions underlined):

**Resolved**, that commencing as of June 2011, each council, commission and committee or appropriate ADA entity of the Association review all policies assigned to it at least as often as every seven~~three~~ years after the adoption of a policy, that policy shall be reviewed by the appropriate ADA agency; if ~~modification~~revision or rescission is suggested, it shall be submitted to the House of Delegates for action.

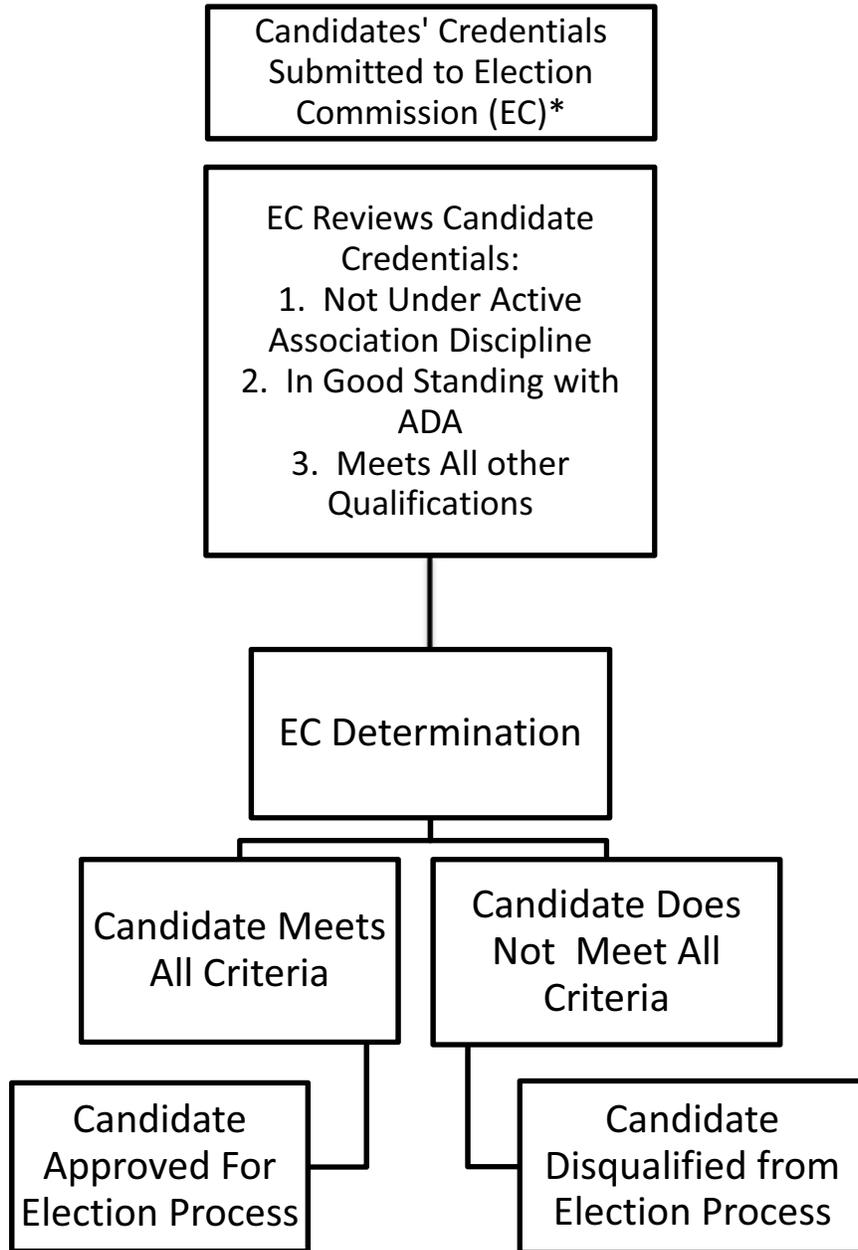
so that the amended Resolution 15H-1995 reads as follows:

**Resolved**, that commencing as of June 2011, each council, commission and committee or appropriate ADA entity of the Association review all policies assigned to it at least as often as every three years; if revision or rescission is suggested, it shall be submitted to the House of Delegates for action.

Appendix 1

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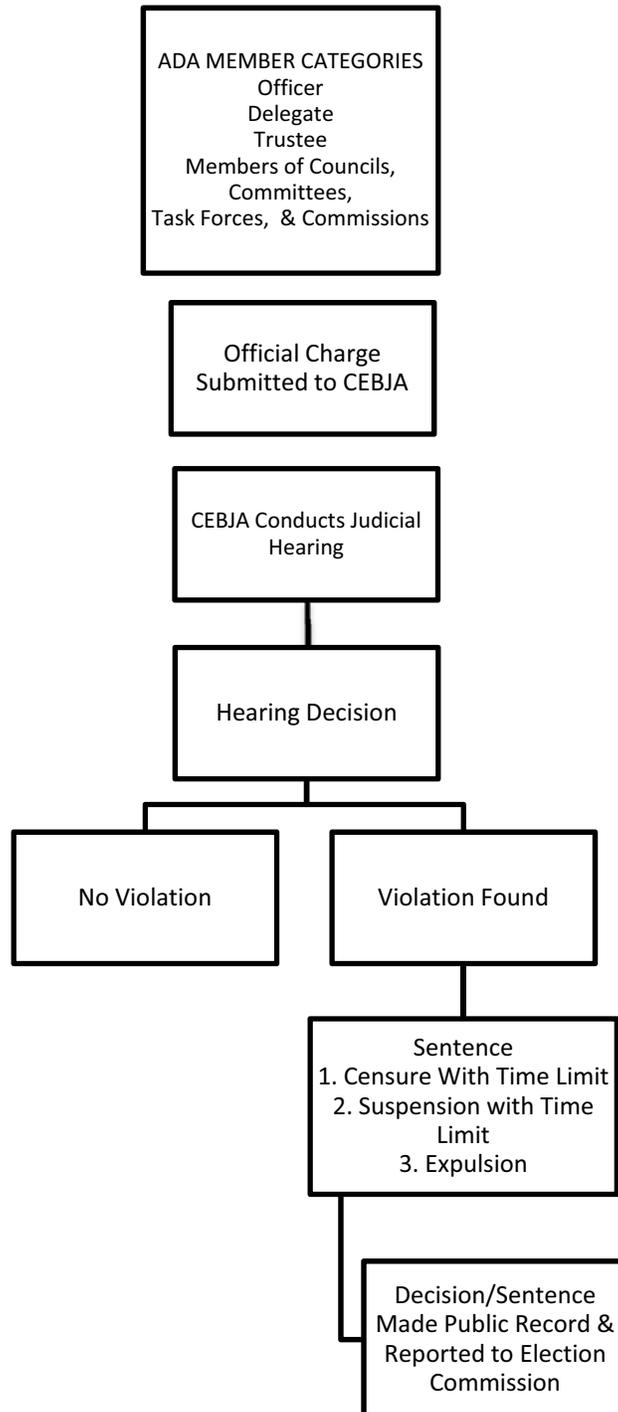
### Candidate Credential Review Election of Officers, Delegates & Alternate Delegates



## Appendix 2

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### Violations of Fiduciary Responsibility Hearing Process



## Appendix 3

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### Potential Grounds for Discipline or Removal from Office\*

1. Continued, gross or willful neglect of the duties of the office.
2. Breach of fiduciary duty to the American Dental Association, its subsidiaries or related entities (collectively "Association"), including:
  - a. Failure to comply with the Association's policies on conflict of interest or otherwise to act in the best interests of the Association, uninfluenced by personal or other considerations
  - b. Failure or refusal to disclose necessary information on matters of Association business
  - c. Failure to keep confidential any exclusive information of the Association protected by secrecy, including confidential information and information subject to the attorney-client privilege
  - d. Failure to act in a fiscally responsible matter, including making unauthorized expenditures or misusing Association funds
  - e. Failure to actively participate in meetings or adequately inform one's self of all reasonably available information necessary to make decisions in the best interests of the Association
  - f. Failure to act in a manner reasonably calculated to protect the Association from violation of the law
  - g. Failure to carry out directives of the House of Delegates or its policies
3. Failure to comply with the Association's Professional Conduct Policy and Prohibition Against Harassment.
4. Unwarranted attacks on the Association, any of its agencies or any person serving the Association in an elected, appointed or employed capacity.
5. Unwarranted refusal to cooperate with any officer, trustee, or council/commission member or staff.
6. Misrepresentation of the Association and any person serving the Association in an elected, appointed or employed capacity to outside persons.
7. Being found to have engaged in conduct subject to discipline pursuant to Chapter XII of the *Bylaws*.
8. Conviction of a felony.

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\* Adapted from the Standing Rules for Councils and Commissions.

## Council on Government Affairs

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**Walker, Mark V.**, Washington, 2010, *chair*  
**Conaty, Thomas P., II**, Delaware, 2010, *vice chair*  
**Bowen, Ronald S.**, Utah, 2013  
**Condrey, James D.**, Texas, 2011  
**Dater, Steven M.**, Michigan, 2012  
**Determan, Amber A.**, South Dakota, 2013  
**Fields, Henry W., Jr.**, Ohio, 2013  
**Jernigan, Kim U.**, Florida, 2012  
**Klima, Rodney J.**, Virginia, 2011  
**McDonald, Fred T.**, Arkansas, 2010  
**Mooney, John J.**, Connecticut, 2012  
**Neary, Matthew J.**, New York, 2011  
**Ray, Herbert L.**, Pennsylvania, 2013  
**Robertson, Stephen W.**, Kentucky, 2010  
**Schinnerer, Donald M.**, California, 2011  
**Swilling, Stacy E.**, Arkansas, *ex officio*\*  
**Testa, Ronald G.**, Illinois, 2012  
**Triftshouser, Roger W.**, New York, *ex officio*<sup>+</sup>  
**Weinman, Richard A.**, Georgia, 2012  
**Spangler, Thomas J.**, director

**Meetings:** The Council met January 21-23 and May 20-22, 2010, in Washington, D.C. The Council's third meeting is scheduled for August 26-28, 2010, in Chicago.

**The Strategic Plan of the American Dental Association:** Goal: Achieve Effective Advocacy for both oral health and the dental profession, within the healthcare, public and policy communities. The new health care reform law, the "Patient Protection and Affordable Care Act" (P.L. 111-148), and the "Health Care and Education Affordability Reconciliation Act of 2010" (P.L. 111-152) was easily the most significant piece of federal legislation in 2010 that will have an effect on the delivery of oral health care in America. The following is a questions and answers document the ADA developed to explain in general terms the potential impact on dentistry and the actions taken by the Association during the lobbying process.

**I support health care reform and am disappointed that the ADA, a leading health care organization, didn't. Please explain.** Improving the oral health of millions of Americans who lack access to dental care is fundamental to the ADA's identity as the nation's leading advocate for oral health. It is by that measure that we assessed all of the major health care reform proposals. Not on how they affect medical care or access to affordable health insurance but rather whether they would

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\* Committee on the New Dentist member without the power to vote.

<sup>+</sup> American Dental Political Action Committee Chair without the power to vote.

have a major, positive impact on oral health. So, despite the final legislation containing some very good oral health provisions, it ignores the easiest and least costly mechanism to immediately improve access to oral health care—improving funding for Medicaid dental services.

**I oppose health care reform and am disappointed that the ADA took so long to declare that it couldn't support the bill. Please explain.** For more than a year, the ADA has been advocating for changes in the various versions of health care reform that have been introduced. Even though each version was flawed, we worked to improve it any way we could. Had we declared our opposition early on, we would not have been in a position to influence anything and the law might have been even more objectionable. On a number of issues, we were able to improve the law and make it less onerous to both dentists and patients (see below).

**What oral health provisions in the health care reform law does the ADA support?** The law contains a number of worthy provisions, including: increased funding for public health infrastructure, including Centers for Disease Control and Prevention (CDC) oral health programs and national oral health surveillance programs; additional funding for school-based health center facilities and Federally Qualified Health Centers (FQHCs); increased Title VII grant program opportunities for general, pediatric or public health dentists; and funding for the National Health Services Corps loan repayment programs. We also pushed for provisions that would require the CDC, in consultation with professional oral health organizations, to establish a five-year, national public education campaign focused on oral health care prevention and education. We strongly believe that education and prevention efforts are lacking in efforts to improve oral health among underserved populations. This campaign, coupled with other efforts to increase oral health literacy, would have a positive impact on the public's oral health.

**What are the ADA's primary concerns with the health care reform law?** We find it particularly disheartening that the law extends Medicaid eligibility to individuals in families with incomes up to 133 percent of the federal poverty level but does nothing to provide a basic adult dental benefit for existing or new Medicaid enrollees. The law also fails to include measures that would remove administrative barriers or do enough to establish data gathering initiatives to help policymakers take additional steps to improve oral health care delivery in Medicaid. Dentists and other practitioners who provide health care services to Medicaid beneficiaries cannot meet the considerable needs of that population while losing money on each encounter, which is too often the case today. Data show that there is a direct relationship between the level of reimbursement and dentist participation in Medicaid and the utilization of services by beneficiaries. Unless the federal government makes an investment in preventing dental disease—which will reduce future Medicaid expenses—oral health will remain neglected and many Americans will continue to suffer needlessly.

This failure to properly fund Medicaid is the primary reason for the ADA's decision not to support the final legislation. However the law contains a number of other provisions that we have consistently opposed, including provisions to allow workforce pilot programs that may lead to non-dentists performing surgical dental procedures. Funding for these provisions would be better spent on increasing funding for Medicaid dental services. We also object to restrictions on Flexible Spending Accounts (FSAs), although we do appreciate that the new law will delay those cuts for two years. Many Americans use these accounts to pay for needed dental care. In addition, the health care law does not adequately address patient protections that should apply to employer-provided health plans offering dental benefits (including free-standing dental plans), such as prohibiting plans from limiting payments on services not covered by the plan. Finally, there is no meaningful medical liability reform.

**I understand that the law will require some medical plans to offer pediatric oral health services. Please explain.** Starting in 2014, the law will require that medical plans offered on newly-created state health insurance exchanges (essentially, virtual marketplaces where insurers will offer plans with identical benefits, so that it is easier for consumers to shop for coverage based upon price, rather than a confusing array of different benefits/co-pays/etc.), include "pediatric services, including oral and vision care" as a required benefit. Stand alone dental coverage will also be allowed to compete in these exchanges. However, even though the Secretary is required to ensure that the scope of the benefit package is equal to the scope of benefits provided under a typical employer plan, there are no assurances that this dental coverage will be substantial, and we fear that the desire to control premium costs will prevail and the benefit will be as meager as is currently found in medical plans that promise a dental benefit.

**How does the health care law affect high deductible plans, such as health savings accounts?** It appears that health savings accounts (HSAs) and HSA "compatible products" (the high deductible medical plans that are purchased along with the HSAs) will continue to effectively operate within the exchanges because most such plans meet the 60 percent actuarial value threshold required as a minimum for all essential benefit packages. After 2014, HSAs can be offered in exchanges (which will cover individuals and small employers) and in group health plans in the large employer market. Individuals (who do not purchase their coverage in an exchange) will be able to renew their HSAs after 2014.

**Does this bill change the way I am reimbursed by insurance?** At this time, the bill does not outline reimbursement requirements for specific services provided by insurers.

**How will health care reform affect me as a dentist?** Many of the systemic changes, such as paying for outcomes and not procedures and adopting health information technology (such as electronic health records), are directed at medicine but will affect dentistry at some point. For example, within two years of the bill's

enactment, the HHS Secretary is required to develop reporting requirements regarding plan coverage and provider reimbursement structures that are designed to improve outcomes. The Secretary is also required to develop provider-level outcomes for hospitals, physicians and other providers. These provisions are intended to address quality and value. At this time it is difficult to determine if dentistry, or what aspect of dentistry, might be included in the Secretary's requirements. The ADA recognizes the importance of developing quality measures at the population level and has taken the lead in developing the Dental Quality Alliance (DQA) to ensure that specific concerns of dentistry are adequately addressed. The ADA has also been engaged in working with federal officials to ensure dentistry's interests are represented with regard to changes due to health information technology.

After 2014, virtually all children will have at least some basic level of dental coverage. This could provide additional opportunities for increased dental visits, although some of those children will be part of an underfunded Medicaid program, thereby making improvements to the Medicaid program an even higher priority. The Medicaid program will be expanded to 133 percent of the federal poverty level in 2014 and children currently in the Children's Health Insurance Program (CHIP) who might be affected by this expansion will stay in the CHIP program until at least 2015, at which time the CHIP program is up for reauthorization.

The entire profession and the public at large could benefit from a reduction in oral disease due to the many programs providing oral health education, prevention and surveillance. The new law offers potential for dentists in the public sector because of increased funding for oral health infrastructure.

**How will health care reform affect me as an employer?** If you have 50 or fewer employees, you do not have to provide health insurance for your employees. Beginning in 2014, your state may develop an exchange to facilitate the purchase of health insurance. Access will be limited in a plan's first few years to businesses with fewer than 100 employees, which may provide an opportunity for you to purchase coverage for your employees. Insurance reforms that may affect you as an employer after the 2014 date include: prohibition on refusal to cover pre-existing conditions; comprehensive coverage; guaranteed issue and renewability; premium rating limits; non-discrimination based on health status; non-discrimination of providers; and prohibition on excessive waiting periods. Qualifying employers with less than 25 employees and average annual wages of less than \$40,000 will be eligible for tax credits, on a sliding scale, to assist with the purchase of health insurance coverage. The law also establishes a new "Simple Cafeteria Plan" for small businesses to enable them to offer tax-free benefits to employees. Beginning in 2011, health insurance issuers will have to maintain a medical loss ratio (the fraction of revenue from a plan's premiums that goes to pay for medical services) of at least 85 percent for the large group market and 80 percent for the individual and small group market in order to avoid paying rebates.

**How will health care reform affect me as an individual who is currently insured?** For the moment, the law does not change your coverage. However, it is difficult to determine what will happen over time. Beginning in 2014 when states begin to offer coverage through health insurance exchanges, your coverage options may change. Plans offered through exchanges will be required to provide essential health benefits and may affect coverage offered by insurers who operate outside of the exchange. Health insurers will also be required to adhere to a number of consumer protections. If you are insured in a high cost plan, your plan may be subject to an excise tax beginning in 2018 if your plan's premium exceeds \$10,200 for individual coverage or \$27,500 for family coverage. In no small part due to the ADA's advocacy, the value of dental and vision plans is not included in this limitation. Flexible Spending Account (FSA) contributions will be limited to \$2,500 annually beginning in 2013. If you are a Medicare beneficiary, you will have access to expanded preventive services through Medicare and that will not be subject to cost-sharing requirements. The law increases Medicare taxes by 0.9 percent for individuals earning more than \$200,000 or more than \$250,000 for couples filing jointly. A new Medicare tax on income derived from interest, dividends and other investments is established for individuals earning over \$200,000 or \$250,000 for couples filing jointly.

**Summary of Federal Legislative and Regulatory Activity Addressing the Impact of Information Technology on the Practice of Dentistry:** As reported last year, *The American Recovery and Reinvestment Act (ARRA) of 2009* included the Health Information Technology for Economic and Clinical Health Act (HITECH Act). As a result of this legislation, both the HIT Policy Committee and the HIT Standards Committee were created within the Department of Health and Human Services to implement many of the provisions of the HITECH Act. The new health care reform law merely served to support changes already underway under ARRA, while calling for the development of interoperable and secure standards and protocols that facilitate enrollment of individuals in federal and state health and human services programs, which also would apply to group health plans and health insurance issuers.

ADA representatives, led by Dr. Robert Faiella (First District trustee), met with officials at the Office of the National Coordinator (ONC) in the Department of Health and Human Services on December 3, 2009, and explained the ADA's position on HIT and electronic health records. On January 13, the Centers for Medicare and Medicaid Services (CMS) issued a Notice of Potential Rule Making (NPRM) entitled "Medicare and Medicaid Programs; Electronic Health Record Incentive Program." This is the proposed rule on "meaningful use" whereby federal grants to offset the cost of moving to an electronic health record are available to practitioners who provide services to Medicare or Medicaid beneficiaries at a level sufficient to qualify as "meaningful." The ADA joined with the Association of State and Territorial Dental Directors, the Medicaid/SCHIP Dental Association, the National Network for Oral Health Access, and the American Association for Dental Research to provide comments on March 12, 2010. Also on January 13, HHS's Office of the National Coordinator for Health Information Technology issued an Interim Final Rule (IFR) entitled "Health Information Technology:

Initial Set of Standards, Implementation Specifications, and Certification Criteria for Electronic Health Record Technology.” The ADA along with the same coalition partners mentioned above submitted comments on March 12, 2010.

Finally, on March 10, the ONC issued another NPRM entitled “Proposed Establishment of Certification Programs for Health Information Technology.” The proposed rule established both a temporary certification program and a permanent certification program each with separate closing dates for comments. The temporary certification program covers the program through the 1<sup>st</sup> quarter of 2012 while the permanent certification program begins in the same quarter. The ADA along with its dental coalition partners submitted a letter on the temporary certification program on April 9 and is in the process of developing comments on the permanent certification program for submission prior to the comment close date of May 10, 2010.

Only one piece of HIT related legislation has achieved any traction following the enactment of ARRA and the HITECH Act. The “Small Business Health Information Technology Financing Act” (H.R. 3014) was introduced by Congresswoman Kathy Dahlkemper (D-PA) on June 24, 2009. This bill passed the House by voice vote on November 18, was received in the Senate on November 19 and was referred to the Senate Small Business and Entrepreneurship Committee. The bill amends the Small Business Act to authorize the Administrator of the Small Business Administration (SBA) to guarantee up to 90% of the amount of a loan (up to specified loan amounts) to a small business health professional to be used for the acquisition and installation of health information technology for the professional's medical practice. The ADA participated in the drafting of this bill and ultimately wrote a letter of support for HR 3014. As of this writing, the Senate has taken no action on this legislation.

**Federal Emerging Issues and Trends:** In addition to *Health Care Reform* discussed above, an emerging issue in 2010 is ADA-developed ERISA reform legislation. Additional federal issues affecting dentistry include antitrust reform and the red flags rule that the Association addressed at the 2009 Washington Leadership Conference (WLC) and were placed on the WLC lobbying agenda again in 2010 in an effort to secure final passage.

*ERISA Reform.* At the WLC, the ADA urged co-sponsorship of the “Dental Coverage Value and Transparency Act” introduced by Rep. Robert Andrews (D-N.J.), which is H.R. 5000. Dental coverage helps 173 million Americans get the dental care that is vital to ensuring good oral and overall health. H.R. 5000 would help consumers receive the full value of their dental coverage, ensure transparency and improve health plan efficiency. Unfair practices have crept into the common policies of dental benefit plans. They hinder patients’ ability to receive the full benefits for which they pay and create unnecessary administrative burdens on health care providers. The only redress is legislative action. The bill requires that all health plans that offer dental benefits will, among other provisions, be prohibited from dictating fees for procedures that the plan does not cover and be required to provide uniform coordination of benefits. (See details in response to Res. 33H later in this report.)

*Antitrust.* The ADA believes that health care consumers and the public generally are adversely affected by the McCarran-Ferguson Act exemption from federal antitrust laws granted to the health insurance industry and supports legislation to repeal the exemption. On February 24, the U.S. House of Representatives overwhelmingly passed antitrust reform, “The Health Insurance Industry Fair Competition Act”, H.R. 4626, by a vote of 406-19. At the 2010 Washington Leadership Conference, the ADA urged the Senate to act quickly to pass H.R. 4626.

*Red Flags Rule.* On November 9, 2007, the Federal Trade Commission (FTC) issued a final regulation implementing the Fair and Accurate Credit Transactions Act of 2003 (FACT Act), which requires financial institutions and creditors to develop and implement written identity theft programs (Red Flags program). In October 2009, the House passed H.R. 3763 by a 400-0 vote, which exempts businesses—including dental practices—with 20 or fewer employees from having to comply with the rule. Soon thereafter, the FTC announced a delay in enforcement of the rule until June 1, 2010. The ADA is urging the Senate to move quickly to pass H.R. 3763 and exempt dentists and other small business with 20 or fewer employees from this rule before the June 1 deadline.

**Additional Federal Advocacy Resources:** The implementation of the recently enacted health care reform law presents a series of potential opportunities and threats on a range of issues pertaining to oral health. A host of federal agencies within the Department of Health and Human Services will be developing regulations in the coming years to fully implement the law, and the next Congress may enact additional laws that alter the current law. While the Council on Government Affairs, ADA Washington staff and current outside consultants have done a very good job advocating on all the federal legislative and regulatory issues facing dentists and patients, the Council believes that the implementation of hundreds of provisions in the new health care reform law will require additional outside resources to maximize the ADA's ability to advocate on behalf of the profession.

The ADA currently contracts with three outside lobbying firms, and although they have assisted the ADA with regulatory issues and federal agency interactions, their primary purpose is to supplement the ADA lobbying staff in achieving legislative advocacy success. The Division has no budget for opinion research or advocacy advertising (either inside-the-Beltway or in congressional districts), and these and other tactics must become routine elements of the ADA's advocacy activities if the ADA is to remain effective in Washington, DC. While it is not expected that each activity will require funding each year, some mix of these tactics must be employed each year. Through the ADA's very successful State Public Affairs program, the ADA provides grants to state dental associations so that they can enlist the necessary outside lobbying and public affairs resources to be successful advocates for the profession with their state governments. This resolution seeks to assure that the ADA has access to the same resources at the federal level.

To provide some background on costs, the requested funding is based upon the following estimates: that an additional lobbying firm, with particular expertise in working with the federal agencies that are charged with implementing the new health care reform law, could cost \$15,000 a month, opinion research on an issue can cost up to \$100,000 (four focus groups and a nationwide poll) and full-page ads in Capitol Hill publications (such as Roll Call, The Hill and Politico) cost approximately \$10,000 per day. Creative costs for an ad cost approximately \$10,000.

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

**21. Resolved**, that the ADA Division of Government and Public Affairs engage the services of at least one additional outside lobbying firm with particular expertise in working with the federal agencies that are charged with implementing the new health care reform law, and be it further

**Resolved**, that the Division be provided with \$380,000 to conduct public opinion research, to run advocacy advertisements in Capitol Hill publications and to employ other related tactics in support of ADA federal advocacy goals.

**Emerging Issues and Trends in the States:** Throughout 2010, the ADA's State Public Affairs Initiative (SPA) has focused its resources heavily on legislative and regulatory issues impacting access to care. Staff anticipates much of the same for 2011. In addition, the following are key activities within the states within the last year.

*Definition of Dentistry – Scope of Practice.* The Kentucky Dental Practice Act has been amended in 2010. The new law adds the ADA definition to the statutory definition of dentistry in Kentucky.

*Dental Assistants.* The **Pennsylvania** Dental Association worked with the bill's sponsor to introduce this legislation that would expand the scope of practice for Expanded Function Dental Assistants (EFDAs). The bill has passed both houses as of mid-April, and the PDA is encouraging the Governor to sign it. EFDAs will be authorized to perform more duties, including polishing teeth, applying fluoride treatments and taking impressions for athletic mouth guards all under dentists' direct supervision. The bill also expands the dental board by two members totaling 12 by adding an EFDA and one additional licensed dentist as members of its State Board of Dentistry.

*Dental Hygiene.* A bill in **Oregon**, sponsored by organized dental hygiene, that would have allowed Limited Access Permitted Dental Hygienist to administer local anesthesia and place temporary restorations "scoop and fill" without the supervision of a dentist was defeated by the Oregon Dental Association. The ODA expects this to surface again in the 2011 legislative session. In **Pennsylvania**, dental hygienists with proper education and training may now apply for a permit to administer local anesthesia but only as authorized by the supervising dentist and only with the direct supervision of the dentist. A rule adopted by the Pennsylvania Board of Dentistry makes Pennsylvania the 43<sup>rd</sup> state to allow this procedure.

The **Florida** Dental Hygiene Association's expansion of scope of practice bill would allow dental hygienists to work pursuant to "public health supervision," i.e., without the prior authorization, presence or supervision of a dentist, in defined health access settings. The Florida Dental Association opposes this attempted expansion into unsupervised practice. A 2010 law enacted in **Kentucky** provides that a dental hygienist licensed by the board may practice as a public health hygienist. A public health hygienist may provide dental hygiene services if provided as part of a dental health program operated through the Department for Public Health or a governing board of health and the hygienist performs only accepted standardized protocols which are contained within the scope of practice of dental hygiene and which are reviewed and approved by the Board of Dentistry and either the Department for Public Health or the dentist member of the governing board of health, as set out in administrative regulation. The Kentucky Dental Association negotiated this provision with organized dental hygiene and did not oppose the bill.

*Regulation of Dental Laboratories.* In 2010, a law was enacted in **Kentucky** requiring that all commercial labs hire either a licensed dentist or a certified dental lab technician and that prostheses be fabricated pursuant to written orders of the referring dentist.

A bill has been introduced in **New York** that would require the establishment of quality standards for dental prostheses and that dental laboratories make full disclosure to dentists and patients of the place of manufacture of dental prosthetic devices. **Oklahoma** regulates the operation of dental laboratories. The state has enacted an amendment that grants the dental board additional authority to inspect dental laboratories. The law also requires that dental labs make available to the prescribing dentist and dental board a list of materials used in fabrication of dental appliances, identify the name and location of the person who fabricated the appliance, and a description of the disinfection methods used in the process.

*Licensure.* The **Wisconsin** Dental Examining Board has adopted a rule that the Wisconsin Dental Association worked with the Board on during rule making process. The rule allows dentists who have proof of having graduated from an international, non-accredited dental program to apply for licensure after successfully completing a CODA-accredited postgraduate program in advanced education in general dentistry or an accredited general dentistry practice residency. The applicant must also have passed Parts I and II of the National written boards and a board approved clinical licensure exam. The **Maine** Dental Association supported a law that has the goal of attracting and keeping recent dental school graduates working in Maine. This law will allow the Board of Dental Examiners to issue a temporary permit valid for one year for the reduced fee of \$50 to new graduates of board-approved dental schools who have passed the exam for licensure in Maine and who work with supervision of a licensed dentist. The regular biennial licensure fee is \$850 so this is a financial incentive to begin practice in Maine with the hope that the dentist will obtain full licensure by paying the regular fee and stay in Maine.

*Continuing Education (CE credit for charitable care).* An innovative bill sponsored by the **New Jersey** Dental Association has become law. The bill grants one-half hour of CE for every hour of free dental care to a child who is under the age of 19 and meets the eligibility requirements for, and is enrolled in, the NJ FamilyCare Program; a child who is in the custody of the Division of Youth and Family Services in the Department of Children and Families; anyone enrolled in the Medicaid program, the Pharmaceutical Assistance to the Aged and Disabled program, or the Senior Gold Prescription Discount Program.

**Response to Assignments from the 2009 House of Delegates:** The following are responses to the resolutions assigned to the Council. Additional information will be provided in the Council's Supplemental Report to the House of Delegates.

*Advocating for ERISA Reform.* Resolution 33H (*Trans.*2009:461; 474) directs the ADA to seek legislation to reform the Employee Retirement Income Security Act (ERISA) to create consumer safeguards under federal law or allow regulation of ERISA plans by the states. The ADA developed a federal ERISA reform legislative proposal with consumer safeguards that apply to dental benefits in all employer-provided plans. The bill was introduced by United States Representative Robert E. Andrews (D-NJ) and applies to free standing dental plans and dental benefits offered as a rider to a medical plan. The bill covers both self-funded plans (typically called ERISA-regulated plans) and fully insured plans regulated by the states (see Appendix 1).

*Federal Nutrition and Food Assistance Programs.* Resolution 37H (*Trans.*2009:461; 474) directs the Association to encourage continued support for federal nutrition and food assistance programs that provide nutrition services and education for infants, children, pregnant and parenting women, the elderly, and other vulnerable groups and to encourage the appropriate government agencies to restrict access to non-nutritious foodstuffs that contribute to the advancement of tooth decay under federal nutrition and food assistance programs. It also calls on the Association to continue to gather the clinically relevant evidence and information concerning associations between diet, nutrition, and oral health.

At its January 2010 meeting, the Council on Government Affairs approved a Washington Office proposal to lobby members of Congress and federal agency staff on the following items pertaining to the resolution:

- *Healthy, Hunger-Free Kids Act of 2010.* The ADA has been lobbying to enhance oral health screenings, assessments, and referrals to dentists in the Special Supplemental Nutrition Program for Women, Infants, and Children (the WIC program). Specifically, the Association has been seeking report language in the WIC program's reauthorization that would clarify the extent to which state and local WIC programs are authorized to do more than make health care referrals to dentists and whether participating in certain oral health initiatives would threaten eligibility for federal WIC funds.

- *Child Nutrition Promotion and School Lunch Protection Act (H.R. 1324, S. 934).* The ADA has been lobbying for passage of legislation that would authorize the United States Department of Agriculture to tie the nutritional requirements for federally reimbursable school meals to the latest “science-based nutrition standards.” It would also compel schools receiving federal school meal funds to require those standards for all foods sold on their campuses during school hours (including foods available for purchase through vending machines, school stores, and a la carte).
- *Food Marketing in Schools Assessment Act (H.R. 3625).* The ADA has been lobbying for passage of a bill that would require the Secretary of Education, in cooperation with the Centers for Disease Control and Prevention, to study and report on the nutritional quality of the types of food and beverages marketed in schools, all media through which foods and beverages are marketed to children in middle and high schools, and mechanisms used to regulate food and beverage marketing in middle and high schools.
- *Federal Trade Commission Report on Food Marketing to Children.* The ADA has been lobbying the Federal Trade Commission (FTC) to strengthen the science base of a report on food marketing aimed at children who are 17 years old or younger, as well as any subsequent standards the agency might develop. The Omnibus Appropriations Act, 2009, requires the agency to prepare the report and submit it to Congress by July 15, 2010.

The Council continues to consult and collaborate with the Council on Scientific Affairs (CSA) as necessary, so that the latest clinically relevant scientific information is available to help inform the Council’s activities and recommendations. Scientific knowledge continues to develop in this area, making this collaboration critical to an effective advocacy program on behalf of the ADA related to federal food assistance programs, including efforts to restrict access to non-nutritious food-stuffs that may contribute to the advancement of tooth decay. Additional information is available online at [www.ada.org/nutritionpolicy](http://www.ada.org/nutritionpolicy).

*Maximum Fees for Non-Benefited Services.* Resolution 59H (*Trans.*2009:461; 481) states that the ADA opposes third party contract provisions that establish fee limits for non-scheduled dental services, that the ADA seek federal legislation to prohibit ERISA plans from applying such provisions, and that the ADA encourage constituent dental societies to work to pass state legislation to prohibit plans from applying such provisions. As detailed earlier in Res. 33H, the “Dental Coverage Value and Transparency Act of 2010,” H.R. 5000, developed by the ADA and introduced on April 13 by Rep. Andrews, would prohibit the application of a plan’s or network’s fee schedule to services for which no benefits or reimbursement are provided. In addition, the ADA’s Department of State Government Affairs (DSGA) has developed a weekly communication program for state dental associations’ directors and government relations staff, providing in-depth details on the week’s successes, challenges and other important information occurring nationwide. Significant communication and guidance

occurs weekly between DSGA and state dental societies focused on policy and political activities in support of bills to prevent fee caps. DSGA also works closely with the National Conference of Insurance Legislators which has proposed model legislation to prevent insurers from capping fees on non-covered services. In 2010, 28 states have filed legislation to prevent insurers from capping fees on non-covered services. Eleven of those have been enacted into law. Counting the Rhode Island law of 2009, 12 states now have non-covered services laws on the books.

*Health Care Reform.* Resolution 60H (*Trans.*2009:461; 482) directs the ADA to (within the context of health care reform legislation) advocate to maintain the private health care system, increase opportunities for coverage, assure that coverage is affordable, portable and available without preexisting conditions, and emphasize prevention strategies. The ADA should also lobby to ensure the legislation is funded in a budget neutral manner that does not tax health care delivery, exempts small businesses from any mandate to provide coverage, includes incentives for individuals to provide coverage, contains medical liability (tort) reform provisions, encourages the use of electronic health records, and supports health savings accounts, flexible spending accounts and other tax incentive programs that allow alternative methods of funding health care costs.

Details have yet to be worked out through the federal regulatory process and many provisions will not be implemented for several years. However, based on the terms of the new health care law (P.L 111-148 and 111-152) alone, it appears that many of the objectives of this resolution were met. Although additional modifications in the law may be required to ensure free standing dental plans are able to fully compete, the dental plans do have access to the health care exchanges that will be established in the states by 2014. All plans will be required to offer an oral health benefit (not yet defined) for children as part of the “essential benefits package,” which could offer opportunities and challenges for dentists in the future, depending on how the benefits are designed and reimbursed.

The new law is designed to cover an additional 32 million individuals, creates an individual mandate to purchase coverage (with certain exceptions) and institutes insurance reforms, such as the elimination of pre-existing conditions provisions. There are several new dental prevention programs, as well as an enhanced emphasis on general health wellness and prevention. There is no tax on health care delivery, as such. However, beginning in 2013, companies that manufacture or import medical devices will have to pay an excise tax of 2.3%; the hospital insurance tax will increase for individuals making more than \$200,000 annually (and for couples making more than \$250,000); beginning in 2014, insurance companies will have to pay an annual fee based on their market share (except for non-profits); and in 2018, a 40% tax will be levied on plans above \$10,200 for single coverage and \$27,500 for family coverage (but this does NOT apply to dental plans which are expressly excluded from this provision).

Small businesses (50 or fewer full time employees) are exempt from any responsibility to provide coverage. There are tax credits for owners of small businesses

that elect to provide coverage. The medical malpractice (tort) reform provision awards grants to states for the development of alternatives to current tort litigation, which the ADA noted in its lobbying efforts was inadequate. The new law does encourage the use of electronic health records but puts restraints on various tax incentive programs. For example, beginning in 2013, there will be a \$2,500 annual limit on the amount of salary reduction contributions to flexible spending arrangements (FSAs) and beginning in 2011, over-the-counter drugs not prescribed by a doctor cannot be reimbursed from health reimbursement arrangements (HRA), flexible spending accounts (FSAs), health savings accounts (HSAs) or Archer medical savings accounts (MSAs). Finally, beginning in 2011, the penalty for nonqualified distributions from health savings accounts and Archer MSAs (such as distributions that are not used to pay for health care expenses) will be increased from 10% to 20%.

The ADA had numerous communications with Congress and the White House to ensure that all parties understood how the health care reform proposals could affect oral health care delivery and the dental profession. ADA's lobbying activities were regularly detailed in *ADA News* articles and on ADA.org at <http://www.ada.org/2389.aspx> which currently contains ADA timelines and Q&A documents, as well as additional information on the new health care law.

**Acknowledgments:** The Council on Government Affairs announces the addition of the following new members: Dr. Ronald S. Bowen, Utah; Dr. Henry W. Fields, Ohio; Dr. Herbert L. Ray, Pennsylvania.

The Council expresses its appreciation to the following members for their dedication to the profession and their efforts to address the many legislative and regulatory issues that come before the Council on Government Affairs on behalf of the dental profession: Chair, Dr. Mark V. Walker, Washington; Vice chair, Dr. Thomas Conaty, Delaware; Dr. Stephen W. Robertson, Kentucky; and Dr. Fred T. McDonald, Arkansas.

The Council would also like to acknowledge the guidance and very valuable insights provided by its Trustee liaison and the Eleventh District trustee, Dr. Mary Krempasky Smith.

## Summary of Resolutions

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**21. Resolved**, that the ADA Division of Government and Public Affairs engage the services of at least one additional outside lobbying firm with particular expertise in working with the federal agencies that are charged with implementing the new health care reform law, and be it further

**Resolved**, that the Division be provided with \$380,000 to conduct public opinion research, to run advocacy advertisements in Capitol Hill publications and to employ other related tactics in support of ADA federal advocacy goals.

## Appendix 1

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111th CONGRESS  
2d Session

### H. R. 5000

To amend the Employee Retirement Income Security Act of 1974 to ensure health care coverage value and transparency for dental benefits under group health plans.

### IN THE HOUSE OF REPRESENTATIVES

APRIL 13, 2010

Mr. ANDREWS introduced the following bill; which was referred to the Committee on Education and Labor

### A BILL

To amend the Employee Retirement Income Security Act of 1974 to ensure health care coverage value and transparency for dental benefits under group health plans.

*Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,*

#### SECTION 1. SHORT TITLE.

This Act may be cited as the “Dental Coverage Value and Transparency Act of 2010.

#### SEC. 2. VALUE AND TRANSPARENCY REQUIREMENTS FOR DENTAL BENEFITS.

(a) In General.—Subpart B of part 7 of subtitle A of title I of the Employee Retirement Income Security Act of 1974 is amended by adding at the end the following new section:

##### SEC. 716. VALUE AND TRANSPARENCY REQUIREMENTS FOR DENTAL BENEFITS.

(a) In General.—The requirements of this section shall apply to group health plans insofar as they provide dental benefits (including, notwithstanding section 732(c)(1), limited scope dental benefits (described in section 733(c)(2))), directly, through health insurance coverage, or otherwise.

(b) Value.—In order to ensure that participants and beneficiaries in a group health plan receive full value from dental benefits, the plan shall meet the following requirements:

(1) UNIFORM COORDINATION OF BENEFITS.—The plan shall provide for coordination of benefits in a manner so that the plan pays the same amount regardless of other coverage for such benefits so long as the total amount paid does not exceed 100 percent of the amount of the applicable claim. Such coordination shall be effected consistent with such rules as the Secretary establishes, based upon similar model regulations developed by the National Association of Insurance commissioners.

(2) EQUITY FOR OUT-OF-NETWORK PROVIDERS THROUGH ASSIGNMENT OF BENEFITS AND COMPARABLE PAYMENTS.—In the case of a plan that provides dental benefits through a network of providers, the plan shall—

(A) permit a participant or beneficiary to designate payment of dental benefits to a provider who is not participating in the network;

(B) provide the same dollar amount of coverage for a given procedure regardless of whether the provider of the procedure is participating in the network; and

(C) not permit the application of the plan's or network's fee schedule to services for which no benefits or reimbursement are provided.

