

# 2011

## Annual Reports and Resolutions

152<sup>nd</sup> Annual Session  
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## Councils and Commissions

## Notes

# Council on Access, Prevention and Interprofessional Relations

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**Davis, Gary S.**, Pennsylvania, 2011, chair  
**Holwager, David**, Indiana, 2012, vice chair  
**Allen, Nolan W.**, Florida, 2012  
**Baber, Greg L.**, Texas, 2011, American Hospital Association  
**Chase, Timothy D.**, Arkansas, 2014  
**Ciebien, Gerald J.**, Illinois, 2012  
**Gill, Eleanor A.**, Mississippi, 2012  
**Hanck, John J.**, Colorado, 2013  
**Hebl, Monica**, Wisconsin, 2013  
**Heddens, Heather B.**, Iowa, 2013  
**Homicz, A.J.**, New Hampshire, 2011  
**Hunke, Philip H.**, Texas, 2014  
**Lang, Melanie S.**, Washington, 2011  
**Miller, David J.**, New York, 2011  
**Napier, Rocky L.**, South Carolina, 2014  
**Pankratz, Todd A.**, Nebraska, 2011, American Medical Association  
**Scott, Brian E.**, California, 2013  
**Swilling, Stacey**, Arkansas, 2011, *ex officio*\*  
**Thompson, William R.**, Tennessee, 2014  
**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 four goals of the *ADA Strategic Plan: 2011-2014*. CAPIR facilitates collaboration and promotes dialogue between the ADA and a broad array of communities of interest and assists members to 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 works closely with external stakeholders in the areas of interprofessional relations, the prevention of oral disease and access to care. The programs and activities described within this annual report of the Council attest to that dedication to dialogue and collaboration with diverse communities that impact the oral health care environment.

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 and barriers to 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, supporting a strong profession that is best able to meet the needs of communities. CAPIR supports the American Indian/Alaska Native Dental Placement Program, the Give Kids A Smile Program, the OralLongevity™

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

campaign, 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 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* authority to recommend policies and formulate programs on issues pertaining to the relationship of dentistry to medicine and the medical dental interface. These include, but are not limited to, 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. In keeping with the ADA's strategic goal #3 to improve public health through a strong collaborative profession, the Interprofessional program area of CAPIR facilitates collaboration and promotes dialogue between the ADA and a broad array of communities of interest in three major areas of interest: accreditation, the dental-medical interface and interprofessional relations.

Value to the profession includes, but is not limited to, dissemination of information on emerging topics of interest to the membership regarding the medical-dental connection, the opportunity to impact areas of interest to the dental profession that relate oral health to overall health and the potential to broaden the scope of oral health care within the total health care system. Program initiatives enhance building relationships with external stakeholders and promotion of collaborative activities to support the dental profession.

**American Diabetes Association:** CAPIR staff continue to work on collaborative opportunities with the American Diabetes Association. Based on meetings with the American Diabetes Association in December 2010 and January 2011, it was determined that there were specific initiatives that crossed inter-divisionally at the ADA. The Division of Science is investigating having the American Diabetes Association participate at the 2011 ADA Annual Session Health Screening Program. Of particular interest is the risk assessment tool developed by the Diabetes Association that could be used by ADA member dentists in their offices. Marketing and Communications staff are continuing to work with GlaxoSmithKline (GSK) to use a portion of the GSK grant to have a booth at one of the 2011 Diabetes Association Expos. The focus will be on oral longevity and will include health promotion materials on oral health. CAPIR plans to develop a presentation for the public on the relationship between diabetes and oral health. CAPIR is also charged with exploring the possibility of engaging volunteers for the Expos from the ADA membership to be "ask the experts" at the Expos.



**Institute of Medicine (IOM) Committee on Preventive Services for Women:** In February 2011, the IOM requested input from CAPIR for the IOM Committee on Preventive Services for Women. CAPIR in collaboration with the Division of Government and Public Affairs and the Division of Science, assisted in developing the testimony emphasizing the special oral health needs of women across a lifetime, noting how gender differences impact oral disease screenings, treatment decisions, and guidelines. Access to healthcare providers who can educate women on prevention and diagnose and manage these oral conditions is an essential part of overall health care.