(c) Transparency.—In order to ensure transparency in the provision of dental benefits to participants and beneficiaries in a group health plan, the plan shall meet the following requirements:

(1) PROHIBITION OF BUNDLING AND DOWN CODING.—The plan shall not—

(A) systematically combine distinct dental procedures codes in a manner that results in a reduced benefit under the plan; or

(B) provide for a change in the benefit code to a less complex (or lower cost) procedure than was reported if such actions are inconsistent with the current dental terminology (CDT) or, for a provider participating in a network, inconsistent with the terms of the network participation agreement.

(2) FAIR PAYMENT TERMS.—The plan shall—

(A) provide for payment of interest (at a rate specified by the Secretary) or other penalty for clean claims paid more than 30 days after the date of their submission;

(B) not seek collection of overpayments more than 90 days after the date of the overpayment; and

(C) not recover overpayments for a dental procedure by withholding payments for unrelated procedures.

(3) TRANSPARENCY IN USE OF LEASE NETWORKS.—A plan may use a network that is leased by a health insurance issuer or other entity to another such issuer or entity (where such leasing is permitted by the contract between a provider and the issuer or other entity) only if the contract language describes in a manner understandable to the average dental provider the terms of such leasing.

(b) Conforming Amendment.—The table of contents of such Act is amended by inserting after the item relating to section 715 the following new item:

“Sec. 716. Value and transparency requirements for dental benefits.”

(c) Effective Date — The amendments made by this section shall apply to plan years beginning more than 1 year after the date of the enactment of this Act.

# Council on Members Insurance and Retirement Programs

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**Browder, Larry F.**, Alabama, 2010, chair  
**Abshere, Philip M.**, New Mexico, 2011  
**Cassat, D. Douglas**, California, 2011, vice chair  
**Collins, Ronald**, Texas, 2013  
**Dodge, Jeffrey E.**, Rhode Island, 2013  
**Dorris, George B., Jr.**, Florida, 2012  
**Eisenhart, Craig A.**, Pennsylvania, 2012  
**Fink, Steven R.**, New Jersey, 2012  
**Gerber, C. Richard**, West Virginia, 2011  
**Imburgia, Louis A.**, Illinois, 2011  
**Jilek, Spencer S.**, Washington, 2012  
**Lo, Garrick**, Washington, *ex officio*\*  
**Morrison, Scott L.**, Nebraska, 2010  
**Rawls, Douglas S.**, South Carolina 2013  
**Rosenbaum, George F.**, Nevada, 2013  
**Shall, Stephen M.**, Ohio, 2010  
**Weinberger, Mark J.**, New York, 2012  
**Zoutendam, Gary L.**, Michigan, 2010  
**Dwyer, David R.**, director

**Mission of the Council:** The Council on Members Insurance and Retirement Programs is the agency of the ADA whose purpose is to enhance the value of Association membership by a) overseeing the sponsored and endorsed insurance and retirement programs and b) aiding dentists in the management of their personal and professional risks through educational activities, informational programs and services.

At its March 2010 meeting, the Council conducted a self evaluation. Based upon its study of its mission and in recognition of the membership's need for risk management services from a trusted source, the Council is submitting a resolution calling for the expansion of its *Bylaws* duties. The proposed new duty would be to develop activities, informational programs and services that will assist dentists in managing the risks they face both personally and professionally.

**22. Resolved**, that Chapter X. COUNCILS, Section 120. DUTIES, Subsection I. COUNCIL ON MEMBERS INSURANCE AND RETIREMENT PROGRAMS, of the ADA *Bylaws* be amended by addition of duty "f" to read as follows:

f. Aid dentists in the management of their personal and professional risks through educational activities, informational programs and services.

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\* Committee on the New Dentist member without the power to vote.

**Purpose of Member Insurance and Retirement Programs:** The member insurance and retirement programs were established to provide benefits of membership. The genesis of each insurance plan was a member need identified by the House of Delegates.

The programs offer products specifically designed to meet the needs of dentists, but at costs lower than those of comparable products generally available in the marketplace. In this way, the programs contribute to the recruitment and retention effort. Surveys have consistently shown these programs to be among the most highly valued benefits offered by the Association.

The programs are also key components of the effort to engage dental students in organized dentistry. In addition to the two student insurance plans, the insurance and retirement programs provide funding for the Association's Success Program as well as various activities of the Committee on the New Dentist and the American Student Dental Association.

**The Strategic Plan of the American Dental Association:** Through all of its activities, the Council supports the Strategic Plan's advocacy goal with respect to the small business interests of dental offices. The Council's risk management activities support this goal by providing resources to dentists that will help them maintain their trusted professional image.

All of the Council's services and the programs it oversees are provided exclusively to members. This supports the Strategic Plan's goal of building the Association's membership. In addition, through its efforts to facilitate communication between organized dentistry and the professional liability insurance industry, the Council is enhancing opportunities for collaborative efforts that could result in improved health care.

### **ADA Members Group Insurance Programs**

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The four ADA member's group insurance programs are underwritten and administered by the Great-West Life & Annuity Insurance Company (Great-West Life.) They are marketed, without the use of agents, by direct mail, advertising and through *ADA.org*.

The Council oversees the administration and marketing of these programs, monitors their claim and investment experience, and their operating expenses. In addition, the Council approves the amount of credits that are used to reduce premiums as well as all changes to the master policies. The Board of Trustees reaffirmed the Council's authority to conduct this business in 2002 by adopting Resolution B-24 (*Trans.2002:265*):

The four insurance programs are as follows:<sup>1</sup>

- The life insurance program consists of the *Term Life Plan*, providing up to \$2 million in coverage to members, a maximum of \$750,000 for their spouse and \$10,000 for eligible dependent children; the *Term Plus* (universal life) *Plan*, available to members only, provides up to \$2 million in coverage; and the *Noncontributory Life Insurance Plan for Dental Students*, provides \$50,000 in coverage.
- The disability insurance program consists of the *Income Protection Plan*, which provides long-term disability insurance to members with monthly benefits of up to \$10,000 when the member is disabled from his/her special area of practice. The *Student Disability Insurance Plan* provides monthly benefits of up to \$2,000 when the member is unable to continue his/her professional studies.
- The *Office Overhead Expense Plan* will reimburse insured members for up to \$25,000 in monthly business expenses when they are totally or partially disabled from their special area of dental practice.
- The *MedCASH Insurance Plan* provides cash payments of up to \$500/day to an insured member or dependent who receives hospital-based medical care. Additional cash payments can be provided for insured persons who are diagnosed with certain critical medical conditions.

**Not-for-Profit Sponsorship:** Since the inception of the member's insurance plans, they have been sponsored by the Association on a not-for-profit basis. Support for this practice was reaffirmed by the House of Delegates in 1993 through the adoption of Resolution 82H (*Trans.*1993:697) which urged that all surpluses generated by these programs be used for benefit improvements, premium reductions and/or refunds for participating members.

**Funding of Council's Budget:** The participants in the member's insurance programs have partially funded the Council's budget since 1972. Originally, the level of funding was 50% of the budget. Currently, the practice is to have the insurance program participants fund approximately two-thirds of the budget. This funding is included in the overall costs of operating the insurance programs when their financial experience is calculated.

On a quarterly basis, Great-West Life transfers to the Association approximately one-fourth of the annual amount needed for the insurance programs' share of the Council's budget. This money comes from the premium payments the Company receives from participating members. These payments are classified as Insurance Reimbursement in the Council's budget. In 2009, Insurance Reimbursement totaled \$506,700, which is approximately one-fourth of 1% (i.e., 25 basis points) of the gross premium generated by the insurance plans.

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<sup>1</sup> This is a general summary of benefits. Benefits are paid in accordance with the terms of the master policies issued to the Association.

**Key Results for 2009:** The Council is pleased to report that, despite the substantial economic turmoil that prevailed during 2009, the member’s insurance programs are each in strong financial condition. Favorable financial experience enabled the Council to reduce the cost of insurance under all plans through an increase in each plan’s premium credit.

The total amount of insurance in force grew by more than 3%. The volume of life insurance in force grew to nearly \$33 billion. The volume of insurance in force under the Income Protection and Office Overhead Expense Plans grew to a combined total of nearly \$170 million by year-end. The total assets of the insurance plans are now in excess of \$645 million.

During the year, more than \$80 million in benefits were paid to participants or their beneficiaries who submitted claims. Based upon information provided by Great-West Life, the Council has concluded that the reserves of all plans are well positioned to withstand future volatility.

**Participation:** Participation in the member’s insurance plans for the past five years is shown in the table below.

<b>Program</b>	<b>2005</b>	<b>2006</b>	<b>2007</b>	<b>2008</b>	<b>2009</b>
Member Term Life <sup>2</sup>	58,545	57,950	57,428	55,143	55,171
Spouse Term Life	20,603	20,252	19,755	19,364	19,259
Child Term Life <sup>3</sup>	8,614	8,381	8,144	7,961	7,764
Student Term Life	10,112	9,860	9,684	11,362	12,344
Term Plus Plan	1,984	1,882	1,765	1,694	1,629
Income Protection	18,249	17,867	17,734	17,596	17,667
Student Disability	552	540	754	872	1,144
Overhead Expense	8,695	8,600	8,534	8,467	8,420
MedCASH	5,887	5,715	5,340	5,101	4,851

The level of participation in the insurance plans generally reflects the demographics of the membership. The average age of participating members is rising; and as the “baby boomer” generation nears retirement, they have a diminishing need for term life, disability income and overhead expense insurance.

The Council believes this “aging off” effect can be mitigated by increasing the amounts of coverage held by younger participants and reinvigorating efforts to increase enrollment by new dentists. In particular, the Council is strengthening the student insurance plans as a “feeder system” for sales to practicing dentists. Towards this end,

<sup>2</sup> In 2005, 2006 and 2007 total participation was overstated as a result of some members having two certificates of insurance. Great-West Life amended its record keeping to correct the statistics for 2008 and 2009.

<sup>3</sup> This is the number of members who are insuring their children.

the Council has encouraged Great-West Life to expand Web-based marketing activities, increase articles in professional publications that build the “trusted advisor” image of the Association; and develop cooperative relationships with ASDA representatives and dental school deans.

**Financial Strength of Insurance Plans:** Based upon an examination of claim experience, assets and reserve requirements, the Council is pleased to report that each of the insurance plans is in excellent financial condition. They each have significant assets in excess of reserve requirements and other funding accounts. Accordingly, the Council has approved reductions in the cost of coverage through the credits to reduce both initial and renewal premiums. In accordance with Resolution B-24 adopted by the Board of Trustees in 2002 (*Trans.2002:265*) the Council has confirmed that each insurance plan’s premium credits do not exceed 5% of the plan’s assets.

The next table shows premium credits for each plan during the past year and those scheduled for 2010.

<b>Program</b>	<b>Payment Date</b>	<b>Credit</b>
Life Insurance Program	January 1, 2009	48%
	July 1, 2009	48%
	January 1, 2010	50%
	July 1, 2010	50%
Income Protection Plan	May 1, 2009	37%
	November 1, 2009	37%
	May 1, 2010	38%
	November 1, 2010	38%
Office Overhead Expense Plan	February 1, 2009	52%
	August 1, 2009	52%
	February 1, 2010	56%
	August 1, 2010	56%
MedCASH Plan	April 1, 2009	34%
	October 1, 2009	34%
	April 1, 2010	35%
	October 1, 2010	35%

**Financial Strength of the Great-West Life & Annuity Insurance Company:** The Council monitors the financial strength of Great-West Life each year, based upon evaluations of the major rating agencies. These ratings are as follows: A.M. Best, A+ (*highest rating out of ten categories*); Fitch, AA+ (*second highest rating out of nine categories*); Moody’s, Aa3 (*second highest rating out of nine categories*); Standard & Poor’s, AA (*second highest rating out of nine categories*).

### **Members Retirement Savings Programs**

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The Association endorses two benefits of membership that provide tax-advantaged ways of saving for retirement. The *Members Retirement Program* is a tax-qualified plan

that offers three types of 401(k) Plans: Simple, Safe Harbor and Traditional, as well as Pension and Profit-Sharing Plans. The *Individual Retirement Account* (IRA) can be adopted as a traditional IRA, Roth IRA, Rollover IRA or SEP. The retirement programs are administered and marketed by the AXA Equitable Life Insurance Company (AXA Equitable).

The Council oversees the administration and marketing of these programs. It also meets semiannually with the AXA Funds Management Group to evaluate the performance of the funds and accounts offered to participants for investment of their deposits in the Members Retirement Program.

Prior to May 1, 2008, the Council served as Trustees of the Members Retirement Program. Effective May 1, 2008, the Members Retirement Program is offered through the AXA Equitable Members Retirement Program Trusts, the trustee for which is the Morgan Chase Bank. The termination of the previous ADA Members Retirement Program trusts and the transfer of their assets to the AXA Equitable Members Retirement Program Trusts was in accordance with the 2007 House of Delegates' adoption of Resolution 9H-2007 (*Trans.2007:368*).

The Board delegated the Council the authority to oversee the Members Retirement Program and to recommend changes when appropriate by adopting Resolution B-96-2006 (*Trans.2006:286*). The 2007 House of Delegates adopted Resolution 9H (*Trans.2007:369*) which amended the *Bylaws* with respect to the Council's duties, to include the duty to advise and recommend courses of action on retirement programs.

**Program Expense Charges:** The Program Expense Charge is the primary source of AXA Equitable's revenue. It is paid by all participants, both employer dentists and their participating employees. For the one-year period beginning May 1, 2009, the Expense Charge was .59% (59 basis points.) For the one-year period beginning May 1, 2010, the Expense Charge will be .52%. This charge will be assessed daily at .52%/365 against each participant's account value. There is also a \$3 quarterly record keeping fee assessed to all participants.

The Expense Charge for the Individual Retirement Account Program ranges from .25% to .28% depending upon the investment fund(s) selected by the participant.

The above Expense Charges and fees do not include investment management fees of the various investment funds offered under the Members Retirement Program and Individual Retirement Account.

**Royalty Payments:** To offset its expenses in endorsing the Retirement Programs, the Association is paid royalties by the AXA Equitable. The royalty for the endorsement of the Members Retirement Program is based upon the assets held in the Program as well as the number of participants. The royalty for the IRA Program is based solely on its assets. These payments are submitted by the Company approximately one month after the end of each calendar quarter. The payments are classified as Royalties in the

Council's budget.<sup>4</sup> In 2009, these payments totaled \$466,411. The Company funds the royalty payments to the Association from the Program Expense Charge.

**Funding of Council's Budget:** Since the participants in the Member Retirement Programs indirectly fund AXA Equitable's royalty payments, the Board of Trustees has used the royalties to fund that portion of the Council's budget which is not reimbursed by the members insurance programs. Any royalty income which exceeds this budget allocation represents general revenue to the Association. In 2009, the royalty revenue exceeded the funding of the Council's budget by \$241,994.

**Financial Strength of AXA Equitable Life Insurance Company:** The assets of the Members Retirement Program and the Individual Retirement Account, with the exceptions of the Guaranteed Rate Accounts<sup>5</sup> listed below, are held in separate accounts of the AXA Equitable Life Insurance Company. AXA Equitable Life Insurance Company advises that by holding them separately, these assets are protected from claims made against the Company by creditors and other policyholders. AXA Equitable Life Insurance Company reported that it continues to have very strong financial ratings as follows: A.M. Best, A+ (*superior*); Fitch, AA- (*very strong*); Moody's, Aa3 (*excellent*); Standard & Poor's, AA- (*very strong*).

**Participation in ADA-endorsed Members Retirement Program:** At the end of 2009, 5,527 members were participating in the ADA-endorsed Members Retirement Program. There were 13,513 additional participants consisting of dental office employees, surviving spouses and the staff of 32 constituent and component dental societies. The most popular plan among employers is the Safe Harbor 401(k) Plan. Approximately 54% of all Program participants are enrolled in this type of Plan; and it is by far the most popular option among start-up plans, representing 75% of new plan's sold.

**ADA-endorsed Members Retirement Program Investment Allocations:** The participants have a choice of 29 investment funds and accounts. The Program's investment options are selected by the AXA Equitable Funds Management Group with a goal of offering a range of risk levels, a variety of asset classes, passive or active investing styles and asset allocation funds that are based either on age-to-retirement or risk tolerance.

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<sup>4</sup> Prior to 2009, the royalty from the IRA Program was classified as Service Income.

<sup>5</sup> Deposits to the Guaranteed Rate Accounts are held in the general account of the AXA Equitable Life Insurance Company.

<b>Members Retirement Program Assets as of December 31, 2009<sup>6</sup></b>		
	<b>Year-end Assets</b>	<b>Percent of Total</b>
TARGET 2015 ALLOCATION	\$ 42,108,462	3.17%
TARGET 2025 ALLOCATION	43,237,358	3.25%
TARGET 2035 ALLOCATION	14,206,624	1.07%
TARGET 2045 ALLOCATION	3,960,797	.30%
AXA CONSERVATIVE-PLUS ALLOCATION	34,119,607	2.57%
AXA MODERATE ALLOCATION	306,869,737	23.09%
AXA MODERATE-PLUS ALLOCATION	73,928,965	5.56%
AXA AGGRESSIVE ALLOCATION	28,898,461	2.17%
EQ/LARGE CAP VALUE PLUS	8,813,425	.66%
EQ/DAVIS NEW YORK VENTURE	13,003,177	.98
EQ/EQUITY 500 INDEX	69,815,037	5.25%
EQ/JPMORGAN VALUE OPPORTUNITIES	19,226,582	1.45%
EQ/LARGE CAP GROWTH PLUS	34,944,439	2.63%
EQ/T. ROWE PRICE GROWTH STOCK	33,364,051	2.51%
EQ/ALLIANCEBERNSTEIN SMALL CAP GROWTH	25,988,776	1.96%
EQ/GAMCO SMALL COMPANY VALUE	20,977,946	1.58%
EQ/SMALL COMPANY INDEX	13,518,324	1.02%
EQ/MID CAP INDEX	11,897,059	.90%
EQ/MID CAP VALUE PLUS	8,315,696	.63%
EQ/VAN KAMPEN MID CAP GROWTH	27,001,741	2.03%
EQ/INTERNATIONAL CORE PLUS	39,029,558	2.94%
EQ/TEMPLETON GLOBAL EQUITY	29,167,194	2.19%
EQ/GLOBAL MULTI-SECTOR EQUITY	33,868,374	2.55%
EQ/CORE BOND INDEX	29,190,164	2.20%
MULTIMANAGER MULTI-SECTOR BOND	11,521,074	.87%
MONEY MARKET GUARANTEE	302,968,351	22.80%
3-YEAR AND 5-YEAR WEEKLY GRAS	48,943,122	3.68%
<b>Total</b>	<b>\$1,328,924,132</b>	<b>100.00%</b>

**ADA-endorsed Individual Retirement Account:** The ADA-endorsed Individual Retirement Account (IRA) is available to members, their spouses and employees. It is administered by the AXA Equitable Life Assurance Society.

As of December 31, 2009, there were 1,889 participants in the ADA-endorsed IRA; and their assets were invested as follows:

<sup>6</sup> As reported by the AXA Equitable, ADA Members Retirement Program Status Report December 31, 2009, presented on March 26, 2010.

<b>ADA-endorsed IRA Program Assets as of December 31, 2009<sup>7</sup></b>		
	<b>Year-end Assets</b>	<b>Percent of Total</b>
1-YEAR AND 3-YEAR WEEKLY GRAS	\$ 4,604,516	6.60%
EQ/MONEY MARKET	13,684,329	19.61%
EQ/ALLIANCEBERNSTEIN COMMON STOCK	17,911,849	25.67%
EQ/ALLIANCEBERNSTEIN INTERMEDIATE GOVERNMENT SECURITIES	2,000,735	2.87%
AXA MODERATE ALLOCATION PORTFOLIO	12,994,134	18.62%
MULTI-MANAGER MULTI-SECTOR BOND	600,606	0.86%
MULTI-MANAGER AGGRESSIVE EQUITY	1,611,636	2.31%
EQ/LARGE CAP VALUE PLUS	3,946,279	5.66%
EQ/EQUITY 500 INDEX	3,904,993	5.60%
MULTIMANAGER SMALL CAP VALUE	1,301,612	1.87%
EQ/LARGE CAP GROWTH PLUS	1,303,605	1.87%
EQ/BLACKROCK INTERNATIONAL VALUE	1,261,774	1.81%
MULTIMANAGER TECHNOLOGY	1,275,483	1.83%
EQ/CAPITAL GUARDIAN RESEARCH	380,765	.55%
EQ/ALLIANCEBERNSTEIN INTERNATIONAL	3,000,731	4.30%
<b>Total</b>	<b>\$69,783,052</b>	<b>100.00%</b>

## **Risk Management Activities**

**Meetings with Dental Professional Liability Insurers:** The Council conducts an ongoing environmental scan of conditions in the dental professional liability insurance markets both with respect to the incidence, severity and causes of malpractice allegations as well as with respect to competition among companies to insure dentists.

In the past year, the Council met with three professional liability insurance companies. They include the Medical Liability Mutual Insurance Company, CNA HealthPro and the Eastern Dentist Insurance Company. During these meetings, the Council discussed emerging trends in the patterns of dental health care, the effects of new technologies, the effects of economic conditions on dentists (i.e., retirement patterns), as well as insurers (i.e., reduced investment income), and other matters that have the potential to affect the quality of patient care and/or professional liability insurance premiums.

Based upon the information provided by these insurers, the Council believes that the incidence and severity of dental malpractice allegations is not increasing significantly. It further believes that the insurance marketplace is competitive and that all dentists having good claim histories have numerous options for their professional liability insurance policies.

<sup>7</sup> As reported by AXA Equitable, ADA Members Retirement Program Status Report December 31, 2009, presented on March 26, 2010.

## Acknowledgements

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**Great-West Life Donation:** The Council wishes to express its appreciation to the Great-West Life & Annuity Insurance Company for its generous \$25,000 donation to the ADA Foundation for the Paffenbarger Research Center.

**AXA Equitable Donation:** The Council wishes to express its appreciation to the AXA Equitable Insurance Company for its generous \$10,000 donation to the ADA Foundation.

**Personnel:** The Council acknowledges with appreciation the many significant contributions made by its members who will complete their terms in 2010. They are: Drs. Larry Browder, Steven Shall, Scott Morrison and Gary Zoutendam. The diligent service and wise judgments of each of these Council members has advanced the interests of the membership both with respect to the insurance and retirement programs as well as in the areas of risk management education. During their terms of service, the Council has made significant improvements to each of the member programs. The guidance provided by these members has been key to the success of these efforts.

## Summary of Resolutions

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**22. Resolved,** that Chapter X. COUNCILS, Section 120. DUTIES, Subsection I. COUNCIL ON MEMBERS INSURANCE AND RETIREMENT PROGRAMS, of the ADA *Bylaws* be amended by addition of duty "f" to read as follows:

- f. Aid dentists in the management of their personal and professional risks through educational activities, informational programs and services.

## Council on Membership

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**Buckenheimer, Terry L.**, Florida, 2010, chair  
**Hughson-Otte, Virginia A.**, California, 2011, vice chair  
**Bainbridge, Jean E.**, Texas, 2013  
**Bauman, Mark A.**, New York, 2013  
**Benson, Sean A.**, Oregon, 2010  
**Card, Rex B.**, North Carolina, 2011  
**Christy, Todd R.**, Michigan, 2011  
**Goad, Jamie Dale**, New Mexico, 2013  
**Jerome, Jennifer J.**, Ohio, *ex officio*\*  
**Martin, William F., III**, Maryland, 2011  
**Moore, T. Delton**, Mississippi, 2012  
**Morledge, George B.**, Arkansas, 2010  
**Rich, Jonathan W.**, Kentucky, 2012  
**Rosenthal, Nancy R.**, Pennsylvania, 2012  
**Thomsen, Brett S.**, Nebraska, 2012  
**Vouras, Lisa**, Massachusetts, 2012  
**Yonan, Kenneth P.**, Illinois, 2013  
**Zucker, William J.**, Ohio, 2010  
**Rauchenecker, Steven M.**, director  
**Bronson, Liz**, manager

**Communicating the Value of ADA Membership:** The Council is committed to communicating ADA member value, without adding cost to the Association or to the member. During the previous year, the Council has done this through a variety of ways, such as:

- Working with the ADA.org redesign team to create a new and improved “Find a Dentist” feature on ADA.org
- Working with the Council on Communications to optimize search engine results for the “Find a Dentist” feature on ADA.org
- Working with constituent societies one-on-one to create strategic recruitment and retention plans and supporting the implementation of these plans
- Studying diverse urban areas with low market share to customize marketing efforts to attract these nonmember dentists.

In addition, the Council on Membership has furthered ADA’s efforts to grow membership through a number of methods, including:

- Increasing awareness of MC<sup>2</sup>: Membership Contact and Connections (MC<sup>2</sup>), a program that provides constituent and component society volunteers and staff

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\* Committee on the New Dentist member without the power to vote.

with the tools, resources, training and consultation needed to support their membership outreach and growth activities

- Completing the tripartite marketing collaborative pilot program and fully implementing the approach across constituent dental societies
- Hosting the ADA Annual Conference on Membership Recruitment and Retention
- Conducting annual member and nonmember research to identify membership opportunities and trends

The Council has undertaken these tasks and focused its efforts to ensure the Association meets its goals.

**The Strategic Plan of the American Dental Association:** The Council continues to review metrics for key activities and prioritize 2010-2011 projects in order to direct Council activity that supports the needs of the Association and the profession. Looking ahead to 2011, the Council identified the tripartite marketing collaborative, web-to-print resources, MC<sup>2</sup> efforts and increasing awareness of the newly re-designed ADA.org, particularly the expanded “Find a Dentist Feature,” as high priority budget items. These important programs support the ADA’s core competency of membership and address key objectives identified in the ADA’s Strategic Plan, most notably helping dentists succeed and excel throughout their careers and enhancing ADA fiscal responsibility by delivering a balanced budget that includes increased non-dues revenue, cost savings, and/or operational efficiencies while safeguarding all ADA assets through optimum compliance.

**Membership Outreach Update:** Through the Council’s leadership, MC<sup>2</sup> continues to expand and gain momentum. Utilizing all available resources, MC<sup>2</sup> continues to move forward making significant progress in addressing its six key membership outreach strategies, including:

1. Unveil MC<sup>2</sup>: Membership, Contact and Connections to all stakeholders.
2. On an annual basis, target specific state and local dental societies that appear to offer membership growth opportunity. Identify and act on specific opportunities to assist these societies during the membership year.
3. Create a knowledge management database of information, tools, examples, samples, best practices and other resources for the tripartite.
4. Enhance the existing set of training and consultative materials, as well as expand the methods by which membership growth training and consultation occur.
5. Leverage the skill set and experience of other volunteers in the tripartite who have demonstrated proven results in membership growth initiatives to use in assisting other dental societies to achieve similar success.

6. Conduct an annual survey of constituents and components to further identify their membership growth assistance needs. Use this information in part, to evaluate success, and to refine and prioritize future efforts.

*Marketing Collaborative.* The tripartite marketing collaborative provides a unique set of tools that expand constituent and component dental society capacity to promote and reinforce member value. Through collaboration, each level of the tripartite can develop membership marketing plans in relation to one another, reinforce the ADA brand and tailor complementary recruitment and retention messages for targeted audiences. For the dental society, additional resources and expertise can be tapped to gain effectiveness and efficiency in pursuing membership growth. With the completion of the pilot program, and the implementation of the web-to-print approach by the conclusion of 2010, all constituent (April) and component societies (October) will have the opportunity to take advantage of this valuable resource.

The marketing collaborative decision package approved by the House of Delegates in 2008 outlined three phases of the project: research, program development and pilot testing. The research phase, completed in 2009, consisted of two parts, 1) gathering perspective as to the most pressing marketing needs among constituent and component dental societies, and 2) identifying why fewer dentists join the ADA in urban geographic areas.

The second phase, program development, which also was completed in 2009, involved using the findings from the phase one research to identify specific needs and develop marketing strategies to target urban areas, lagging markets and specific geographic areas with the greatest opportunity for membership growth. This combined approach provided the unique opportunity to strengthen current recruitment and retention strategies, while offering proven tactical resources to help increase membership in all markets, particularly those offering the best chance for growth.

The three collaborative campaigns piloted in 2009 included \$0 quarter year dues, membership reinstatement and general dentist recruitment. ADA staff facilitated one-day workshops with constituent and component societies that resulted in collaborative marketing plans linking membership growth strategies and tactics across each level of the tripartite. Based on these plans, the ADA worked collaboratively with constituent and component pilot participants to develop copy and coordinate the design, production and distribution of all related communications pieces, which included brochures, postcards, e-communications, fax and an outbound calling program. Results have been encouraging and the collaborative process was well-received.

*\$0 Quarter Year Dues.* In September 2009, a national \$0 quarter year dues mailing was sent to eligible dentists in all states except California, New Jersey and Texas, which were targeted through the Marketing Collaborative. The creative theme of the national campaign focused on overcoming career challenges by choosing to join the American Dental Association. End-of-year numbers indicate a strong response to the national campaign, with 375 dentists joining.

An additional 351 dentists were recruited through the marketing collaborative states, i.e. California, New Jersey and Texas and their components. For these constituents and their components, these results reflect an increase of 181 members compared to the previous year. The following shows the comparison of 2008 results to the 2009 collaborative approach:

<b>Constituent and Component</b>	<b>2008 Results</b>	<b>2009 Collaborative Results</b>
<b>California Dental Association Los Angeles Dental Society</b>	78 new members 6 new members	151 new members (94% increase) 20 new members (233% increase)
<b>New Jersey Dental Association Southern Dental Society</b>	42 new members. 3 new members	53 new members (26% increase) 7 new members (130% increase)
<b>Texas Dental Association Greater Houston Dental Society</b>	41 new members 11 new members	106 new members (158% increase) 14 new members (27% increase )

*Reinstatement Campaign.* In November 2009, a reinstatement campaign was conducted to increase membership counts before the end of that year. The ADA typically undertakes a national-level campaign to reinstate lapsed members in the fall. As part of the marketing collaborative pilot, Florida, Michigan and New York participated in a customized approach to this campaign. Communications included a reinstatement postcard, a fax or letter from the ADA president (communications were sent via fax when the number was available and via mail if it was not), and an outbound calling program. The pilot calling program included the ability to take dues payments over the phone, which the national program did not. It is also important to note that the 2008 campaign lasted four months, while the 2009 pilot effort lasted slightly more than two months. A comparison of the results of these campaigns follows:

<b>Constituent and Component</b>	<b>2008 Results</b>	<b>2009 Collaborative Results</b>
<b>FDA and Atlantic Coast District Dental Association</b>	36 members	42 members (Increase of 6)
<b>MDA and Detroit District Dental Society</b>	0 members	20 members (Increase of 20)
<b>NYSDA and Second District Dental Society</b>	98 members	106 members (Increase of 8)

*General Dentist Recruitment Campaign.* The third pilot campaign targets nonmember general dentists. This campaign was undertaken in Maryland, Illinois and Pennsylvania and has no corresponding national campaign. The general dentist campaign is designed to highlight member value and deliver helpful practice resources. The campaign will conclude in June 2010 with resulting metrics being compiled and reported at that time. Dental society feedback gathered through the training programs indicates

a strong interest in the program. Anecdotal feedback, which will be validated through the Council on Membership's district survey and using a more extensive quantitative survey in the fall, has been positive.

Other than awaiting the results of the general dentist campaign, the final phase of the marketing collaborative has been completed. Overall, nine constituent and nine component societies worked collaboratively with the ADA, and by doing so, exceeded previous results.

The results of the pilot effort thus far validate the potential for MC<sup>2</sup> and the marketing collaborative to build upon and positively contribute to state and local dental society membership growth initiatives. Working with state and local dental societies, staff from the Membership, Tripartite Relations and Marketing division of the ADA, under the direction of the Council on Membership, developed and implemented a membership recruitment, retention and outreach plan for each pilot state and their chosen component, as well as developed related marketing materials. In addition, a web-to-print vendor was selected to manage the process to design, print and distribute tripartite collaborative marketing materials. The pilot study demonstrated that through a collaborative approach, the tripartite can efficiently and effectively reach existing and prospective members in a consistent and complementary manner.

Thus far in 2010, a renewal campaign and a half-year dues campaign have been initiated with constituents through the marketing collaborative approach. The member retention campaign began in April. The half-year dues campaign started in May. Through the pilot program, it was determined it would be most effective to create a comfort level with the state dental societies first. By doing so, the states could assist with implementation at the component level. A third national campaign will be conducted in the fall utilizing all three tripartite levels. The fall campaign will occur in September, focusing on member value, and encourage 2011 early renewal. Additional marketing collateral templates are being created to help state and local societies conduct ad-hoc promotions and campaigns separate from the three major campaigns noted.

**Annual Session Promotional Incentive:** The reduction of registration fees for nonmember dentists attending annual session continues to be a successful strategy for highlighting the value of ADA membership to dentists who may be reluctant to join the Association. As of April 28, 2009, of the 258 nonmember attendees who took advantage of the nonmember reduced rate at the 2009 ADA annual session in Hawaii, 20 have joined the ADA including 16 who are pending renewals for 2010. In 2008, 371 nonmember dentists took advantage of the one-time reduced nonmember rate to attend the 2008 ADA annual session and as of end-of-year 2009, 65 of them had joined the Association.

**Membership Research:** Several membership research studies were undertaken in 2009 to inform the Council on the wants and needs of ADA members, nonmembers and the public. The research conducted is highlighted below:

*Student / New Dentist Qualitative Study.* This qualitative study was commissioned by the Council on Membership, and was comprised of focus groups and telephone interviews with current dental students and recent graduates (both members and nonmembers). It examined what attracted them to dentistry in the first place, where they expect to be in ten years, their thoughts about opportunities to serve low income and rural communities, and their take on professional organizations with specific focus on ADA, the American Student Dental Association (ASDA), and study clubs. The study also examined their use of ADA products and resources and inquired about their preferences for advocacy goals. In addition, discussion groups were conducted among leaders of ASDA in order to compare the perspectives of highly involved students to students overall.

Focus group findings revealed a preference for small group practice settings, rather than solo practice, especially among dental students. Satisfaction with the dental profession was high. Preferences on advocacy were stated in the following areas: educating the public on the importance of oral health, providing greater access of care (especially to children), fighting for the dental profession and its autonomy and requiring high standards for dental treatment.

*Student / New Dentist Quantitative Web Survey.* A follow-up Web survey of dental students and recent graduates is in development as of April 30 and will quantify trends identified in the qualitative research.

*Loyalty Metrics Survey.* This annual survey, also commissioned by the Council on Membership, was intended to form the baseline for critical membership metrics going forward. In addition to an overall satisfaction question it fielded the three critical questions that comprise the composite loyalty measure, which are: likelihood to recommend; likelihood to renew; and overall value.

The study also compared a series of brand statements that were developed as part of the brand initiative and first tested one year ago. And it tested a series of new brand messages to see how they resonate with members. Findings were positive, with 91.6% of members indicating they are “extremely,” “very,” or “moderately” satisfied with the ADA. Seventy-five percent of members indicated they are “extremely” or “very” likely to recommend ADA membership, and 68.1% say their ADA membership value is “excellent” or “good.” The loyalty metrics survey will be conducted annually.

*Nonmember research.* Council on Membership research for 2010 includes a nonmember study. The last nonmember needs and opinions research was conducted in 2003. This study will be undertaken in the summer and fall of 2010.

*Target market research.* The year 2010 brings quantitative research of current and former affiliate members as well as dentists serving in the federal services.

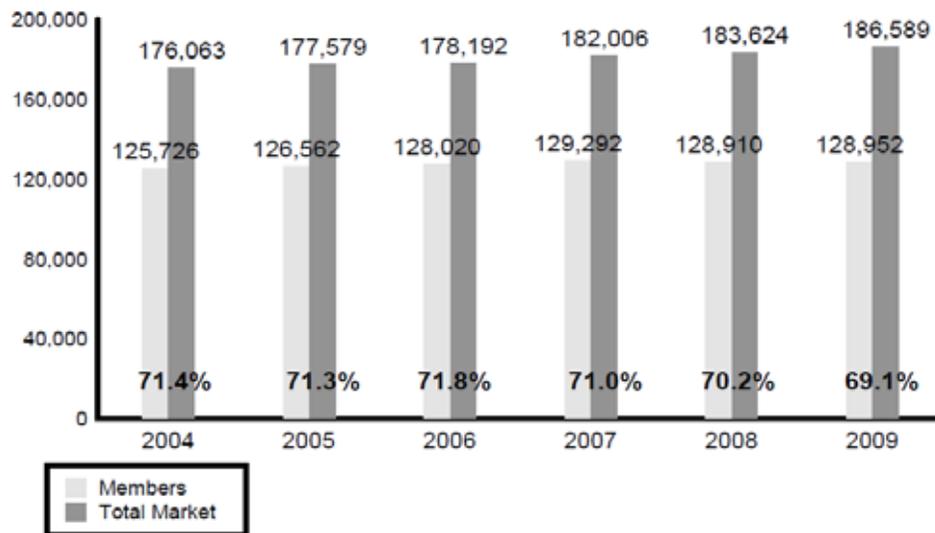
*Social Media Consumer Survey.* Of the various forms of online media available to consumers today, general Internet Web sites are the most universally accepted and are

accessed by nearly all consumers. These are followed, in order, by social media applications, YouTube videos, blogs/forums, podcasts and iPhone applications. While the younger audience (18-34) is more engaged online, those 35 and up are also actively involved with over 50% participating in social media and YouTube.

An oral piercing podcast was viewed by all survey participants. The podcast resonated well with consumer audiences of all ages, earning particularly high marks on being understandable and the knowledge of the hosts. Viewers also approved the length, technical level and balance between dialog and graphics/animation. Since YouTube is nearly three times as popular as podcasts, this channel may be a preferred vehicle to communicate ADA podcasts to the general public.

**Membership Market Share:** At end-of-year 2009, the ADA's membership market share among active licensed dentists decreased by 1.1 percentage points to 69.1% from end-of-year 2008 (Table 1). In spite of the economic downturn, the ADA experienced a net increase of 42 active licensed members over end-of-year 2008. The total number of ADA members in all membership categories increased an additional 413 members from 172,092 in 2008 to 172,505 in 2009. The total market of active, licensed dentists grew at a faster rate in 2009, increasing by 2,965. This compares to an increase in market size of 1,618 from 2007 to 2008.

**Table 1: ADA Market Share  
Active Licensed Dentists**



Source: 2009 ADA Dentist Masterfile

The ADA continues to increase the number of active licensed members over time. However, because the market size continues to grow at a faster rate, ADA market share has dropped. To illustrate the point, the 69.1% ADA market share in 2009 is the lowest achieved since ADA began tracking market share in 1993. Concurrently, the number of members 128,952 is the second largest membership count of active, licensed dentists

achieved during this same period (Table 2). The highest count was achieved in 2007, just prior to the current economic recession. This demonstrates that ADA efforts to increase membership have been successful. However, new efforts to sustain market share growth may be required. Current activities generate incremental market share gains at best, largely due to the high market share the ADA enjoys. Through Council activity and the ADA's operational plan metrics, both market share and membership continue to be monitored and reported to the Board of Trustees and the House of Delegates.

**Table 2**

**Membership Growth and Market Share from 1993 – 2009**

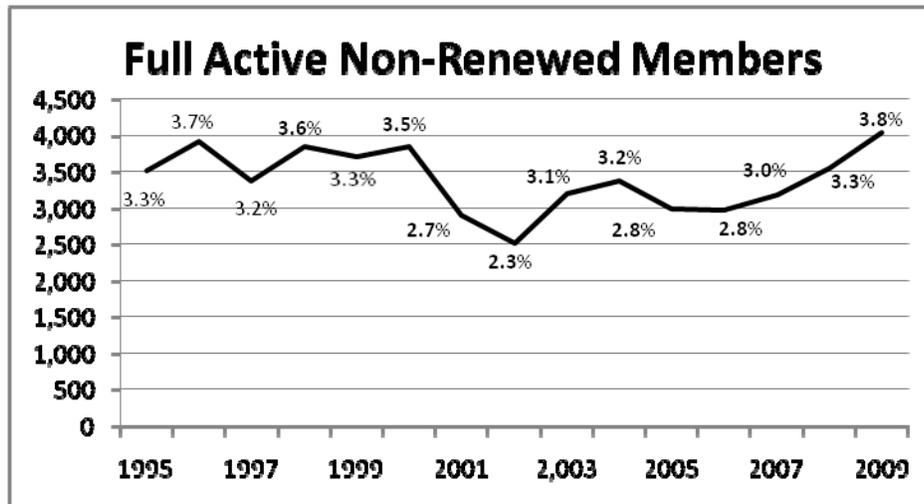
<b>Year</b>	<b>Active Licensed Members</b>	<b>Change from Previous Year</b>	<b>Total Market of Active Licensed Dentists</b>	<b>Change from Previous Year</b>	<b>Market Share %</b>	<b>Change from Previous Year</b>
2009	128,952	42	186,589	2,965	69.10%	-1.1%
2008	128,910	-382	183,624	1,618	70.20%	-0.8%
2007	129,292	1,272	182,006	3,814	71.00%	-0.8%
2006	128,020	1,458	178,192	613	71.80%	0.5%
2005	126,562	836	177,579	1,516	71.30%	0.3%
2004	125,726	2,581	176,063	2,538	71.00%	0.6%
2003	123,145	2,039	173,525	1,467	70.40%	0.0%
2002	121,106	3,828	172,058	5,447	70.40%	0.0%
2001	117,278	685	166,611	1,058	70.40%	-1.0%
2000	116,593	-2,414	165,553	-1,044	71.40%	0.0%
1999	119,007	-312	166,597	-483	71.40%	0.0%
1998	119,319	-465	167,080	2,140	71.40%	-1.2%
1997	119,784	928	164,940	1,918	72.60%	-0.3%
1996	118,856	1,289	163,022	2,939	72.90%	-0.5%
1995	117,567	2,139	160,083	3,012	73.40%	-0.1%
1994	115,428	-1,061	157,071	333	73.50%	-0.8%
1993	116,489	---	156,738	---	74.30%	---

Source: End-of-year ADA Active Licensed Market Share Reports

A membership goal of 128,950 active licensed members has been set in ADA's 2010 Operational Plan. This number has been shared with the Board and with Council Chairs. Achieving the 2010 membership goal, while factoring in an expected increase in market size of 3,000 active licensed dentists, it is anticipated that ADA's market share will be at 68.5% at the end of 2010 a change of -.0.6%.

The active non-renew percentage rose half a percentage point from 3.3% to 3.8% at year end. There were 4,041 active non-renews in 2009 compared to 3,548 in 2008, an increase of 493. Table 3 shows the percent of full active non-renewing members from 1995 through 2009.

Table 3



Source: 2009 ADA Dentist Masterfile

With such a high rate of ADA member retention, it will take a combination of significant shifts in market share in target markets such as ethnically diverse dentists, foreign-trained dentists, and women dentists while ADA retains its largest market; the general practitioner to increase market penetration overall (Table 4).

**Table 4**  
**Year-End 2008 vs. Year-End 2009**  
**Members by Target Market for Active Licensed Dentists**

Target Group	Increase/ Decrease in 2009 Members	2008 Membership Market Share Percentage	2009 Membership Market Share Percentage	Increase/ Decrease in market percentage points 2008/2009	Increase/ Decrease in Market 2008/2009
Women Dentists	1,031	63.3	62.4	-0.9	2,965
All Faculty (Full-time and Part-time)	-3	73.2	72.1	-1.1	2,261
Full-time Faculty	732	64.8	68.4	3.6	109
General Practitioners	-41	67.4	66.3	-1.1	2,300
Specialists	83	81.1	80.5	-0.6	665
Federal Dental Service	58	61.2	61.5	0.3	71
Foreign Trained Dentists	52	50.8	50.4	-0.4	196
Minority Dentists	445	54.4	54.0	-0.4	1,066
New Dentists	356	69	68.4	-0.6	923

Source: 2009 ADA Dentist Masterfile - NOTE: Target Markets overlap and should not be added together.

**End-of-Year 2009 Target Market Membership Statistics:** In 2009, there was an increase in active, licensed members in all target groups except the all faculty group and general practitioners. Concerns related to privacy and security continues to be an issue, and as a result, the Federal Dental Services Membership Office is not always able to reconcile its records with every branch of service. As a result, there may be nonmember dentists who are no longer in service who were counted in the total market at year-end, which would actually contribute to a lower market share for federal dental service dentists. The Tripartite System database of federal service dentists is believed to be substantially accurate. Despite this issue, the number of federal dentist members increased by 58 in 2009.

**ADA Direct Membership Marketing:** In 2009, in support of Membership Outreach goals, direct marketing contact included:

- Nonmember dentists in private practice
- Lapsed members
- New dentists one to four years out of dental school (with expanded efforts to help convert recent dental school graduates into the appropriate category of membership)
- Non-practicing dentists
- Full- and part-time faculty
- Graduate students

*Diverse (Minority) Dentists.* Building inclusion continues to be an important target for the ADA. The number of known minority ADA member dentists increased by 445 from 16,543 at end-of-year 2008 to 16,988 at end-of-year 2009. During this time the market grew by 1,066 dentists, and as a result, market share decreased by 0.4 percentage points. It is important to note that this data is self-reported and there are a large number of active licensed dentists of unknown racial/ethnic background. The Health Policy Resources Center is now including a question on this topic in the Distribution of Dentists Survey that is sent to one-third of dentists each year, and will likely improve the quality of the data the ADA has on the race/ethnicity of dentists in the United States; the ADA should have a more accurate picture in about three years. The Council on Membership's Membership Marketing Plan includes specific outreach to nonmember dentists in under-represented target markets in 2010.

*Recent Graduates.* Follow-up evaluation of conversion efforts for recent graduates revealed that there are dentists who are eligible for the Reduced Dues Program who have not taken advantage of it, as well as some who did so for a period of time, but then dropped out. In order to ascertain reasons for nonmembership, the ADA sent a letter on behalf of the Committee on the New Dentist chair which included a feedback form. A total of 208 dentists, out of 1,233 targeted, responded. The top response overall was "I want to be a member but can't afford it" at 48%, followed by "my employer doesn't pay my dues" at 15%, and "I thought I was a member" at 13%. Reasons varied by how recently the respondent graduated, with the newest grads more likely to cite confusion related to the membership process and those who have been out of school for a few years more likely to cite financial reasons.

*Federal Dentists / 2010 Strategic Promotional Incentive.* The overall FDS market share of active, licensed dentists remained strong at end-of-year 2009 at 61.5%, which was up slightly from 2008 when market share was 61.2%. The total number of members (including both active duty and transition year) increased by 52 dentists and the overall market increased by 71 dentists.

Looking at active duty dentists alone, the end-of-year 2009 market share at 60.2% was an increase over end-of-year 2008 at 59.3%. There was an increase in the number of active duty dentists in 2009, with 202 more dentists serving. The previous trend toward utilizing civilian dentists in place of commissioned officers in the military is seen to be reversing and all branches of the military are recruiting additional numbers of dentists.

The number of “transition year” members—those who maintain direct ADA members in the year following their separation from active duty—decreased from 209 to 148, likely related to the retention of dentists in the military.

The ADA Board of Trustees approved a 2010 strategic promotional incentive as a way for the ADA to increase membership by providing a one-time reduction in dues for nonmembers in specific target markets, as recommended by the Council on Membership. The promotion was targeted to nonmember dentists working in any branch of the federal services, including the Army, Air Force, Navy, U.S. Public Health Service, U.S. Department of Veterans Affairs and other federal employment. Although these dentists may choose to become tripartite members (depending on where they are practicing), most join as direct members, which means they do not pay constituent or component dues. The program provides a 50% reduction in dues at the ADA level for the 2010 membership year. In response to two timed mailings, an e-mail communication and special promotion within *Federal Dental News*, a total of 84 applications have been received and processed in the ADA’s FDS membership office, a 7.9% response rate, as of April 30, 2010. By comparison, the response rate to the 2009 strategic promotional incentive offered in 2008 to public and community health dentists working at the state/local levels was just 1%.

A Web survey of member and nonmember federal service dentists has been developed and will be conducted in 2010.

*Graduate Students.* Nonmember graduate students received a total of three recruitment mailings in 2009, as well as electronic communications messages. The messages in this communication highlighted a call to action to join the ADA, and value was demonstrated by the wealth of benefits received for such a reasonable dues rate of \$30. By end-of-year 2009, a total of 3,087 dentists had paid the \$30 graduate student rate, an increase of 4.2% over end of year 2008, when graduate student membership was 2,958 (Table 5).

**Table 5**  
**Graduate Student Membership**

	<b>Members at End-of-Year 2009</b>	<b>Percent</b>	<b>Members at End-of-Year 2008</b>	<b>Percent</b>
<b>Direct</b>	2,002	65%	1,774	60%
<b>Tripartite</b>	819	26%	863	29%
<b>Federal</b>	266	9%	321	11%
<b>Total</b>	<b>3,087</b>		<b>2,958</b>	

In order to increase the quality and frequency of communication to the graduate student membership category, the Department of Membership Marketing continued publishing an electronic publication for graduate students called the *Resident Report*. The publication is well-received with an average open rate of 38.9%. *Resident Report* will be published four times in 2010 and will continue to target graduate students/residents and program directors. The Reduced Dues Program continues to be an appealing offer for recent dental school graduates who enter a graduate program or residency following graduation or within their first few years out of school. The program now allows those who enter a graduate program or residency to put the reduced dues on hold while they are in training and then pick up where they left off following completion of the program.

All nonmember graduate students are targeted with recruitment communications at the half year mark. In addition, graduate program directors receive a graduate student membership informational mailing in July, which also includes graduate student brochures and applications. Graduate students are also targeted with ongoing communications that promote the importance of membership as it related to maintaining eligibility in the Reduced Dues Program. As of April 30, 2010, a total of 2,100 dentists have paid graduate student membership rates, slightly ahead of graduate student membership at this time last year.

*Nonpracticing Dentists.* As of April 30, a total of 54 non-practicing dentist members had paid 2010 dues (compared to 75 members at end-of-year 2009 and 55 who were paid members at that time last year). There are 4,760 individuals known to be eligible for this category of membership. To increase the number of non-practicing dentist members, all nonmembers eligible for this category received a recruitment mailing in April 2010.

*Affiliate Membership.* Affiliate members, non-U.S. dentists practicing outside the United States, pay a flat rate of \$75 for affiliate membership, or a \$12 rate available to dentists in countries identified by the FDI World Dental Federation as least developed and low income. To offset the reduced rate, affiliate members have access to the complete text of *The Journal of the American Dental Association (JADA)* on ADA.org:

there is an additional charge to receive *JADA* by mail. As of April 30, 2010, there were 1,686 affiliate members. Of these, 1,389 paid \$75 and 307 paid \$12. This compares to 1,915 affiliate members as of April 30, 2009, and 2,500 as of December 31, 2009.

In order to evaluate the variability in membership numbers from year to year and the comparatively high non-renew rate, ongoing electronic surveys will be conducted of new and lapsed affiliate members to identify reasons for joining, perceptions of member value, and reasons for nonrenewal.

**Dental Student Outreach and Conversion:** A key metric for the ADA is the dental student conversion rate—the percentage of new dental school graduates who become ADA members the following year. Since 1982, when the ADA began measuring conversion rate, the low was the class of 1999, when conversion at end-of-year 2000 was 48.1%. With increased focus on dental student conversion, the rate has continued to increase. For the class of 2008 at end-of-year 2009, the conversion rate is 65.8%. This is an increase of 1.7% when compared to the class of 2007 at end-of-year 2008; the conversion rate was 64.0%.

Conversion for the class of 2009 at the end-of-year 2009 is well underway. Thirty-four percent of the class of 2009 provided post-graduation practice plans and 64% did not, subsequently receiving the Options mailing. This represents a 10% increase compared to the class of 2008 for this same type of request.

A total of 48% of new graduate members were transferred to an appropriate constituent society by the end of 2009. Of these 2,145 new graduate members, 1,421 (66.2%) transferred to tripartite dental societies, 479 (22.3%) to direct graduate student membership, 242 (11.3%) to federal services, and 3 (.13%) to direct ADA membership. This compares to 48% conversion of the class of 2008 at end-of-year 2008. Conversion for the class of 2008 at end-of-year 2009 came in at 65.7%, an improvement over the class of 2007 at end-of-year 2008, which was 63.6%.

All nonmember recent graduates were targeted with end-of-year communications that promoted membership in the years following dental school graduation and the importance of maintaining active membership to stay eligible for the Reduced Dues Program.

Student conversion activities include a “Where Are You Going” communication, sent in March, May and August of 2009 via direct mail and e-mail. This mailing is used to track the post-graduation plans for the class of 2009. As an incentive, all respondents received a coupon to purchase a County Demographic Report for \$25 (the member-price is \$75). To encourage early responses, the Office of Student Affairs (OSA) randomly gave away 50 Demographic Reports to those who responded online by the deadline. The total response rate was 34%. As a follow-up, the “New Graduate Information Form” was sent in November to graduates who did not respond to the initial “Where Are You Going” communication. The response rate as of May 17 is 19.5% following three mailings; the OSA expects to receive a few more responses from the

final mailing this spring. Additional "New Graduate Information Form" mailings will go out as needed. The ADA also continues to gather post-graduation practice plans and contact information from the class of 2008. The contact information obtained from the new graduate communications is shared with membership outreach and membership information managers for transmission to the constituent dental societies on a monthly basis.

The OSA coordinates outreach to dental students, provides resources to the tripartite and works closely with ASDA to recruit and serve student members. Outreach includes informational resources including the seasonal mailers, *Dental Student Loan Repayment Programs & Resources*, *Dental Boards and Licensure Information for the New Graduate* and its companion piece *The Patient Guide to the Clinical Licensure Exam*, electronic communications, and InfoPaks on issues of interest to dental students available on ADA.org and by request.

The OSA also manages the Student Block Grant program, which provides reimbursement to constituent dental societies of up to \$3,000 per state for outreach initiatives for dental students upon completion of a descriptive form and submission with receipts. Additionally, constituent societies with dental schools that have total enrollment over 500 were eligible for additional funding. The schools with enrollment of more than 500 were: The University of Pennsylvania (Pennsylvania Dental Association); Boston University (Massachusetts Dental Society); University of Southern California (California Dental Association); Tufts University (Massachusetts Dental Society); and New York University (New York State Dental Association). The New York State Dental Association was eligible for \$6,000 as NYU's enrollment exceeds 750. The remaining schools and corresponding dental associations were eligible for \$5,000.

During the 2009 calendar year, the OSA processed reimbursements totaling \$169,005 of the \$195,000 potential reimbursement level. Through a reported 184 programs, states reached an estimated 18,900 students. Therefore, the grant paid \$33.74 per student for these reported activities. It is noted that 16 states, more than half of participating states, reported expenses that exceeded the ADA reimbursement allocation. Use of additional funding for activities with the five schools with large enrollment varied. Massachusetts took full advantage, receiving \$10,000 for activities with Boston and Tufts. The California Dental Association also used all of the \$5,000 eligible for the University of Southern California student outreach. Pennsylvania Dental Association and New York State Dental Association did not use all of available funds.

The total budget for 2010 is \$175,000 (reflecting the fact that not all eligible societies take advantage of it) and the program will continue with the same criteria from 2009 in 2010. Lunch and learns, mentoring receptions, freshman orientation and Success programs continue to be popular interactive programs. Through April 30, seven constituent dental societies have submitted requests for reimbursement, totaling more than \$18,000.

*Student Market Share.* The ADA tracks student market share by school on a monthly basis and benchmarks as of July 1 each year, reflecting the academic year cycle. Again in 2009, a strong percentage of students joined and renewed as student members of ASDA and the ADA. Table 6 reflects the market share for the 2008-2009 academic year reported July 1, 2009. In addition, the ADA continues to see modest interest in the International Dental Student membership category, which provides a ways for students attending dental school outside of the United States to join ASDA/ADA. The ADA reports a total of 14 international dental student members at the end of 2009.

**Table 6**  
**2008 – 2009 Student Market Share**

<b>Class Level</b>	<b>Member</b>	<b>Market Share</b>	<b>Nonmember</b>	<b>Market Share</b>	<b>Total Market</b>
Freshmen	4108	84.5%	751	15.5%	4859
Sophomore	4191	85.0%	740	15.0%	4931
Junior	4095	84.3%	764	15.7%	4,889
Senior	4227	85.0%	747	15.0%	4974
<b>Total</b>	<b>16,621</b>	<b>84.7%</b>	<b>3002</b>	<b>15.3%</b>	<b>19,270</b>

*Success Dental Student Programs.* The OSA coordinates the Success Dental Student Programs. In December 2009, the Board of Trustees adopted Resolution B-114, assigning oversight of the Success Dental Student Programs to the Committee on the New Dentist. Information relative to Success will now be reported through the Committee on the New Dentist's Annual Report.

**ADA Reduced Dues Program:** In 2003, the ADA House of Delegates considered the opportunity to expand the ADA Reduced Dues Program to include an additional year at \$0. Sensitive to the high level of student debt and the additional expense associated with transition to practice, the resolution was adopted. The 2003 ADA House of Delegates requested that information regarding the financial impact of the expansion be reported (*Trans.2003:354*). For the first few years, the immediate annual financial impact grew as more new graduates were in the revised program. The program had the effect of reducing the total amount paid over the first few years following graduation, as members who would have paid 25% paid \$0, members who would have paid 50% paid 25%, members who would have paid 75% paid 50%, and members who would have transitioned to 100% dues paid 75%.

For the 2009 membership year, assuming that all the members in the ADA Reduced Dues Program would have been members even if the program expansion had not occurred, the revenue forgone equals \$1,542,024. This number is expected to remain stable in the future; increases would be driven by either an increase in dues or an increase in the number of recent graduate members. For example, a \$20 dues increase would result in an increase in revenue forgone of about \$60,000. A 5% increase in

membership participation among recent graduates would result in an increase of revenue forgone of \$71,000.

The ADA Reduced Dues Program has been effective in encouraging membership among new practitioners. The gap between the new dentist market share and the overall market share is very low: at end-of-year 2009, the new dentist market share was 68.4% compared to the overall of 69.1%. Membership participation among new graduates has markedly increased. In 2009, members in the first four years out of dental school, paying \$0 to 75% of full dues, totaled 12,384. In 2004, members in the first four years out of dental school paying 25% to 100% of full dues totaled 10,042.

Given the continued growth in the level of student debt on graduation and the current economic climate, the need for the ADA Reduced Dues Program as currently configured is anticipated to continue. As the financial impact has stabilized and the program is successful in facilitating ADA membership among recent graduates, this metric will not be reported in the future.

### **Response to Assignments from the 2009 House of Delegates:**

*Promotion of Activities for Retired Members.* The House of Delegates referred Resolution 76H-2009 (*Trans.*2009:486) to the Council on Membership for further study. The resolution states:

**Resolved**, that the Council on Membership consider and promote activities for members approaching retirement and retired members to increase retention, and be it further

**Resolved**, that the Council report its findings to the 2010 House of Delegates.

In response, at its February meeting, the Council discussed a report outlining the current activities that the ADA has in place for this market and made the following recommendations:

- ADA investigate other membership associations and their strategies to recruit and retain retiring members
- A print and/or electronic newsletter and/or a column in *ADA News* be explored to target retired and/or retiring dentists
- ADA staff in collaboration with the Division on Communications investigate the most efficient and effective way to communicate with the retiring/retired market
- Collaborating with the Council on Communications in order to provide the greatest benefit to the retired dentist market
- Encouraging state and local dental societies to focus on retention efforts among retired and retiring dentists.

After discussion, at its June 2010 meeting, the Council will then report its findings to the 2010 House of Delegates in its supplemental report.

*ADA.org "Find a Dentist" Search Engine Optimization Proposal.* The 2009 House of Delegates adopted Resolution 20H-2009 (*Trans.2009:486*) put forth by the Council on Membership and the Council on Communications regarding the search engine optimization of "Find a Dentist" on the revamped ADA.org. The adopted resolution states:

**Resolved**, that the "Find a Dentist" feature on ADA.org be promoted to the public via search engine optimization to increase the result in various related searches.

Since the adoption of this resolution the IT division has updated the "Find a Dentist" feature and it is now prominently located on the home page of ADA.org. In addition, internal search engine optimization has been completed and the Find a Dentist portion of ADA.org now shows up among the top results when "Find a Dentist" is typed into major search engines, thus promoting the ADA again as America's Leading Advocate for Oral Health. A request for proposal has been developed to gain assistance in generating a high search engine position for the Find A Dentist portion of the Web site within more granular geographic searches ("Find A Dentist" in Chicago Illinois). The proposal will be distributed to prospective vendors prior to the Council's meeting in mid-June.

**Meetings:** The Council met at the ADA Headquarters Building on February 19-20, 2010, and will meet again on June 13-14, 2010. Dr. S. Jerry Long, trustee, Fifteenth District, serves as the Board of Trustees' liaison to the Council.

**Personnel:** At the close of the 2010 annual session, the terms of four highly regarded members of the Council will end: Dr. Terry L. Buckenheimer, 2006-2010, who served as chair of the Council for 2009-2010; Dr. Sean A. Benson, 2006-2010, who served as chair, Subcommittee on Strategic Membership issues 2008-2010; Dr. George B. Morledge, 2006-2010; and Dr. William J. Zucker, 2006-2010. The Council wishes to acknowledge these individuals for their thoughtful and determined leadership and for the many contributions they made during their years on the Council.

**Resolutions:** This report is informational and no resolutions are presented.

# Joint Commission on National Dental Examinations

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**Horn, Bruce D.**, Oklahoma, 2010, chair, American Association of Dental Boards  
**Radack, Stephen T., III**, Pennsylvania, 2011, vice chair, American Dental Association  
**Byrne, Ellen B.**, Virginia, 2012, American Dental Education Association  
**Conard, George D., Jr.**, West Virginia, 2011, American Association of Dental Boards  
**Cunningham, Kari**, Ohio, 2010, American Student Dental Association  
**Dixon, Barbara Leatherman**, Utah, 2010, American Dental Hygienists' Association  
**Donahue, Jeri Ann**, Wyoming, 2013, American Association of Dental Boards  
**Glass, Birgit J.**, Texas, 2013, American Dental Education Association  
**Seeley, Ron J.**, North Dakota, 2010, American Dental Association  
**Shampaine, Guy**, Maryland, 2013, American Association of Dental Boards  
**Sill, J. Stephen**, Nevada, 2012, American Association of Dental Boards  
**Spielman, Andrew**, New York, 2011, American Dental Education Association  
**St. Cyr, Zeno W., II**, Maryland, 2010, Public Member  
**Trager, Peter S.** Georgia, 2013, American Dental Association  
**Trinca, Samuel A.**, Louisiana, 2012, American Association of Dental Boards  
**Kramer, Gene A.**, secretary  
**Hinshaw, Kathleen J.**, senior manager  
**Krawczak, June**, manager  
**Tsai, Tsung-Hsun**, manager  
**Vanek, Carol A.**, manager

**Meetings:** The Joint Commission on National Dental Examinations (JCNDE) met at the ADA Headquarters Building, Chicago, on April 14, 2010. Most of the topics considered by the Joint Commission had been reviewed by one of four standing committees. The Committees on Administration, Dental Hygiene, and Examination Development met on April 13, 2010. The fourth standing committee of the Joint Commission, the Committee on Research and Development, met on September 18, 2009, and January 8, 2010.

**Summary of the 2010 National Dental Examiners' Advisory Forum:** The Joint Commission hosted the National Dental Examiners' Advisory Forum on Monday, April 12, 2010. The Forum included several informational presentations by members of the Joint Commission and staff. Forum topics included a brief history and purpose of the Joint Commission, the proposed integrated written National Board Dental Examination, examination security and ethical test preparation, and the decision to implement pass/fail reporting.

**Integrated Written National Board Dental Examination:** The purpose of the National Board Dental Examinations, Part I and Part II, is to assist state boards of dentistry in determining the qualifications of dentists who seek licensure to practice dentistry. Part I assesses candidates' knowledge and problem solving skills in the basic biomedical and dental sciences, while Part II assesses the candidates' knowledge and problem solving skills in the clinical dental sciences and patient management. The JCNDE is currently

conducting a five-year project to determine the desirability and feasibility of developing and administering a single comprehensive examination, which would ultimately supplant the present two-part examination program. During the initial stages of this project, a task force is determining the possible content of such an examination as well as potential item types.

**Communication with the Communities of Interest:** The JCNDE has initiated several activities to enhance its communication with the communities of interest. Among others, the JCNDE Newsletter has been redesigned so that it can be quickly scanned for basic information or read for details related to the information. During the redesign of the ADA Web site, a microsite for the JCNDE was developed using the JCNDE logo and color scheme. This microsite includes all the information relative to the National Board examinations. The Guides have been redesigned to make the information contained therein more accessible to candidates.

### **Trends in the Number of Examination Candidates and Pass Rates:**

*Part I of the National Board Dental Examinations.* As shown in Table 1, with the exception of the years 2005 to 2007 and 2009, the number of Part I examinations administered to candidates enrolled in accredited dental school programs remained stable at approximately 5,000 throughout the 10-year period beginning in 2000. However, the number of examinations administered increased to 5,471 and 5,889 in 2005 and 2006, respectively and then declined to 4,419 in 2007. Also as shown, the failure rates were consistent for the years 2000 through 2004 at approximately 11%. The rate increased to 15.4% in 2005, and then fluctuated slightly from 2006 through 2009. Table 2 provides information on failure rates for 2009 for candidates from both accredited and non-accredited dental education programs as well as rates for both first-time and repeat test-takers.

The number of examinations administered to those who graduated from non-accredited programs increased from approximately 4,000 in 2000 to a high of 5,676 in 2002. The numbers decreased to fewer than 3,000 from 2004 to 2008, with a slight increase in 2009 to 3,306. The failure rates were over 60% from 2000 to 2003. Since then the failure rates have declined. During 2009, the failure rate was 36.9%.

**Table 1**

### **Number of Part I Examinations Administered and the Associated Fail Rates**

Test Date	Accredited		Non-Accredited	
	Total	% Failed*	Total	% Failed*
2000	4,765	10.8%	4,067	65.2%
2001	4,663	10.4%	5,337	63.9%
2002	4,833	13.2%	5,676	64.6%
2003	5,201	12.8%	4,388	64.7%
2004	4,956	12.0%	2,776	54.0%
2005	5,471	15.4%	2,507	47.8%
2006	5,889	9.4%	2,862	42.2%
2007	4,419	4.9%	2,060	37.5%
2008	5,115	9.4%	2,879	40.9%
2009	5,485	7.2%	3,306	36.9%

\*Includes both first-time and repeat test-takers

**Table 2****Failure Rates for First-Time and Repeating Candidates Part I**

		<b>Total Number</b>	<b>Number Failed</b>	<b>Fail Rate</b>
<b>Computer Version January – December 2009</b>				
Accredited				
	First-time	4,878	260	5.3%
	Repeating	604	134	22.2%
Non-accredited				
	First-time	1,684	648	38.5%
	Repeating	1,622	571	35.2%

*Part II of the National Board Dental Examinations.* As shown in Table 3, the number of examinations administered to candidates from accredited programs remained stable at just under 5,000 from 2000 to 2007. During 2008 and 2009 the numbers increased to 5,159 and 5,309, respectively. In general, the failure rates have declined over the past 10 years. In 2009 however, the failure rate increased to 17.4%. Table 4 shows failure rates for 2009 for first-time and repeating candidates by educational program status.

**Table 3****Number of Part II Examinations Administered and the Associated Fail Rates**

<b>Test Date</b>	<b>Accredited</b>		<b>Non-Accredited</b>	
	<b>Total</b>	<b>% Failed*</b>	<b>Total</b>	<b>% Failed*</b>
2000	4,710	10.7%	1,637	40.9%
2001	4,692	9.6%	2,129	38.7%
2002	4,771	9.6%	2,505	41.4%
2003	4,610	10.2%	2,178	44.0%
2004	4,807	9.8%	1,272	45.4%
2005	4,568	6.9%	1,008	40.0%
2006	4,175	8.7%	866	38.5%
2007	4,869	8.1%	1,092	35.6%
2008	5,159	7.4%	1,078	33.7%
2009	5,309	17.4%	966	53.8%

\*Includes both first-time and repeat test-takers

**Table 4****Failure Rates for First-Time and Repeating Candidates Part II**

<b>Computer Version January – December 2009</b>		<b>Total Number</b>	<b>Number Failed</b>	<b>Fail Rate</b>
Accredited				
	First-time	4,726	648	13.7%
	Repeating	583	277	47.5%
Non-accredited				
	First-time	631	274	43.4%
	Repeating	335	246	73.4%

The number of examinations administered to graduates of non-accredited programs was highest in 2002 at 2,505, while only 866 examinations were administered to graduates of non-accredited programs in 2006. The failure rates have tended to decline through 2008. The failure rate of 33.7% during 2008 was the lowest observed over the 10-year period. The failure rate increased to 53.8% in 2009.

In light of the increased failure rate in 2009 for students graduating from an accredited program taking Part II for the first time, both the American Dental Education Association and the American Student Dental Association made several requests of the JCNDE. First, the JCNDE considered requests by ADEA to perform a review of the standard setting process, conduct an unscheduled Part II standard setting exercise and rescore Part II. Other requests included a review of changes to Part II, including cognitive level of items. Based on the evidence that the pass/fail point on Part II is valid and that no technical errors were found in scoring, the JCNDE took no action relative to these requests. Second, the JCNDE considered requests by ASDA to recalibrate Part II, explain the question review process, shorten the time between retakes, and reduce the retake fee. The JCNDE took no action relative to these requests but provided detailed written responses to questions that had been submitted by ASDA.

*National Board Dental Hygiene Examination.* Concerning the Dental Hygiene examination, Table 5 shows the total number of examinations administered to candidates in accredited programs during the 10-year period beginning in 2000. As shown, the number of examinations increased annually from 6,443 in 2000 to 7,407 in 2008. There was a slight decline to 6,980 in 2009. The failure rate was stable during 2003 through 2006. However, the failure rates fell to 6.1% in 2009. Table 6 shows failure rates for 2009 for first-time and repeating candidates by educational program status.

**Table 5**

**Number of Dental Hygiene Examinations Administered and the Associated Fail Rates**

Test Date	Accredited	
	Total	% Failed*
2000	6,443	13.8%
2001	6,452	10.7%
2002	6,657	12.7%
2003	6,656	11.4%
2004	6,860	11.6%
2005	6,941	11.6%
2006	7,228	11.9%
2007	7,265	7.6%
2008	7,407	9.5%
2009	6,980	6.1%

\*Includes both first-time and repeat test-takers

**Table 6**

**Failure Rates for First-Time and Repeating Candidates  
National Board Dental Hygiene Examination**

		Total Number	Number Failed	Fail Rate
<b>Print 2009</b>				
Accredited				
	First-time	4,690	142	3.0%
	Repeating	79	47	59.5%
Non-accredited				
	First-time	40	21	52.5%
	Repeating	53	39	73.6%
<b>Computer 2009</b>				
Accredited				
	First-time	2,018	141	7.0%
	Repeating	272	146	53.7%
Non-accredited				
	First-time	130	33	25.4%
	Repeating	62	44	71.0%
<b>Total 2009</b>				
Accredited				
	First-time	6,708	283	4.2%
	Repeating	351	193	55.0%
Non-accredited				
	First-time	170	54	31.8%
	Repeating	115	83	72.2%

**Selection of Test Constructors for National Board Examinations:** Each year, the Joint Commission communicates with constituent dental societies, dental schools, dental hygiene programs and state boards of dentistry requesting applications for new test constructors to fill vacancies on a rotating basis. During its recent meeting, the Joint Commission reappointed 67 dental test constructors and 22 dental hygiene test constructors to another one-year term and selected 18 new dental and five new dental hygiene test constructors.

**Research and Development Activities:** The Joint Commission's Committee on Research and Development met on September 18, 2009, and on January 8, 2010, to review examination results, statistics and trends, ongoing research and development projects, as well as review small grant proposals.

*Reliability of Classification Decisions at the Pass/Fail Point on the National Board Dental and Dental Hygiene Examinations.* Studies for evaluating the reliability and validity of the pass/fail point on the National Board Dental and Dental Hygiene Examinations were conducted. Two statistics were used in these studies: classification accuracy—the probability of correct classification, false positive rate, and false negative rate and classification consistency—the probabilities of consistent classification and misclassification. The editions studied were one edition of Part I used to set the standard in 2007, one edition of Part II used for standard setting in 2008, and the 2009

print spring edition of the National Board Dental Hygiene Examination. Data used were based on the item responses from 1,325 candidates who were enrolled in accredited dental schools and who took Part I for the first time in 2008, the item responses from 1,252 candidates who were enrolled in accredited dental schools and who took Part II for the first time in 2008, and the item responses from 4,560 candidates who took the print spring edition of the Dental Hygiene examination for the first time in 2009. Results from outcome assessment of the standard-setting studies and analyses of decision accuracy and consistency of the pass/fail point affirmed that the pass/fail points on the National Board Dental and Dental Hygiene Examinations are highly reliable and valid.

*Practice Analysis and Alignment of Content Specifications for the National Board Dental Hygiene Examination.* A validity study, including a practice analysis survey, was conducted. Of the practice analysis surveys distributed, the responses of 1,388 full-time practitioners were used. The survey required that respondents rate 56 competencies for importance to patient care on a scale of 1 to 5, with a 1 indicating little relevance to patient care and a 5 indicating critical to patient care. The 56 competencies were based on the *Competencies for Entry into the Profession of Dental Hygiene* promulgated by the American Dental Education Association and the *Accreditation Standards* published by the Commission on Dental Accreditation of the American Dental Association. The ratings of the competencies were used to determine the recommended content of the examination and the number of items devoted to the various content elements included in the content specifications. The results confirmed that the existing content specifications are appropriate, with some minor changes.

*The Innovative Dental Assessment Research and Development Grants Program.* For the 2009-2010 funding cycle, three proposals were received and evaluated by peer reviewers. The proposals were evaluated for relevance to the goals of the program, for completeness and feasibility, and finally for the potential of the outcomes of the research to contribute substantially to the literature related to educational measurement. The Joint Commission accepted for funding the research proposed by David Shin, Ph.D., senior research scientist, Pearson, entitled *Implications of Converting the NBDE and the NBDHE to a Computer Adaptive Testing Format*.

**Acknowledgments:** The Joint Commission acknowledges with appreciation the contributions made by Ms. Kari Cunningham, Ms. Barbara Leatherman Dixon, Dr. Bruce D. Horn, Dr. Ron J. Seeley and Mr. Zeno W. St. Cyr who complete their terms on the Joint Commission this year.

**Resolutions:** This report is informational in nature and no resolutions are presented.

## Council on Scientific Affairs

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**Rethman, Michael P.**, Hawaii, 2010, chair  
**Hellstein, John W.**, Iowa, 2012, vice chair  
**Armstrong, Steven R.**, Iowa, 2011  
**Buhite, Robert J., Sr.**, New York, 2011  
**Burgess, John O.**, Alabama, 2011  
**Chalian, G. Garo**, Colorado, 2013  
**Crews, Karen M.**, Mississippi, 2010  
**Harrel, Stephen K.**, Texas, 2013  
**Lingen, Mark W.**, Illinois, 2010  
**Miller, Keri L.**, Alabama, *ex officio*\*  
**Sauk, John J.**, Kentucky, 2012  
**Slavkin, Harold C.**, California, 2012  
**Somerman, Martha J.**, Washington, 2013  
**Streckfus, Charles F.**, Texas, 2012  
**Taylor, George W., III**, Michigan, 2011  
**Whitaker, S. Bryan**, Arkansas, 2013  
**Wong, David T.W.**, California, 2010  
**Wright, J. Timothy**, North Carolina, 2012  
**Zentz, Ronald R.**, senior director

**Meetings:** The Council on Scientific Affairs (CSA) met on November 9-11, 2009, and April 26-28, 2010, at ADA Headquarters in Chicago. A third meeting is scheduled for July. This may be the last year that the Council is able to meet three times a year, if budget cuts made during the Administrative Review process are incorporated by the Board of Trustees in the 2011 budget submitted to the House of Delegates.

Dr. Dennis W. Engel, trustee, Ninth District, served as the Board of Trustees' liaison to the Council. Dr. W. Carter Brown served as liaison from the ADA Council on Communications, and Dr. Keri Miller participated as *ex officio* representative from the Committee on the New Dentist. Mr. Andrew Bohnsack, third-year student at the University of Minnesota School of Dentistry, served as representative of the American Student Dental Association.

**The Strategic Plan of the American Dental Association:** The Council serves the public, the dental profession, and other health professions as a primary source of timely, relevant and emerging information on the science of dentistry and promotion of oral health. To fulfill this mission, the Council closely aligns its activities with the defined objectives of the *ADA Strategic Plan: 2007-2010* and looks forward to beginning the planning process for 2011 and beyond based on the *ADA Strategic Plan: 2011-2014*. From developing evidence-based clinical recommendations and the *ADA Professional Product Review* to administering the ADA Seal of Acceptance Program, the Council's

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\* Committee on the New Dentist member without the power to vote.

programs aim to fulfill key strategic priorities and promote the highest standards of science relevant to dentistry. The Council also considers the ADA Strategic Plan when developing plans for CSA programs and initiatives, particularly those that are proposed to the House of Delegates for budgetary support.

As the ADA's primary scientific agency, the Council engages key collaborators across the health care community to prepare the *ADA Professional Product Review*, evidence-based clinical recommendations, peer-reviewed journal reports, ADA policies, and Council statements. Along with administering the ADA Seal of Acceptance Program, the Council provides leadership in dental standards and guidelines, develops print and online resources, and evaluates emerging issues for their implications on the profession.

The Council serves as a scientific adviser to the ADA Foundation (ADAF), primarily providing guidance to the Paffenbarger Research Center (PRC) and the Health Screening Program (HSP). In this capacity, the Council is closely monitoring implementation of an investment plan for PRC's future based on the report which the Board of Trustees submitted last year to the House of Delegates with the Council's input. Two members of the Council serve on an ADA Foundation workgroup that is preparing recommendations to the ADAF Board of Directors.

Each year, the Council establishes short-term objectives based on House resolutions and goals targeted in the ADA Strategic Plan. The Council's objectives for 2010 include the following:

- Address resolutions from the 2009 House of Delegates.
- Complete a self-assessment report and thoroughly review two major CSA *Bylaws* responsibilities, implement changes, re-align resources or activities, and/or propose *Bylaws* duty changes to address issues.
- Pursue collaboration with external organizations to extend the reach and impact of ADA resources in providing information important to oral health. Some examples in 2010 are: dissemination of xerostomia information within existing budgeted resources; collaboration with the American Academy of Orthopaedic Surgeons on evidence-based recommendations; and working with the American Heart Association on an oral-systemic health manuscript.

The Council is also closely monitoring the implementation of recommendations it developed in 2009 to support the future of the Paffenbarger Research Center (PRC). At its spring 2010 meeting, the Council expressed concerns with the pace of implementing certain recommendations designed to enhance PRC operations in support of its research programs.

Building on its research relationships with PRC and others, the Council advances dental standards by developing product evaluation guidelines for the ADA Seal of Acceptance Program, ANSI/ADA standards in collaboration with the ADA Standards Committee on Dental Products, and by participation in outside standards

organizations, such as the International Standards Organization, whose standards can impact dentistry.

The Council is dedicated to the development of evidence-based recommendations and EBD resources through strong alliances across internal and external agencies, allowing the ADA to share viewpoints and reach consensus on issues of shared interest. The Council works closely with the ADA Center for Evidence-Based Dentistry in reviewing the best available evidence on key clinical issues, such as oral cancer screening, with the goal of helping dentists integrate evidence-based resources in clinical settings.

To facilitate CSA's ongoing evaluation of emerging issues, research organizations and government agencies, such as NIDCR and the CDC, provide timely informational updates at the Council's triannual meetings, which offer a forum for mutual assessment of clinically relevant issues across the health care community. The Council is also expanding collaborations with dental specialty organizations, military dental researchers, and practice-based research networks to learn more about their respective research projects, and to collect data on clinical evaluations of professional products in clinical settings.

Pursuant to the ADA Strategic Plan, the Council supports the Association's EBD programs to increase dentists' understanding and utilization of evidence-based resources to improve patient care. In collaboration with the ADA Center for Evidence-Based Dentistry, current and former CSA members serve the profession as ADA Evidence Reviewers, who critically appraise systematic reviews and prepare critical summaries for publication on the ADA's EBD Web site and periodically in *JADA*.

In spring 2010, the Council completed an internal self-assessment to review the efficiency and productivity of CSA's current programs, and to ensure that CSA's duties are appropriately represented in the ADA *Bylaws*. In reviewing CSA's *Bylaws* duties and role within the ADA, the Council determined that several *Bylaws* amendments should be proposed to the 2010 House of Delegates to update its duties in a manner that directly supports the current ADA Strategic Plan.

In brief, the Council prepared the following draft *Bylaws* amendments in suitable wording to address CSA's current areas of support and responsibility, including:

- Support for the ADA Center for Evidence-Based Dentistry, and the promotion of evidence-based practice.
- Updating *Bylaws* duty "a" to "develop and promote a biennial research agenda, and propose an appropriate budget for studies that are recommended by the Council to be conducted by the ADA."
- Updating *Bylaws* duty "g" to clarify that CSA's expertise is primarily in coordinating "development of national and international standardization programs for dental products," per its activities with the Seal of Acceptance Program, the ADA Standards Committee on Dental Products, and the International

Organization for Standardization/Technical Committee 106 (note: the Council on Dental Practice coordinates standardization activities related to dental informatics).

The Council's proposed *Bylaws* amendments are presented below and are consistent with the continued provision of high levels of service to the profession and the public. The Council recommends adoption of the following resolution:

**23. Resolved**, that Chapter X. COUNCILS, Section 120. DUTIES, Subsection K. COUNCIL ON SCIENTIFIC AFFAIRS, of the ADA *Bylaws*, be amended as follows (additions are underscored; deletions are struck through):

K. COUNCIL ON SCIENTIFIC AFFAIRS: The duties of the Council shall be to:

- a. Develop and promote an ~~annual~~ biennial research agenda ~~with and propose an appropriate means for funding budget for studies that are recommended by the Council to be conducted by the ADA.~~
- b. Identify emergent issues and areas of research that require response from the research community.
- c. Report results on the latest scientific developments to practicing dentists.
- d. Evaluate and issue statements to the profession regarding the efficacy of concepts, procedures and techniques for use in the treatment of patients.
- e. Guide, assist and act as scientific liaison to the American Dental Association Foundation and serve as its peer-review body.
- f. Represent the Association on scientific and research matters, promote evidence-based practice, and maintain liaison with related regulatory, research and professional organizations.
- g. Encourage the development and improvement of materials, instruments and equipment for use in dental practice, and to coordinate development of national and international standardization programs for dental products.
- h. Determine the safety and effectiveness of, and disseminate information on, materials, instruments and equipment that are offered to the public or the profession and further critically evaluate statements of efficacy and advertising claims.
- i. Study, evaluate and disseminate information with regard to the proper use of dental therapeutic agents, their adjuncts and dental cosmetic agents that are offered to the public or the profession.
- j. Award the American Dental Association Seal of Acceptance to dental products that meet the Association's requirements for acceptance.
- k. Promote efforts to develop the dental research workforce and to involve students in dental research.
- l. Study, evaluate and disseminate information on those aspects of the dental practice environment related to the health of the public, dentists and dental auxiliaries.
- m. Serve as the primary resource for scientific inquiries from the public and the profession.

- n. Guide, assist and collaborate with the ADA Center for Evidence-Based Dentistry.

**Response to Assignments from the 2009 House of Delegates:** In 2010, the Council addressed the following resolutions from the 2009 House of Delegates.

*Oral Health Effects of Dry Mouth from Medications.* Resolution 45-2009 (*Trans.* 2009:415; 421) was referred to the Council for study and report to the 2010 House of Delegates. The resolution asked the ADA to encourage the FDA to modify the prescribing information (e.g., package inserts) for drugs that induce xerostomia to include warnings about oral health effects.