**American Medical Association (AMA):** Dr. Donald Seago, Fifth District trustee, and CAPIR staff, attended the interim meeting of the AMA and the Organized Medical Staff Section (OMSS) interim meeting on November 4-9, 2010, and provided testimony at the Reference Committee on Legislation in favor of the resolution to retract the AMA Scope of Practice Data Series pertaining to oral surgeons, submitted by the American Association of Oral and Maxillofacial Surgeons (AAOMS). The resolution did not pass primarily due to the contention by plastic surgeons that the training of the M.D./D.M.D. or D.D.S. is superior to that of the single degree oral surgeon. Also on the AMA agenda were several other resolutions that impact the dental profession. The AMA voiced its concerns with Accountable Care Organizations (ACOs), the Provider Enrollment, Chain, and Ownership System (PECOS), Medicare enrollment, routine immunization of physicians and health care workers, and The Joint Commission's (TJC) Primary Care Home Initiative and MS.01.01.01 (standards for medical staff activities). CAPIR staff will continue to monitor these issues.

**American Hospital Association (AHA):** The ADA has been involved with the AHA for many years through CAPIR. The ADA joined as an associate member in January 2011. CAPIR staff and the Interprofessional Relations Subcommittee Chair attended the AHA meeting in Washington, D.C., April 9-12, 2011. The agenda included an impressive array of speakers including, Admiral Thad Allen, Governor Jeb Bush, Senator Orin Hatch, (R-Utah) and former Senator Alan Simpson (R-Wyo.) and several others from Congress. The theme was "Pursuing Excellence. One Vision, One Voice." The focus on advocacy included the Affordable Care Act, Medicaid, regulatory relief and budget challenges.

**American Academy of Pediatrics (AAP):** CAPIR now participates on the AAP's Section on Pediatric Dentistry and Oral Health (SOPDOH) Executive Committee. SOPDOH focuses on improving communications between pediatricians and dentists through educational programs and advocacy to improve oral health. This year work by the SOPDOH Executive Committee has included a review of an oral health risk assessment tool for pediatricians and review of the AAP dietary recommendations for infants, children and adolescents. CAPIR in collaboration with the Center for Evidence-Based Dentistry contributed an article to the SOPDOH newsletter regarding the clinical guidelines for prescription of dietary fluoride supplements.

**Health Resources Service Administration (HRSA)/ADA/American Congress of Obstetricians and Gynecologists (ACOG) Collaboration:** CAPIR supports the collaboration between the ADA, HRSA and the ACOG. Building on meetings held in 2010 between the ADA and HRSA leadership, a workgroup has been formed to develop an action plan to promote the importance of perinatal oral health. The workgroup is planning to expand by inviting representation by the American Academy of Pediatrics (AAP) and the American Academy of Family Physicians (AAFP).

**The Joint Commission (TJC):** Dr. David Whiston continues to serve as the ADA Commissioner on The Joint Commission's Board of Commissioners through the end of 2011. He completed his service as Chair of The Joint Commission Board of Commissioners in November 2010. CAPIR volunteers and staff appointed to TJC committees attended meetings throughout the year to monitor issues impacting the dental profession. In 2011, new representatives to the Professional and Technical Advisory Committees (PTACs) were appointed. CAPIR developed a PTAC manual and instituted periodic conference calls to discuss issues that impact the dental profession. In January, the PTAC group sent recommended guidelines to TJC on oral hygiene practices in hospital settings to prevent ventilator acquired pneumonias (VAPs). Another area of interest is improving oral health care in long term care settings.