The Council considered ways to address the concerns raised by the resolution within the FDA's regulatory framework and with existing ADA resources. The Council agreed to undertake the following actions to enhance communication about this issue to the public and report back to the House:

- Collaborate with the FDA Office of Public Information to develop content for the FDA public Web site (note: the FDA collaborates with WebMD and other portals to distribute its online content).
- Promote articles in the *ADA News*, updates to information on ADA.org, patient brochures, and other dry mouth resources.
- Explore with the American Pharmacists Association (APhA) opportunities for communicating with the public and pharmacists, who are a trusted source of information on prescription and over-the-counter medications that may cause dry mouth, as well as products to treat the condition.
- Collaborate with the *Pharmacist's Letter* to publish a brief professional update in their monthly newsletter, plus a companion "detail document" to aid pharmacists and patients in the management of dry mouth.

The Council does not recommend that ADA pursue encouraging the FDA to modify the prescribing information (e.g., package inserts) for drugs that induce xerostomia to include warnings about oral health effects because FDA rules governing development of warning labels makes that impractical. Drug warnings are authored by manufacturers in negotiation with the FDA, generally for a specific drug. By definition, warnings are only required for clinically significant adverse reactions. Communications with the FDA indicate that this would not cover secondary oral effects related to medication-induced dry mouth.

*Prevention of Medication (Bisphosphonate)-associated Osteonecrosis of the Jaw.* The Council asked its existing Advisory Committee on Antiresorptive Therapy and Osteonecrosis of the Jaw to consider House Resolution 63H-2009 (*Trans.*2009:434) and propose appropriate actions for Council consideration. The resolution advised in part that "for physicians prescribing bisphosphonates, it is recommended that the physician refer the patient to their dentist for evaluation prior to beginning or during the very early stages of bisphosphonate treatment."

Following a meeting conducted by conference call, the Advisory Committee recommended that the Council communicate the benefits of oral examinations for all individuals, especially those at risk for oral health complications from medications or medical conditions. The Advisory Committee requested that CSA provide this guidance to medical and pharmaceutical organizations, such as the National Osteoporosis Foundation (NOF), the *Pharmacist's Letter*, and the American Medical Association, with specific reference to bisphosphonate drugs and other antiresorptive therapies. Two members of the Advisory Committee are members of NOF, and will serve as liaisons to that organization. The Council adopted all of these recommendations and has begun implementing them.

Currently, the Advisory Committee is updating the 2008 CSA recommendations on dental management of patients on oral bisphosphonate therapy. Preventive therapy will be considered by the Advisory Committee, and addressed in an updated report to the profession.

*Tooth Whitening Safety.* Resolution 80H-2009 (*Trans.*2009:438) is in two parts. The first part directed CSA to develop guidance based on the scientific evidence on the safety of agents used in tooth whitening products and to publish the guidance and distribute it to the constituent societies. The second part directed the Council, in conjunction with the Council on Government Affairs, to “advocate to federal agencies that fund, promote or perform research that they pursue research on the safe levels of agents used for tooth whitening.”

Last year, the Council developed and published a report on tooth whitening in response to a 2008 House resolution. The Council decided that the best way to respond to Resolution 80H-2009 would be to update that report as needed to reflect any new scientific evidence and to provide the constituents with user-friendly guidance based on the report and any new whitening safety information to use in their advocacy efforts. The Council expects to have the guidance document ready to review at its July 2010 meeting, which will permit distribution to the constituents this summer.

To fulfill the House’s directive for research into the safe levels of agents used for tooth whitening, the Council put out a call for safety information directly to manufacturers and researchers in the tooth whitening field, as well as updating its own literature review. Responses to the call for information will also help to identify high-priority needs for further research. Based on this information and deliberations at its July 2010 meeting, the Council will work with the Council on Government Affairs to map out an advocacy approach to the federal agencies that fund, promote or perform research so it can be implemented without delay.

## **Evidence-Based Dentistry**

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**ADA Center for Evidence-Based Dentistry:** The ADA Center for Evidence-Based Dentistry (EBD) functions under the guidance of the Council on Scientific Affairs. Primary activities of the EBD Center in 2010 are highlighted in the sections below.

*Evidence-Based Dentistry Web site.* Funded by a grant from the National Library of Medicine and NIDCR (grant number G08 LM008956) to the ADA Foundation, the EBD Web site ([ebd.ada.org](http://ebd.ada.org)) was launched on March 10, 2009. The Web site features the following resources:

- *A database of over 1,300 systematic reviews.* Updated monthly to provide the latest evidence-based reviews.
- *Critical summaries of systematic reviews.* One-page synopses of systematic reviews, with clinical implications written by practicing dentists trained in critical assessment.
- *Clinical recommendations.* These provide useful tools that can be applied in making evidence-based clinical treatment decisions.
- *Links to many other useful resources.* A central resource for EBD information, including links to EBD tutorials, glossaries, and databases.

Nearly 32,000 visits were made to the EBD Web site in its first year of availability, well above the Center's initial goal of 25,000 visits. The Web site has an extensive portal for collaborator contribution that enables staff to efficiently manage and track multiple concurrent projects. Two key groups of volunteers contribute to the EBD Web site:

- *Critical Review Panel* - a panel of EBD experts, consultants and clinicians that provides oversight for the EBD Web site and the critical summaries. The current list of Critical Review Panel members can be accessed at: <http://ebd.ada.org/Contact.aspx>.
- *ADA Evidence Reviewers* - clinicians who receive training to critique systematic reviews and write critical summaries of systematic reviews that are published on the EBD Web site. As part of its commitment to the EBD Web site, the ADA funds up to two ADA Evidence Reviewer workshops annually, which provides training to at least ten ADA Evidence Reviewers per workshop. One workshop was conducted in August 2009 at ADA Headquarters in Chicago, and another is scheduled for August 2010, also at ADA Headquarters. The ADA Center for EBD also received an Administrative Supplement grant to conduct three additional workshops at dental schools, which were conducted at Louisiana State University (November 2009), Temple University (January 2010), and New York University (March 2010).

Several enhancements to the EBD Web site were completed this year, including adding a real simple syndication (RSS) feed with funding support from an Administrative Supplement grant, and updates to the Web site portal to enable volunteers to perform their work more efficiently.

In its next phase, the EBD Web site will develop content for the general public. Aspects of this project will include Web site construction, working with focus groups, and conducting surveys of both dentists and members of the general public. It is

anticipated that this section of the Web site, including plain-language summaries of systematic reviews, will be launched in fall of 2010.

*Evidence-Based Clinical Recommendations Program.* To realize its vision of disseminating the best available evidence and helping practitioners implement EBD, the ADA Center for Evidence-Based Dentistry instituted the Clinical Recommendations Program in 2006. Clinical recommendations are the result of more than a year's effort by various experts who volunteer their time to objectively synthesize the available evidence to answer key questions on the practice of dentistry. The following clinical recommendation projects were conducted in 2009-2010:

- Oral Cancer Clinical Recommendations - An expert panel met on April 13-15, 2009, to develop clinical recommendations on oral cancer screening. The panel addressed questions relating to: oral cancer screening through visual and tactile examinations performed by a dentist; use of adjuncts in conjunction with visual and tactile examination; and oral cancer screening of specific population subgroups. These recommendations were finalized, approved by the Council, and accepted for publication in the May 2010 issue of *JADA*.
- Fluoride and Infant Formula Clinical Recommendations - When the ADA established its Interim Guidance on Fluoride Intake for Infants and Young Children in November 2006, plans were made to follow an evidence-based process to provide definitive recommendations. An expert panel was convened in November 2008 to develop clinical recommendations on reconstitution of liquid and powder concentrate infant formula with water containing optimal levels of fluoride. The expert panel is currently drafting the recommendations and corresponding report.
- Clinical Recommendations on Fluoride Supplements - An expert panel was convened in July 2008 to develop evidence-based clinical recommendations on the use of fluoride supplements. The panel is in the process of completing the draft clinical recommendations and corresponding report.

*Evidence-Based Dentistry Champion Conferences.* Supported by a three-year educational grant to the ADA from Procter & Gamble (2008-2010), and in collaboration with *The Journal of Evidence-Based Dental Practice*, the ADA convened the 2010 EBD Champion Conference on March 26-27. The 2010 conference included an optional pre-conference workshop, which provided a hands-on tutorial on using online resources to identify the best available evidence. Approximately 100 EBD Champions have participated in each of the EBD Champion Conferences, which aimed to establish a network of dentists to promote the application of an evidence-based approach to patient care.

The EBD Center is conducting an extensive evaluation of the EBD Champion Conferences, including a pre-conference survey (4-6 weeks before the conference), a survey conducted at the end of the conference, and a follow-up survey planned for eight months after the 2010 conference. Preliminary feedback from EBD Champion Conference participants has been overwhelmingly positive, with dentists celebrating the

program as “a great forum for knowledge and new ideas,” and “extremely educational, entertaining and necessary.”

The Council supports a decision package that was submitted with the EBD Center’s 2011 budget to continue this successful program in 2011 and beyond. In addition, federal grants will be sought to provide supplemental funds.

*ADA/Forsyth Course on Evidence-Based Dentistry.* The EBD Center collaborated with The Forsyth Institute to pilot a five-day intensive EBD course, which was held in October 2009 at The Forsyth Institute in Boston. The course drew 27 participants, who were educated on critical appraisal of systematic reviews and clinical studies, online citation management and more. Course participants were from academia, third-party payer groups, and public and private health care providers, plus public health administrators, news reporters, and editors. After completing the course, dentist attendees indicated that the program “helped immeasurably,” and that it “provided excellent tools to aid in the appraisal of systematic reviews.” This new initiative was aligned with the Center’s vision to help dentists implement EBD and promote collaborations with external agencies.

The Board has approved collaborating with The Forsyth Institute to offer this weeklong EBD course again in 2010. The course is scheduled for September 27-October 1, and will accommodate up to 35 participants. It is anticipated that all direct costs and most indirect costs will be covered by attendee tuition (course tuition in 2009 was \$2,500, with ADA members receiving a 20% discount; 100% of direct costs and 66% of indirect costs were covered by attendee tuition). Sources of supplemental funding for this ADA/Forsyth EBD course are being sought through government grants for 2011 and beyond.

### **Response to Assignments from the 2008 House of Delegates:**

*ADA Member Access to Cochrane Library.* The 2008 House of Delegates adopted Resolution 46H-2008 (*Trans.*2008:455), which directed the ADA Board of Trustees “to explore negotiations with the Cochrane Collaboration to obtain full access to The Cochrane Library services by all ADA members.” The Cochrane Library offers evidence from a number of sources, including systematic reviews of the scientific literature and clinical trials, and it is intended to foster evidence-based decision-making.

While this House resolution was originally assigned to the ADA Division of Science, the ADA Department of Library Services has assumed oversight of this project. In spring 2009, funding was approved to provide ADA members with an online subscription for one year. This subscription began in March 2010, and provides all ADA members with full access to The Cochrane Library. Member dentists are encouraged to access The Cochrane Library’s resources through the ADA Library’s Web site at <http://www.ada.org/goto/library>.

## Scientific Information and Research

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**Antibiotic Prophylaxis for Dental Patients with Total Joint Replacements:** The Council is collaborating with the American Academy of Orthopaedic Surgeons (AAOS) on the development of evidence-based guidelines on antibiotic prophylaxis for the prevention of bacteremia in patients with total joint replacement. In April 2010, the Council nominated individuals to serve on a collaborative workgroup, which plans to begin work by summer 2010. As of April 2010, the workgroup has not been formally assembled, but it will be co-chaired by the AAOS and ADA with representatives from CSA, Council of Dental Education and Licensure (CDEL), Council on Dental Practice (CDP), and Council on Dental Benefit Programs (CDBP). The workgroup will also include representatives from the following organizations:

American Association of Hip and Knee Surgeons  
College of American Pathologists  
Infectious Diseases Society of America  
Musculoskeletal Tumor Society  
Scoliosis Research Society

The first workgroup meeting will take place in 2010, and additional meetings will be held in 2011. The final document is expected to be completed in 2011.

In addition, the AAOS committee that issued the 2009 information statement on antibiotic prophylaxis met in March 2010, and decided to put a disclaimer on the current AAOS information statement. Although the AAOS has not approved the exact wording of the disclaimer, it is expected to inform readers that the AAOS and ADA are collaborating on a guideline on this topic and that the statements made about dental prophylaxis will likely be modified.

**ADA/PDR Guide to Dental Therapeutics:** In spring 2010, the Council assessed its advisory role with the Guide to Dental Therapeutics, which is now developed by the ADA and Physicians' Desk Reference (PDR). The Council established a panel of CSA members and consultants to provide editorial support and guidance as required in the development of the sixth edition (2012) of the *ADA/PDR Guide to Dental Therapeutics*. The panel will assist in the development of a chapter that will feature CSA/ADA statements, evidence-based clinical recommendations and other resources related to dental therapeutics.

**CSA Programs at 2010 Annual Session:** In partnership with the Council on Annual Sessions and *The Journal of the American Dental Association*, the Council will present three Open Clinical and Science Forums at the 2010 ADA annual session on the topics of fluoride, oral cancer, and cone beam computed tomography. The Centers for Disease Control and Prevention (CDC) is collaborating with the ADA on the fluoride program, which will provide a discussion forum for reviewing the available evidence on topical fluoride, community water fluoridation, and fluoride supplements.

The Open Clinical and Science Forums will be moderated by Dr. Michael Glick, *JADA* editor, and Dr. Daniel Meyer, senior vice president, Science/Professional Affairs. These programs are intended to bring together clinicians, scientists, and expert opinion leaders at annual session to consider controversial and emerging issues on key clinical topics.

## Review of Association Policies

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Consistent with its responsibility to periodically review existing ADA policy and recommend that it be updated or rescinded as appropriate, the Council conducted sunset review of selected science policies and recommends rescission of two policies, which are now out of date.

**ADA Policy on Promotion of Dental Materials to the Public:** This policy (*Trans.*1997:716) encourages manufacturers to voluntarily submit direct-to-consumer advertising for professional dental products to CSA for review. Just last year, the Council recommended—and the House adopted—an amendment to this policy that removed a reference to the now-closed Seal of Acceptance Program for professional dental products. The Council now recommends rescinding the policy in its entirety.

There are several reasons for this recommendation. First, the policy is ineffective. No manufacturer has ever submitted direct-to-consumer advertising to the Council for review. Second, the policy is unnecessary. The U.S. Food and Drug Administration keeps close tabs on direct-to-consumer advertising of professional products, assisted by reports of alleged violations by one manufacturer against another. The Council remains actively involved in reviewing advertising of products in the ADA Seal of Acceptance Program, and science staff routinely review advertising submitted to ADA programs according to the ADA Advertising Standards.

The following resolution is presented for the House's consideration:

**24. Resolved**, that the ADA policy statement entitled Promotion of Dental Materials to the Public (*Trans.*1997:716) be rescinded.

**Endorsement of Science Fairs:** The ADA has two policies dealing with science fairs. They are:

**15-1959-H. Resolved**, that constituent and component dental societies be urged to intensify support of, and active participation in, science fairs at the state and community levels.

**19-1957-H. Resolved**, that the Science Fair movement be endorsed and the constituent and component dental societies urged to support projects and otherwise participate actively in science fairs at the community and state levels.

The Council believes that these policies are largely duplicative and, therefore, recommends rescission of the older one. The following resolution is presented for the House's consideration:

**25. Resolved**, that the ADA policy statement entitled Endorsement of Science Fairs (*Trans.*1957:366) be rescinded.

**Science Brief on Acetaminophen and Liver Injury:** In 2010, the Council prepared a new Science Brief on acetaminophen-containing medications in anticipation of guidance from the U.S. Food and Drug Administration (FDA) for reducing the incidence of acetaminophen-induced liver toxicity. Acetaminophen is a popular pain reliever and fever reducer that is widely available over-the-counter and in prescription medications. Dentists routinely prescribe combination acetaminophen products, such as Vicodin or Lortab, for the treatment of mild-to-moderate pain. However, patients are often unaware that their medications contain acetaminophen, or that using multiple acetaminophen medications concurrently can contribute to potential adverse events, such as acute liver injury.

The CSA Science Brief on acetaminophen and liver injury is available online at ADA.org, and promotes patient education, short-term prescribing of acetaminophen medications following routine invasive procedures, and other safety controls. Member dentists are invited to submit feedback on this resource or any Council statements or issues to the ADA by email at [science@ada.org](mailto:science@ada.org).

**ADA Research Agenda:** The Council is charged with responsibility for developing an annual dental research agenda to inform organizations, individual researchers, and appropriate funding agencies of the profession's key research priorities, as viewed by ADA members. The 2009-2010 ADA Research Agenda is available online at [www.ada.org/goto/research](http://www.ada.org/goto/research), and features a targeted list of four primary goals and corresponding objectives of importance for dentistry.

Over the past four years, the Research Agenda has focused on key short-term dental research priorities, providing a more concise resource for ADA research advocacy and communications. As indicated in the proposed revisions to CSA's *Bylaws* duties (Resolution 23), the Council has recommended developing a Research Agenda for the profession on a biennial cycle. The Council concluded that setting the ADA Research Agenda for a two-year period would strengthen the Agenda's focus on the highest priority dental research needs and bolster ADA lobbying efforts to provide stronger advocacy for dental research funding on Capitol Hill.

When considering dental research priorities for the next draft ADA Research Agenda (for 2010-2011), the Council will carefully consider the need to include further study on the "safe levels of agents used for tooth whitening as a priority matter," as recommended in House Resolution 80H-2009. The 2009-2010 Research Agenda calls for continued evaluations on the safety and effectiveness of both new and existing products, including "cosmetic" products (Objective 2-1). Therefore, the current

Research Agenda supports advocacy efforts for research on whitening through its call for “longitudinal assessment of safety and patient outcomes, including pre- and post-market studies.”

Pending approval by the Council and the Board of Trustees, the updated ADA Research Agenda will be distributed in fall 2010 to the National Institute for Dental and Craniofacial Research (NIDCR), American Association for Dental Research (AADR), American Dental Education Association (ADEA), dental schools, dental practice-based research networks, and other research organizations.

**Caries Classification System Testing:** For some time, dentists, researchers, epidemiologists and others, in the U.S. and abroad, have discussed the shortcomings of the century-old, G.V. Black classification system. The Black system is essentially a static restorative classification system that does not adequately describe the dynamic caries disease process. There is growing demand for a system that will accommodate differences in disease state and activity, and various groups have proposed new systems.

In August 2008, the Council hosted a two-day international conference to develop consensus on a new caries classification system (CCS). Conference attendees agreed that the profession needs a system that communicates dental caries as a disease continuum, facilitates patient-centered management of caries, encourages treatment of early lesions while they are still reversible, recognizes the need for different treatments on the same tooth (depending on location/size of lesion), allows documentation of lesion progression over time, and allows improved evidence-based data collection and comparisons.

A CSA decision package was approved for the 2010 budget, enabling the ADA to host a second stakeholder conference to continue collection and evaluation of data, and consider recommendations on adoption of a new caries classification system. Plans are now underway to field-test the model system in typical dental practices and other clinical settings as well as in academia. The Council continued its collaboration with the PEARL practice-based research network in the development and implementation of a study to investigate dentists' utilization of the new CCS.

The Council plans to work with ADEA, other professional and specialty organizations, and the ADA Survey Center to survey dental schools and other stakeholders (e.g., pediatric dentists, third-party payers, state public health systems) to assess how caries instruction and classification are taught, and their views of potential changes to their curricula. As of spring 2010, the Council is overseeing development of an online CE course and training program addressing early caries detection, diagnosis, and treatment with currently available instruments and materials. The intent is to promote CCS utilization by local study clubs, larger stakeholder groups, and dental schools to gather data on the system's utility and effectiveness.

Working closely with CSA consultants, the Council is planning to develop specific protocols for the entire range of clinical evaluation studies required to validate the Caries Classification System. CSA will review a general research plan at its July 2010 meeting, as well as plans for a possible meeting of CCS stakeholders at ADA Headquarters in fall/winter 2010.

**New Science Content at ADA.org:** In 2009-2010, the Council updated the scientific content on the following A-Z professional topic pages for the newly redesigned ADA.org:

- best management practices for amalgam waste
- amalgam separators
- antibiotic prophylaxis
- bisphenol A
- infection control
- radiography
- methicillin-resistant *Staphylococcus aureus* (MRSA) [patient information]

As noted earlier in this report, the Council also developed a Science Brief for ADA.org on Acetaminophen and Liver Injury, in anticipation of FDA guidance on acetaminophen-containing medications (over-the-counter and/or prescription). The ADA Division of Science also continued to provide online news coverage of emerging dental research for “Science in the News” at ADA.org, an A-Z topic page that provides perspectives on dental science news stories in the mainstream media. To date this year, “Science in the News” has addressed a stillbirth case associated with the possible transmission of oral bacteria, collaborative strategies to improve early childhood oral health, and the relationship between obesity, oral health, and chronic disease incidence. Member dentists are encouraged to e-mail feedback on CSA’s online information to [science@ada.org](mailto:science@ada.org).

**Information Technology Update:** This section addresses Resolution B-115-2004 (*Trans.*2004:272), which asks ADA councils to summarize programs, projects, or policies related to the impact of information technology (IT) on dental practice.

Digital media and mobile communications technology have become ingrained in society and are taking on a prominent role in dentistry, especially for younger dentists. The digital age has fundamentally changed the way practitioners and patients obtain information. Access to digital resources for professional use and for patients/consumers has never been so easy, so broad, and at the same time so overwhelming as it is today. Maintaining relevance in this constantly evolving environment presents a tremendous challenge for the CSA and ADA.

In this context, emerging studies are taking a closer look at dentists’ information needs, a primary area of interest for CSA as it strives to reach more dentists with the scientific information they need at the point of care. In one recent study of a small sample of dentists, two primary unmet information needs were identified: better visual representation of dental problems; and patient-specific, evidence-based information

(Song M, Spallek H, Polk D, Schleyer T, Wali T. BMC Med Inform Decis Mak 2010 Feb 2;10:7). Through online resources such as the new EBD Web site and its online database of searchable systematic reviews, the ADA is working to meet and fulfill the previously unmet information needs of practicing dentists. The Council will continue to develop high-quality information supported by sound science, and evidence-based clinical recommendations that dentists can use at chairside.

The transition to a new ADA.org in 2010 will help CSA and other agencies meet member and consumer needs for accurate and reliable Web content to support clinical decision-making and the Association's goal to be the most trusted source of dental health care information. The Council and Division of Science staff contribute extensively to online content for the professional and consumer components of ADA.org. In today's environment, the ADA must continue to evaluate and update its communication methods, while maintaining the basis for its communications in sound science. Member dentists are encouraged to visit the following links for online scientific resources supported by the Council on Scientific Affairs or Division of Science on ADA.org:

- The *ADA Professional Product Review* ([www.ada.org/goto/ppr](http://www.ada.org/goto/ppr))
- ADA Center for Evidence-Based Dentistry ([ebd.ada.org](http://ebd.ada.org))
- The ADA Seal of Acceptance Program ([www.ada.org/goto/seal](http://www.ada.org/goto/seal))
- ADA Research Agenda ([www.ada.org/goto/research](http://www.ada.org/goto/research))
- Science in the News ([www.ada.org/goto/sciencenews](http://www.ada.org/goto/sciencenews))

## Product Evaluations and Evaluation Criteria

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**Professional Product Evaluation Program:** The *ADA Professional Product Review*<sup>™</sup> (*Review*) is a quarterly publication of the Council, which is mailed with *JADA* to ADA members and subscribers. The *Review* featured evaluations of the following professional product categories this year:

- Summer 2009—Electrosurgical Systems
- Fall 2009—Curing Lights
- Winter 2010—Polishing Systems
- Spring 2010—Restorative Materials

At its November 2009 meeting, the Council approved expanding the *ADA Professional Product Review* into three subject areas that were most requested by members in online surveys: dental therapeutics, new technology, and clinical techniques. To assist in this expansion, an expert panel on dental therapeutics has been assembled to evaluate the scope and objectives of this initiative. Former Council member Dr. Peter Jacobsen is serving as chair of the expert panel on dental therapeutics. The Council is also exploring the most feasible venue for expanding the publication to address clinical techniques as well.

*Clinical evaluations with external collaborators.* Beginning in 2008, with the Council's recommendation and Board approval, the *Review* began to establish research collaborations with dental schools and practice-based research networks to obtain additional clinically relevant data for future publication. The results of the dental school pilot program will be presented at the 2010 ADA annual session and published in a future issue of the *Review*. Without additional resources, the *Review* has only expanded the program with volunteer assistance.

In 2011, PPR will use the savings garnered from reducing print production costs to expand clinical evaluation collaborations with dental schools and external researchers. However, this plan may be threatened by cuts in the program's base budget that were required to meet the Division of Science's budget reduction targets for 2011. These cuts would turn PPR from a print to an online publication, even though 9 out of 10 readers surveyed prefer the print version. The Council is concerned with the impact this change would have on the quality and integrity of this significant new member benefit. Staff is exploring all options to generate revenue that would allow PPR to remain a print publication. Individuals seeking further information can contact the *Review* by e-mail at [paprclinical@ada.org](mailto:paprclinical@ada.org).

**ADA Seal of Acceptance Program for Over-the-Counter Products:** The Council has reached the point in its revitalization of the Seal of Acceptance Program when it is ready to implement a marketing plan to drive consumer demand for Seal products and persuade manufacturers to seek the Seal on more over-the-counter (OTC) oral health products. The Council reviewed research conducted by the ADA marketing department in December 2009 and January 2010 on how dentists, hygienists, consumers and manufacturers view the ADA Seal Program. A key finding of the research is that the Seal Program remains widely recognized and trusted by all of these audiences, even though participation by manufactures of OTC dental products in the program has declined. The surveys also revealed that a primary reason for the declining participation is that the Seal Program has not had the visibility with consumers it once enjoyed.

At its April 2010 meeting, the Council approved a marketing plan developed in conjunction with the ADA marketing department and funded by a 2011 decision package. The decision package requests funding for a pilot program with three major components to reach 120,000 consumers, 75,000 school children, ADA member dentists and dental hygienists. Hygienists were included because they are the most likely source of patient information on OTC oral health products in the dental office. If the pilot program is successful, the plan calls for rolling it out on a national level with corporate sponsorship. The data gathered during the pilot phase would be used to convince Seal participants of the value of promoting the Seal on their products.

Marketing is expensive. The decision package has seven elements with a total budget of \$318,310. Unfortunately, the decision package was not recommended for funding during preliminary development of the 2011 ADA budget. The Council will not learn until June whether the Board accepts this recommendation. In the meantime, the Council is using its existing (limited) resources to highlight the ADA Seal to consumers.

An example is the increased prominence of the Seal of Acceptance Web area on the recently updated and revised ADA.org (<http://www.ada.org/sealprogramproducts.aspx>). At the Seal Program Web area, consumers can obtain an array of information about the Acceptance Program. Plans are underway to feature detailed information on each ADA-Accepted product in the Seal Program Web area. This online promotion will allow consumers to compare the features they want from ADA-Accepted oral care products and provide more information about why the Council accepted the product.

In March 2010, the Seal Program participated in an all-day promotional event sponsored by Tom's of Maine, a manufacturer of several ADA-Accepted toothpastes, mouthrinses and flosses. At this event, the Seal Program was highlighted to the editors of 35 women's magazines and blog sites. Women's magazines were selected because surveys show that most oral care product purchases are made by women 25 to 40 years of age.

**Potential New Category for the Seal Program—Over-the-Counter Tobacco Cessation Products:** Periodically, the OTC Seal of Acceptance Program adds new categories of products when the category is determined to be relevant to some aspect of oral health. The impetus for doing this is greater if there is also interest in the category expressed by dentists, consumers, or industry. One such category that the Council is researching is over-the-counter products that help stop smoking and the use of smokeless tobacco. Examples of products that would fit into this category are OTC nicotine gums, lozenges and patches. The Council is considering this product category because it is well established that tobacco use can exacerbate periodontitis and contribute to the development of oral and pharyngeal cancer. In addition, several manufacturers of OTC tobacco cessation products have expressed interest in applying for the ADA Seal of Acceptance.

The Council is currently developing Acceptance Program Guidelines for OTC Products for the Cessation of Smoking and Use of Smokeless Tobacco, which will detail the types of studies that would be required for this product category to demonstrate safety and effectiveness. The Council expects to finish work on the guidelines in the fall of 2010 and be in the position to accept product submissions to the category by winter 2010-11.

**Standards Activities:** In accordance with CSA's *Bylaws* duties, the Council coordinates the development of national and international standards programs for dental products. The Council conducts these standards activities through the ADA Standards Committee on Dental Products (SCDP) and the International Organization for Standardization/Technical Committee 106, Dentistry (ISO/TC106). The Council's role has become increasingly important in recent years as the ADA pursues the strategic goal to "lead in the advancement of standards" for the profession.

*ADA SCDP.* The ADA SCDP currently has over 90 projects registered with the American National Standards Institute (ANSI). In 2009-2010, the ADA SCDP submitted new standards for amalgam separators, oral rinses and manual interdental brushes, plus revised standards for casting investments and refractory die materials, to ANSI for

approval as American National Standards. In addition, a technical report on the effects of dental lasers on oral tissue was completed and published. To date, the U.S. Food and Drug Administration has recognized some 25 ANSI/ADA specifications for use in the FDA's premarket evaluation of dental products.

*ISO/TC106.* Through the Council, the ADA sponsors U.S. participation in ISO/TC106, Dentistry, as Secretariat of the U.S. Technical Advisory Groups. At present, the Association holds the Secretariats for two of the seven subcommittees in ISO/TC106: Subcommittee 2, Prosthodontics, and Subcommittee 8, Implants. Council staff also participate in the working groups of ISO/TC106 as convenors and experts, and by presenting Association positions on standardization issues to this international organization.

The importance of ISO standards development continues to expand globally and in the United States as well. As of December 2009, 36 ISO standards have been adopted as ADA standards, with additional ISO standards under consideration. In recent years, the Council has reemphasized the need for clinically relevant standards and test methods both nationally and internationally. Furthermore, with the development of new test methods based on results of testing for the *Professional Product Review*, standardization based on clinical relevance is becoming the expected product of the standards development process in both the ADA SCDP and ISO.

*Outside Standards Committees.* External organizations develop standards that can affect the dental profession in areas such as sterilization procedures, nitrous oxide sedation, laser safety and indoor air quality. At times, the final voluntary standards adopted by these organizations may be adopted by federal, state or local regulatory agencies. Association participation in the creation of these standards is essential to ensure that the practice of dentistry is properly represented in the standards developed by these organizations.

In 2009-2010, ADA representatives nominated by CSA attended meetings of the following outside organizations to present Association positions on their standards: American Society of Heating, Refrigerating and Air-Conditioning Engineers (ASHRAE); Association for the Advancement of Medical Instrumentation (AAMI); National Fire Protection Association (NFPA); and the Laser Institute of America (LIA). This year, ADA representation at AAMI meetings resulted in modifications to the standard for sterilization to allow for weekly testing. In addition, the revised NFPA standard for health care facilities will have a separate section that covers dental offices to prevent confusion with requirements for hospitals.

**Guidelines Development:** In product areas without established ADA standards, the Council develops Acceptance Program guidelines as criteria for dental product evaluation. Although the Council has phased out the Seal Program for professional products, new and revised guidelines remain of considerable importance for the Council's evaluation of consumer products. Guidelines have also been used to assist in investigation of the safety and efficacy of professional products for the *ADA Professional Product Review*.

Currently, the Council has completed or is developing Acceptance Program guidelines in some 50 product areas. In 2009-2010, the Council revised or completed guidelines for chewing gums without active anticaries agents and products for the treatment of dentinal hypersensitivity. Guidelines that are under development or revision include: tobacco cessation products, adjunctive dental therapies, and chemotherapeutic agents to arrest or control periodontitis.

**Emerging Issues and Trends:** The Council continues to align its evaluation of emerging issues with the priority objectives of the ADA Strategic Plan. The Council reviews key issues and trends through mega-issue discussions, review of ADA scanning reports, strategic planning sessions related to CSA programs and objectives, and collaboration and interaction with external and internal ADA agencies.

ADA sponsorship of the January 2010 National Roundtable for Dental Collaboration (NRDC) meeting in Chicago illuminated many scientific issues that are common to various dental stakeholder organizations. Participants at the 2010 NRDC identified the following primary goals for dental organizations, which highlight the importance of science and research:

- Communicate the value and importance of oral health to the public and policymakers (e.g., oral health as integral to primary health care).
- Broaden communication and collaboration regarding dental research, science, policy and practice from members of the dental family, and develop systems for sustaining collaborations.
- Importance of science in dental education and the future of dental education.

The National Roundtable meeting also included discussions on the following current or emerging topic areas, which are being addressed by CSA or represent topics that will be included in future CSA plans and activities:

- Recommendations and guidelines supported by the latest scientific information (e.g., antibiotic premedication topics; comparative effectiveness; evidence-based dentistry and clinical recommendations; risk assessment and disease management; development and application of evidence from dental practice-based research networks).
- Product safety and effectiveness (alcohol in mouthrinse; acetaminophen combination products; tooth whitening; cone beam computed tomography; medication-induced dry mouth; contaminants in dental materials and other products; medication-associated osteonecrosis; dental standards development; denture adhesives).
- Disease classification and management (caries classification and risk assessment; science-based diagnostic criteria and coding; new therapeutic methods and techniques for caries and periodontal disease; expanding research on existing therapies [such as fluoride and laser therapy]).

- Medical/oral health relationships (nutrition and oral health; occupational hazards in dentistry; oral cancer; salivary diagnostics; oral-systemic disease associations).

With many stakeholders sharing interests in science-related emerging issues, it appears likely that scientific topics and CSA initiatives will be prime candidates for future collaboration opportunities, and may offer the ADA ways to leverage its resources and increase its impact on the profession and patients alike.

The Council also participated in a scanning process to develop an ADA Environmental Summary Report, which was submitted to the Board of Trustees in December 2009, as part of an ongoing process to develop the ADA Strategic Plan for 2011-2014. Council representatives participated in the ADA Collaborative Planning Conference in January 2010. The conference provided an opportunity to discuss several emerging topic areas and explore collaboration opportunities and plans among ADA agencies.

**Personnel:** In 2009-2010, Dr. Michael Rethman served a third term as Council chair, and Dr. John Hellstein served as vice chair. In fall 2009, the Council welcomed five new members: Dr. G. Garo Chalian, Dr. Stephen K. Harrel, Dr. Harold Slavkin, Dr. Martha Somerman, and Dr. S. Bryan Whitaker. The Council recognizes the following members, whose terms will end in fall 2010, for their service to the Association and the profession: Dr. Karen Crews, Dr. Mark Lingen, Dr. Michael Rethman, and Dr. David Wong.

## **Summary of Resolutions**

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**23. Resolved**, that Chapter X. COUNCILS, Section 120. DUTIES, Subsection K. COUNCIL ON SCIENTIFIC AFFAIRS, of the ADA *Bylaws*, be amended as follows (additions are underscored; deletions are struck through):

K. COUNCIL ON SCIENTIFIC AFFAIRS: The duties of the Council shall be to:

- Develop and promote an ~~annual~~ biennial research agenda ~~with and propose an appropriate means for funding budget for studies that are recommended by the Council to be conducted by the ADA.~~
- Identify emergent issues and areas of research that require response from the research community.
- Report results on the latest scientific developments to practicing dentists.
- Evaluate and issue statements to the profession regarding the efficacy of concepts, procedures and techniques for use in the treatment of patients.
- Guide, assist and act as scientific liaison to the American Dental Association Foundation and serve as its peer-review body.
- Represent the Association on scientific and research matters, promote evidence-based practice, and maintain liaison with related regulatory, research and professional organizations.

- g. Encourage the development and improvement of materials, instruments and equipment for use in dental practice, and to coordinate development of national and international standardization programs for dental products.
- h. Determine the safety and effectiveness of, and disseminate information on, materials, instruments and equipment that are offered to the public or the profession and further critically evaluate statements of efficacy and advertising claims.
- i. Study, evaluate and disseminate information with regard to the proper use of dental therapeutic agents, their adjuncts and dental cosmetic agents that are offered to the public or the profession.
- j. Award the American Dental Association Seal of Acceptance to dental products that meet the Association's requirements for acceptance.
- k. Promote efforts to develop the dental research workforce and to involve students in dental research.
- l. Study, evaluate and disseminate information on those aspects of the dental practice environment related to the health of the public, dentists and dental auxiliaries.
- m. Serve as the primary resource for scientific inquiries from the public and the profession.
- n. Guide, assist and collaborate with the ADA Center for Evidence-Based Dentistry.

**24. Resolved**, that the ADA policy statement entitled Promotion of Dental Materials to the Public (*Trans.* 1997:716) be rescinded.

**25. Resolved**, that the ADA policy statement entitled Endorsement of Science Fairs (*Trans.* 1957:366) be rescinded.

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**ADA Business  
Enterprises, Inc.**

# Notes

# ADA Business Enterprises, Inc.

Wholly-Owned Subsidiary Annual Report and Financial Affairs

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**Faiella, Robert A.**, Massachusetts, *chair*

**Introduction:** Since 1989, ADA Business Enterprises, Inc, (ADABEI) has been a wholly-owned subsidiary of the American Dental Association (“Association”) that manages the for-profit activities organized by the Association. ADABEI’s primary mission is to provide the Association member value with endorsed products and programs. This member value has typically included products and services for dental practices which feature special benefits, discounted pricing and increased customer service levels.

For 2009, ADABEI’s main business objectives included:

1. Managing the core business of endorsement product lines to maximize member benefits and revenues; adding additional member value to the existing program; attracting new customers; retaining existing customers; and growing brand awareness through marketing efforts.
2. New Credit Card Endorsement—Finalizing the RFP search and negotiation for a new credit card provider to replace the ending endorsement with Citibank and launch into market.
3. Wind down operations of ADA Intelligent Dental Marketing (“ADAidm”), a marketing company partially owned by ADABEI since 2007.

**Endorsements:** The mission of the endorsement program (Program) is to enhance member value by providing a broad range of products and services from industry leading providers to support the business aspects of the dental practice, and increase royalties to support the ADA’s non-dues revenue.

**Products:** In 2009, the Program included 13 key products and services from 11 vendor relationships:

- Credit card—Citibank USA, NA. (converted to new provider in November 2009)
- Credit card processing—Chase Paymentech LP
- Patient financing—CareCredit LLC
- Practice Financing & Commercial Real Estate—Matsco Companies
- Payroll and tax management services—SurePayroll, Inc.
- Message on Hold and Appointment Reminders—InTouch Practice Communications
- Staff apparel—Lands’End Business Outfitters, Inc.
- Health Savings Accounts—Msaver Resources LLC

- Digital & Paper Patient Charts—The Dental Record
- Shipping—FedEx and Meridian One Corporation
- Appliances—Whirlpool VIP program and Meridian One Corporation

Five new programs were launched in 2009.

- In January 2009, DHL closed its U.S. shipping operations. Working with Meridian One Corporation, Federal Express agreed to become the new endorsed provider of shipping services.
- In early 2009, after a full RFP process, a new provider was selected for Message on Hold and Appointment Reminder products—InTouch Practice Communications. This company won the endorsement after completing a market place analysis and analyzing product features, pricing, relationship management metrics, and financials and replaced the previous long standing endorsed provider (Tel-A-Patient). InTouch Practice Communications and their two endorsed products were launched into the market in July—via Web site, e-mail and an *ADA News* article.
- An endorsement for appliances for members' practices or homes, with Whirlpool, and Meridian One, was launched in November 2009 to strong early success. This new program entitles members to employee level discounts on brands including Whirlpool, KitchenAid, Maytag and Amana.
- Finally, a soft launch of the U.S. Bank credit card was completed in November 2009. U.S. Bank began accepting applications for new customers via a Web site link. However the existing portfolio of customers did not convert until April and May of 2010.

**Marketing – New Branding:** Following member research conducted in 2008, a new brand was launched in February 2009. The new brand name, selected with member input was:



The new brand was launched in February 2009 through various marketing channels and has received positive feedback from both members and endorsed providers.

**Marketing:** Members are able to learn about the Program through mail and e-mail channels and are able to access the many products and services via:

- Toll-free number at 800-ADA-2308, or
- On the web site at [www.adabusinessresources.com](http://www.adabusinessresources.com).

**State Dental Society Endorsements:** In 2009, 37 state dental societies endorsed one or more products in the *ADA Business Resources* program. In 2009, over \$495,947 in program royalties were paid to state dental societies, the majority of which is contributed

by the endorsements of the Credit Card with Citibank USA, NA and Patient Financing with CareCredit LLC. In addition, ADABEI shared a one-time bonus payment for the credit card conversion with the 12 states that endorse the ADA Credit Card that totaled \$311,814. Total state payments combined totaled \$807,761.

**Company Financials:** Both ADA and ADABEI receive income from the Program. The ADA licenses its name and member list to endorsed providers in exchange for royalty and list fees, and ADABEI receives a service fee for providing marketing services.

With the preponderance of credit based products in the Program (such as credit cards, practice financing, patient financing), overall revenue was impacted by the global economic downturn in 2009. The endorsement program generated \$5,686,886 of core royalty and service revenue in 2009, 6.6% below the budget of \$6,092,379. The ADA received approximately 57% of this revenue stream, \$3,239,328, with the remainder (\$2,447,558) directed to ADABEI.

In addition, ADABEI received a one-time payment of \$4,026,156 from Citibank due to the termination provision in their contract. This one-time payment was shared with the endorsing state dental societies with the same formula as used in prior years.

ADABEI was able to reduce core business expenses to compensate for some of the decline in revenue, however with the extraordinary and unplanned expenses for the ADAidm wind down, overall, ADABEI's 2009 Pre-Tax Income/Expense was a loss totaling (\$848,886).

The loss notwithstanding, however, as in prior years, ADABEI made a \$60,000 contribution to the ADA Foundation in 2009.

Although showing signs of improvement, economic conditions in 2010 continue to be challenging and are expected to continue to impact the revenue generated in the Endorsement program. The 2010 ADABEI budget was built cautiously to include the planned impact of the economic recovery on sales as well as the loss of two endorsements in 2009 (Pitney Bowes for Postage Meters and Citibank's Line of Credit). The resulting 2010 ADABEI program budget is \$5,396,067 or 5.1% less than 2009 actual revenue. This revenue plan along with carefully managed expenses, however should allow the ADA to receive \$2,743,557 in royalty income from the endorsed providers in 2010, which equals the amount planned for in the 2010 ADA Budget.

Through April 2010, ADABEI has earned \$1,626,056 in royalties, 8.2% under the targeted budget of \$1,770,549. The down economy and ADABEI's financial based products are the primary drivers of the revenue shortfall. Despite the early revenue shortfall, ADABEI still anticipates the program delivering the full ADA royalty income.

With the expenses related to the ADAidm wind down complete, and with the one time payment from the credit card program received in 2009, in June 2010, ADABEI announced a dividend payment of \$536,050 to the ADA. This amount is anticipated to

be returned to the ADA reserves and is consistent with the amount drawn to meet the budget demands for the 2009 HOD.

**Governance:** On March 21, 2009, the ADA, as the sole stockholder of ADABEI, restructured the ADABEI Board of Directors. All 12 voting directors were removed. The ADA Board then re-appointed as directors the two trustees and the two dentists who were on the ADABEI Board prior to March 21, 2009. To streamline the emergency nature of the ADAidm wind down, in June 2009 a single ADA Trustee was appointed as the sole director and chairman of the ADABEI Board (see below).

A comprehensive study was initiated by the ADA Board to examine ADABEI's corporate purpose and business activities. The process evaluated the applicable business, tax and legal advantages and disadvantages of the current corporate structure. ADABEI also hired a consultant to evaluate "best practices" of for-profit subsidiaries of not-for-profit organizations. A report will be forthcoming for consideration by the ADA Board of Trustees (acting for the sole shareholder).

**ADA Intelligent Dental Marketing LLC (ADAidm):** Initially formed on January 31, 2007, ADAidm was a joint venture between the initial co-founders and ADABEI. ADAidm was to provide branding, identity and marketing services to dental practices.

ADAidm began operations on February 1, 2007. In 2008, ADAidm sales were \$4,400,000; however, total expenses were higher than anticipated and resulted in a net loss of (\$327,000). Debts and accounts payable increased throughout 2008, becoming problematic by the end of the year. In March and June of 2009, ADABEI made three loans to ADAidm totaling \$238,415 to fund the completion of specific client projects, payments to key vendors and refunds to customers.

As a result of information received by the ADA Board and the Audit Committee, KPMG was retained in early 2009 to perform a detailed audit to include ADABEI and ADAidm, with a final presentation to the ADA Board in June 2009. During this time, ADAidm ownership was restructured. By June 9, 2009, both original owners of ADAidm (Class A members) transferred their ownership shares to ADABEI, resulting in ADABEI owning 100% of the shares of ADAidm. There was no consideration paid to the Class A member in exchange for their interests.

As a result of the June 2009 KPMG report, a decision was made to wind down ADAidm's operations. The ADA Board, acting for the sole shareholder of ADABEI, took definitive action by dismissing the ADABEI Board of Directors and appointing a single director and chairman to resolve the ADAidm issues and oversee the ongoing ADABEI affinity programs. Soon thereafter, appropriate ADABEI senior staff personnel changes were made, and ADABEI began to immediately wind down the operation of ADAidm, with an emphasis on protecting those ADA members who were ADAidm customers. The ADAidm customers and stakeholders were immediately contacted regarding the wind down of the ADAidm entity. Accounting systems were analyzed, customer and vendor accounts were clarified, and payments were made immediately as customer and

vendor accounts were validated. The ADAidm entity was physically closed in Salt Lake City, Utah on July 31, 2009, and all operations for the ADAidm wind down process moved to the ADABEI Chicago offices.

Through December 2009, ADABEI incurred approximately \$4.9 million for expense related to the wind-down of ADAidm, including refunds to customers for undelivered goods and services and payments of outstanding balances to vendors. In addition, other costs have been incurred to wind-down operations. Total costs related to the wind-down of ADAidm are not expected to exceed \$5.7 million. This reflects ADABEI's full commitment to seeing that Association members were treated fairly and equitably regardless of the disposition of ADAidm.

By the end of the calendar year, December 31, 2009, the following key activities had been completed.

- With the majority of the customer refunds complete, 100% of Accounts Receivable were written off.
- Each customer file had been reviewed, resulting in refund analysis for 580+ individual customers that had unfulfilled projects, resulting in \$3.2 million in refunds for these customers.
- Additionally, 500+ other individual customer contracts and files were reviewed and analyzed.
- ADAidm services of Web site hosting and maintenance, as well as 800 number call tracking services, were transitioned to alternative vendors by December 31, 2009.
- Approximately 170 customers who had remaining promotion usable items (letters and postcards) in inventory were identified. All customers were contacted by ADABEI to see if they had interest in the return of their pieces.
- Approximately 1,100 graphic artwork files were reviewed and copied to a CD and returned to each client for use in the future.
- Approximately 80 customers had signed up from TreatmentPro, a case acceptance software package. This product is jointly owned through contractual agreement with Treeline. The parties cannot act without mutual agreement, and ADABEI is currently undergoing an evaluation of this asset.

#### **Survey of Affected Customers:**

- Finally, ADABEI undertook a survey of all affected customers (including members and nonmembers). The survey was executed from December 2009 through February of 2010. The primary goal was to measure impact on ADA membership. The secondary goal of the survey was to assess closure for customers during survey (had they received their refunds, artwork, etc.). The survey was managed by the ADA Survey Center and implemented by MSC using both phone and e-mail questionnaires. Phone contact was the preferred method used. Three phone attempts were made for each customer. E-mail follow ups

were also sent. A total of 928 customers were on the survey list. Five hundred nineteen (56%) successful contacts were made.

- The summary survey results were as follows:
  - 90% reported satisfaction with the ADABEI handling of their ADAidm issue.
  - 83% experienced no change or a positive change in their perception of the ADA.
  - 91% experienced no change or a positive change in their perception of the ADA after taking ADABEI's role into account.
  - 92% experienced no change or a positive change in their opinion of ADA membership.
- The survey results strongly support that ADABEI's intervention in the ADAidm situation presents a very successful case of managing a large and potentially damaging service recovery issue.
- Through March 31, 2010, ADAidm customers are renewing their ADA membership on pace, or slightly ahead of, the overall membership.

**Resolutions:** This report is informational and no resolutions are presented.

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# Resolutions

# Notes

## Resolutions

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### Pennsylvania Dental Association

#### Amendment of the ADA *Bylaws*: Composition of Voting Members of the House of Delegates

The following resolution was adopted by the Pennsylvania Dental Association and submitted on May 20, 2010.

**Background:** The *Bylaws* do state in Chapter I that active, life and retired members have the privilege of serving as delegates or alternates. However, when we look at Chapter V., Section 10. A. VOTING MEMBERS, the only restriction for delegates is that they be officially certified by the constituent. Nothing contained in this section defines which classes of members can be officially certified by the constituent. Furthermore, Chapter V., Section 10. E. ALTERNATE DELEGATES states, "Each constituent dental society and each federal dental service may select **from among its active, life and retired members** the same number of alternate delegates as delegates." If we state this requirement for alternates, certainly we should state the same requirement for delegates.

#### Resolution

**26. Resolved**, that the ADA *Bylaws* Chapter V, Section 10 be amended as follows (new language underscored):

*Section 10. COMPOSITION.*

A. VOTING MEMBERS. The House of Delegates shall be limited to four hundred sixty (460) voting members for the two years 2004 to 2005 inclusive. Thereafter, the number of voting members shall be determined by the methodologies set forth in Section 10C of this Chapter. It shall be composed of the officially certified delegates of the constituent dental societies, who shall be active, life or retired members, two (2) officially certified delegates from each of the five (5) federal dental services, who shall be active, life or retired members and five (5) student members of the American Student Dental Association who are officially certified delegates from the American Student Dental Association.

## South Dakota Dental Association

### Evidence-Based Guidelines on Antibiotic Prophylaxis for Dental Patients with Total Joint Replacement

The following resolution was adopted by the South Dakota Dental Association and submitted on May 17, 2010.

**Background:** The American Dental Association and the American Academy of Orthopedic Surgeons (AAOS) have formed a workgroup that is jointly developing new evidence-based guidelines on antibiotic prophylaxis for dental patients with total joint replacements.

#### Resolution

**27. Resolved,** that the American Dental Association and the American Academy of Orthopedic Surgeons (AAOS) be urged to continue to update the joint guidelines on antibiotic prophylaxis for dental patients with total joint replacements, and be it further

**Resolved,** that the ADA ensure that the workgroup's discussion includes the consideration of the importance of a pre joint-replacement dental evaluation.

## South Dakota Dental Association

### Funding for Treatment of Medicaid Patients Under the Health Care Reform Act (HCRA)

The following resolution was adopted by the South Dakota Dental Association and submitted on May 17, 2010.

**Background:** On March 24, 2010, the President signed the Health Care Reform Act (HCRA). The HCRA will add millions of previously uninsured children to the rolls of Medicaid and CHIP. It is critical that the American Dental Association take a leadership role in assuring that these patients receive high quality oral health care. The increase in patients seeking care under HCRA will increase the call for care to be provided by non-dentists at a lower level of quality. It is critical for the ADA to address the issues raised by other stake holders in this arena. The ADA must convince policy makers and legislators that if adequate resources are applied to this issue, all children can have high quality oral health care delivered by licensed dentists in the dental home. The concept of a stable high quality dental home delivering care to all patients must be the goal of all stake holders in this area. Every available study proves that dentists are uniquely qualified to deliver this care. Multiple examples have conclusively proven that if reimbursement for care provided is fair and adequate that access issues evaporate.

## Resolution

**28. Resolved**, that the American Dental Association call for adequate federal funding to be provided for the treatment of Medicaid patients under the Health Care Reform Act (HCRA), and be it further

**Resolved**, that the ADA pursue a federal standard for reimbursement for dental care to be set at a minimum of the 75th percentile of the prevalent commercial insurer in each state, and be it further

**Resolved**, that the ADA pursue a plan whereby Medicaid-enrolled individuals will be able to access dental care at a rate comparable to that for individuals with commercial insurance.

### Eighth Trustee District

#### ADA Public Relations Campaign

The following resolution was adopted by the Eighth Trustee District and submitted on May 11, 2010.

**Background:** As more outside groups are beginning to look toward mid-level dental providers to address the access to dental care issue, it is imperative that the message of the American Dental Association members be part of this growing public conversation. It is not enough for dentists to talk amongst themselves about the pros and cons of what the further development of mid-level dental provider could do to the existing dental care delivery system in the United States. On behalf of its members, the ADA needs to educate and engage the public about the extensive training that is required to become a dentist and the real barriers that exist in providing care to the underserved population in this country.

The ADA's brochure *Dentists: Doctors of Oral Health* explains the high level of education and training that is required to become a dentist in the United States. At a minimum, a general dentist has at least four years of highly specialized academics after obtaining an undergraduate bachelor's degree. The curricula during the first two years of dental and medical school are essentially the same, yet this standard is not commonly understood by the public at large.

This ADA brochure contains information that the ADA should disseminate to policymakers, media and the public to remind them that oral health care is being provided by "doctors" and that any new dental provider will have a dramatically lower level of education and clinical skill. A full national public relations campaign should be developed using multiple media formats to spread this message.

The ADA public relations campaign should discuss why an underserved population exists. The most common problem that created the underserved is that they are attempting to access dental care via the states' Medicaid program. In virtually every

state, these programs have been underfunded for decades to a point that many dentists cannot afford to provide care to the Medicaid population. Any level of dental provider will face these same economic realities.

The campaign should also show that many in the underserved population are the ones most likely to have complicating medical conditions and are utilizing a higher number of medications. If this population is difficult for dentists to treat, how could someone with only two years of education beyond high school be expected to competently provide care to this group of patients.

The funding for the ADA public relations campaign should be funded by using any necessary means. Reserves are maintained for unforeseen matters that arise such as this and should also be considered. This recent wave of interest in mid-level dental providers by the W.K. Kellogg Foundation, Pew Charitable Trusts and the Institute of Medicine will only get bigger and the American Dental Association needs to be on top of the wave and not be crushed by it.

As in the past, it will be the responsibility of the appropriate reference committee to determine the source of funding for this resolution which could include, but not be limited to, dues, special assessment, reserves or any other creative means.

### **Resolution**

**29. Resolved**, that the ADA undertake a multi-media public relations campaign to educate the public on the level of education that dentists receive and how that would compare to any lower level of provider, and be it further

**Resolved**, that the ADA public relations campaign should also emphasize the difficulties that dentists face when treating the underserved population, and be it further

**Resolved**, that the ADA public relations campaign be funded up to \$30 million through any necessary funding including using the reserves of the Association.

### **Eighth Trustee District**

#### **Public Disclosure of Dentists Participating in Medicaid and SCHIP on Federal Web Site**

The following resolution was adopted by the Eighth Trustee District and submitted on May 11, 2010.

**Background:** The Children's Health Insurance Programs Reauthorization Act (CHIPRA) requires the secretary of Health and Human Services to list on the [www.InsureKidsNow.gov](http://www.InsureKidsNow.gov) Web site all dentists that have enrolled to participate in Medicaid or SCHIP.

For over a decade, Illinois has worked with its state Medicaid agency and its dental program administrator to only promote and make public the names of enrolled dentists that were actually taking new patients. Dentists could be enrolled but their name never given out to the public.

Participating dentists could designate how many and which type of patients they would currently accept to treat. Dentists could chose to work closely with a local school, Head Start or religious organization and only take patients from them and not from the general public. This worked well and allowed some dentists to marginally participate in the program without their names being widely broadcast as taking new patients. This referral arrangement was overturned by the Center for Medicare and Medicaid Services (CMS) as not being in compliance since it did not list all enrolled dentists.

This has begun to cause some dentists to end their participation in the Medicaid program out of fear that they could no longer control referrals. The relationships that the dentist had with other organizations ended as they did not want their name on a list that was available to the general public.

How is the public served by being given the name of an enrolled dentist that is not taking new patients? It is upsetting to the patient as they believe they are being given correct information from the CMS Web site and it also is disruptive to a dentist's practice when it has to repeatedly tell patients that they are no longer taking new Medicaid or SCHIP patients.

The American Dental Association should seek a legislative solution to only list participating dentists that wish to have their name on this public Web site.

### **Resolution**

**30. Resolved**, that the ADA, through legislation, seek to change the current requirement within CMS so that the [www.insurekidsnow.gov](http://www.insurekidsnow.gov) Web site would only list those dentists that choose to have their names made public and are taking new patients.

### **American Student Dental Association and Pennsylvania Dental Association**

#### **Participation in Dental Outreach Programs**

The following resolution adopted by the American Student Dental Association and Pennsylvania Dental Association and submitted on May 21, 2010.

**Background:** A growing number of dental students, pre-dental students, and others are participating in dental outreach programs. Individuals in these programs often perform irreversible procedures, including but not limited to operative dentistry, administration of anesthesia and extraction of teeth, despite lacking adequate education

and training. In some cases, these outreach programs fail to provide the participants with adequate direct supervision by qualified individuals.

If training is offered, it is given on-site immediately prior to treatment and fails to give inexperienced students sufficient education of anatomy, proper technique, and the potential consequences of the procedure; therefore, be it

### **Resolution**

**31. Resolved**, that it be policy of the American Dental Association (ADA) that any participant in a dental outreach program (e.g., international service trips, domestic service trips, volunteerism in underserved areas, etc.) be strongly encouraged:

To adhere to the ASDA Student Code of Ethics and the *ADA Principles of Ethics and Code of Professional Conduct*;

To be directly supervised by dentists licensed to practice or teach in the United States;

To perform only procedures for which the student has received proper education and training;

and, be it further

**Resolved**, that the ADA work with national and international health organizations to end the practice of irreversible dental procedures, worldwide, by parties other than fully licensed dental professionals, or properly educated and trained dental students, and be it further

**Resolved**, that this policy be transmitted to all dental schools and pre-dental programs and organizations.

## **2009 Resolution Referred to 2010 House of Delegates**

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### **Council on Ethics, Bylaws and Judicial Affairs**

#### **Editorial Changes to the ADA Constitution**

In conducting its review, the subcommittee further noted instances in the *ADA Constitution* where editorial revisions could be made to improve the syntax and readability of the document and render the *Constitution* more consistent in style to the *ADA Bylaws*. The full Council approved by unanimous vote the subcommittee-recommended revisions in the *ADA Constitution*. Accordingly, the following resolutions are introduced to the 2009 House of Delegates for consideration. According to the *ADA Constitution*, constitutional amendments proposed must lay over for one year or be approved by unanimous vote after having been considered at a previous meeting during the same session of the House of Delegates.

## Resolution

**8-2009. Resolved,** that the ADA *Constitution* be amended by incorporating the changes indicated below (deletions stricken through):

### ARTICLE III • ORGANIZATION

*Section 50.* CONSTITUENT SOCIETIES: Constituent societies of this Association shall be those dental societies or dental associations chartered as ~~such~~ in conformity with Chapter II of the *Bylaws*.

*Section 60.* COMPONENT SOCIETIES: Component societies of this Association shall be those dental societies or dental associations organized as ~~such~~ in conformity with Chapter III of the *Bylaws* of this Association and in conformity with the bylaws of their respective constituent societies.

*Section 70.* TRUSTEE DISTRICTS: The constituent societies of the Association and the federal dental services shall be grouped into seventeen (17) trustee districts, ~~as provided in Chapter IV of the *Bylaws*.~~

### ARTICLE IV • GOVERNMENT

*Section 10.* LEGISLATIVE BODY: The legislative and governing body of this Association shall be a House of Delegates which may be referred to as “the House” or “this House,” ~~as provided in Chapter V of the *Bylaws*.~~”

*Section 20.* ADMINISTRATIVE BODY: The administrative body of this Association shall be a Board of Trustees, which may be referred to as “the Board” or “this Board” ~~as provided in Chapter VII of the *Bylaws*.~~”

### ARTICLE V • OFFICERS

*Section 10.* ELECTIVE OFFICERS: The elective officers of this Association shall be a President, a President-elect, a First Vice President, a Second Vice President, a Treasurer and a Speaker of the House of Delegates, each of whom shall be elected by the House of Delegates ~~as provided in Chapter VIII of the *Bylaws*.~~

*Section 20.* APPOINTIVE OFFICER: The appointive officer of this Association shall be an Executive Director who shall be appointed by the Board of Trustees ~~as provided in Chapter IX of the *Bylaws*.~~

# Notes

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# ADA Audit

# Notes

**ADA** American  
Dental  
Association®

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## **American Dental Association and Subsidiaries**

### **Consolidated Financial Statements** (With Report of Independent Certified Public Accountants)

**December 31, 2008 and 2007**

# **American Dental Association and Subsidiaries**

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## INDEPENDENT AUDITOR'S REPORT

**Audit • Tax • Advisory**

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Board of Directors  
American Dental Association

We have audited the accompanying consolidated statements of financial position of the American Dental Association and Subsidiaries (the "Association") as of December 31, 2008 and 2007, and the related consolidated statements of activities and cash flows for the years then ended. These financial statements are the responsibility of the Association's management. Our responsibility is to express an opinion on these financial statements based on our audits.

We conducted our audits in accordance with auditing standards generally accepted in the United States of America. Those standards require that we plan and perform the audits to obtain reasonable assurance about whether the financial statements are free of material misstatement. An audit includes consideration of internal control over financial reporting as a basis for designing audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the Association's internal control over financial reporting. Accordingly, we express no such opinion. An audit includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements. An audit also includes assessing the accounting principles used and significant estimates made by management, as well as evaluating the overall financial statement presentation. We believe that our audits provide a reasonable basis for our opinion.

In our opinion, the financial statements referred to above present fairly, in all material respects, the financial position of the American Dental Association and Subsidiaries as of December 31, 2008 and 2007, and the changes in their net assets and their cash flows for the years then ended, in conformity with accounting principles generally accepted in the United States of America.

Our audits were conducted for the purpose of forming an opinion on the basic consolidated financial statements taken as a whole of the Association. The consolidating information included in schedules 1 through 3 is presented for purposes of additional analysis and is not a required part of the basic consolidated financial statements. Such information has been subjected to the auditing procedures applied in the audits of the basic consolidated financial statements and, in our opinion, is fairly stated in all material respects in relation to the 2008 basic consolidated financial statements taken as a whole.

A handwritten signature in black ink that reads "Grant Thornton LLP".

Chicago, Illinois  
February 12, 2010

# American Dental Association and Subsidiaries

## Consolidated Statements of Financial Position

December 31, 2008 and 2007

	<u>2008</u>	<u>2007</u>
<b>ASSETS</b>		
Cash and cash equivalents	\$ 6,108,254	7,963,291
Receivables, net (Note 2)	7,020,377	6,597,613
Deferred taxes (Note 6)	--	274,513
Income taxes receivable	481,626	428,861
Prepaid expenses and other assets (Notes 1 and 7)	2,470,180	2,925,945
Inventories, net of reserves of \$214,000 in 2008 and \$885,000 in 2007	707,357	611,207
Marketable securities (Note 3)	76,272,988	109,731,203
Other investments	--	368,091
Property and equipment, net (Note 4)	51,989,110	54,533,632
Funds held for deferred compensation (Note 5)	4,498,481	5,811,290
<b>TOTAL ASSETS</b>	<b><u>\$ 149,548,373</u></b>	<b><u>189,245,646</u></b>
<b>LIABILITIES AND NET ASSETS</b>		
<b>Liabilities:</b>		
Accounts payable and accrued liabilities	\$ 10,579,407	12,158,649
Income taxes payable	4,782	5,499
Deferred revenues	10,342,621	12,213,421
Liability for deferred compensation (Note 5)	4,498,481	5,811,290
Post-retirement benefit obligation (Notes 1 and 7)	12,219,586	10,033,961
Pension liability (Notes 1 and 7)	17,870,263	2,736,770
<b>TOTAL LIABILITIES</b>	<b><u>55,515,140</u></b>	<b><u>42,959,590</u></b>
<b>Net assets (Note 8):</b>		
Unrestricted	82,628,790	131,107,601
Temporarily restricted	8,875,041	12,667,195
Permanently restricted	2,529,402	2,511,260
<b>TOTAL NET ASSETS</b>	<b><u>94,033,233</u></b>	<b><u>146,286,056</u></b>
<b>TOTAL LIABILITIES AND NET ASSETS</b>	<b><u>\$ 149,548,373</u></b>	<b><u>189,245,646</u></b>

See accompanying notes to consolidated financial statements.

# American Dental Association and Subsidiaries

## Consolidated Statements of Activities

Years Ended December 31, 2008 and 2007

	<u>2008</u>	<u>2007</u>
<b>REVENUES</b>		
Membership dues	\$ 54,196,747	53,700,630
Advertising	9,944,920	6,710,723
Rental income	5,384,111	4,977,610
Publication and product sales	8,412,212	6,702,316
Testing and accreditation fees	13,499,275	12,433,333
Meeting and seminar income	9,659,718	12,017,934
Grants, contributions and sponsorships (including temporarily restricted contributions of \$3,801,350 in 2008 and \$4,293,083 in 2007 and permanently restricted contributions of \$18,142 in 2008 and \$30,320 in 2007)	8,368,661	8,032,573
Royalties	10,905,158	11,201,646
Investment (loss) income (including temporarily restricted (loss) income of (\$2,780,372) in 2008 and \$1,040,845 in 2007)	(31,334,060)	9,310,257
Equity in loss of other investments	(368,091)	(231,909)
Other income (including temporarily restricted income of \$34,009 in 2008 and \$21,000 in 2007)	<u>2,975,840</u>	<u>3,295,807</u>
<b>TOTAL REVENUES</b>	<u>91,644,491</u>	<u>128,150,920</u>
<b>EXPENSES</b>		
Staff compensation, taxes and benefits (Note 7)	53,893,769	52,778,368
Printing, publication and marketing	14,386,724	13,279,102
Meeting expenses	2,864,653	4,474,277
Travel expenses	6,908,904	6,431,242
Consulting fees and outside services	10,700,456	10,410,172
Professional services	8,440,392	7,960,020
Office expenses	5,255,139	5,230,413
Facility and utility expenses	4,642,159	4,650,216
Grants and awards	3,456,987	2,560,092
Royalty expenses	710,326	809,644
Depreciation and amortization	6,752,317	6,776,016
Bank and credit card fees	935,757	899,707
Other expenses	<u>2,400,542</u>	<u>2,424,859</u>
<b>TOTAL EXPENSES</b>	<u>121,348,125</u>	<u>118,684,128</u>
Net (loss) income before income tax	(29,703,634)	9,466,792
Income tax expense (Note 6)	<u>(1,909,417)</u>	<u>(631,483)</u>
Net (loss) income	(31,613,051)	8,835,309
Pension- and post-retirement health plan-related changes other than net periodic pension cost (Notes 1 and 7)	(20,639,772)	--
Effect of adoption of SFAS 158 for pension plan and other post-retirement benefits (Notes 1 and 7)	<u>--</u>	<u>(13,024,568)</u>
Decrease in net assets	(52,252,823)	(4,189,259)
Net assets at beginning of year	<u>146,286,056</u>	<u>150,475,315</u>
Net assets at end of year	<u>\$ 94,033,233</u>	<u>146,286,056</u>

See accompanying notes to consolidated financial statements.

# American Dental Association and Subsidiaries

## Consolidated Statements of Cash Flows

Years Ended December 31, 2008 and 2007

	<u>2008</u>	<u>2007</u>
<b>CASH FLOWS FROM OPERATING ACTIVITIES</b>		
Decrease in net assets	\$ (52,252,823)	(4,189,259)
Adjustments to reconcile decrease in net assets to net cash provided by operating activities		
Pension- and post-retirement health plan-related changes other than net pension cost	20,639,772	--
Change in accounting for adoption of SFAS 158	--	13,024,568
Depreciation and amortization	6,752,317	6,776,016
Deferred income tax expense (benefit)	274,513	(162,453)
Unrealized depreciation in fair value of marketable securities	34,509,295	197,864
Net realized gain on sale of marketable securities	(1,640,359)	(5,651,113)
Equity in net loss of other investments	368,091	231,909
Gain on sale of property and equipment	(19,590)	(12,063)
Contributions of stock	(137,278)	(82,837)
Provision for uncollectible loans receivable	--	(1,881)
Contributions received for long-term purposes	(18,142)	(30,320)
Changes in assets and liabilities:		
Receivables, net	(422,764)	755,698
Income taxes receivable	(52,765)	59,924
Prepaid expenses and other assets	455,765	(259,113)
Inventories, net	(96,150)	659,233
Prepaid pension	--	(3,795,048)
Accounts payable and accrued liabilities	(1,579,242)	(1,382,321)
Income taxes payable	(717)	2,949
Deferred revenues	(1,870,800)	2,971,624
Post-retirement benefit obligation	1,115,649	991,388
Pension liability	(4,436,303)	--
Net cash provided by operating activities	<u>1,588,469</u>	<u>10,104,765</u>
<b>CASH FLOWS FROM INVESTING ACTIVITIES</b>		
Purchase of marketable securities	(41,336,699)	(31,204,787)
Sale of marketable securities	42,063,256	30,316,647
Loan repayments	--	19,709
Investment in joint venture	--	(600,000)
Acquisitions of property and equipment	(4,207,795)	(8,521,705)
Proceeds from sale of property and equipment	19,590	12,063
Net cash used by investing activities	<u>(3,461,648)</u>	<u>(9,978,073)</u>
<b>CASH FLOWS FROM FINANCING ACTIVITIES</b>		
Contributions received for long-term purposes	<u>18,142</u>	<u>30,320</u>
Net (decrease) increase in cash and cash equivalents	(1,855,037)	157,012
Cash and cash equivalents at beginning of year	<u>7,963,291</u>	<u>7,806,279</u>
Cash and cash equivalents at end of year	<u>\$ 6,108,254</u>	<u>7,963,291</u>
<b>SUPPLEMENTAL DISCLOSURE OF CASH FLOW INFORMATION</b>		
Cash paid during the year for income taxes	<u>\$ 1,688,774</u>	<u>731,063</u>

See accompanying notes to consolidated financial statements.

# American Dental Association and Subsidiaries

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## Notes to Consolidated Financial Statements, December 31, 2008 and 2007

### 1. Significant Accounting Policies

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**Basis of Presentation:** The American Dental Association (Association) is organized as an association of members of the dental profession, residing primarily in the United States of America and is designed, as its corporate purpose states, "to encourage the improvement of the health of the public and to promote the art and science of dentistry".

The accompanying consolidated financial statements include the accounts of the Operating and Reserve Divisions of the Association, the American Dental Political Action Committee (ADPAC), the American Dental Association Foundation (ADAF), and the Association's wholly-owned for-profit subsidiary, ADA Business Enterprises, Inc. (ADABEI).

ADPAC promotes the Association's political and legislative agenda.

ADAF was organized to operate exclusively for charitable, scientific and educational purposes.

ADABEI manages the for-profit activities organized by the Association through four divisions: The CEO office (reflecting the cost of Board and executive oversight), business and financial services (offering a range of financial services to Association members in conjunction with Citibank USA, a Citigroup affiliate, and various other service providers under the title of ADA Member Advantage), marketing services (capturing the equity share of ADA Intelligent Dental Marketing, LLC (ADAidm) operating results and expenses directly related to support ADAidm), and new business development (focused on identifying and developing new products and services for ADA members).

All significant intercompany accounts and transactions have been eliminated in consolidation.

**Use of Estimates:** In preparing financial statements in conformity with accounting principles generally accepted in the United States of America, management is required to make estimates and assumptions that affect the reported amounts of assets and liabilities, the disclosure of contingent assets and liabilities at the date of the financial statements, and the reported amounts of revenues, expenses, gains and losses during the reporting period. Actual results could differ from those estimates.

**Cash and Cash Equivalents:** Cash equivalents at December 31, 2008 and 2007 consist primarily of interest bearing deposits under overnight repurchase agreements. The Association, ADPAC, ADAF and ADABEI each maintain their cash balances in financial institutions which at times may exceed federally insured limits. The Association, ADPAC, ADAF and ADABEI have not experienced any losses in such accounts and believe they are not exposed to any significant credit risk on cash.

**Receivables:** The allowance for doubtful receivables is determined after considering a number of factors, including the length of time receivables are past due, the Association's previous loss history, the customer's current ability to pay its obligations and the condition of the general economy as a whole. Uncollectible accounts are written off, and payments subsequently received on such receivables are credited to the allowance for doubtful receivables. Receivables include pledges receivable for unconditional promises for which payment has not been received. Pledges receivable are recognized at the estimated present value of expected future cash flows net of allowances.

**Marketable Securities:** Investments in marketable securities are carried at fair value based on quoted market prices. Realized and unrealized investment gains and losses are included within investment income in the accompanying consolidated financial statements. Net realized capital gains or losses on sales are calculated based on the average cost of securities sold.

Marketable securities held in the Operating Division are available for current use while marketable securities held in the Reserve Division are not intended for current use. Reserve Division assets may be used for operations upon approval of the Board of Trustees, with subsequent reporting to the Association's House of Delegates. Investment expenses of \$74,341 and \$81,269 in 2008 and 2007, respectively, are included in professional services in the accompanying consolidated financial statements.

## American Dental Association and Subsidiaries

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### Notes to Consolidated Financial Statements, December 31, 2008 and 2007 (continued)

**Other Investments:** The equity method is used for accounting for the investment in ADA Intelligent Dental Marketing, LLC (ADAidm). ADABEI had a 50% ownership interest in ADAidm during 2008 and 2007. Effective June 9, 2009, ADABEI had a 100% ownership interest in ADAidm.

**Inventories:** Inventories, consisting principally of salable educational materials and supplies, are carried at the lower of cost or market (net realizable value). Cost is primarily determined using the first-in, first-out method.

**Property and Equipment:** Property and equipment are stated at cost, less accumulated depreciation and amortization. Depreciation is computed on the straight-line method once assets are put into service over the estimated useful lives of the assets, which are as follows:

Buildings	30-55 years
Building improvements	7-20 years
Furniture, equipment and libraries	3-20 years

Tenant leasehold improvements are amortized over the shorter of their estimated useful lives or the remaining term of the lease.

**Valuation of Long-Lived Assets:** The Association periodically evaluates the carrying value of its long-lived assets, including, but not limited to, property and equipment and other assets. The carrying value of long-lived assets are considered impaired when the undiscounted cash flow from such assets are separately identifiable and estimated to be less than their carrying value. In that event, a loss is recognized based on the amount by which the carrying value exceeds the fair value of the long-lived assets. Fair value is determined primarily using the anticipated cash flows discounted at a rate commensurate with the risk involved. Pursuant to Statement of Financial Accounting Standards ("SFAS"), No. 144 "*Accounting for the Impairment or Disposal of Long-Lived Assets*," long-lived assets that are to be disposed of are to be written down to their fair value if such fair value is less than cost.

**Deferred Compensation:** The Association has a deferred compensation plan. Participation is limited to ADA officers, trustees and certain upper management employees whose compensation rate is at least \$100,000 per year. This is a non-qualified plan governed by Section 457 of the Internal Revenue Code. Investments held for deferred compensation are carried at market value and are not available for current use.

**Revenue and Expense Recognition:** Membership dues and assessments are recognized as income during the membership year, which ends on December 31. Amounts received in advance are deferred to the subsequent year. Unearned membership dues and assessments, which have been included in deferred revenues in the accompanying consolidated financial statements, amounted to approximately \$5,331,000 and \$6,958,000 at December 31, 2008 and 2007, respectively.

Periodical subscriptions are recognized as revenue over the terms of the subscriptions. Subscriptions paid in advance are recorded as deferred revenue. Advertising revenue and direct publication costs are recognized in the period the related publication is issued.

Rental income from the Association's Headquarters Building and Washington, DC Office Building is recorded as revenue when earned.

Testing fees are recognized as income when the related examinations are administered.

Contributions, which are defined as nonreciprocal transfers, are recognized as revenues in the period pledged or received and classified according to the existence or absence of donor-imposed restrictions. When a donor restriction has been satisfied by incurring expenses consistent with the designated purpose, temporarily restricted net assets are reclassified to unrestricted net assets for reporting of related expenses. Unconditional promises are recognized at the estimated present value of expected future cash flows net of allowances. Promises made and collected in the same reporting period are recorded when received in the appropriate net asset category. Conditional promises are recorded when the conditions are substantially met.

# American Dental Association and Subsidiaries

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## Notes to Consolidated Financial Statements, December 31, 2008 and 2007 (continued)

Corporate grants that do not constitute contributions are recognized as income when costs of the related programs or projects are incurred. Corporate grants received but not yet expended are reported as deferred revenues. Grants to other organizations are recorded as expense when authorized by the Board of Trustees.

Royalties and service fees are recognized when earned pursuant to agreements with service providers.

**Pension and Other Postretirement Benefits:** Pension costs are determined under the projected unit credit cost method. This method determines the present value of benefits projected to retirement with increases in salary and service, and allocates (attributes) pension costs to prior and current periods based upon the relationship of service to date versus service projected to retirement. In September 2006, the Financial Accounting Standards Board issued Statement of Financial Accounting Standards No. 158, "*Employers' Accounting for Defined Benefit Pension and Other Post-Retirement Plans*" ("SFAS 158"). SFAS 158 requires the Association to fully recognize and disclose an asset or liability for the over-funded or under-funded status of its benefit plans in financial statements as of December 31, 2007 and to recognize changes in that funded status as a change in unrestricted net assets in the year in which the changes occur.

The adoption of SFAS 158 in 2007 resulted in a decrease in prepaid pension of \$9,260,340, an increase in pension liabilities of \$2,736,770, an increase in other post-retirement benefit obligations of \$1,027,458 and a decrease in net assets of \$13,024,568.

**Income Taxes:** Deferred taxes are established for temporary differences between the financial reporting basis and the tax basis of assets and liabilities. Deferred taxes are based upon enacted tax rates, which would apply during the period in which taxes become payable or recoverable, and the adjustment of cumulative deferred taxes for any changes in the tax rate.

**Net Assets:** Net assets subject to donor-imposed stipulations are classified as temporarily or permanently restricted net assets while net assets not subject to such restrictions are classified as unrestricted net assets. If a restriction is fulfilled in the same time period in which the contribution is received, the Association reports the support as unrestricted.

**Fair Value Measurements:** Effective January 1, 2008, the Association adopted Statement of Financial Accounting Standards ("SFAS") No. 157, "*Fair Value Measurements*." SFAS No. 157 defines fair value, establishes a framework for measuring fair value, establishes a fair value hierarchy based on the inputs used to measure fair value and enhances disclosure requirements for fair value measurements. SFAS No. 157 maximizes the use of observable inputs and minimizes the use of unobservable inputs by requiring that the observable inputs be used when available.

Observable inputs are inputs that market participants would use in pricing the asset or liability based on market data obtained from independent sources. Unobservable inputs reflect assumptions that market participants would use in pricing the asset or liability based on the best information available in the circumstances. The hierarchy is broken down into three levels based on the transparency of inputs as follows:

Level 1 - Quoted prices are available in active markets for identical assets or liabilities as of the report date. A quoted price for an identical asset or liability in an active market provides the most reliable fair value measurement because it is directly observable to the market.

Level 2 - Pricing inputs are other than quoted prices in active markets, which are either directly or indirectly observable as of the report date. The nature of these securities include investments for which quoted prices are available but which are traded less frequently and investments that are fairly valued using other securities, the parameters of which can be directly observed.

Level 3 - Securities that have little to no pricing observability as of the report date. These securities are measured using management's best estimate of fair value, where the inputs into the determination of fair value are not observable and require significant management judgment or estimation.

## American Dental Association and Subsidiaries

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### Notes to Consolidated Financial Statements, December 31, 2008 and 2007 (continued)

Inputs are used in applying the various valuation techniques and broadly refer to the assumptions that market participants use to make valuation decisions, including assumptions about risk. Inputs may include price information, volatility statistics, specific and broad credit data, liquidity statistics, and other factors. A financial instrument's level within the fair value hierarchy is based on the lowest level of any input that is significant to the fair value measurement. However, the determination of what constitutes "observable" requires significant judgment by the Association. The Association considers observable data to be that market data that is readily available, regularly distributed or updated, reliable and verifiable, not proprietary, and provided by independent sources that are actively involved in the relevant market. The categorization of a financial instrument within the fair value hierarchy is based upon the pricing transparency of the instrument and does not necessarily correspond to the Association's perceived risk of that instrument.

In February 2007, the Financial Accounting Standards Board issued SFAS No. 159, "*The Fair Value Option for Financial Assets and Financial Liabilities*." SFAS No. 159 provides the Association with an option to elect fair value as the initial and subsequent measurement attribute for most financial assets and liabilities and certain other items. The fair value option election is applied on an instrument-by-instrument basis (with some exceptions) is irrevocable, and is applied to an entire instrument. The fair value option election may be made as of the date of initial adoption for existing eligible items. Subsequent to initial adoption, the Association may elect the fair value option at initial recognition of eligible items, on entering into an eligible firm commitment, or when certain specified reconsideration events occur. Unrealized gains and losses on items for which the fair value option has been elected will be reported in the statements of activities.

The Association did not elect any changes to fair value measurements upon the adoption of SFAS No. 159 in 2008.

**Valuation of Financial Instruments:** The Association's financial instruments are marketable securities. Marketable securities with values based on quoted market prices in active markets, and which are therefore classified within Level 1, include active listed equities and equity funds, bonds and bond funds and money market securities. The Association does not adjust the quoted price for such instruments.

Investment that trade in markets that are not considered to be active, but are valued based on quoted market prices, dealer quotations or alternative pricing sources supported by observable inputs are classified within Level 2. The Association does not own investments classified with Level 2.

Investment classified within Level 3 have significant unobservable inputs, as they trade infrequently or not at all. The Association's level 3 investment consists of a mutual fund that was organized to invest through a master feeder structure into two limited partnerships. In turn, these limited partnerships invest in a portfolio of hedge funds, managed by separate investment managers. The Association may make withdrawals from the mutual fund on a monthly basis. Significant unobservable inputs are inherent in the nature of such investments in investment funds which result in the Association's investment in this mutual fund being classified as Level 3.

For level 3 valuation techniques, the Association uses unobservable inputs that reflect assumptions market participants would be expected to use in pricing the asset. Unobservable inputs are used to measure fair value to the extent that observable inputs are not available and are developed based on the best information available under the circumstances. In developing unobservable inputs, market participant assumptions are used if they are reasonably available without undue cost and effort.

**FASB Staff Position 117-1:** In August 2008, the FASB issued FASB Staff Position (FSP) 117-1, "*Endowments of Not-For-Profit Organizations: Net Asset Classifications of Funds Subject to an Enacted Version of the Uniform Prudent Management of Institutional Funds Act, and Enhanced Disclosures for All Endowment Funds*." FSP 117-1 is effective for fiscal years ending after December 15, 2008. FSP 117-1 addresses the net asset classification of donor-restricted endowment funds for organizations subject to an enacted version of the 2006 Uniform Prudent Management of Institutional Funds Act (UPMIFA). A key component of FSP 117-1 is a requirement to classify the portion of a donor-restricted endowment fund that is not classified as permanently restricted net assets as temporarily restricted net assets until

# American Dental Association and Subsidiaries

## Notes to Consolidated Financial Statements, December 31, 2008 and 2007 (continued)

appropriated for expenditure. In addition, FSP 117-1 requires new disclosures about an organization's donor-restricted and board-designated endowment funds. Since a version of UPMIFA was not enacted in Illinois until June 30, 2009, the Foundation is only required to adopt the disclosure requirements of FSP 117-1 for the year ended December 31, 2008. The objective of the disclosures is to provide information so that financial statement users can understand the net asset classification, net asset composition, changes in net asset compositions, spending policy and related investment policy pertaining to an organization's endowment funds. The disclosures relating to FSP 117-1 are presented in note 9.