TJC continues to focus on addressing critical issues in health care delivery to assist organizations in striving to attain the highest level of quality and patient safety in all health care delivery settings. Topics of interest to the ADA include the standards for the primary medical home, the TJC's Center for Transforming Healthcare projects and increased efforts by TJC to establish standards for hospitals overseas. Regarding the primary medical home standards, much of the discussion by members of the various committees pertains to scope of practice issues and the role of the physician on a medical team. In 2010, the Board of Commissioners approved recommended changes to hospital medical staff standard MS.01.01.01. The revised standard became effective on March 31, 2011. MS.01.01.01 supports patient safety and quality of care through 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.

*Joint Commission Center for Transforming Healthcare.* The Joint Commission Center for Transforming Healthcare was established in 2009 and aims to solve health care's most critical safety and quality problems. The Center utilizes a proven systematic approach to analyze specific breakdowns in care and discover their underlying causes to develop targeted solutions that solve these complex problems. The Center's first initiative addressed lack of compliance with hand washing protocols that contribute to health care-associated infections that kill nearly 100,000 Americans each year and cost U.S. hospitals \$4 billion-\$29 billion annually to combat. Projects underway target breakdowns in hand-off communications and safeguards to prevent wrong site surgery. As one of the five corporate sponsors of The Joint Commission, the ADA is privileged to participate in TJC initiatives designed to improve the quality and safety of healthcare. The Board of Trustees approved a donation in the amount of \$5,000 to TJC Center for Transforming Healthcare for 2012 at its April 2011 meeting. The rationale for an ADA contribution is two-fold: 1) as health care reform moves quickly, the Center represents a private-sector solution for achieving the goals of safety and quality improvement, along with a reduction of long-term growth of healthcare costs; and 2) for the corporate sponsors, the appeal of the Center bridges the public good it provides and the alignment with the mandate for health care reform.

**Accreditation Association for Ambulatory Healthcare (AAAHC):** The AAAHC is a private, non-profit organization formed in 1979. It is a leader in developing standards to advance and promote patient safety, quality and value for ambulatory health care through peer-based accreditation processes, education and research. AAAHC currently accredits over 4,000 organizations in a wide variety of ambulatory health care settings, including ambulatory and office based surgery centers, dental practices, managed care organizations, and Indian and student health centers. CAPIR staff is the appointed Official Observer for the ADA.

Of interest to the ADA is the work by AAAHC to develop a dental survey to be used for accrediting dental practices, particularly applicable to oral surgery practices in states requiring evidence of accreditation in order to provide care under the state practice act. The American Association of Oral and Maxillofacial Surgeons (AAOMS) is a member of AAAHC and is actively involved in the development of the dental model for accreditation. In 2010, AAAHC contracted with the Health Resources and Services Administration (HRSA) and continues to expand its relationship with HRSA to conduct surveys at Federally Qualified Health Centers (FQHCs). As regulatory organizations press for more accountability by ambulatory care centers, it is important for the ADA to continue to monitor the impact on the dental profession.

The Council recommended to the Board of Trustees that the ADA become a member of the AAAHC in order to position the ADA to contribute to important decisions impacting dentistry in the area of accreditation. This request was approved by the Board at its April 2011 meeting for membership in 2012.

**Organization for Safety, Asepsis and Prevention (OSAP):** CAPIR continues to collaborate with the Organization for Safety, Asepsis and Prevention (OSAP). In 2009, CAPIR staff represented the ADA on a committee to develop an Infection Control Site Assessment and Checklist for settings that use portable equipment or mobile vans without operatories. At its June 2010 meeting, CAPIR passed a resolution directing the Interprofessional Relations Subcommittee to review the final checklist tools and supporting documents developed by OSAP and to submit the referenced documents to the ADA Division of Legal

Affairs, the Council on Scientific Affairs, and the Council on Dental Practice for review, and to determine how to disseminate the tool to ADA members with direction from the Council on Communications. OSAP recently finalized the checklist tools which are now posted on their website at [www.OSAP.org](http://www.OSAP.org).