**FASB Staff Position – FIN 48-3:** In December 2008, the Financial Accounting Standards Board issued FASB Staff Position (FSP) FIN 48-3, "Effective Date of FASB Interpretation No. 48 for Certain Nonpublic Enterprises." FSP FIN 48-3 permits an entity within its scope to defer the effective date of FASB Interpretation 48 (Interpretation 48), *Accounting for Uncertainty in Income Taxes*, to its annual financial statements for fiscal years beginning after December 15, 2008. The Association has elected to defer the application of Interpretation 48 for the year ending December 31, 2008. The Association evaluates its uncertain tax positions using the provisions of FASB Statement 5, *Accounting for Contingencies*. Accordingly, a loss contingency is recognized when it is probable that a liability has been incurred as of the date of the financial statements and the amount of the loss can be reasonably estimated. The amount recognized is subject to estimate and management judgment with respect to the likely outcome of each uncertain tax position. The amount that is ultimately sustained for an individual uncertain tax position or for all uncertain tax positions in the aggregate could differ from the amount recognized.

**Reclassifications:** Certain 2007 amounts have been reclassified to conform to the 2008 presentation.

### 2. Receivables

Receivables at December 31, 2008 and 2007 consist of the following:

	<u>2008</u>	<u>2007</u>
Trade receivables	\$ 3,829,906	4,082,555
Royalties receivable	2,048,840	2,169,818
Grants and contracts receivable	371,752	169,637
Tenant receivables	1,014,738	305,625
Pledges receivable	168,899	296,760
Loans receivable	--	26,061
Other	41,473	58,218
Total	<u>7,475,608</u>	<u>7,108,674</u>
Less allowance for doubtful receivables	<u>455,231</u>	<u>511,061</u>
Net receivables	<u>\$ 7,020,377</u>	<u>6,597,613</u>

Unconditional promises for which payment has not been received are recorded in the financial statements as pledges receivable and revenue of the appropriate net asset category. Amounts due in more than one year are recorded at the present value of estimated future cash flows discounted at rates applicable to the year in which pledges were received, which range from 3.29% to 4.85%.

## American Dental Association and Subsidiaries

### Notes to Consolidated Financial Statements, December 31, 2008 and 2007 (continued)

Unconditional promises are expected to be realized in the following periods:

	<u>2008</u>	<u>2007</u>
In one year or less	\$ 33,002	221,101
Between one year and five years	47,000	30,000
More than five years	104,091	63,329
Less discount	<u>(15,194)</u>	<u>(17,670)</u>
	168,899	296,760
Less allowance for uncollectible pledges	<u>50,500</u>	<u>45,000</u>
	<u>\$ 118,399</u>	<u>251,760</u>

Changes in the Association's allowance for doubtful receivables for the years ended December 31, 2008 and 2007 are as follows:

	<u>2008</u>	<u>2007</u>
Beginning balance	\$ 511,061	373,000
Provision for uncollectible accounts	195,742	297,031
Accounts written-off	(276,198)	(158,970)
Recoveries	<u>24,626</u>	<u>--</u>
Ending balance	<u>\$ 455,231</u>	<u>511,061</u>

### 3. Marketable Securities

Marketable securities at December 31, 2008 and 2007 consisted of the following:

	<u>2008</u>		<u>2007</u>	
	<u>Cost</u>	<u>Market</u>	<u>Cost</u>	<u>Market</u>
Money market funds	\$ 1,798,787	1,798,787	3,307,370	3,307,370
Bonds and bond funds	27,273,874	26,035,141	29,548,629	29,267,778
Equities and equity funds	<u>68,645,402</u>	<u>48,439,060</u>	<u>63,810,986</u>	<u>77,156,055</u>
	<u>\$ 97,718,063</u>	<u>76,272,988</u>	<u>96,666,985</u>	<u>109,731,203</u>

The fair value of marketable securities held in the Reserve Division amounted to \$48,703,245 and \$70,516,669 at December 31, 2008 and 2007, respectively.

The following table sets forth by level, within the fair value hierarchy, the Association's assets at fair value as of December 31/2008:

	<u>Level 1</u>	<u>Level 2</u>	<u>Level 3</u>	<u>Total</u>
Money market funds	\$ 1,798,787	--	--	1,798,787
Bonds and bond funds	26,035,141	--	--	26,035,141
Equities and equity funds	<u>42,250,706</u>	<u>--</u>	<u>6,188,354</u>	<u>48,439,060</u>
	<u>\$70,084,634</u>	<u>--</u>	<u>6,188,354</u>	<u>76,272,988</u>

# American Dental Association and Subsidiaries

## Notes to Consolidated Financial Statements, December 31, 2008 and 2007 (continued)

Investment (loss) income for the years ended December 31, 2008 and 2007 consisted of the following:

	<u>2008</u>	<u>2007</u>
Interest and dividends	\$ 2,614,995	3,469,078
Net realized and unrealized (depreciation) appreciation in fair value of marketable securities	(32,861,640)	5,453,905
Net realized and unrealized (depreciation) appreciation on funds held for deferred compensation	<u>(1,087,415)</u>	<u>387,274</u>
	<u>\$ (31,334,060)</u>	<u>9,310,257</u>

The following table summarizes the changes in fair values associated with SFAS No. 157 level 3 assets:

	Mutual Fund
Balance as of December 31, 2007	—
Purchases	\$ 6,515,000
Unrealized losses	<u>(326,646)</u>
Balance as of December 31, 2008	<u>\$ 6,188,354</u>

All net unrealized losses in the table above are reflected in the accompanying Statements of Activities.

### 4. Property and equipment

Property and equipment at December 31, 2008 and 2007 consisted of the following:

	<u>2008</u>			<u>2007</u>		
	<u>Chicago, IL</u>	<u>Washington, DC</u>	<u>Total</u>	<u>Chicago, IL</u>	<u>Washington, DC</u>	<u>Total</u>
Land	\$ 712,113	3,030,000	3,742,113	712,113	3,030,000	3,742,113
Building	12,381,169	9,602,195	21,983,364	12,381,169	9,602,195	21,983,364
Building improvements	66,789,981	2,040,095	68,830,076	65,879,070	755,392	66,634,462
Furniture and equipment	36,309,914	947,303	37,257,217	35,280,150	882,384	36,162,534
Film and book libraries and exhibits	606,243	—	606,243	591,139	—	591,139
Tenant leasehold improvements	<u>1,299,350</u>	<u>1,331,033</u>	<u>2,630,383</u>	<u>1,039,079</u>	<u>1,139,328</u>	<u>2,178,407</u>
	<u>118,098,770</u>	<u>16,950,626</u>	<u>135,049,396</u>	<u>115,882,720</u>	<u>15,409,299</u>	<u>131,292,019</u>
Less accumulated depreciation and amortization	<u>74,663,192</u>	<u>8,397,094</u>	<u>83,060,286</u>	<u>68,809,349</u>	<u>7,949,038</u>	<u>76,758,387</u>
	<u>\$43,435,578</u>	<u>8,553,532</u>	<u>51,989,110</u>	<u>47,073,371</u>	<u>7,460,261</u>	<u>54,533,632</u>

# American Dental Association and Subsidiaries

## Notes to Consolidated Financial Statements, December 31, 2008 and 2007 (continued)

Effective December 31, 2007, costs related to renovation and asbestos abatement for the Association's Headquarters building that were previously accumulated within the Capital Improvement and ADA Renovation Programs were transferred to ADA building improvements. Construction activity for these programs was substantially complete at December 31, 2007. Prior to transfer, cumulative amounts of building improvements for these programs at December 31, 2007 were:

	2007	
	Capital Improvement Program	ADA Renovation Program
Asbestos abatement	\$ 6,179,519	3,214,731
Remodeling	16,620,137	29,371,932
	<u>22,799,656</u>	<u>32,586,663</u>
Less accumulated depreciation	13,842,241	7,681,021
	<u>\$ 8,957,415</u>	<u>24,905,642</u>

The Capital Improvement Program encompassed remodeling and asbestos abatement activities primarily on tenant space funded by a four-year \$55 dues increase for Association members, effective from 1993 to 1996, relating to this endeavor. The Capital Improvement Account within the Operating Division was established to classify revenues, expenses, assets and liabilities restricted to this activity.

The ADA Renovation Program, approved by the 2000 House of Delegates, extended the remodeling activities to Association-occupied space in the Headquarters Building. To help fund this initiative, a six-year \$30 dues assessment for Association members was enacted, effective from 2001 to 2006. Additionally, \$2.5 million was transferred from the Capital Improvement Account in 2000 with another \$1.5 million transferred from the Building Fund in 2001. Also, \$1.0 million of the annual budgeted provision from the Operating Account to the Building Fund was redirected to the Renovation project beginning in 2002. On January 1, 2004 the Building Fund was eliminated and monies were transferred to the ADA's operating account. \$1.0 million was directed from the operating account to the renovation project beginning in 2004. The ADA Renovation Program Account within the Operating Division was established to classify the revenues, expenses, assets and liabilities restricted to the remodeling and asbestos abatement of Association-occupied space in the Headquarters Building.

The Association leases portions of both the Headquarters Building and the Washington, DC Office Building to unrelated parties under operating leases with varying terms. These amounts may be adjusted upon renewal of the leases. Minimum future rentals to be earned from leases currently in effect as of December 31, 2008 are:

2009	\$ 4,326,272
2010	4,353,242
2011	4,250,005
2012	4,036,751
2013	2,961,138
Thereafter	6,715,020
	<u>\$26,642,428</u>

Building expenses include the cost of facilities occupied by the Association, as well as those costs related to other tenants.

### 5. Deferred Compensation

Pursuant to agreements between the Association and certain officers and employees of the Association and its affiliates, portions of their compensation have been retained by the Association and invested as directed by those participants. The assets are owned by the Association until distributed to the participants after termination of employment or services.

# American Dental Association and Subsidiaries

## Notes to Consolidated Financial Statements, December 31, 2008 and 2007 (continued)

### 6. Income Taxes

The Association and ADAF have received favorable determination letters from the Internal Revenue Service stating that they are exempt from taxation on income related to their exempt purposes under Section 501(a) of the Internal Revenue Code as organizations described in sections 501(c)(6) and 501(c)(3), respectively. As exempt organizations, the Association and ADAF are subject to federal and state income taxes on income determined to be unrelated business taxable income. ADPAC is exempt from federal income taxes under section 527 of the Internal Revenue Code, except on net investment income. The income of the Association's for-profit subsidiary, ADABEI, determined separately, is also subject to federal and state income taxes.

Income tax expense for the years ended December 31, 2008 and 2007 is as follows:

	<u>2008</u>	<u>2007</u>
Current:		
Federal	\$ 1,279,789	640,548
State	355,115	153,388
Current income tax expense	<u>1,634,904</u>	<u>793,936</u>
Deferred:		
Federal	222,889	(131,903)
State	51,624	(30,550)
Deferred income tax expense (benefit)	<u>274,513</u>	<u>(162,453)</u>
Income tax expense	<u>\$ 1,909,417</u>	<u>631,483</u>

Income tax expense differs from the amount computed by applying the statutory federal income tax rate of 34% to income before income tax expense primarily because a significant portion of consolidated income is exempt from income tax.

Deferred taxes receivable at December 31, 2008 and 2007 consisted of:

	<u>2008</u>	<u>2007</u>
Deferred tax asset resulting from:		
Postretirement	\$ 52,573	47,582
Charitable contributions	76,177	52,886
Start-up costs	85,208	85,208
Investment in ADAidm	170,368	95,425
Allowance for doubtful accounts not currently deductible	15,423	--
Net operating loss carryforward	231,502	--
AMT credit carryforward	14,050	--
	<u>645,301</u>	<u>281,101</u>
Deferred tax liability resulting from furniture and equipment	<u>(5,032)</u>	<u>(6,588)</u>
Deferred tax assets, net	640,269	274,513
Valuation allowance	<u>(640,269)</u>	<u>--</u>
Total net deferred tax assets, net of valuation allowance	<u>\$ --</u>	<u>274,513</u>

## American Dental Association and Subsidiaries

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### Notes to Consolidated Financial Statements, December 31, 2008 and 2007 (continued)

The Association has set up a full valuation allowance for its net deferred tax assets as it has determined will not meet the more likely than not threshold for recovery of these assets.

As of December 31, 2008, net operating loss carryforwards for federal tax purposes totaling \$504,752 are available to offset future taxable income of ADABEI and expire as follows: \$32,791 in 2027 and \$471,961 in 2028. As of December 31, 2008, net operating loss carryforwards for state tax purposes totaling \$1,242,962 are available to offset future taxable income, and expire as follows: \$733,835 in 2019 and \$509,127 in 2020.

#### **7. Employee Benefit Plans**

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**Defined Benefit Plan and Supplemental Plan:** The Association sponsors a noncontributory defined benefit pension plan, which covers substantially all employees of the Association, its subsidiaries and affiliates meeting certain eligibility requirements. Generally, the Association's funding policy is to contribute annually to the pension plan such amounts that may be deducted for Federal income tax purposes. Retirement benefit payments are based on years of credited service, average compensation during the five years of employment that produce the highest average, and the average Social Security limit at employment termination date.

# American Dental Association and Subsidiaries

## Notes to Consolidated Financial Statements, December 31, 2008 and 2007 (continued)

Pursuant to agreements between the Association and a certain prior employee, the Association also maintains a frozen unfunded supplemental retirement income plan funded through Association general assets. Investments designated for the supplemental plan of \$344,986 and \$447,605 at December 31, 2008 and 2007, respectively, are carried at fair value and included in prepaid expenses and other assets.

The Internal Revenue Service has informed the Employees' Retirement Trust administration that the plan is qualified under provisions of the Code and, therefore, the related trust is exempt from federal income taxes. The Employees' Supplemental Trust is a non-qualified plan and as such is not exempt from federal income taxes.

The following table sets forth the plans' funded status and amounts recognized in the Association's consolidated financial statements:

	2008			2007 Total
	Employees' Retirement Trust	Employees' Supplemental Trust	Total	
<b>Change in benefit obligation</b>				
Benefit obligation, beginning of year	\$ 84,092,639	875,522	84,968,161	80,137,315
Service cost	3,993,816	--	3,993,816	3,444,857
Interest cost	5,809,325	59,033	5,868,358	5,383,694
Actuarial loss (gain)	(288,096)	31,660	(256,436)	(494,840)
Benefits paid	(4,905,474)	(92,796)	(4,998,270)	(3,502,865)
Benefit obligation, end of year	<u>\$ 88,702,210</u>	<u>873,419</u>	<u>89,575,629</u>	<u>84,968,161</u>
<b>Change in plan assets</b>				
Fair value of plan assets, beginning of year	82,231,391	--	82,231,391	70,475,383
Actual return on plan assets	(13,330,651)	--	(13,330,651)	7,726,077
Employer contributions	7,710,100	92,796	7,802,896	7,532,796
Benefits paid	(4,905,474)	(92,796)	(4,998,270)	(3,502,865)
Plan assets, end of year	<u>\$ 71,705,366</u>	<u>--</u>	<u>71,705,366</u>	<u>82,231,391</u>
<b>Funded status, end of year</b>				
Fair value of plan assets	71,705,366	--	71,705,366	82,231,391
Benefit obligation	<u>88,702,210</u>	<u>873,419</u>	<u>89,575,629</u>	<u>84,968,161</u>
Funded status	(16,996,844)	(873,419)	(17,870,263)	(2,736,770)
Unrecognized net actuarial loss	--	--	--	--
Pension liability	<u>\$(16,996,844)</u>	<u>(873,419)</u>	<u>(17,870,263)</u>	<u>(2,736,770)</u>
<b>Components of net periodic benefit cost</b>				
Service cost	\$ 3,993,816	--	3,993,816	3,444,857
Interest cost	5,809,325	59,033	5,868,358	5,383,694
Expected return on plan assets	(7,015,636)	--	(7,015,636)	(5,980,593)
Recognized net loss	508,620	11,435	520,055	889,790
Net periodic benefit cost	<u>\$ 3,296,125</u>	<u>70,468</u>	<u>3,366,593</u>	<u>3,737,748</u>
<b>Weighted average assumptions as of December 31:</b>				
Discount rate	6.86%	6.86%	6.86%	6.95%
Expected return on plan assets	8.00%	8.00%	8.00%	8.00%
Rate of compensation increase	3.50%	3.50%	3.50%	4.50%

## American Dental Association and Subsidiaries

### Notes to Consolidated Financial Statements, December 31, 2008 and 2007 (continued)

The discount rate is determined each year as of the measurement date, based on a review of interest rates associated with long-term high quality corporate bonds. The discount rate determined on each measurement date is used to calculate the benefit obligation as of that date, and is also used to calculate the net periodic benefit cost for the upcoming plan year.

The pension fund's expected return on assets assumption is derived from a review of actual historical returns achieved by the pension trust and anticipated future long-term performance of individual asset classes with consideration given to the appropriate investment strategy. While the method gives appropriate consideration to recent trust performance and historical returns, the assumption represents a long-term prospective return. The expected return on plan assets determined on each measurement dates is used to calculate the net periodic benefit cost for the upcoming plan year.

The actual allocations for the pension assets as of December 31, 2008 and 2007, and target allocations by asset category, are as follows:

Asset Category	2008		2007	
	Actual Allocation	Target Allocation	Actual Allocation	Target Allocation
Fixed income	57%	40%	41%	40%
Equity				
Small cap	8%	12%	12%	12%
Large cap value	13%	18%	17%	18%
Large cap growth	13%	18%	18%	18%
International	9%	12%	12%	12%
	<u>100%</u>	<u>100%</u>	<u>100%</u>	<u>100%</u>

Pension assets are allocated with a goal to achieve diversification between and within various asset classes. The target asset allocations are expected to earn an average annual rate of return of approximately 8% measured over a planning horizon of 20 years with a reasonable and acceptable level of risk. Actual allocation percentages will vary from target allocation percentages based upon short term fluctuations in cash flows and benefit payments.

Domestic equity includes securities of domestic companies listed on the US exchanges or traded OTC, diversified across industry and individual holdings. International equity includes securities primarily of companies located outside the US diversified across countries and industries. Fixed income refers to a diversified portfolio of marketable debt instruments with an average quality rating of at least AA or equivalent.

Required pension contributions under Employee Retirement Income Security Act (ERISA) regulations will be approximately \$7,645,000 in 2009.

The table below reflects the total pension benefits expected to be paid in each of the next five years and in the aggregate for the five years thereafter.

2009	\$ 3,610,116
2010	\$ 3,996,354
2011	\$ 4,454,306
2012	\$ 4,941,087
2013	\$ 5,462,923
2014-2018	\$ 37,704,728

# American Dental Association and Subsidiaries

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## Notes to Consolidated Financial Statements, December 31, 2008 and 2007 (continued)

**401(k) Plan:** The Association has a savings and retirement plan for all eligible employees. The Association matches 50% of contributed amounts up to a maximum of \$500 per participant each year. The Association's contributions under this plan were \$226,054 in 2008 and \$229,978 in 2007.

The Internal Revenue Service has informed the Savings Plan administrator that the plan is qualified under provisions of the Code and, therefore, the related trust is exempt from federal income taxes.

**Executive Parity Plan:** The Association has established the Executive Parity Plan which compensates executives of the Association and its subsidiaries who suffered restrictions in their pension benefits beginning in 1994 as a result of the Omnibus Budget Reconciliation Act. This is a deferred compensation arrangement which allows the Compensation Committee of the Board of Trustees to set aside, on an annual basis, a specified cash amount for those individuals who suffered a benefit loss during the year, to be paid upon vesting. Awards totaling \$728,236 and \$462,283 (reflected in accrued liabilities) at December 31, 2008 and 2007 respectively, were granted, after payments totaling \$1,219,979 in 2008 and \$554,437 in 2007 were made to participants.

## American Dental Association and Subsidiaries

### Notes to Consolidated Financial Statements, December 31, 2008 and 2007 (continued)

**Postretirement Health Plan:** The Association sponsors a contributory defined benefit postretirement health plan, which covers substantially all employees of the Association, its subsidiaries and affiliates. The plan provides both medical and dental benefits.

The following table sets forth the plan's funded status:

	<u>2008</u>	<u>2007</u>
<b>Change in benefit obligation</b>		
Benefit obligation, beginning of year	\$ 10,033,961	11,188,704
Service cost	498,968	479,882
Interest cost	760,669	683,631
Actuarial loss (gain)	1,252,277	(1,963,829)
Benefits paid	(326,289)	(354,427)
Benefit obligation, end of year	<u>\$ 12,219,586</u>	<u>10,033,961</u>
<b>Change in plan assets</b>		
Fair value of plan assets, beginning of year	\$ --	--
Actual return on plan assets	--	--
Employer contributions	326,289	354,427
Benefits paid	(326,289)	(354,427)
Plan assets, end of year	<u>\$ --</u>	<u>--</u>
<b>Funded status, end of year</b>		
Fair value of plan assets	\$ --	--
Benefit obligation	12,219,586	10,033,961
Funded status	<u>\$ (12,219,586)</u>	<u>(10,033,961)</u>
<b>Components of net periodic benefit cost</b>		
Service cost	\$ 498,968	479,882
Interest cost	760,669	683,631
Amortization of transition obligation	182,302	182,302
Net periodic benefit cost	<u>\$ 1,441,939</u>	<u>1,345,815</u>
<b>Weighted average assumptions used to determine obligations at December 31:</b>		
Discount rate	6.86%	6.95%
<b>Weighted average assumptions used to determine net periodic benefit cost for the years ended December 31:</b>		
Discount rate	6.95%	6.75%
Health care cost trend rate	6.00%	6.00%
<b>Assumed health care cost trend rates at December 31:</b>		
Health care cost trend rate assumed next year	6.00%	6.00%
Ultimate trend rate	6.00%	6.00%
Year that trend reached ultimate rate	2008	2008

## American Dental Association and Subsidiaries

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### Notes to Consolidated Financial Statements, December 31, 2008 and 2007 (continued)

The Association expects to contribute approximately \$484,734 to the postretirement health plan in 2009.

The Medicare Prescription Drug, Improvement and Modernization Act of 2003 (the Act) became law on December 8, 2003. The Act adds a prescription drug benefit under Medicare (Medicare Part D) and provides a federal subsidy to retiree health care benefit plan sponsors that provide a benefit that is at least actuarially equivalent to Medicare Part D. The Association currently provides post-retirement benefits to retirees under three plans. The Association compared the Medicare Part D plan to its retiree prescription drug coverages using actuarial equivalencies and reflecting the retiree premiums and cost sharing provisions of the various plans. The Association concluded that the prescription drug benefit provided under these plans is actuarially equivalent to the benefit provided under the Act, and is and will be entitled to the employer subsidy available under the Act.

The employer contribution under the Association's retiree health plan is limited to increases of not more than 6% per year, cumulative from 1993/1994. The Association has chosen the application of FSP FAS 106-2, remeasuring plan assets and its accumulated postretirement benefit obligation (APBO) at December 31, 2006 to reflect the effects of the Medicare Act upon the accounting for the Association's post retirement health plan. Because of the overriding limit on employer contributions under the Plan, the impact of the Medicare subsidy upon the accounting for the Plan is minimal.

The remeasurement for the subsidy reduced the APBO related to benefits attributed to past service by \$154,984 at year end (\$103,046 as of January 1). The effect of the subsidy on the measurement of net periodic postretirement cost for 2008 is a reduction of \$25,290 and is recognized evenly throughout the fiscal year. The effects include lower service costs of \$18,335 and lower interest costs of \$6,955.

The table below reflects the postretirement health payments expected in each of the next five years and in the aggregate for the five years thereafter:

	<u>Gross Payments</u>	<u>Net Payments After Medicare Part D Adjustment</u>
2009	\$ 484,734	453,542
2010	\$ 497,977	465,840
2011	\$ 536,950	501,597
2012	\$ 582,632	543,479
2013	\$ 632,062	588,667
2014-2018	\$ 4,052,799	3,750,440

## American Dental Association and Subsidiaries

Notes to Consolidated Financial Statements, December 31, 2008 and 2007 (continued)

### 8. Net Assets

The following activity impacted unrestricted, temporarily restricted and permanently restricted net assets during 2008 and 2007:

	2008			2007				
	Unrestricted	Temporarily Restricted	Permanently Restricted	Total	Unrestricted	Temporarily Restricted	Permanently Restricted	Total
Revenues	\$ 90,571,362	1,054,987	18,142	91,644,491	122,378,398	5,354,928	30,320	127,763,646
Net assets released from restrictions	4,847,141	(4,847,141)	--	--	4,736,235	(4,736,235)	--	--
Total revenues	95,418,503	(3,792,154)	18,142	91,644,491	127,114,633	618,693	30,320	127,763,646
Expenses, including income taxes	123,257,542	--	--	123,257,542	118,928,337	--	--	118,928,337
Net (loss) income	(27,839,039)	(3,792,154)	18,142	(31,613,051)	8,186,296	618,693	30,320	8,835,309
Pension-related changes other than net periodic pension cost	(20,639,772)	--	--	(20,639,772)	--	--	--	--
Effect of adoption of SFAS 158	--	--	--	--	(13,024,568)	--	--	(13,024,568)
(Decrease) increase in net assets	(48,478,811)	(3,792,154)	18,142	(52,252,823)	(4,838,272)	618,693	30,320	(4,189,259)
Net assets at beginning of year	131,107,601	12,667,195	2,511,260	146,286,056	135,945,873	12,048,502	2,480,940	150,475,315
Net assets at end of year	\$ 82,628,790	8,875,041	2,529,402	94,033,233	131,107,601	12,667,195	2,511,260	146,286,056

# American Dental Association and Subsidiaries

## Notes to Consolidated Financial Statements, December 31, 2008 and 2007 (continued)

### 8. Net Assets (continued)

Temporarily restricted net assets at December 31, 2008 and 2007 were available for the following purposes:

	<u>2008</u>	<u>2007</u>
Campaign for innovation in dental education	\$ 1,133,564	1,593,718
Trusts	640,934	867,288
Extramural programs	249,487	209,240
Research	73,503	31,203
Awards	314,724	418,995
Education	156,642	167,705
Access	1,096,782	1,698,910
Political and legislative	1,252,098	1,707,199
Relief program	<u>3,957,307</u>	<u>5,972,937</u>
	<u>\$ 8,875,041</u>	<u>12,667,195</u>

Temporarily restricted trusts include funds restricted by donors for periodontal research, public education in dental health and memorial commemoration.

Temporarily restricted net assets were released from donor restrictions during 2008 and 2007 by incurring expenses satisfying the restricted purposes as follows:

	<u>2008</u>	<u>2007</u>
Campaign for innovation in dental education	\$ 626,170	1,620,439
Trusts	468	557
Extramural programs	3,916	163,019
Research	24,221	60,477
Awards	27,964	18,930
Education	149,169	182,058
Access	1,337,992	906,657
Political and legislative	2,313,055	1,444,940
Relief program	<u>364,186</u>	<u>339,158</u>
	<u>\$4,847,141</u>	<u>4,736,235</u>

Permanently restricted net assets at December 31, 2008 and 2007 totaled \$2,529,402 and \$2,511,260 respectively. Earnings on these net assets are restricted by donors for children's oral health and education in dental entrepreneurship and leadership.

### 9. Endowment Funds

The Association's endowments consist of various individual funds to support access to care and educational activities within the ADA Foundation (ADAF). Net assets related to the ADAF endowments are donor-restricted funds, classified and reported based upon the donor-imposed restrictions. The ADAF does not have board-designated endowment funds.

The ADAF accounts for endowment net assets by preserving the fair value of the original gift as of the gift date of the donor-restricted endowment fund absent explicit donor stipulations to the contrary. As a result, the ADAF classifies as permanently restricted net assets the original value of gifts donated to the permanent endowment and the original value of

## American Dental Association and Subsidiaries

### Notes to Consolidated Financial Statements, December 31, 2008 and 2007 (continued)

subsequent gifts to the permanent endowment. Earnings on the permanent endowments are classified as temporarily restricted net assets in accordance with the direction of the applicable donor gift instrument. The remaining portion of the donor-restricted endowment fund that is not classified in permanently restricted net assets is classified as temporarily restricted net assets, according to donor stipulations. Temporarily restricted net assets are released from restriction when appropriated for expenditure by the Foundation for the donor-stipulated purpose.

To make a determination to expend or accumulate donor-restricted endowment funds, the ADAF considers a number of factors, including the duration and preservation of the fund, purposes of the donor-restricted fund, general economic conditions, the possible effects of inflation and deflation, the expected total return from income and the appreciation of investments, other resources of the ADAF and the investment policies of the ADAF.

From time to time, the fair value of assets associated with individual donor-restricted endowment funds may fall below the level that the donor requires the ADAF to retain permanently. Deficiencies of this nature that are reported in unrestricted net assets were \$618,448 as of December 31, 2008. These deficiencies resulted from unfavorable market fluctuations that occurred during 2008. There were no such deficiencies as of December 31, 2007.

The ADAF has adopted investment and spending policies for endowment assets that attempt to enhance its ability to support activities, provide long-term real, inflation adjusted growth in assets and support financial flexibility and liquidity. Under this policy, as approved by its Board of Directors, the ADAF's assets are to be adequately diversified to provide a high degree of stability of principal in order to maintain the ability to provide financial assistance to support education and access to care programs. The assets are to be invested in a manner that is intended to grow in real, inflation-adjusted terms and maintain its ability to support spending needs. In addition, the assets are to be efficiently structured to provide the highest level of return within the risk parameters established by its Board.

There are distinct asset pools and the asset allocation of the pools is the major determinant of investment risk exposure, real return levels and current income generation. The endowments have variable spending needs, and the related asset pools are structured to support the spending needs.

The ADAF has an active Finance Committee that meets regularly to ensure the objectives of the investment policy are being met, and the strategies used to meet the objectives are in accordance with the investment policy.

During 2008, the ADAF had the following activities related to endowment net assets:

	Unrestricted	Temporarily Restricted	Permanently Restricted	Total
Endowment net assets, beginning of year	\$ --	374,152	2,511,260	2,885,412
Investment returns				
Interest and dividends	--	70,459	--	70,459
Realized gain on sale of investments	--	48,681	--	48,681
Net unrealized loss on investments	(618,448)	(386,685)	--	(1,005,133)
Total investment return	(618,448)	(267,545)	--	(885,993)
New additions				
Contributions	--	--	18,142	18,142
Total new additions	--	--	18,142	18,142
Appropriation of endowment assets for expenditures	--	(106,607)	--	(106,607)
Total change in endowment net assets	(618,448)	(374,152)	18,142	(974,458)
Endowment net assets, end of year	\$ (618,448)	--	2,529,402	1,910,954

# American Dental Association and Subsidiaries

## Notes to Consolidated Financial Statements, December 31, 2008 and 2007 (continued)

### 10. Expenses by Functional Classification

The following table summarizes the costs of providing various programs and activities on a functional basis:

	<u>2008</u>	<u>2007</u>
Administrative Services	\$ 6,999,886	6,935,513
Legal Affairs	2,762,249	2,193,762
Government Affairs	8,453,953	7,189,415
Membership and Dental Society Services	6,461,879	6,508,451
Global Affairs	1,054,802	1,014,367
Conference and Meeting Services	8,871,689	10,717,000
Finance and Operations	4,108,562	3,899,109
Headquarters Building	4,468,606	4,623,920
DC Building	883,346	778,821
Salable Materials	4,087,905	4,378,005
Central Administration	22,471,614	19,554,845
Information Technology and Standards	7,004,240	6,731,624
Dental Practice	4,359,780	5,332,432
Health Policy Resources Center	1,741,787	1,785,281
Education	11,191,843	9,696,649
Science	4,356,864	3,844,907
Publishing	9,445,557	7,540,677
Corporate Relations	442,230	598,874
Activities Funded from Reserves	241,063	763,801
Grant from ADA to ADAF	3,233,192	3,435,452
	<u>112,641,047</u>	<u>107,522,905</u>
Capital Improvement Account	--	991,919
ADA Renovation Program	--	1,783,748
Reserve Division Investment Account	1,130,716	1,402,651
Eliminations of intercompany activity -		
Grant from ADA to ADAF	(3,233,192)	(3,435,452)
Reserve Division earnings transfer	(1,130,716)	(1,402,651)
Renovation disbursements	--	(55,370)
Headquarters building management office rent expense	(31,392)	(31,392)
	<u>109,376,463</u>	<u>106,776,358</u>
ADPAC	2,313,055	1,444,940
ADAF (including fundraising expenses of \$705,223 in 2008 and \$756,047 in 2007)	9,951,097	9,973,336
ADABEI	3,323,134	3,000,980
Eliminations of intercompany activity -		
Legal expenses	(17,303)	(67,953)
ADABEI rental charges	(79,278)	(81,601)
Accounting fees charged to ADAF	(27,000)	(27,000)
Printing expenses	(40,197)	(239,488)
Advertising, sponsorship and promotion	(444,460)	(257,759)
Meeting expenses	(50,840)	(50,013)
Research expenses	(32,105)	--
Donation from ADABEI to ADAF	(60,000)	(60,000)
Other contributions between ADA and ADAF	--	(10,000)
Overhead recovery	(955,024)	(1,086,189)
	<u>\$123,257,542</u>	<u>119,315,611</u>

## **American Dental Association and Subsidiaries**

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### Notes to Consolidated Financial Statements, December 31, 2008 and 2007 (continued)

#### **11. Commitments and Contingencies**

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The Association is involved in various asserted and unasserted claims incidental to the normal conduct of its business. In the opinion of management and the Association's legal counsel, the ultimate disposition of these matters will not have a material adverse effect on the consolidated results of operations or financial position of the Association.

#### **12. Subsequent Events**

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Effective May 19, 2009, ADABEI held a 75% interest in ADAidm after one of the Class A members transferred his 25% interest in ADAidm to ADABEI. Effective June 9, 2009, the remaining Class A member surrendered his shares to ADABEI, resulting in ADABEI owning 100% of the shares of ADAidm. There was no consideration paid to the Class A members in exchange for their interests.

Subsequent to these transactions, ADABEI announced on July 10, 2009 that ADAidm would cease operations due to significant production and operational difficulties.

Through December 2009, ADABEI has incurred approximately \$4.9 million for costs related to the wind-down of ADAidm, including refunds to customers for undelivered goods and services and payments of outstanding balances to vendors. In addition, other costs have been incurred to wind-down operations. Total costs related to the wind-down of ADAidm are not expected to exceed \$5.7 million.

ADABEI entered into a termination agreement with Citibank on August 7, 2009, pursuant to which program assets were transferred to ADABEI's designated buyer, US Bank National Association ND dba Elan Financial Services. ADABEI received a \$3.7 million premium share from Citibank on September 2, 2009 related to this termination. Distributions of \$289,242 from these funds were made to endorsing state societies in 2009.

**CONSOLIDATING INFORMATION**

**American Dental Association and Subsidiaries**  
**CONSOLIDATING STATEMENT OF FINANCIAL POSITION**  
 December 31, 2008

	<u>General Fund</u>							Total		
	<u>Operating Division</u>		<u>Reserve Division</u>			<u>Capital</u>				
	Operating Account	Formation Account	Investment Account	General Fund	ADPAC	ADAF	ADABEI		Eliminations	Total
<b>ASSETS</b>										
Cash and cash equivalents	4,122,940	-	-	4,122,940	1,129,734	582,670	272,910	-	-	6,108,254
Receivables, net	5,422,491	-	-	5,422,491	-	1,092,258	505,628	-	-	7,020,377
Due from (to) affiliates	1,066,367	-	21,781	1,088,148	-	(715,691)	(372,557)	-	-	-
Income taxes receivable	120,512	-	-	120,512	-	-	361,114	-	-	481,626
Prepaid expenses and other assets	2,301,146	-	-	2,301,146	133,750	28,809	6,475	-	-	2,470,180
Inventories, net	707,357	-	-	707,357	-	-	-	-	-	707,357
Marketable securities	7,442,721	-	48,703,245	56,145,966	-	18,328,235	1,798,787	-	-	76,272,988
Other investments	-	-	-	-	-	-	-	-	-	-
Investment in subsidiaries	-	2,507,526	-	2,507,526	-	-	-	(2,507,526)	-	-
Property and equipment, net	51,589,918	-	-	51,589,918	-	386,229	12,963	-	-	51,989,110
Funds held for deferred compensation	4,498,481	-	-	4,498,481	-	-	-	-	-	4,498,481
<b>Total Assets</b>	<b>77,271,933</b>	<b>2,507,526</b>	<b>48,725,026</b>	<b>128,504,485</b>	<b>1,263,484</b>	<b>19,702,610</b>	<b>2,585,320</b>	<b>(2,507,526)</b>	<b>-</b>	<b>149,548,373</b>
<b>LIABILITIES AND NET ASSETS</b>										
Liabilities:										
Accounts payable and accrued liabilities	9,131,483	-	301,404	9,432,887	6,604	1,062,122	77,794	-	-	10,579,407
Income taxes payable	-	-	-	-	4,782	-	-	-	-	4,782
Deferred revenues	10,232,864	-	-	10,232,864	-	108,757	-	-	-	10,342,621
Liability for deferred compensation	4,498,481	-	-	4,498,481	-	-	-	-	-	4,498,481
Post-retirement benefit obligation	-	-	12,219,586	12,219,586	-	-	-	-	-	12,219,586
Pension liability	17,870,263	-	-	17,870,263	-	-	-	-	-	17,870,263
<b>Total Liabilities</b>	<b>41,733,091</b>	<b>-</b>	<b>12,520,990</b>	<b>54,254,081</b>	<b>11,386</b>	<b>1,171,879</b>	<b>77,794</b>	<b>-</b>	<b>-</b>	<b>55,515,140</b>
Net assets:										
Common stock	-	-	-	-	-	-	100,100	(100,100)	-	-
Additional paid-in capital	-	-	-	-	-	-	500,000	(500,000)	-	-
Unrestricted	35,538,842	2,507,526	36,204,036	74,250,404	-	8,378,386	1,907,426	(1,907,426)	-	82,628,790
Temporarily restricted	-	-	-	-	1,252,098	7,622,943	-	-	-	8,875,041
Permanently restricted	-	-	-	-	-	2,529,402	-	-	-	2,529,402
<b>Total Net Assets</b>	<b>35,538,842</b>	<b>2,507,526</b>	<b>36,204,036</b>	<b>74,250,404</b>	<b>1,252,098</b>	<b>18,530,731</b>	<b>2,507,526</b>	<b>(2,507,526)</b>	<b>-</b>	<b>94,033,233</b>
<b>Total Liabilities and Net Assets</b>	<b>77,271,933</b>	<b>2,507,526</b>	<b>48,725,026</b>	<b>128,504,485</b>	<b>1,263,484</b>	<b>19,702,610</b>	<b>2,585,320</b>	<b>(2,507,526)</b>	<b>-</b>	<b>149,548,373</b>

American Dental Association and Subsidiaries  
 CONSOLIDATING STATEMENT OF ACTIVITIES  
 Year ended December 31, 2008

	Operating Division		General Fund Reserve Division		ADPAC	ADAF	ADABEI	Eliminations	Total
	Operating Account	Capital Formation Account	Investment Account	Total General Fund					
<b>REVENUES</b>									
Membership dues	\$ 54,196,747	-	-	54,196,747	-	-	-	-	54,196,747
Advertising	10,109,332	-	-	10,109,332	-	-	-	(164,412)	9,944,920
Rental income	5,494,781	-	-	5,494,781	-	-	-	(110,670)	5,384,111
Publication and product sales	8,584,837	-	-	8,584,837	24,416	-	-	(197,041)	8,412,212
Testing and accreditation fees	13,499,275	-	-	13,499,275	-	-	-	-	13,499,275
Meeting and seminar income	9,688,058	-	-	9,688,058	-	22,500	-	(50,840)	9,659,718
Grants, contributions and sponsorships	2,406,631	-	-	2,406,631	1,813,834	7,591,699	-	(3,443,503)	8,368,661
Royalties	6,671,458	-	-	6,671,458	-	1,784,828	2,453,872	(5,000)	10,905,158
Investment (loss) income	(168,866)	(1,187,884)	(23,134,834)	(24,491,584)	13,664	(6,962,776)	49,469	57,167	(31,334,060)
Equity in loss of other investments	-	-	-	-	-	-	(368,091)	-	(368,091)
Other income	3,924,760	-	-	3,924,760	30,456	19,948	(999,324)	-	2,975,840
<b>Total Revenues</b>	<b>114,407,013</b>	<b>(1,187,884)</b>	<b>(23,134,834)</b>	<b>90,084,295</b>	<b>1,857,954</b>	<b>2,480,615</b>	<b>2,135,250</b>	<b>(4,913,623)</b>	<b>91,544,491</b>
<b>EXPENSES</b>									
Staff compensation, taxes and benefits	47,991,208	-	-	47,991,208	-	4,695,693	1,209,273	(2,405)	53,893,769
Printing, publication and marketing	12,812,286	-	-	12,812,286	491,323	663,757	774,137	(354,779)	14,386,724
Meeting expenses	2,806,915	-	-	2,806,915	9,025	72,132	30,607	(54,026)	2,864,653
Travel expenses	6,456,525	-	-	6,456,525	21,264	315,401	115,714	-	6,908,904
Consulting fees and outside services	9,147,121	-	-	9,147,121	171,143	992,523	389,689	-	10,700,456
Professional services	7,896,885	-	-	7,896,885	39,883	420,158	127,769	(44,303)	8,440,392
Office expenses	5,011,661	-	-	5,011,661	31,548	221,111	25,511	(34,692)	5,255,139
Facility and utility expenses	4,670,420	-	-	4,670,420	-	-	82,409	(110,670)	4,642,159
Grants and awards	454,452	-	-	454,452	1,534,300	1,587,340	60,000	(179,105)	3,456,987
Grant to ADA Foundation	3,233,192	-	-	3,233,192	-	-	-	(3,233,192)	-
Royalty expenses	715,326	-	-	715,326	-	89,639	5,874	(5,000)	710,326
Depreciation and amortization	6,656,804	-	-	6,656,804	-	-	-	-	6,752,317
Bank and credit card fees	927,245	-	-	927,245	8,512	-	-	-	935,757
Other expenses	2,289,865	-	-	2,289,865	-	-	-	-	2,400,542
<b>Total Expenses</b>	<b>111,069,905</b>	<b>-</b>	<b>-</b>	<b>112,200,621</b>	<b>2,306,998</b>	<b>9,951,097</b>	<b>2,990,916</b>	<b>(6,101,507)</b>	<b>121,348,125</b>
Net (loss) income before income tax	3,337,108	(1,187,884)	(24,265,550)	(22,116,326)	(449,044)	(7,470,482)	(855,666)	1,187,884	(29,703,634)
Income tax expense	(1,571,142)	-	-	(1,571,142)	(6,057)	-	(332,218)	-	(1,909,417)
<b>Net (loss) income</b>	<b>1,765,966</b>	<b>(1,187,884)</b>	<b>(24,265,550)</b>	<b>(23,687,468)</b>	<b>(455,101)</b>	<b>(7,470,482)</b>	<b>(1,187,884)</b>	<b>1,187,884</b>	<b>(31,613,051)</b>
Pension- and postretirement health plan-related changes other than net periodic pension cost	(19,569,796)	-	(1,069,976)	(20,639,772)	-	-	-	-	(20,639,772)
(Decrease) increase in net assets	<b>(17,803,830)</b>	<b>(1,187,884)</b>	<b>(25,335,526)</b>	<b>(44,327,240)</b>	<b>(455,101)</b>	<b>(7,470,482)</b>	<b>(1,187,884)</b>	<b>1,187,884</b>	<b>(52,252,823)</b>
Net assets at beginning of year	55,407,856	3,695,410	59,474,378	118,577,644	1,707,199	26,001,213	3,095,310	(3,095,310)	146,286,056
Equity transfers	(2,065,184)	-	2,065,184	-	-	-	-	-	-
<b>Net assets at end of year</b>	<b>35,538,842</b>	<b>2,507,526</b>	<b>36,204,036</b>	<b>74,250,404</b>	<b>1,252,098</b>	<b>18,530,731</b>	<b>1,907,426</b>	<b>(1,907,426)</b>	<b>94,033,233</b>