**Collaboration With Centers for Disease Control and Prevention (CDC):** In conjunction with the Department of State Government Affairs, and representatives of CDC, CAPIR has been participating in a project to address inappropriate oral health usage within emergency rooms (ERs). The utilization of emergency departments to provide oral health emergency care is often cited anecdotally as being on the rise and of concern to both hospital management and public health officials seeking to increase access to primary oral health care. With increasing demand on public safety net systems and declining state resources to fund public expenditures in this regard, finding appropriate data to support enhancing the dental public health infrastructure through public/private collaboration is critical. Current work on the project includes 1) working with a researcher from Marquette University to review current studies and analyze overall trends; 2) continuing work on analysis of data from the Biosense surveillance system; and 3) reviewing data from other sources on a national scope and comparing the findings with the CDC data. These analyses will contribute to defining the key indicators to capture reliable data on use of the ER for dental treatment and methodology for future analysis. The goal of the project is to develop a summary report to be used in advocacy for improving access to care for underserved populations.

**The National Roundtable for Dental Collaboration (NRDC):** In collaboration with the Department of Dental Society Services, CAPIR assisted in the preparations for convening the first National Roundtable for Dental Collaboration in 2010. Presidents and executive directors from 15 recognized specialty associations and other dental organizations attended the Roundtable. The purpose of the meeting was to find common ground for joint action and to provide a venue for dental associations and dental specialty organizations to collaborate in the development and application of a process for routine and effective communication, to identify and assess common challenges in the delivery of oral health care, and to work collaboratively to address those challenges towards improving oral health and overall health. CAPIR has taken the lead on follow-up activities. In 2010, this included planning for the 2011 annual conference, coordinating the quarterly conference calls of the executive directors and handling the administrative duties for the Roundtable participants.

The second annual meeting of the NRDC was held on January 7-8, 2011, at the ADA Headquarters Building in Chicago. The purpose of this meeting was to identify and assess common challenges in the delivery of oral health care, and to work collaboratively to address those challenges towards improving oral health and overall health. In 2011, the Roundtable invited several new organizations to participate including the Hispanic Dental Association, the National Dental Association, the American Association of Women Dentists, and the National Network for Oral Health Access, and the Organization for Safety, Asepsis and Prevention. An invitation was also extended to the Society of American Indian Dentists and it is anticipated they will join in 2011. Consensus has been reached to continue to work together through an annual meeting, quarterly conference calls attended by the executive directors and to explore initiating a public awareness campaign on the importance of oral health to overall health.

One viable initiative for the NRDC is the pursuit of a national social marketing campaign focused on the importance of oral health, planned and executed by the Ad Council. The Ad Council is a private non-profit organization with a 65-year history of developing campaigns to deliver critical messages to the American public. The cost of a proposed oral health campaign program is limited to the costs of developing the actual campaign and is estimated by the Ad Council to be slightly less than \$3 million. All advertising media exposure on television, radio, newspapers, and magazines, is donated. The estimated value of the donated space is approximately \$25-30 million each year for three years.

The process and cost have been discussed among NRDC members, and a confirmed date (June 13, 2011) has been set when the concept will be presented to the Ad Council at its New York City offices for its consideration. The Dental Trade Alliance Board of Directors has made a commitment of \$1 million over three years. The campaign will be directed at children's oral health. Should the Ad Council accept the proposal, this initiative will be overseen by the Council on Communications and at least three ADA divisions: the Division of Communications, Division of Dental Practice/Professional Affairs and the

Division of Government and Public Affairs. At its April 2011 meeting, the Board of Trustees approved a resolution that the American Dental Association enter into a memorandum of understanding with other members of the NRDC to pursue the possibility of a national public awareness children's oral health campaign by the Ad Council and that the ADA commit up to \$350,000 per year for three years, should the Ad Council agree to take on the work of a children's oral health national social marketing campaign and aggressively pursue investment commitments by other members of the National Roundtable for Dental Collaboration.

**Oral Health Care Series:** CAPIR continues to work with the Department of Product Development and Sales to publish a text on oral health care and other health conditions with Wiley-Blackwell publishers. The book will consist of concise, attractive, easy-to-follow information, designed to be used by general dentists to assist them in the treatment of individuals with complex medical conditions or unique physiology that may affect their oral health. It is anticipated the guide will also be a useful resource for physicians. The current timeline projects a launch date of June 2012 for release of the book.