**American Dental Association and Subsidiaries**  
**CONSOLIDATING STATEMENT OF CASH FLOWS**  
 Year ended December 31, 2008

	General Fund						Total			
	Operating Division		Reserve Division		Total					
	Operating Account	Capital Formation Account	Investment Account	General Fund	ADPAC	ADAF		ADABEI	Eliminations	Total
Cash flows from operating activities:										
Increase (decrease) in net assets	(17,803,830)	(1,187,884)	(25,335,526)	(44,327,240)	(455,101)	(7,470,482)	(1,187,884)	1,187,884	(52,252,823)	
Adjustments to reconcile increase (decrease) in net assets to net cash provided (used) by operating activities:										
Pension- and postretirement health plan- related changes other than net periodic pension cost	19,569,796	-	1,069,976	20,639,772	-	-	-	-	20,639,772	
Depreciation and amortization	6,656,804	-	-	6,656,804	-	89,639	5,874	-	6,752,317	
Deferred income tax expense (benefit)	444,005	-	26,149,147	26,593,152	-	7,916,143	-	-	34,509,295	
Unrealized depreciation (appreciation) in fair value of marketable securities	626,754	-	(1,883,596)	(1,256,842)	-	(383,517)	-	-	(1,640,359)	
Net realized (gain) loss on sale of marketable securities	-	1,187,884	-	1,187,884	-	-	368,091	(1,187,884)	368,091	
(Gain) loss on sale of property and equipment	(19,590)	-	-	(19,590)	-	(137,278)	-	-	(19,590)	
Contributions of stock	-	-	-	-	-	(18,142)	-	-	(18,142)	
Contributions received for long-term purposes	-	-	-	-	-	-	-	-	-	
Changes in assets and liabilities:										
Receivables, net	(175,515)	-	-	(175,515)	-	(283,262)	36,013	-	(422,764)	
Income taxes receivable	(109,470)	-	-	(109,470)	-	-	56,705	-	(52,765)	
Prepaid expenses and other assets	543,440	-	-	543,440	(77,500)	(3,700)	(6,475)	-	455,765	
Inventories, net	(96,150)	-	-	(96,150)	-	-	-	-	(96,150)	
Due from/to affiliated organizations	374,812	-	(236,963)	137,849	-	(16,923)	(120,926)	-	-	
Accounts payable and accrued liabilities	(1,156,104)	-	(491,744)	(1,647,848)	104	194,773	(126,271)	-	(1,579,242)	
Income taxes payable	(1,799,684)	-	-	(1,799,684)	(717)	(71,116)	-	-	(1,870,800)	
Deferred revenues	(4,436,303)	-	1,115,649	(3,320,654)	-	-	-	-	(3,320,654)	
Post-retirement benefit obligation	-	-	-	-	-	-	-	-	-	
Pension liability	-	-	-	-	-	-	-	-	-	
Net cash provided (used) by operating activities	2,618,965	-	386,943	3,005,908	(533,214)	(183,865)	(700,360)	-	1,588,469	
Cash flows from investing activities:										
Purchase of marketable securities	(22,805,177)	-	(17,306,854)	(40,112,031)	-	(1,184,707)	(39,961)	-	(41,336,699)	
Sale of marketable securities	24,500,000	-	14,854,727	39,354,727	-	1,777,931	930,598	-	42,063,256	
Acquisitions of property and equipment	(3,975,969)	-	-	(3,975,969)	-	(231,826)	-	-	(4,207,795)	
Proceeds from sale of property and equipment	19,590	-	-	19,590	-	-	-	-	19,590	
Net cash (used) provided by investing activities	(2,261,556)	-	(2,452,127)	(4,713,683)	-	361,398	890,637	-	(3,461,648)	
Cash flows from financing activities:										
Contributions received for long-term purposes	-	-	-	-	-	18,142	-	-	18,142	
Net cash provided by financing activities	-	-	-	-	-	18,142	-	-	18,142	
Net (decrease) increase in cash and cash equivalents	357,409	-	(2,065,184)	(1,707,775)	(533,214)	195,675	190,277	-	(1,855,037)	
Cash and equivalents at beginning of year	5,830,715	-	-	5,830,715	1,662,948	386,995	82,633	-	7,963,291	
Equity transfers funded with cash	(2,065,184)	-	2,065,184	-	-	-	-	-	-	
Cash and cash equivalents at end of year	4,122,940	-	-	4,122,940	1,129,734	582,670	272,910	-	6,108,254	

# ADA Foundation

Dental Education | Access to Care | Research | Charitable Assistance

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## **Financial Statements**

(With Report of Independent Certified Public Accountants)

**December 31, 2008 and 2007**



## INDEPENDENT AUDITOR'S REPORT

Audit • Tax • Advisory

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Board of Directors  
American Dental Association Foundation

We have audited the accompanying statement of financial position of American Dental Association Foundation as of December 31, 2008 and 2007, and the related statements of activities and cash flows for the years then ended. These financial statements are the responsibility of American Dental Association Foundation's management. Our responsibility is to express an opinion on these financial statements based on our audits.

We conducted our audit in accordance with auditing standards generally accepted in the United States of America and the standards applicable to financial audits contained in *Government Auditing Standards*, issued by the Comptroller General of the United States. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free of material misstatement. An audit includes consideration of internal control over financial reporting as a basis for designing audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of American Dental Association Foundation's internal control over financial reporting. Accordingly, we express no such opinion. An audit includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements. An audit also includes assessing the accounting principles used and the significant estimates made by management, as well as evaluating the overall financial statement presentation. We believe that our audits provide a reasonable basis for our opinion.

In our opinion, the financial statements referred to above present fairly, in all material respects, the financial position of American Dental Association Foundation as of December 31, 2008 and 2007, and the changes in its net assets and its cash flows for the years then ended in conformity with accounting principles generally accepted in the United States of America.

In accordance with *Government Auditing Standards*, we have also issued our report dated October 23, 2009, on our consideration of American Dental Association Foundation's internal control over financial reporting and on our tests of its compliance with certain provisions of laws, regulations, contracts, and grant agreements and other matters. The purpose of that report is to describe the scope of our testing of internal control over financial reporting and compliance and the results of that testing, and not to provide an opinion on the internal control over financial reporting or on compliance. That report is an integral part of an audit performed in accordance with *Government Auditing Standards* and should be considered in assessing the results of our audit.

Our audits were conducted for the purpose of forming an opinion on the basic financial statements taken as a whole. The accompanying detailed statement of activities by fund for the year ended December 31, 2008, is presented for purposes of additional analysis and is not a required part of the financial statements. Such information has been subjected to the auditing procedures applied in the audits of the financial statements and, in our opinion, is fairly stated in all material respects in relation to the basic financial statements taken as a whole.

Chicago, Illinois  
October 23, 2009

*Grant Thornton LLP*

# American Dental Association Foundation

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## Statements of Financial Position

December 31, 2008 and 2007

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	<u>2008</u>	<u>2007</u>
<b>ASSETS</b>		
Cash	\$ 582,670	386,995
Receivables, net	1,092,258	808,996
Prepaid expenses	28,809	25,109
Marketable securities (Note 3)	18,328,235	26,316,807
Furniture and equipment, net (Note 4)	<u>386,229</u>	<u>244,042</u>
<b>TOTAL ASSETS</b>	<u>\$ 20,418,201</u>	<u>27,781,949</u>
<b>LIABILITIES AND NET ASSETS</b>		
<b>Liabilities:</b>		
Accounts payable and accrued liabilities	\$ 513,772	574,259
Due to constituent societies	25,627	38,128
Due to the American Dental Association (Note 12)	715,591	732,514
Grants payable, net (Note 5)	522,723	254,962
Deferred revenues	<u>109,757</u>	<u>180,873</u>
<b>TOTAL LIABILITIES</b>	<u>1,887,470</u>	<u>1,780,736</u>
<b>Net assets:</b>		
Unrestricted	8,378,386	12,529,957
Temporarily restricted (Note 8)	7,622,943	10,959,996
Permanently restricted (Note 8)	<u>2,529,402</u>	<u>2,511,260</u>
<b>TOTAL NET ASSETS</b>	<u>18,530,731</u>	<u>26,001,213</u>
<b>TOTAL LIABILITIES AND NET ASSETS</b>	<u>\$ 20,418,201</u>	<u>27,781,949</u>

See accompanying notes to financial statements.

# American Dental Association Foundation

## Statements of Activities

Years Ended December 31, 2008 and 2007

	2008			2007				
	Unrestricted	Temporarily Restricted	Permanently Restricted	Total	Unrestricted	Temporarily Restricted	Permanently Restricted	Total
<b>REVENUE</b>								
Government contracts and grants	\$ 2,170,926	--	--	2,170,926	1,980,239	--	--	1,980,239
Royalties	1,784,828	--	--	1,784,828	1,324,089	--	--	1,324,089
Other grants and contributions	540,783	1,628,655	18,142	2,187,580	249,336	2,021,762	30,320	2,301,418
American Dental Association grant (Note 12)	2,874,332	358,861	--	3,233,193	2,955,202	480,250	--	3,435,452
Investment (loss) income	(4,168,740)	(2,794,036)	--	(6,962,776)	972,506	1,025,133	--	1,997,639
Publication and product sales	24,416	--	--	24,416	3,975	--	--	3,975
Meeting and seminar income	22,500	--	--	22,500	23,500	--	--	23,500
Other income	16,395	3,553	--	19,948	68,713	--	--	68,713
Net assets released from restrictions (Note 10)	2,534,086	(2,534,086)	--	--	3,291,295	(3,291,295)	--	--
<b>TOTAL REVENUE</b>	<b>5,799,526</b>	<b>(3,337,053)</b>	<b>18,142</b>	<b>2,480,615</b>	<b>10,868,855</b>	<b>235,850</b>	<b>30,320</b>	<b>11,135,025</b>
<b>EXPENSES (Note 11)</b>								
Staff compensation, taxes and benefits (Note 12)	4,695,693	--	--	4,695,693	4,777,874	--	--	4,777,874
Printing, publication and marketing	663,757	--	--	663,757	721,311	--	--	721,311
Meeting expenses	72,132	--	--	72,132	73,225	--	--	73,225
Travel expenses	315,401	--	--	315,401	343,372	--	--	343,372
Consulting fees and outside services	992,523	--	--	992,523	1,309,663	--	--	1,309,663
Professional services	420,158	--	--	420,158	295,907	--	--	295,907
Laboratory and office expenses	221,111	--	--	221,111	267,079	--	--	267,079
Grants and awards	1,587,340	--	--	1,587,340	1,052,981	--	--	1,052,981
Depreciation	89,639	--	--	89,639	71,640	--	--	71,640
Other expenses, including indirect costs (Note 12)	893,343	--	--	893,343	1,060,284	--	--	1,060,284
<b>TOTAL EXPENSES</b>	<b>9,951,097</b>	<b>--</b>	<b>--</b>	<b>9,951,097</b>	<b>9,973,336</b>	<b>--</b>	<b>--</b>	<b>9,973,336</b>
(Decrease) increase in net assets	(4,151,571)	(3,337,053)	18,142	(7,470,482)	895,519	235,850	30,320	1,161,689
Net assets at beginning of year	12,529,957	10,959,996	2,511,260	26,001,213	11,634,438	10,724,146	2,480,940	24,839,524
Net assets at end of year	\$ 8,378,386	7,622,943	2,529,402	18,530,731	12,529,957	10,959,996	2,511,260	26,001,213

See accompanying notes to financial statements.

# American Dental Association Foundation

## Statements of Cash Flows

Years Ended December 31, 2008 and 2007

	<u>2008</u>	<u>2007</u>
<b>CASH FLOWS FROM OPERATING ACTIVITIES</b>		
(Decrease) increase in net assets	\$ (7,470,482)	1,161,689
Adjustments to reconcile (decrease) increase in net assets to net cash used by operating activities:		
Contributions of stock	(137,278)	(82,837)
Provision for uncollectible loans receivable	--	(1,881)
Depreciation	89,639	71,640
Net unrealized depreciation (appreciation) in fair value of marketable securities	7,916,143	(35,485)
Net realized gain on sale of marketable securities	(383,517)	(1,307,984)
Contributions received for long-term purposes	(18,142)	(30,320)
Changes in assets and liabilities:		
Receivables	(283,262)	39,758
Prepaid expenses	(3,700)	40,265
Accounts payable and accrued liabilities	(60,487)	128,361
Due to constituent societies	(12,501)	22,963
Grants payable	267,761	141,396
Due to affiliated organizations	(16,923)	(560,291)
Deferred revenues	(71,116)	106,161
Net cash used by operating activities	<u>(183,865)</u>	<u>(306,565)</u>
<b>CASH FLOWS FROM INVESTING ACTIVITIES</b>		
Loan repayments	--	19,709
Purchase of marketable securities	(1,184,707)	(733,391)
Sale and maturity of marketable securities	1,777,931	85,388
Acquisition of furniture and equipment	(231,826)	(151,876)
Net cash provided (used) by investing activities	<u>361,398</u>	<u>(780,170)</u>
<b>CASH PROVIDED BY FINANCING ACTIVITIES</b>		
Contributions received for long-term purposes	<u>18,142</u>	<u>30,320</u>
Net increase (decrease) in cash	195,675	(1,056,415)
Cash at beginning of year	<u>386,995</u>	<u>1,443,410</u>
Cash at end of year	<u>\$ 582,670</u>	<u>386,995</u>

See accompanying notes to financial statements.

# American Dental Association Foundation

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## Notes to Financial Statements, December 31, 2008 and 2007

### 1. Significant Accounting Policies

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**Basis of Presentation:** The American Dental Association Foundation (Foundation), an affiliated foundation of the American Dental Association (Association), was organized to operate exclusively for charitable, scientific and educational purposes.

The Foundation is an Illinois not-for-profit corporation.

**Use of Estimates:** In preparing financial statements in conformity with accounting principles generally accepted in the United States of America, management is required to make estimates and assumptions that affect the reported amounts of assets and liabilities, the disclosure of contingent assets and liabilities at the date of the financial statements, and the reported amounts of revenues, expenses, gains and losses during the reporting period. Actual results could differ from those estimates.

**Cash:** The Foundation maintains its cash balance in financial institutions which at times may exceed federally insured limits. The Foundation has not experienced any losses in such accounts and believes it is not exposed to any significant credit risk on cash.

**Receivables:** Receivables primarily consist of amounts due under federal government sponsored grants and contracts, royalties, and pledges receivable. Amounts related to federal grants and contracts and royalties are estimated to be fully collectible and, accordingly, no allowance for uncollectible amounts has been recorded. Pledges receivable are recognized at the estimated present value of expected future cash flows net of allowances. The allowance for uncollectible pledges receivable is determined after considering a number of factors, including the Foundation's previous loss history and a review of the status of individual pledges.

**Loans Receivable:** The loan programs consist of educational retraining loans, loans to disaster victims and loans to assist in the treatment of chemically dependent dentists. The disaster victims and chemically dependent loan programs were discontinued prior to December 31, 2006; remaining loans outstanding of \$26,061 were fully reserved at December 31, 2007 and written off during 2008. There were no educational retraining loans outstanding at December 31, 2008 and 2007.

**Marketable Securities:** Investments in marketable securities are carried at fair value. The fair value of investments in marketable securities is based on quoted market prices. Net realized capital gains or losses on sales are calculated based on the weighted average cost of securities sold.

**Furniture and Equipment:** Furniture and equipment are stated at cost less accumulated depreciation. Depreciation is computed on the straight-line method over the estimated useful lives of the assets, which is five to ten years.

**Grants Payable:** Grants to other organizations are recorded as expense when authorized by the Board of Directors. Grants payable beyond one year are reported at the present value of their estimated future cash flows.

**Revenue Recognition:** Contributions, which are defined as nonreciprocal transfers, are recognized as revenues in the period pledged or received and classified according to the existence or absence of donor-imposed restrictions. When a donor restriction has been satisfied by incurring expenses consistent with the designated purpose, temporarily restricted net assets are reclassified to unrestricted net assets for reporting of related expenses. Unconditional promises are recognized at the estimated present value of expected future cash flows net of allowances. Promises made and collected in the same reporting period are recorded when received in the appropriate net asset category. Conditional promises are recorded when the conditions are substantially met.

Corporate grants that do not constitute contributions are recognized as income when costs of the related programs or projects are incurred. Corporate grants received but not yet expended are reported as deferred revenues. Grants to other organizations are recorded as expense when authorized by the Board of Directors.

# American Dental Association Foundation

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## Notes to Financial Statements, December 31, 2008 and 2007 (continued)

**Contributed Facilities:** The Foundation occupies, without charge, certain premises located in government-owned research facilities. No amounts have been reflected in the financial statements for their use as no objective basis is available to measure the value of such facilities.

**Net Assets:** Net assets subject to donor-imposed stipulations are classified as temporarily or permanently restricted net assets while net assets not subject to such restrictions are classified as unrestricted net assets.

**Fair Value Measurements:** Effective January 1, 2008, the Foundation adopted Statement of Financial Accounting Standards ("SFAS") No. 157, "*Fair Value Measurements*." SFAS No. 157 defines fair value, establishes a framework for measuring fair value, establishes a fair value hierarchy based on the inputs used to measure fair value and enhances disclosure requirements for fair value measurements. SFAS No. 157 maximizes the use of observable inputs and minimizes the use of unobservable inputs by requiring that the observable inputs be used when available.

Observable inputs are inputs that market participants would use in pricing the asset or liability based on market data obtained from independent sources. Unobservable inputs reflect assumptions that market participants would use in pricing the asset or liability based on the best information available in the circumstances. The hierarchy is broken down into three levels based on the transparency of inputs as follows:

Level 1 - Quoted prices are available in active markets for identical assets or liabilities as of the report date. A quoted price for an identical asset or liability in an active market provides the most reliable fair value measurement because it is directly observable to the market.

Level 2 - Pricing inputs are other than quoted prices in active markets, which are either directly or indirectly observable as of the report date. The nature of these securities include investments for which quoted prices are available but which are traded less frequently and investments that are fairly valued using other securities, the parameters of which can be directly observed.

Level 3 - Securities that have little to no pricing observability as of the report date. These securities are measured using management's best estimate of fair value, where the inputs into the determination of fair value are not observable and require significant management judgment or estimation.

Inputs are used in applying the various valuation techniques and broadly refer to the assumptions that market participants use to make valuation decisions, including assumptions about risk. Inputs may include price information, volatility statistics, specific and broad credit data, liquidity statistics, and other factors. A financial instrument's level within the fair value hierarchy is based on the lowest level of any input that is significant to the fair value measurement. However, the determination of what constitutes "observable" requires significant judgment by the Foundation. The Foundation considers observable data to be that market data that is readily available, regularly distributed or updated, reliable and verifiable, not proprietary, and provided by independent sources that are actively involved in the relevant market. The categorization of a financial instrument within the fair value hierarchy is based upon the pricing transparency of the instrument and does not necessarily correspond to the Foundation's perceived risk of that instrument.

In February 2007, the Financial Accounting Standards Board issued SFAS No. 159, "*The Fair Value Option for Financial Assets and Financial Liabilities*." SFAS No. 159 provides the Foundation with an option to elect fair value as the initial and subsequent measurement attribute for most financial assets and liabilities and certain other items. The fair value option election is applied on an instrument-by-instrument basis (with some exceptions) is irrevocable, and is applied to an entire instrument. The fair value option election may be made as of the date of initial adoption for existing eligible items. Subsequent to initial adoption, the Foundation may elect the fair value option at initial recognition of eligible items, on entering into an eligible firm commitment, or when certain specified reconsideration events occur. Unrealized gains and losses on items for which the fair value option has been elected will be reported in the statements of activities.

The Foundation did not elect any changes to fair value measurements upon the adoption of SFAS No. 159 in 2008.

# American Dental Association Foundation

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## Notes to Financial Statements, December 31, 2008 and 2007 (continued)

**Valuation of Financial Instruments:** The Foundation's financial instruments are marketable securities. All Foundation marketable securities have values based on quoted market prices in active markets, and are therefore classified within Level 1. These marketable securities include active listed equities and equity funds, bonds and bond funds and money market securities. The Foundation does not adjust the quoted price for such instruments.

**FASB Staff Position 117-1:** In August 2008, the FASB issued FASB Staff Position (FSP) 117-1, "*Endowments of Not-For-Profit Organizations: Net Asset Classifications of Funds Subject to an Enacted Version of the Uniform Prudent Management of Institutional Funds Act, and Enhanced Disclosures for All Endowment Funds.*" FSP 117-1 is effective for fiscal years ending after December 15, 2008. FSP 117-1 addresses the net asset classification of donor-restricted endowment funds for organizations subject to an enacted version of the 2006 Uniform Prudent Management of Institutional Funds Act (UPMIFA). A version of UPMIFA was enacted in Illinois June 30, 2009. A key component of FSP 117-1 is a requirement to classify the portion of a donor-restricted endowment fund that is not classified as permanently restricted net assets as temporarily restricted net assets until appropriated for expenditure. In addition, FSP 117-1 requires new disclosures about an organization's donor-restricted and board-designated endowment funds. The objective of the disclosures is to provide information so that financial statement users can understand the net asset classification, net asset composition, changes in net asset compositions, spending policy and related investment policy pertaining to an organization's endowment funds. The disclosures relating to FSP 117-1 are presented in note 9. The adoption of FSP 117-1 and the enactment of UPMIFA had no effect on the Foundation's financial statements.

**FASB Staff Position FIN 48-3:** In December 2008, the Financial Accounting Standards Board issued FASB Staff Position (FSP) FIN 48-3, "Effective Date of FASB Interpretation No. 48 for Certain Nonpublic Enterprises." FSP FIN 48-3 permits an entity within its scope to defer the effective date of FASB Interpretation 48 (Interpretation 48), *Accounting for Uncertainty in Income Taxes*, to its annual financial statements for fiscal years beginning after December 15, 2008. The Foundation has elected to defer the application of Interpretation 48 for the year ending December 31, 2008. The Foundation evaluates its uncertain tax positions using the provisions of FASB Statement 5, *Accounting for Contingencies*. Accordingly, a loss contingency is recognized when it is probable that a liability has been incurred as of the date of the financial statements and the amount of the loss can be reasonably estimated. The amount recognized is subject to estimate and management judgment with respect to the likely outcome of each uncertain tax position. The amount that is ultimately sustained for an individual uncertain tax position or for all uncertain tax positions in the aggregate could differ from the amount recognized.

**Reclassifications:** Certain 2007 amounts have been reclassified to conform to the 2008 presentation.

## 2. Pledges Receivable

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Included in receivables are unconditional promises for which payment has not been received which are recorded in the financial statements as pledges receivable and revenue of the appropriate net asset category. Amounts due in more than one year are recorded at the present value of estimated future cash flows, discounted at rates applicable to the years in which the pledges were received, which range from 3.29% to 4.85%.

# American Dental Association Foundation

## Notes to Financial Statements, December 31, 2008 and 2007 (continued)

Unconditional promises are expected to be realized in the following periods:

	<u>2008</u>	<u>2007</u>
In one year or less	\$ 33,002	221,101
Between one year and five years	47,000	30,000
More than five years	104,091	63,329
Less discount	<u>(15,194)</u>	<u>(17,670)</u>
	168,899	296,760
Less allowance for uncollectible pledges	<u>(50,500)</u>	<u>(45,000)</u>
	<u>\$ 118,399</u>	<u>251,760</u>

Charges in allowance for uncollectible pledges were as follows:

	<u>2008</u>	<u>2007</u>
Beginning balance	\$ 45,000	--
Provision for uncollectible pledges	5,500	116,182
Write-offs of uncollectible pledges	<u>--</u>	<u>(71,182)</u>
Ending balance	<u>\$ 50,500</u>	<u>45,000</u>

At December 31, 2008 and 2007 there were also outstanding donor intentions to pay totaling \$602,789 and \$762,789, respectively, for the Foundation's Campaign for Innovation in Dental Education. These intentions are not unconditional promises and therefore have not been included in the Foundation's financial statements.

### 3. Marketable Securities

Marketable securities, recorded at fair value based upon quoted market prices, consisted of the following at December 31, 2008 and 2007:

	<u>2008</u>		<u>2007</u>	
	<u>Cost</u>	<u>Market</u>	<u>Cost</u>	<u>Market</u>
Equities and equity funds	\$ 15,810,684	10,075,127	15,830,238	17,736,796
Bonds and bond funds	8,606,701	8,253,108	8,041,630	7,962,065
Money market funds	<u>--</u>	<u>--</u>	<u>617,946</u>	<u>617,946</u>
	<u>\$ 24,417,385</u>	<u>18,328,235</u>	<u>24,489,814</u>	<u>26,316,807</u>

Investment (loss) income consisted of the following for the years ended December 31, 2008 and 2007:

	<u>2008</u>	<u>2007</u>
Interest and dividends	\$ 569,850	654,170
Net realized and unrealized (depreciation) appreciation in fair value of marketable securities	<u>(7,532,626)</u>	<u>1,343,469</u>
Total investment (loss) income	<u>\$ (6,962,776)</u>	<u>1,997,639</u>

# American Dental Association Foundation

## Notes to Financial Statements, December 31, 2008 and 2007 (continued)

### 4. Furniture and Equipment

Furniture and equipment at December 31, 2008 and 2007 consisted of the following:

	<u>2008</u>	<u>2007</u>
Furniture and equipment	\$ 2,104,023	1,872,197
Less accumulated depreciation	1,717,794	1,628,155
	<u>\$ 386,229</u>	<u>244,042</u>

### 5. Grants Payable

Grants payable at December 31, 2008 and 2007 consisted of the following:

	<u>2008</u>	<u>2007</u>
Early childhood caries research	\$ 214,244	--
Dental sedation and anesthesia course development	62,158	--
Dental education scholarships	35,000	81,667
Oral health for underserved children	241,635	199,998
	<u>553,037</u>	<u>281,665</u>
Less unamortized discount	<u>(30,314)</u>	<u>(26,703)</u>
Net grant payable	<u>\$ 522,723</u>	<u>254,962</u>

The dental education scholarships were awarded in 2006 to five education institutions. The amount of the oral health grant, initially awarded to one organization in 2007 was increased in 2008. The early childhood and dental sedation grants were each awarded to separate organizations in 2008. Grants are payable in the following years:

	<u>2008</u>	<u>2007</u>
2008	\$ --	146,666
2009	326,138	134,999
2010	226,899	--
	<u>\$ 553,037</u>	<u>281,665</u>

### 6. Relief Program Contributions and Grants

The rules of the Relief Program provide that refunds of contributions may be made to constituent societies if those societies have been established as charitable organizations having purposes consistent with those of the Relief Program, and have been accorded tax-exempt status under the Internal Revenue Code. Prior to payment of any refund, constituent society relief funds are also required to submit annual financial statements. As of December 31, 2008 and 2007, \$25,627 and \$38,128 are reflected as due to constituent societies for the annual campaigns that ended December 31, 2008 and 2007, respectively.

Grants to relief recipients are recorded when the grant is paid. Conditional commitments for future grant payments previously authorized are not recorded as grant expense, and amounted to \$117,928 and \$59,621 at December 31, 2008 and 2007, respectively. The Relief Program retains the right to discontinue future payments to grant recipients at any time. Grants paid are usually shared equally by the Relief Program and the recipient's constituent society.

# American Dental Association Foundation

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## Notes to Financial Statements, December 31, 2008 and 2007 (continued)

### 7. Income Taxes

The Foundation has received a favorable determination letter from the Internal Revenue Service stating that it is exempt from taxation on income related to its exempt purpose under Section 501(a) of the Internal Revenue Code as an organization described in Section 501(c)(3). There was no significant unrelated business income in 2008 or 2007 and therefore a provision for income taxes was not required.

### 8. Temporarily and Permanently Restricted Net Assets

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Temporarily restricted net assets at December 31, 2008 and 2007 were available for the following purposes:

	<u>2008</u>	<u>2007</u>
Campaign for innovation in dental education	\$ 1,133,564	1,593,718
Trusts	640,934	867,288
Extramural programs	249,487	209,240
Research	73,503	31,203
Awards	314,724	418,995
Education	156,642	167,705
Access	1,096,782	1,698,910
Relief program	<u>3,957,307</u>	<u>5,972,937</u>
	<u>\$ 7,622,943</u>	<u>10,959,996</u>

Temporarily restricted trusts include funds restricted by donors for awareness and support for dental education issues, periodontal research, public education in dental health and memorial commemoration.

Permanently restricted net assets at December 31, 2008 and 2007 totaled \$2,529,402 and \$2,511,260, respectively. Earnings on these net assets are restricted by donors for children's oral health and education in dental entrepreneurship and leadership.

### 9. Endowment Funds

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The Foundation's endowments consist of various individual funds to support access to care and educational activities. Net assets related to the Foundation endowments are donor-restricted funds, classified and reported based upon the donor-imposed restrictions. The Foundation does not have board-designated endowment funds.

The Foundation accounts for endowment net assets by preserving the fair value of the original gift as of the gift date of the donor-restricted endowment fund absent explicit donor stipulations to the contrary. As a result, the Foundation classifies as permanently restricted net assets the original value of gifts donated to the permanent endowment and the original value of subsequent gifts to the permanent endowment. Earnings on the permanent endowments are classified as temporarily restricted net assets in accordance with the direction of the applicable donor gift instrument. The remaining portion of the donor-restricted endowment fund that is not classified in permanently restricted net assets is classified as temporarily restricted net assets, according to donor stipulations. Temporarily restricted net assets are released from restriction when appropriated for expenditure by the Foundation for the donor-stipulated purpose.

To make a determination to expend or accumulate donor-restricted endowment funds, the Foundation considers a number of factors, including the duration and preservation of the fund, purposes of the donor-restricted fund, general economic conditions, the possible effects of inflation and deflation, the expected total return from income and the appreciation of investments, other resources of the Foundation and the investment policies of the Foundation.

# American Dental Association Foundation

## Notes to Financial Statements, December 31, 2008 and 2007 (continued)

From time to time, the fair value of assets associated with individual donor-restricted endowment funds may fall below the level that the donor requires the Foundation to retain permanently. Deficiencies of this nature that are reported in unrestricted net assets were \$618,448 as of December 31, 2008. These deficiencies resulted from unfavorable market fluctuations that occurred during 2008. There were no such deficiencies as of December 31, 2007.

The Foundation has adopted investment and spending policies for endowment assets that attempt to enhance its ability to support activities, provide long-term real, inflation adjusted growth in assets and support financial flexibility and liquidity. Under this policy, as approved by the Board of Directors, the Foundation's assets are to be adequately diversified to provide a high degree of stability of principal in order to maintain the ability to provide financial assistance to support education and access to care programs. The assets are to be invested in a manner that is intended to grow in real, inflation-adjusted terms and maintain its ability to support spending needs. In addition, the assets are to be efficiently structured to provide the highest level of return within the risk parameters established by the Board.

There are distinct asset pools and the asset allocation of the pools is the major determinant of investment risk exposure, real return levels and current income generation. The endowments have variable spending needs, and the related asset pools are structured to support the spending needs.

The Foundation has an active Finance Committee that meets regularly to ensure the objectives of the investment policy are being met, and the strategies used to meet the objectives are in accordance with the investment policy.

During 2008, the Foundation had the following activities related to endowment net assets:

	Unrestricted	Temporarily Restricted	Permanently Restricted	Total
Endowment net assets, beginning of year	\$ --	374,152	2,511,260	2,885,412
Investment returns				
Interest and dividends	--	70,459	--	70,459
Realized gain on sale of investments	--	48,681	--	48,681
Net unrealized loss on investments	<u>(618,448)</u>	<u>(386,685)</u>	--	<u>(1,005,133)</u>
Total investment return	(618,448)	(267,545)	--	(885,993)
New additions				
Contributions	--	--	18,142	18,142
Total new additions	--	--	18,142	18,142
Appropriation of endowment assets for expenditures	--	(106,607)	--	(106,607)
Total change in endowment net assets	<u>(618,448)</u>	<u>(374,152)</u>	<u>18,142</u>	<u>(974,458)</u>
Endowment net assets, end of year	<u>\$ (618,448)</u>	<u>--</u>	<u>2,529,402</u>	<u>1,910,954</u>

# American Dental Association Foundation

## Notes to Financial Statements, December 31, 2008 and 2007 (continued)

### 10. Net Assets Released from Donor Restrictions

Net assets were released from donor restrictions during 2008 and 2007 by incurring expenses satisfying the restricted purposes as follows:

	<u>2008</u>	<u>2007</u>
Campaign for innovation in dental education	\$ 626,170	1,620,439
Trusts	468	557
Extramural programs	3,916	163,019
Research	24,221	60,477
Awards	27,964	18,930
Education	149,169	182,058
Access	1,337,992	906,657
Relief program	364,186	339,158
	<u>\$ 2,534,086</u>	<u>3,291,295</u>

### 11. Expenses by Functional Classification

The following table summarizes the costs of providing various programs or activities on a functional basis for the years ended December 31, 2008 and 2007:

	<u>2008</u>	<u>2007</u>
Association sponsored research	\$ 1,976,445	2,008,856
Federal government sponsored research	1,980,135	2,051,455
Corporate and donor sponsored programs relating to research, education, access and awards	4,268,113	4,180,697
Relief grants	209,964	154,471
Fundraising	705,223	756,047
Administrative and general	811,217	821,810
	<u>\$ 9,951,097</u>	<u>9,973,336</u>

### 12. Transactions With Related Parties

The Foundation receives an annual grant from the Association for sponsorship of the Foundation's research activities and the development of a national campaign to support dental education. The grant amounted to \$3,233,193 and \$3,435,452 in 2008 and 2007, respectively. The Foundation receives accounting, financial and administrative services from the Association as may be required. In 2008 and 2007, the Foundation paid \$607,031 and \$702,068, respectively, for such services. The Foundation paid \$50,000 to the Association for sponsorship of Oral Longevity Continuing Education programs at Annual Session in 2008. The Foundation paid \$121,715 to the Association for printing and distribution of a supplement related to Oral Longevity in 2007.

The Association sponsors a noncontributory defined benefit pension plan and a savings and retirement plan which cover substantially all employees of the Association, its subsidiaries and affiliates meeting certain eligibility requirements. Pension expense charges are allocated to the Foundation in connection with its employees' participation in the Association's retirement plans. These expenses amounted to \$630,800 and \$591,100 for 2008 and 2007, respectively. Information is not sufficient to permit the Foundation to determine its share, if any, of unfunded, vested benefits.

# American Dental Association Foundation

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## Notes to Financial Statements, December 31, 2008 and 2007 (continued)

The Association sponsors a contributory defined benefit postretirement health plan, which covers substantially all employees of the Association, its subsidiaries and affiliates. The Foundation expensed postretirement benefit charges of \$104,644 and \$102,248 for 2008 and 2007, respectively, associated with participating Foundation employees.

The Association established the Executive Parity Plan, a deferred compensation arrangement, which compensates executives who suffered restrictions in their pension benefits as a result of the Omnibus Reconciliation Act. The Foundation expensed \$3,764 in 2008 and \$0 in 2007 for awards granted to Foundation participants.

Pursuant to agreements between the Association and certain officers and employees of the Association and its affiliates, portions of their compensation have been retained by the Association and invested as directed by those participants. The assets are owned by the Association until distributed to the participants after termination of employment or services.

Periodically, expenses of one organization may be paid by an affiliated organization and subsequently reimbursed.

The Foundation received donations of \$60,000 from ADA Business Enterprises, Inc. (a wholly-owned subsidiary of the Association) in both 2008 and 2007. The Foundation performed a survey of lead in dental crowns research for the ADA in 2008 and was reimbursed \$32,105.

## **DETAILED STATEMENT OF ACTIVITIES**

# American Dental Association Foundation

## Detailed Statement of Activities by Fund

Year Ended December 31, 2008

	ADA Sponsored	Federal Government Sponsored	Corporate And Donor Sponsored	Relief Program	Eliminations	Total
<b>REVENUE</b>						
Government contracts and grants	\$ --	2,170,926	--	--	--	2,170,926
Royalties	--	--	1,784,828	--	--	1,784,828
Other grants and contributions	--	--	2,115,101	72,479	--	2,187,580
American Dental Association grant	2,874,332	--	358,861	--	--	3,233,193
Investment loss	--	--	(5,235,300)	(1,727,476)	--	(6,962,776)
Publication and product sales	--	--	24,416	--	--	24,416
Meeting and seminar income	--	--	22,500	--	--	22,500
Other income	292,270	385	14,983	3,553	(291,243)	19,948
<b>TOTAL REVENUE</b>	<b>3,166,602</b>	<b>2,171,311</b>	<b>(914,611)</b>	<b>(1,651,444)</b>	<b>(291,243)</b>	<b>2,480,615</b>
<b>EXPENSES</b>						
Staff compensation, taxes and benefits	2,609,356	1,159,935	836,160	90,242	--	4,695,693
Printing, publication and marketing	10,555	366	628,607	24,229	--	663,757
Meeting expenses	12,825	3,825	55,482	--	--	72,132
Travel expenses	56,656	15,501	234,260	8,984	--	315,401
Consulting fees and outside services	17,743	192,948	781,832	--	--	992,523
Professional services	358,982	2,481	329,722	20,216	(291,243)	420,158
Laboratory and office expenses	35,440	25,048	150,072	10,551	--	221,111
Grants and awards	--	--	1,377,376	209,964	--	1,587,340
Depreciation	3,746	19,301	66,592	--	--	89,639
Other expenses, including indirect costs	46,617	580,031	266,695	--	--	893,343
<b>TOTAL EXPENSES</b>	<b>3,151,920</b>	<b>1,999,436</b>	<b>4,726,798</b>	<b>364,186</b>	<b>(291,243)</b>	<b>9,951,097</b>
Increase (decrease) in net assets	14,682	171,875	(5,641,409)	(2,015,630)	--	(7,470,482)
Net assets (deficit) at beginning of year	46,807	(78,111)	19,941,828	6,090,689	--	26,001,213
Fund transfer	--	107,917	(107,917)	--	--	--
Net assets at end of year	\$ 61,489	201,681	14,192,502	4,075,059	--	18,530,731



**ADA** American  
Dental  
Association®

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**ADA Business Enterprises, Inc.**  
(A Wholly-Owned Subsidiary of American Dental Association)

**Financial Statements**  
(With Report of Independent Certified Public Accountants)

**December 31, 2008 and 2007**

# ADA Business Enterprises, Inc.®

211 East Chicago Avenue  
Suite 1180  
Chicago, Illinois 60611-2637  
T 312.440.4700  
F 312.440.2594

April 2, 2010

Re: Management Discussion and Analysis of ADA Business Enterprises, Inc. Audited Financial Statements for the years ended December 31, 2008 and 2007

Dear Members of the ADA House of Delegates:

Attached are the ADA Business Enterprises, Inc. ("ADABEI") Financial Statements and Auditor's Opinion for the years ended December 31, 2008 and 2007. ADABEI is a wholly-owned subsidiary of the American Dental Association ("Association") that manages the for-profit activities organized by the Association. ADABEI's primary mission is to provide Association member value through endorsed products and programs. This member value has typically included special products and services created specifically for dental practices which feature discounted pricing and increased customer service levels.

As you will note, the investment in ADA Intelligent Dental Marketing, LLC ("ADAidm") has been written down to zero value as of December 31, 2008. Although ADABEI carried this investment's book value as \$368,091 at December 31, 2007, subsequent events in 2009, including an investigation by KPMG directed by the ADA Audit Committee, revealed significant problems with this joint venture. The Management Discussion and Analysis ("MD&A") presented here is intended to provide a more complete picture of these issues, their underlying causes, and the events leading to that decision.

ADAidm was initially formed on January 31, 2007 as a joint venture between the initial co-founders (Mr. Joel Harris and Dr. Rob Thorup, who founded Intelligent Dental Marketing in 2003) and ADABEI, to provide branding, identity, and marketing services to dentists and dental practices. These services included logo and website design, search engine optimization, direct mail, print ads, referral brochures, and case acceptance software, in addition to related products.

During the process of evaluating and developing the joint venture, the co-founders misrepresented the financial information presented to ADABEI and the ADA as the basis for the decision. There was insufficient due diligence performed to determine the validity of the financial information presented, and as a result, ADABEI paid \$600,000 for a 50% interest in the joint venture. However, soon after the entity was formed, ADABEI became aware that certain initial assets were misrepresented, requiring the value of the net accounts receivable needed to be adjusted down by approximately \$500,000. In addition, it became evident soon thereafter that the financial position and operating results of ADAidm were materially misstated prior to the development of the joint venture. These misstatements included, but were not limited to, the value of reported revenues, the accounts receivable, and reported expenses. It also became evident that ADAidm lacked sufficient internal financial controls to allow management to competently manage the business, as outlined in a letter from Grant Thornton ("auditors") to the management and Board of Directors of ADAidm dated March 8, 2008, which characterized a number of internal control deficiencies. It should be noted that a "control deficiency" exists when the design or operation of the internal controls does not allow management or employees, in the normal course of performing their assigned functions, to prevent or detect misstatements on a timely basis. These deficiencies, individually or in

April 2, 2010  
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combination, may give rise to a *"significant deficiency"* or *"material weakness,"* in order of increasing seriousness to the organization.