**National Interprofessional Initiative on Oral Health (NIOH):** NIOH has developed both a structure and process for a consortium of individuals from multiple health professional and philanthropic organizations to focus and engage primary care providers on how best to integrate oral health into primary care. CAPIR is exploring potential synergistic opportunities with the NIOH.

**Oral Health America (OHA):** In 2010, OHA approached the ADA regarding sponsorship of a May 2011 conference on diabetes and oral health. The Council recommended that the ADA become a media sponsor for the event, in keeping with the ADA's strategic goals: to provide support to dentists so they may succeed and excel throughout their careers; to be the trusted resource for oral health information that will help people be good stewards of their own oral health; and to improve public health outcomes through a strong collaborative profession and through effective collaboration across the spectrum of our external stakeholders. CAPIR staff has worked with the Division of Legal Affairs, marketing and communications to execute an agreement which was signed in March 2011. The Marketing Department has actively worked on promotional materials. For more information on the program, go to: [www.nyas.org/DentalDiabetes](http://www.nyas.org/DentalDiabetes).

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## Preventive Health and Fluoridation Activities and Trends

**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 Divisions of Science, Government and 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:

*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 annual NFAC meeting was held July 18-19, 2011.

*Status via CDC Fluoridation Census.* On September 15, 2010, the CDC released the latest statistics on community water fluoridation for the nation via their website. The latest data show that in 2008, 72.4% of the U.S. population on public water systems, or a total of 195.5 million people, had access to optimally fluoridated water. This is an increase from 2006, when 69.2% of the U.S. population on public water systems, or 184 million people, received fluoridated water. Implementation of fluoridation programs in California contributed significantly to the increase. Twenty-seven states plus the District of Columbia have achieved the *Healthy People 2010* objective of having 75% of their population on public water systems receive fluoridated water. With these most recent statistics, the two newest states to achieve the Healthy People objective are Delaware and Oklahoma. If the trend continues, it is anticipated that when the next CDC Fluoridation Census is released that using data through 2010, the HP 2010 goal of 75% may have been met.

*Healthy People 2020.* In December 2010, the Healthy People Objectives for 2020 were released by the U.S. Department of Health and Human Services (HHS). Oral Health Objective 13 for fluoridation sets a new target of 79.6%, effectively increasing the goal of the proportion of the U.S. population served by community water systems with optimally fluoridated water by 10%.

*Fluoridation Activities of the Federal Government.* The first quarter of 2011 began with the U.S. Department of Health and Human Services (HHS) and the Environmental Protection Agency (EPA) issuing a joint announcement on January 7 regarding “new scientific assessments and actions on fluoride.” It had been long anticipated that EPA would issue information on the risk assessments recommended in the 2006 advisory report completed by the National Academies related to natural levels of fluoride in drinking water. The timing of the joint announcement was unexpected as it had been anticipated that the HHS announcement would come sometime later. As it turned out, the EPA risk assessment documents were used as references to support the HHS action. Specifically, the HHS proposed that community water systems adjust the amount of fluoride to 0.7 mg/L (from the current range of 0.7 to 1.2 mg/L) to achieve an optimal fluoride level. HHS noted that for the purpose of this guidance, the optimal concentration of fluoride in drinking water is the concentration that provides the best balance of protection from dental caries while limiting the risk of dental fluorosis. CAPIR’s National Fluoridation Advisory Committee (NFAC) was assigned the task of evaluating the documents and preparing preliminary comments to be shared with other ADA internal agencies prior to submission to HHS. ADA submitted comments to HHS that supported the HHS recommendation and provided recommendations for implementation and surveillance. ADA also noted that it would supply separate comments on the more than 975 pages of EPA documents prior to the July 5, deadline. NFAC also took the lead on developing preliminary comments for the EPA. While finalization of the HHS recommendation is anticipated in months following the deadline for comments, action on the EPA documents may take an extended period of time (possibly years) as the EPA will use these documents and comments to make a decision to establish new federal goals for the maximum levels of fluoride in drinking water.

CAPIR collaborated with a number of internal agencies to ensure that members were notified of the announcement in a timely manner via an ADA e-Gram and press release. An *ADA News* story followed. ADA’s comments to HHS are posted to the advocacy pages of ADA.org.

The immediate effect of the HHS/EPA actions has been an increase in challenges to fluoridation. A number of communities have opted not to wait for finalization of the HHS recommendation and have already complied with the new fluoride level of 0.7mg/L. In some communities that have long been fluoridated, this recommendation has brought fluoridation to the attention of the consumers and decision-

makers. Some other communities who were considering fluoridation have been convinced that they should take no action until all of the federal government recommendations are finalized. States with mandatory fluoridation laws are faced with amending existing regulations to comply with the new fluoride level. In at least three states, the state fluoridation acts will need to be amended through the legislature. Those opposed to fluoridation have used the federal activity as a gateway to flaunt their concerns.

*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 with a significant spike noted after the HHS and EPA announcements. 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 the past year, fluoridation assistance has been provided to societies and members in states including, but not limited to: Alaska, Arkansas, California, Colorado, Florida, Idaho, Iowa, Maine, Massachusetts, Michigan, Missouri, New Hampshire, New Jersey, New York, Ohio, Oregon, South Carolina, Tennessee, Texas, Utah, Virginia, Wisconsin and Wyoming.

*State Public Affairs.* In the past year, fluoridation technical assistance has been provided to the Florida, Louisiana, Maine, Nebraska and New Hampshire dental associations through CAPIR's participation in the ADA State Public Affairs Initiative.

*California Proposition 65 Review of Fluoridation.* NFAC continues to monitor the activity of the California Environmental Protection Agency's Office of Environmental Health Hazard Assessment (OEHHA) Proposition 65 review of fluoride as a possible carcinogen. The release of a Hazard Identification Document that was anticipated in 2010 has not yet occurred.

*Court Ruling on Challenge to Fluoridation in Washington State.* On September 23, 2010, the Washington State Supreme Court ruled in a 5-4 vote to uphold a lower court's decision regarding the power of the City of Port Angeles to implement fluoridation without a public vote. Following implementation of fluoridation in 2006, opposition groups filed suit after the city refused to act on petitions filed to force a public vote on the issue. In its ruling the court found that the city's fluoridation program is not subject to the initiative process because it was an administrative action. Only legislative actions can be challenged by an initiative.

*Historic California Fluoridation Vote.* On September 28, 2010, the City Council of Watsonville, CA voted 4-3 to accept funding from the California Dental Association Foundation to implement fluoridation. State health officials had taken the position that the Foundation's grant offer triggered the California fluoridation statute that requires cities of 10,000 or more people to fluoridate if an outside entity covers costs. The city had been told it would face a fine of \$200 per day beginning on September 29 if it did not comply with the law. Watsonville is the first, and only, city in California where the state has needed to move to enforce the law. Fluoridation has been an active issue in Watsonville for over a decade.

*Largest Non-fluoridated U.S. City Fluoridates.* When the City Council voted unanimously to establish a fluoridation program in 2008, San Diego held the distinction of being the largest non-fluoridated city in the United States. That status ended on January 31, 2011, when San Diego began fluoridating the city's drinking water. Of the 50 largest U.S. cities, only San Jose, Portland, OR, Fresno, Honolulu and Wichita remain unfluoridated.

*New State Fluoridation Mandate.* In March 2011, the Arkansas State Dental Association and its extensive coalition supported passage of a state fluoridation bill (SB 359 now known as Act 197) designed to bring fluoridation to communities over 5,000 people in that state. The Arkansas Delta Dental Foundation agreed to fund all capital expenses for the implementation of the bill which was passed swiftly through the state legislature in just over 30 days and is expected to affect approximately 32 communities. While approximately 60% of Arkansans already have fluoridated water, this bill will ensure that number will rise to more than 80%. Arkansas joins 12 other states with laws designed to provide state-wide fluoridation.