It should be noted that the March 8, 2008 Grant Thornton letter identified two "control deficiencies" and seven "significant deficiencies" to ADAidm management.

Operational and management difficulties continued, with little evidence that ADAidm management made the necessary corrections in the internal controls needed to manage the business accordingly. As a result, ADAidm management requested two loans from ADABEI in February and March, 2009, in order to refund unhappy customers and fulfill direct mail contracts. The loan amounts were for \$48,415 and \$102,000, respectively. However, in spite of repeated requests, ADAidm was unable to provide documentation supporting the use of the loan amounts as requested.

As a result of information received by the ADA Board of Trustees and the Audit Committee, KPMG was retained in early 2009 to perform a detailed audit to include ADABEI and ADAidm, with the final report presented to the ADA Board in June, 2009. During this time, ADAidm ownership was restructured. Effective May 19, 2009, one of the Class A members transferred his 25% interest in ADAidm to ADABEI. Effective June 9, 2009, the remaining Class A member surrendered his shares to ADABEI, resulting in ADABEI owning 100% of the shares of ADAidm. There was no consideration paid to the Class A members in exchange for these interests.

As a result of the June, 2009 KPMG report, it was decided to wind down ADAidm's operations. The ADA Board, acting as the sole shareholder of ADABEI, took definitive action by dismissal of the ADABEI Board of Directors and appointing a single director and chairman to resolve ADAidm issues and oversee the ongoing ADABEI affinity programs. Soon thereafter, appropriate ADABEI senior staff personnel changes were made, and ADABEI began immediately to wind down the operation of ADAidm, with an emphasis on protecting those ADA members who were ADAidm customers. The ADAidm customers and stakeholders were immediately contacted regarding the wind down of the ADAidm entity. Accounting systems were analyzed, customer and vendor accounts were clarified, and payments made immediately as customer and vendor accounts were validated. The ADAidm entity was physically closed in Salt Lake City on July 31, 2009, and all operations for the ADAidm wind-down process moved to the ADABEI Chicago offices.

As of December 31, 2009, the ADAidm wind-down process noted the following actions:

- With the majority of customer refunds complete, 100% of Accounts Receivable had been written off.
- Completed refund analysis and refund processing for 580+ individual customers that had unfulfilled projects resulted in \$3.2M in refunds for these impacted customers.
- Additionally, 500+ other individual customer contracts and files have been reviewed and analyzed.
- Website hosting and maintenance as well as 800 number call tracking services would be completely transitioned to alternative vendors by December 31, 2009.

April 2, 2010  
Page 3

- 1,140 total accounts were identified (961 ADA members and 159 non-members), with approximately 20 with unidentified membership status.
- ADABEI has had 67 requests from customers for second reviews of their cases.
- 500+ customers were identified that had websites hosted by ADAidm. ADABEI paid for these sites to be hosted by a company (Treeline) until November 7, 2009. ADABEI also paid customers' transition fees. Each member was notified via 4 e-mails and 2 hard copy letters that they had to select a new provider by November 7, 2009.
- Approximately 170 customers were identified who had remaining usable promotional items (letters and postcards) in inventory. The customers were given three choices:
  - Contact Consolidated (the mail house) directly to have materials shipped to the doctor (at the doctor's expense);
  - Contact Consolidated to have them complete the mailing (at the doctor's expense);
  - Do nothing and the inventory will be destroyed as of December 31, 2009.
- The ADAidm files contained approximately 1,100 different files of customer artwork and designs. A temporary designer was hired to review and copy each file to a CD and mail them to clients for use in the future with minimal or no design cost.
- 351 members had purchased phone response tracking – through two different providers hired by ADAidm. ADABEI notified all members that ADABEI would pay for their lines to stay active through December 31, 2009 and then they would need to transition.
- Approximately 80 customers had signed up for Treatment Pro. This product is jointly owned through contractual agreement with Treeline. The parties cannot act without mutual agreement, and ADABEI is currently undergoing an evaluation of this asset.
- ADABEI has undertaken a survey of all affected customers (including members and nonmembers) which is now underway regarding the management of the wind-down process, and early results are positive.

Through December 2009, ADABEI incurred approximately \$4.9 million for costs related to the wind-down of ADAidm, including refunds to customers for undelivered goods and services and payments of outstanding balances to vendors. In addition, other costs have been incurred to wind-down operations. These costs include three loans made by ADABEI totaling \$230,415 to ADAidm in March and June 2009 which were fully reserved by ADABEI at December 31, 2008. Total costs related to the wind-down of ADAidm are not expected to exceed \$5.7 million. This reflects ADABEI's full commitment to seeing that Association members were treated fairly and equitably regardless of the disposition of ADAidm.

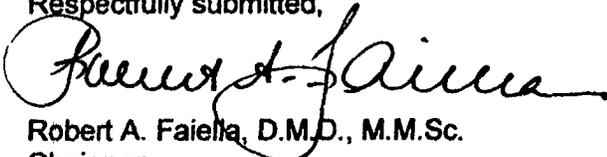
It should be noted that in a subsequent communication to ADABEI, the auditors stated that former ADABEI management failed to provide timely oversight and monitoring of their investment in ADAidm as well as to act and respond in a timely manner to the internal control deficiencies. This inadequate control and oversight of ADAidm by former ADABEI leadership was deemed to be a material weakness. This finding supported the June 2009 audit observation that there was inadequate control and oversight of ADAidm by ADABEI, and, in turn, by the ADA. It was noted that if appropriate monitoring of the financial records and reporting had been performed, it is likely that the problems identified would have been detected earlier and managed at an earlier date.

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Page 4

The ADA Board of Trustees, Audit Committee, and current ADABEI management have since addressed a detailed corrective action plan to address internal control issues and implement recommendations from the KPMG audit report that include strengthened governance and oversight to prevent this type of investment failure from happening again.

ADABEI management is also currently preparing a "best practices" report regarding for-profit entities under not-for-profit organizations for consideration by the ADA Board of Trustees (acting as the sole shareholder) in the overview of the future of ADABEI as wholly-owned subsidiary of the American Dental Association.

Respectfully submitted,

A handwritten signature in black ink, appearing to read "Robert A. Faiella". The signature is written in a cursive style with a large initial "R".

Robert A. Faiella, D.M.D., M.M.Sc.  
Chairman  
ADA Business Enterprises, Inc.



**REPORT OF INDEPENDENT CERTIFIED PUBLIC ACCOUNTANTS**

**Audit • Tax • Advisory**

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Board of Directors

ADA Business Enterprises, Inc. and American Dental Association

We have audited the accompanying balance sheets of ADA Business Enterprises, Inc. (a wholly-owned subsidiary of the American Dental Association) (the "Company") as of December 31, 2008 and 2007, and the related statements of operations and retained earnings and cash flows for the years then ended. These financial statements are the responsibility of the Company's management. Our responsibility is to express an opinion on these financial statements based on our audits.

We conducted our audits in accordance with auditing standards generally accepted in the United States of America as established by the American Institute of Certified Public Accountants. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free of material misstatement. An audit includes consideration of internal control over financial reporting as a basis for designing audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the Company's internal control over financial reporting. Accordingly, we express no such opinion. An audit also includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements, assessing the accounting principles used and significant estimates made by management, as well as evaluating the overall financial statement presentation. We believe that our audits provide a reasonable basis for our opinion.

In our opinion, the financial statements referred to above present fairly, in all material respects, the financial position of ADA Business Enterprises, Inc. as of December 31, 2008 and 2007, and the results of its operations and its cash flows for the years then ended, in conformity with accounting principles generally accepted in the United States of America.

Our audits were conducted for the purpose of forming an opinion on the basic financial statements taken as a whole of ADA Business Enterprises, Inc. The accompanying divisional statement of operations is presented for purposes of additional analysis and is not a required part of the basic financial statements. Such information has been subjected to the auditing procedures applied in the audits of the basic financial statements and, in our opinion, is fairly stated in all material respects in relation to the 2008 basic financial statements taken as a whole.

A handwritten signature in cursive script that reads "Grant Thornton LLP".

Chicago, Illinois  
February 12, 2010

# ADA Business Enterprises, Inc.

(A wholly-owned subsidiary of American Dental Association)

## Balance Sheet

December 31, 2008 and 2007

	<u>2008</u>	<u>2007</u>
<b>ASSETS</b>		
Cash and cash equivalents	\$ 272,910	82,633
Receivables, net	505,628	510,070
Deferred taxes (Note 5)	--	274,513
Income taxes receivable	361,114	417,819
Prepaid expenses	6,475	--
Marketable securities (Note 2)	1,798,787	2,689,424
Investment in ADAidm (Note 3)	--	368,091
Furniture and equipment, net (Note 4)	12,963	18,837
<b>TOTAL ASSETS</b>	<b><u>\$ 2,957,877</u></b>	<b><u>4,361,387</u></b>
<b>LIABILITIES AND STOCKHOLDER'S EQUITY</b>		
<b>Liabilities:</b>		
Accounts payable and accrued liabilities	\$ 77,794	204,065
Due to affiliated organizations, net (Note 6)	372,557	461,912
<b>TOTAL LIABILITIES</b>	<b><u>450,351</u></b>	<b><u>665,977</u></b>
<b>Stockholder's equity:</b>		
Common stock, \$1 par value;		
Authorized 101,000 shares; issued and outstanding 100,100 shares	100,100	100,100
Additional paid-in capital	500,000	500,000
Retained earnings	1,907,426	3,095,310
<b>TOTAL STOCKHOLDER'S EQUITY</b>	<b><u>2,507,526</u></b>	<b><u>3,695,410</u></b>
<b>TOTAL LIABILITIES AND STOCKHOLDER'S EQUITY</b>	<b><u>\$ 2,957,877</u></b>	<b><u>4,361,387</u></b>

See accompanying notes to financial statements.

# ADA Business Enterprises, Inc.

(A wholly-owned subsidiary of American Dental Association)

## Statements of Operations and Retained Earnings

Years Ended December 31, 2008 and 2007

	<u>2008</u>	<u>2007</u>
<b>REVENUES</b>		
Royalties and service fees	\$ 2,453,872	2,326,997
Investment income	49,469	152,654
	<u>2,503,341</u>	<u>2,479,651</u>
<b>TOTAL REVENUES</b>		
<b>EXPENSES</b>		
Staff compensation, taxes and benefits	1,209,273	1,089,514
Printing and marketing expenses	774,137	966,433
Consulting fees and outside services	389,669	630,927
Professional services	127,769	258,620
Facility and utility costs	82,409	83,924
Office expense	25,511	38,483
Donation to the American Dental Association Foundation	60,000	60,000
Meeting expenses	30,607	45,884
Travel expenses	115,714	117,779
Depreciation	5,874	9,616
Other expenses, including allocated general and administrative expenses	169,953	141,052
	<u>2,990,916</u>	<u>3,442,232</u>
<b>TOTAL EXPENSES</b>		
Operating loss before equity in net loss of ADAidm and income tax (expense) benefit	(487,575)	(962,581)
Equity in net loss of ADAidm	(368,091)	(231,909)
	<u>(855,666)</u>	<u>(1,194,490)</u>
Net loss before income tax (expense) benefit	(855,666)	(1,194,490)
Income tax (expense) benefit (Note 5)	(332,218)	441,252
	<u>(1,187,884)</u>	<u>(753,238)</u>
Net loss		
Retained earnings at beginning of year	3,095,310	3,848,548
Retained earnings at end of year	<u>\$ 1,907,426</u>	<u>3,095,310</u>

See accompanying notes to financial statements.

# ADA Business Enterprises, Inc.

(A wholly-owned subsidiary of American Dental Association)

## Statements of Cash Flows

Years Ended December 31, 2008 and 2007

	<u>2008</u>	<u>2007</u>
<b>CASH FLOWS FROM OPERATING ACTIVITIES</b>		
Net loss	\$ (1,187,884)	(753,238)
Adjustments to reconcile net loss to net cash used by operating activities:		
Depreciation	5,874	9,616
Deferred income tax expense (benefit)	274,513	(162,453)
Equity in net loss of ADAidm	368,091	231,909
Changes in assets and liabilities:		
Receivables	4,442	4,689
Income taxes receivable	56,705	(328,274)
Prepaid expenses	(6,475)	--
Accounts payable and accrued liabilities	(126,271)	72,711
Due to affiliated organizations	(89,355)	118,322
Net cash used by operating activities	<u>(700,360)</u>	<u>(806,718)</u>
<b>CASH FLOWS FROM INVESTING ACTIVITIES</b>		
Purchase of marketable securities	(39,961)	(136,070)
Sale of marketable securities	930,598	352,000
Investment in ADAidm	--	(600,000)
Net cash provided (used) by investing activities	<u>890,637</u>	<u>(384,070)</u>
Net increase (decrease) in cash and cash equivalents	190,277	(1,190,788)
Cash and cash equivalents at beginning of year	82,633	1,273,421
Cash and cash equivalents at end of year	<u>\$ 272,910</u>	<u>82,633</u>

### SUPPLEMENTAL DISCLOSURE OF CASH FLOW INFORMATION

Cash paid during the year for income taxes	<u>\$ 1,000</u>	<u>49,475</u>
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See accompanying notes to financial statements.

# ADA Business Enterprises, Inc.

(A wholly-owned subsidiary of American Dental Association)

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## Notes to Financial Statements, December 31, 2008 and 2007

### 1. Significant Accounting Policies

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**Basis of Presentation:** ADA Business Enterprises, Inc. (ADABEI), a wholly-owned subsidiary of the American Dental Association (Association), manages the for-profit activities organized by the Association.

ADABEI's activities are organized in four divisions, which are the CEO office, business and financial services, marketing services, and new business development. The CEO office reflects the costs of Board and executive oversight and various expenses not allocated to the other divisions. The business and financial services division offers a range of products and services to Association members in conjunction with Citibank USA, a Citigroup affiliate, and various other service providers under the title of ADA Member Advantage. The marketing services division captures ADABEI's equity share of ADA Intelligent Dental Marketing, LLC (ADAidm) operating results and all ADABEI expenses directly related to support of ADAidm. The new business development division is focused on identifying and developing new products and services for ADA members.

**Use of Estimates:** In preparing financial statements in conformity with accounting principles generally accepted in the United States of America, management is required to make estimates and assumptions that affect the reported amounts of assets and liabilities, the disclosure of contingent assets and liabilities at the date of the financial statements, and the reported amounts of revenues, expenses, gains and losses during the reporting period. Actual results could differ from those estimates.

**Cash and Cash Equivalents:** Cash equivalents at December 31, 2008 and 2007 consist of interest bearing deposits under overnight repurchase agreements. ADABEI maintains its cash balances in financial institutions which at times may exceed federally insured limits. ADABEI has not experienced any losses in such accounts and believes it is not exposed to any significant credit risk on cash and cash equivalents.

**Marketable Securities:** Marketable securities are carried at fair value. The fair values of the marketable securities are based on quoted market prices.

**Investment in ADAidm:** The equity method is used for accounting for the investment in ADAidm. ADABEI has a 50% ownership interest in ADAidm.

**Furniture and Equipment:** Furniture and equipment are stated at cost less accumulated depreciation. Depreciation is computed on the straight-line method over three to ten years, the estimated useful lives of the assets.

**Revenue Recognition:** Royalties and service fees are recognized when earned pursuant to agreements with service providers.

**Income Taxes:** Deferred taxes are established for temporary differences between the financial reporting basis and the tax basis of assets and liabilities, based upon enacted tax rates which would apply during the period in which taxes become payable or recoverable, and the adjustment of cumulative deferred taxes for any changes in the tax rate.

**Fair Value Measurements:** Effective January 1, 2008, ADABEI adopted Statement of Financial Accounting Standards ("SFAS") No. 157, "*Fair Value Measurements*." SFAS No. 157 defines fair value, establishes a framework for measuring fair value, establishes a fair value hierarchy based on the inputs used to measure fair value and enhances disclosure requirements for fair value measurements. SFAS No. 157 maximizes the use of observable inputs and minimizes the use of unobservable inputs by requiring that the observable inputs be used when available.

Observable inputs are inputs that market participants would use in pricing the asset or liability based on market data obtained from independent sources. Unobservable inputs reflect assumptions that market participants would use in pricing the asset or liability based on the best information available in the circumstances. The hierarchy is broken down into three levels based on the transparency of inputs as follows:

# ADA Business Enterprises, Inc.

(A wholly-owned subsidiary of American Dental Association)

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## Notes to Financial Statements, December 31, 2008 and 2007

Level 1 - Quoted prices are available in active markets for identical assets or liabilities as of the report date. A quoted price for an identical asset or liability in an active market provides the most reliable fair value measurement because it is directly observable to the market.

Level 2 - Pricing inputs are other than quoted prices in active markets, which are either directly or indirectly observable as of the report date. The nature of these securities include investments for which quoted prices are available but which are traded less frequently and investments that are fairly valued using other securities, the parameters of which can be directly observed.

Level 3 - Securities that have little to no pricing observability as of the report date. These securities are measured using management's best estimate of fair value, where the inputs into the determination of fair value are not observable and require significant management judgment or estimation.

Inputs are used in applying the various valuation techniques and broadly refer to the assumptions that market participants use to make valuation decisions, including assumptions about risk. Inputs may include price information, volatility statistics, specific and broad credit data, liquidity statistics, and other factors. A financial instrument's level within the fair value hierarchy is based on the lowest level of any input that is significant to the fair value measurement. However, the determination of what constitutes "observable" requires significant judgment by ADABEI. ADABEI considers observable data to be that market data that is readily available, regularly distributed or updated, reliable and verifiable, not proprietary, and provided by independent sources that are actively involved in the relevant market. The categorization of a financial instrument within the fair value hierarchy is based upon the pricing transparency of the instrument and does not necessarily correspond to ADABEI's perceived risk of that instrument.

In February 2007, the Financial Accounting Standards Board issued SFAS No. 159, *"The Fair Value Option for Financial Assets and Financial Liabilities."* SFAS No. 159 provides ADABEI with an option to elect fair value as the initial and subsequent measurement attribute for most financial assets and liabilities and certain other items. The fair value option election is applied on an instrument-by-instrument basis (with some exceptions) is irrevocable, and is applied to an entire instrument. The fair value option election may be made as of the date of initial adoption for existing eligible items. Subsequent to initial adoption, ADABEI may elect the fair value option at initial recognition of eligible items, on entering into an eligible firm commitment, or when certain specified reconsideration events occur. Unrealized gains and losses on items for which the fair value option has been elected will be reported in the statements of activities.

ADABEI did not elect any changes to fair value measurements upon the adoption of SFAS No. 159 in 2008.

**Valuation of Financial Instruments:** ADABEI's financial instruments are marketable securities. Marketable securities are carried at fair value based on quoted market prices. ADABEI investments, which consist of money market funds, have values based on quoted market prices in active markets, and are therefore classified within Level 1. ADABEI does not adjust the quoted price for such instruments.

**FASB Staff Position – FIN 48-3:** In December 2008, the Financial Accounting Standards Board issued FASB Staff Position (FSP) FIN 48-3, "Effective Date of FASB Interpretation No. 48 for Certain Nonpublic Enterprises." FSP FIN 48-3 permits an entity within its scope to defer the effective date of FASB Interpretation 48 (Interpretation 48), *Accounting for Uncertainty in Income Taxes*, to its annual financial statements for fiscal years beginning after December 15, 2008. ADABEI has elected to defer the application of Interpretation 48 for the year ending December 31, 2008. ADABEI evaluates its uncertain tax positions using the provisions of FASB Statement 5, *Accounting for Contingencies*. Accordingly, a loss contingency is recognized when it is probable that a liability has been incurred as of the date of the financial statements and the amount of the loss can be reasonably estimated. The amount recognized is subject to estimate and management judgment with respect to the likely outcome of each uncertain tax position. The amount that is ultimately sustained for an individual uncertain tax position or for all uncertain tax positions in the aggregate could differ from the amount recognized.

**Reclassifications:** Certain 2007 amounts have been reclassified to conform to the 2008 presentation.

# ADA Business Enterprises, Inc.

(A wholly-owned subsidiary of American Dental Association)

## Notes to Financial Statements, December 31, 2008 and 2007

### 2. Marketable Securities

Marketable securities, recorded at fair value based upon quoted market prices, consisted of the following at December 31, 2008 and 2007.

	2008		2007	
	Cost	Market	Cost	Market
Money market funds	<u>\$ 1,798,787</u>	<u>1,798,787</u>	<u>2,689,424</u>	<u>2,689,424</u>

Investment income consisted of interest income for the years ended December 31, 2008 and 2007.

### 3. Investment in ADAidm

Effective January 31, 2007, ADABEI entered into an agreement with unrelated individuals to establish a new company, ADA Intelligent Dental Marketing, LLC (ADAidm) for the purpose of providing marketing services to dental practices. Under the agreement, ADABEI acquired a 50% interest in ADAidm for \$600,000, which has been accounted for under the equity method. ADABEI's 2007 and 2008 operational results include losses in each year on its investment in ADAidm. These losses led to the write-down to zero value at December 31, 2008 of ADABEI's investment in ADAIDM. This investment's book value had been shown as \$368,091 on December 31, 2007. Subsequent to December 31, 2008, and for the reasons described in Note 7, ADABEI obtained controlling interest of ADAidm and decided to wind down ADAidm's operations.

### 4. Furniture and Equipment

Furniture and equipment at December 31, 2008 and 2007 consisted of the following:

	2008	2007
Furniture and equipment	\$ 135,759	135,759
Less accumulated depreciation	122,796	116,922
	<u>\$ 12,963</u>	<u>18,837</u>

# ADA Business Enterprises, Inc.

(A wholly-owned subsidiary of American Dental Association)

## Notes to Financial Statements, December 31, 2008 and 2007

Income tax (expense) benefit differs from the amount computed by applying the statutory federal income tax rate of 34% to income before income tax benefit for the years ended December 31, 2008 and 2007, as follows:

	<u>2008</u>	<u>2007</u>
Statutory federal income tax	\$ 290,926	406,127
State income taxes	41,226	57,551
Valuation allowance	(640,269)	--
Other, net	(24,101)	(22,426)
Income tax (expense) benefit	<u>\$ (332,218)</u>	<u>441,252</u>

Net deferred tax assets at December 31, 2008 and 2007 consisted of:

	<u>2008</u>	<u>2007</u>
Deferred tax assets resulting from:		
Post-retirement health benefits	\$ 52,573	47,582
Charitable contributions	76,177	52,886
Start-up costs	85,208	85,208
Investment in ADAidm	170,368	95,425
Allowance for doubtful accounts not currently deductible	15,423	--
Net operating loss carryforward	231,502	--
AMT credit carryforward	14,050	--
	<u>645,301</u>	<u>281,101</u>
Deferred tax liability resulting from furniture and equipment	<u>(5,032)</u>	<u>(6,588)</u>
Deferred tax assets, net	640,269	274,513
Valuation allowance	(640,269)	--
Total net deferred tax assets, net of valuation allowance	<u>\$ --</u>	<u>274,513</u>

The company has set up a full valuation allowance for its net deferred tax assets, as it has determined will not meet the more likely than not threshold for recovery of these assets.

As of December 31, 2008, net operating loss carryforwards for federal tax purposes totaling \$504,752 are available to offset future taxable income of ADABEI, and expire as follows: \$32,791 in 2027 and \$471,961 in 2028. As of December 31, 2008, net operating loss carryforwards for state tax purposes totaling \$1,242,962 are available to offset future taxable income, and expire as follows: \$733,835 in 2019 and \$509,127 in 2020.

### 6. Transactions With Related Parties

The Association provides ADABEI with administrative and legal services as may be required. The allocated cost of such services amounted to \$140,766 and \$205,101 during the years ended December 31, 2008 and 2007, respectively. ADABEI paid \$91,956 and \$145,531 during the years ended December 31, 2008 and 2007, respectively, for advertising, meeting and marketing services. During both 2008 and 2007, the Association paid ADABEI \$5,000 for cooperative marketing expenses.

The Association sponsors a noncontributory defined benefit pension plan and a savings and retirement plan, which cover substantially all employees of the Association, its subsidiaries, and affiliates meeting certain eligibility requirements. In addition to the allocated expenses described above are pension expense charges associated with ADABEI employees who are participants in the Association's retirement plans, amounting to \$118,300 and \$114,200 in 2008 and 2007, respectively. Information is not sufficient to permit ADABEI to determine its share, if any, of unfunded vested benefits.

# ADA Business Enterprises, Inc.

(A wholly-owned subsidiary of American Dental Association)

## Notes to Financial Statements, December 31, 2008 and 2007

Additionally, the Association sponsors a contributory defined benefit postretirement health plan, which covers substantially all employees of the Association, its subsidiaries and affiliates. ADABEI expensed postretirement benefit charges of \$13,342 and \$11,734 for the years ended December 31, 2008 and 2007, respectively, associated with participating employees.

The Association established the Executive Parity Plan, a deferred compensation arrangement, which compensates executives who suffered restrictions in their pension as a result of the Omnibus Reconciliation Act. ADABEI expensed \$30,507 in 2008 and \$131,150 in 2007 for awards granted to ADABEI participants.

The Association also leases office space to ADABEI. Rent expense under this lease amounted to \$79,278 and \$81,601 during 2008 and 2007, respectively. The office space lease expires September 30, 2016. Minimum future rentals to be paid on the office lease are \$73,767 in 2009, \$75,978 in 2008, \$78,253 in 2011, \$80,597 in 2012, \$83,029 in 2013 and \$241,156 thereafter.

During both 2008 and 2007, ADABEI authorized payment of charitable contributions of \$60,000 to the American Dental Association Foundation, a not-for-profit affiliate.

Periodically, expenses of one organization may be paid by an affiliated organization and subsequently reimbursed.

At December 31, 2008 and 2007, amounts due (to) from affiliated organizations were as follows:

	<u>2008</u>	<u>2007</u>
American Dental Association	\$(372,557)	(493,483)
ADAidm	--	31,571
	<u>\$(372,557)</u>	<u>(461,912)</u>

### 7. Subsequent Events

Effective May 19, 2009, one of the Class A members transferred his 25% interest in ADAidm to ADABEI. Effective June 9, 2009, the remaining Class A member surrendered his shares to ADABEI, resulting in ADABEI owning 100% of the shares of ADAidm. There was no consideration paid to the Class A members in exchange for their interests.

Subsequent to these transactions, ADABEI announced on July 10, 2009 that ADAidm would cease operations due to significant production and operational difficulties.

Through December 2009, ADABEI has incurred approximately \$4.9 million for costs related to the wind-down of ADAidm, including refunds to customers for undelivered goods and services and payments of outstanding balances to vendors. In addition, other costs have been incurred to wind-down operations. Total costs related to the wind-down of ADAidm are not expected to exceed \$5.7 million.

ADABEI entered into a termination agreement with Citibank on August 7, 2009, pursuant to which program assets related to the affinity credit card were transferred to ADABEI's designated buyer, US Bank National Association ND dba Elan Financial Services. ADABEI received a \$3.7 million premium share from Citibank on September 2, 2009 related to this termination. Distributions of \$289,242 from these funds were made to endorsing state dental societies in 2009.

## Divisional Statement of Operations

# ADA Business Enterprises, Inc.

(A wholly-owned subsidiary of American Dental Association)

## Divisional Statement of Operations

Year Ended December 31, 2008

	<u>CEO Office</u>	<u>Business &amp; Financial Services</u>	<u>Marketing Services</u>	<u>New Business Development</u>	<u>Total</u>
<b>REVENUES</b>					
Royalties and service fees	\$ --	2,453,872	--	--	2,453,872
Investment income	49,469	--	--	--	49,469
<b>TOTAL REVENUES</b>	<b>49,469</b>	<b>2,453,872</b>	<b>--</b>	<b>--</b>	<b>2,503,341</b>
<b>EXPENSES</b>					
Staff compensation, taxes and benefits	120,853	734,108	--	354,312	1,209,273
Printing and marketing expenses	--	767,495	--	6,642	774,137
Consulting fees and outside services	--	--	--	389,669	389,669
Professional services	105,675	10,325	2,688	9,081	127,769
Facility and utility costs	--	82,409	--	--	82,409
Office expense	1,421	17,409	77	6,604	25,511
Donations to the ADA Foundation	60,000	--	--	--	60,000
Meeting expenses	93	30,514	--	--	30,607
Travel expenses	25,677	23,628	2,932	63,477	115,714
Depreciation	--	5,874	--	--	5,874
Other expenses, including allocated general and administrative expenses	20,656	111,526	37,731	40	169,953
<b>TOTAL EXPENSES</b>	<b>334,375</b>	<b>1,783,288</b>	<b>43,428</b>	<b>829,825</b>	<b>2,990,916</b>
Operating (loss) income before equity in net loss of ADAidm and income tax	(284,906)	670,584	(43,428)	(829,825)	(487,575)
Equity in net loss of ADAidm	--	--	(368,091)	--	(368,091)
Net (loss) income before income tax expense	(284,906)	670,584	(411,519)	(829,825)	(855,666)
Income tax (expense) benefit	(84,593)	18,208	(199,806)	(66,027)	(332,218)
Net (loss) income	\$ (369,499)	688,792	(611,325)	(895,852)	(1,187,884)

# **ADPAC**

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## **American Dental Political Action Committee**

### **Financial Statements**

(With Report of Independent Certified Public Accountants)

**December 31, 2008 and 2007**

# American Dental Political Action Committee

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## Report of Independent Certified Public Accountants

Board of Directors  
American Dental Political Action Committee

We have audited the accompanying statements of financial position of the American Dental Political Action Committee (the Committee) as of December 31, 2008 and 2007, and the related statements of activities and cash flows for the years then ended. These financial statements are the responsibility of the Committee's management. Our responsibility is to express an opinion on these financial statements based on our audits.

We conducted our audits in accordance with auditing standards generally accepted in the United States of America as established by the American Institute of Certified Public Accountants. Those standards require that we plan and perform the audits to obtain reasonable assurance about whether the financial statements are free of material misstatement. An audit includes consideration of internal control over financial reporting as a basis for designing audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the Committee's internal control over financial reporting. Accordingly, we express no such opinion. An audit also includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements, assessing the accounting principles used and significant estimates made by management, as well as evaluating the overall financial statement presentation. We believe that our audits provide a reasonable basis for our opinion.

In our opinion, the financial statements referred to above present fairly, in all material respects, the financial position of the Committee at December 31, 2008 and 2007, and the results of its operations and cash flows for the years then ended, in conformity with accounting principles generally accepted in the United States of America.

Our audits were conducted for the purpose of forming an opinion on the basic financial statements taken as a whole of the American Dental Political Action Committee as of and for the years ended December 31, 2008 and 2007. The schedule of expenses by natural classification is presented for purposes of additional analysis and is not a required part of the basic financial statements. Such information has been subjected to the auditing procedures applied in the audits of the basic financial statements and, in our opinion, is fairly stated in all material respects in relation to the basic financial statements taken as a whole.

McLean, Virginia  
December 24, 2009

*Grant Thornton LLP*

# American Dental Political Action Committee

## Statements of Financial Position

December 31, 2008 and 2007

	2008		2007		Total
	Hard Dollar Fund	Soft Dollar Fund	Hard Dollar Fund	Soft Dollar Fund	
<b>ASSETS</b>					
Cash	\$ 241,944	887,790	457,549	1,205,399	1,662,948
Prepaid expense	--	133,750	--	56,250	56,250
<b>TOTAL ASSETS</b>	<b>\$ 241,944</b>	<b>1,021,540</b>	<b>457,549</b>	<b>1,261,649</b>	<b>1,719,198</b>
<b>LIABILITIES AND NET ASSETS</b>					
Accrued liabilities	\$ 678	10,708	762	11,237	11,999
Net assets	241,266	1,010,832	456,787	1,250,412	1,707,199
<b>TOTAL LIABILITIES AND NET ASSETS</b>	<b>\$ 241,944</b>	<b>1,021,540</b>	<b>457,549</b>	<b>1,261,649</b>	<b>1,719,198</b>

See accompanying notes to financial statements.



## American Dental Political Action Committee

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### Statements of Cash Flows

Years Ended December 31, 2008 and 2007

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	<u>2008</u>	<u>2007</u>
<b>CASH FLOWS FROM OPERATING ACTIVITIES</b>		
Net (decrease) increase in net assets	\$ (455,101)	382,843
Change in assets and liabilities:		
Prepaid expenses	(77,500)	(56,250)
Accrued liabilities	<u>(613)</u>	<u>(5,004)</u>
Net (decrease) increase in cash	(533,214)	321,589
Cash at beginning of year	<u>1,662,948</u>	<u>1,341,359</u>
Cash at end of year	<u>\$1,129,734</u>	<u>1,662,948</u>
<b>SUPPLEMENTAL DISCLOSURE OF CASH FLOW INFORMATION</b>		
Cash paid during the year for income taxes	<u>\$ 6,774</u>	<u>2,588</u>

See accompanying notes to financial statements.

# American Dental Political Action Committee

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Notes to Financial Statements, December 31, 2008 and 2007

## 1. Significant Accounting Policies

---

**Basis of Presentation:** The American Dental Political Action Committee (the Committee) is a non-profit, unincorporated committee of dentists and others, formed to raise funds to promote the improvement of public health and government; to become aware of government, the important political issues, and the records of officeholders and candidates; and to assist dentists and others in organizing themselves for more effective political action.

The Committee is associated with, and the majority of administrative expenses of the Committee are paid directly by, the American Dental Association (ADA).

**Basis of Accounting:** The Committee prepares its financial statements on the accrual basis of accounting. Consequently, revenue is recognized when earned, and expenses when the obligation is incurred.

**Fund Accounting:** To ensure observance of limitation and restrictions on the use of resources, the Committee records its transactions in two self-balancing funds, as follows:

**Hard Dollar Fund** – Contributions received directly from members or transfers from affiliated committees' hard dollar funds are recorded in this fund. Contributions are used primarily for the support of candidates for federal office and political committees for assisting persons in political work.

**Soft Dollar Fund** – Member contributions received from dentists paid from their professional corporations are recorded in this fund. Expenses related to educating dentists about the political process and government, and incurred in connection with various dental seminars and miscellaneous administrative costs, are paid from this fund.

**Use of Estimates:** In preparing financial statements in conformity with accounting principles generally accepted in the United States of America, management is required to make estimates and assumptions that affect the reported amounts of assets and liabilities, the disclosure of contingent liabilities at the date of the financial statements and the reported amounts of revenues and expenses during the reporting period. Actual results could differ from those estimates.

**Cash:** Cash at December 31, 2008 and 2007 consists of operating funds maintained in interest-bearing checking accounts. The Committee maintains these account balances in financial institutions which at times may exceed federally insured limits. The Committee has not experienced any losses in such accounts and believes it is not exposed to any significant credit risk on cash.

**Revenue Recognition:** Contributions received by the Committee are recognized as revenue in the period received.

## American Dental Political Action Committee

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### Notes to Financial Statements, December 31, 2008 and 2007

**Income Taxes:** In December 2008, the Financial Accounting Standards Board (FASB) issued FASB Staff Position (FSP) FIN 48-3, "Effective Date of FASB Interpretation No. 48 for Certain Nonpublic Enterprises." FSP FIN 48-3 permits an entity within its scope to defer the effective date of FASB Interpretation 48 (Interpretation 48), *Accounting for Uncertainty in Income Taxes*, to its annual financial statements for fiscal years beginning after December 15, 2008. The Committee has elected to defer the application of Interpretation 48 for the year ending December 31, 2008. The Committee evaluates its uncertain tax positions using the provisions of FASB Statement 5, *Accounting for Contingencies*. Accordingly, a loss contingency is recognized when it is probable that a liability has been incurred as of the date of the financial statements and the amount of the loss can be reasonably estimated. The amount recognized is subject to estimate and management judgment with respect to the likely outcome of each uncertain tax position. The amount that is ultimately sustained for an individual uncertain tax position or for all uncertain tax positions in the aggregate could differ from the amount recognized.

**Reclassifications:** Certain 2007 amounts have been reclassified to conform to the 2008 presentation.

#### 2. Income Taxes

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The Committee is exempt from federal income taxes under Section 527 of the Internal Revenue Code, except on net investment revenue. Income taxes of \$4,782 and \$5,499 were included in accrued liabilities as of December 31, 2008 and 2007, respectively. Income taxes are included in general and administrative expenses.

**SUPPLEMENTAL INFORMATION**

# American Dental Political Action Committee

## Schedule of Expenses by Natural Classification

Years Ended December 31, 2008 and 2007

	2008			2007		
	Hard Dollar Fund	Soft Dollar Fund	Total	Hard Dollar Fund	Soft Dollar Fund	Total
<b>EXPENSES</b>						
Candidate support	\$1,458,200	--	1,458,200	1,103,813	--	1,103,813
Contributions	--	51,100	51,100	--	10,940	10,940
Printing and marketing	--	242,354	242,354	--	86,024	86,024
Special events	--	55,156	55,156	--	36,466	36,466
Special projects	--	193,813	193,813	--	51,198	51,198
Meetings expense	--	9,025	9,025	--	895	895
Travel	--	21,264	21,264	--	--	--
Consulting fees	--	133,605	133,605	--	92,951	92,951
Outside services	--	37,538	37,538	--	500	500
Honoraria	--	39,883	39,883	--	15,000	15,000
Membership dues	--	9,400	9,400	--	5,000	5,000
Office expense	--	22,148	22,148	--	3,228	3,228
Grants and awards	--	25,000	25,000	--	25,000	25,000
Bank and credit card charges	8,493	19	8,512	8,264	124	8,388
Income taxes	773	5,284	6,057	800	4,737	5,537
<b>TOTAL EXPENSES</b>	<b>\$1,467,466</b>	<b>845,589</b>	<b>2,313,055</b>	<b>1,112,877</b>	<b>332,063</b>	<b>1,444,940</b>

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# Appendix

# Notes

# Index of Resolutions

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<b>Res. 1</b>	<i>Reports: 57</i>	<b>Council on Dental Benefit Programs</b> Amendment of the Statement on Determination of Usual, Customary and Reasonable Fees
<b>Res. 2</b>	<i>Reports: 58</i>	<b>Council on Dental Benefit Programs</b> Amendment of the Definitions of Fraudulent and Abusive Practices in Dental Benefit Plans and Claims
<b>Res. 3</b>	<i>Reports: 58</i>	<b>Council on Dental Benefit Programs</b> Amendment of the Standards for Dental Benefit Plans
<b>Res. 4</b>	<i>Reports: 59</i>	<b>Council on Dental Benefit Programs</b> Amendment of the Policy “American Dental Association Dental Health Program for Children”
<b>Res. 5</b>	<i>Reports: 59</i>	<b>Council on Dental Benefit Programs</b> Statement on Dental Consultants
<b>Res. 6</b>	<i>Reports: 61</i>	<b>Council on Dental Benefit Programs</b> Legislation to Require Dental Benefit Plans to Provide Dental Consultant Information
<b>Res. 7</b>	<i>Reports: 63</i>	<b>Council on Dental Benefit Programs</b> Dental Practice Parameters
<b>Res. 8</b>	<i>Reports: 66</i>	<b>Council on Dental Benefit Programs</b> Definitions to “Usual” and “Customary” Fees
<b>Res. 9</b>	<i>Reports: 75</i>	<b>Council on Dental Education and Licensure</b> Amendment of the ADA <i>Bylaws</i> Regarding the Name of CDEL’s Standing Committee on Dental Education
<b>Res. 10</b>	<i>Reports: 75</i>	<b>Council on Dental Education and Licensure</b> Amendment of the ADA <i>Bylaws</i> to Update Terminology in the Duties of the Council on Dental Education and Licensure
<b>Res. 11</b>	<i>Reports: 82</i>	<b>Council on Dental Education and Licensure</b> Amendment of the ADA <i>Bylaws</i> , Duties of the Council on Dental Education and Licensure Relating to the Recognition of Interest Areas in General Dentistry
<b>Res. 12</b>	<i>Reports: 82</i>	<b>Council on Dental Education and Licensure</b> Criteria for Recognition of Interest Areas in General Dentistry
<b>Res. 13</b>	<i>Reports: 92</i>	<b>Council on Dental Education and Licensure</b> Acceptance of Formal Continuing Medical Education Courses Offered by ACCME Accredited CE Providers
<b>Res. 14</b>	<i>Reports: 96</i>	<b>Council on Dental Education and Licensure</b> Amendment of the Policy “Recommended Curricula Changes”
<b>Res. 15</b>	<i>Reports: 123</i>	<b>Council on Ethics, Bylaws and Judicial Affairs</b> Process to Address Violations by Candidates for Elective or Appointive Office and Current ADA Elective and Appointive Officers

- Res. 16**    *Reports: 124*    **Council on Ethics, Bylaws and Judicial Affairs**  
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- Res. 17**    *Reports: 126*    **Council on Ethics, Bylaws and Judicial Affairs**  
Amendment of the ADA *Bylaws* Regarding Term of Delegates and Alternate Delegates
- Res. 18**    *Reports: 128*    **Council on Ethics, Bylaws and Judicial Affairs**  
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- Res. 19**    *Reports: 129*    **Council on Ethics, Bylaws and Judicial Affairs**  
Amendment of the ADA *Principle of Ethics and Code of Professional Conduct*—Section 3.F. Professional Demeanor in the Workplace
- Res. 20**    *Reports: 130*    **Council on Ethics, Bylaws and Judicial Affairs**  
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- Res. 24**    *Reports: 198*    **Council on Scientific Affairs**  
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- Res. 30**    *Reports: 223*    **Eighth Trustee District**  
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**Res. 31**     *Reports: 223*     **American Student Dental Association and Pennsylvania Dental Association**  
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**2009 Resolutions Referred to the 2010 House of Delegates**

**8-2009**     *Reports: 224*     **Council on Ethics, Bylaws and Judicial Affairs**  
Editorial Changes to the ADA *Constitution*

# Notes