*ADA/Association of State and Territorial Dental Directors (ASTDD)/Centers for Disease Control and Prevention (CDC) Fluoridation Awards.* CAPIR collaborated with the ASTDD and the CDC, Division of Oral Health on the ADA/ASTDD/CDC Fluoridation Awards presented at the National Oral Health Conference (NOHC) in April 2011. In addition to the community and state awards presented, Dr. Steven M. Levy, member of the ADA's National Fluoridation Advisory Committee, received the Fluoridation Merit Award for his significant contribution to fluoridation research and support of fluoridation efforts. Besides an *ADA News* story on the awards, CAPIR worked with Communications staff to ensure information was posted on ADA.org about the awards and with *ADA News* staff on a template press release for use by constituents.

*Public and Professional Education.* At the 2010 National Oral Health Conference, CAPIR staff participated in a panel titled "What You Need to Know About Fluorides and Fluoridation." On October 10, 2010, the *Open Clinical and Science Forum on Fluoride* was held at the ADA annual session hosted by the ADA Council on Scientific Affairs and *The Journal of the American Dental Association*. Included on the expert panel were Dr. Howard Pollick, member of the National Fluoridation Advisory Committee and expert ADA fluoridation spokesperson. It was estimated that more than 800 persons attended the forum where they learned about the outcomes of the two fluoride-related EBD reviews to be published in *JADA*. Joined by Mr. Greg Hill, J.D., assistant executive director, Kansas Dental Association, CAPIR staff made a presentation on water fluoridation at the 2010 Oral Health Kansas annual meeting in December 2010. CAPIR staff also joined ADA Communications staff in presenting a Fluoridation Spokespersons Training program on July 15, 2011, for the South Carolina Dental Association.

*New Fluoride and Fluoridation Hub on ADA Website.* Following a recommendation by NFAC and a vote of CAPIR in January 2010, a new fluoride and fluoridation hub was launched on the ADA website at [www.ada.org/fluoride.aspx](http://www.ada.org/fluoride.aspx) on September 23, 2010. The Council approved an aggressive, multi-year business plan as presented by Electronic Media staff that is designed to improve ADA's placement on search returns for fluoridation on the Internet.

*Evidence-Based Dentistry. Evidence-Based Clinical Recommendations on the Prescription of Dietary Fluoride Supplements for Caries Prevention* was published in the December 2010 *JADA*. The January 2011 edition of *JADA* contained the *Evidence-Based Clinical Recommendations Regarding Fluoride Intake From Reconstituted Infant Formula and Enamel Fluorosis*. Both documents were accompanied by a "Chairside Guide" that professionals could use to discuss the recommendations with their patients. CAPIR expert consultants served on both evidence-based dentistry expert panels. These two documents compliment the first ADA evidence-based dentistry clinical recommendations which detailed recommendations for professionally applied topical fluoride. CAPIR staff participated in an ADA constituent national issues conference call on January 6, 2011, which focused on the results of the two evidence-based dentistry documents as well as their possible impact on the public and the profession. In collaboration with the Divisions of Communication and Marketing, and Science staff, CAPIR staff provided information on the current national landscape for fluoridation as well as possible fluoridation campaign challenges that might be anticipated following the publication of the two evidence-based dentistry documents.

*Fluoride Legislative User Information Database (FLUID).* On March 16, 2011, the Children's Dental Health Project (CDHP) announced the launch of the FLUID website at [fluidlaw.org](http://fluidlaw.org). FLUID is the first publicly available database on the legal status of community water fluoridation in the United States and includes a comprehensive online compilation of court decisions, laws, and policies related to community water fluoridation. In addition, the database contains information from all 50 states and U.S. territories. A versatile and easy-to-use tool that will allow states and municipalities to research and compare their current or proposed policies with others across the country, FLUID can aid policy-makers in making informed decisions based on legal fact. CAPIR and Department of State Government Affairs staff served on the advisory committee that assisted the Children's Dental Health Project develop the database. The American University Washington College of Law's Health Law and Policy Project will oversee all ongoing research on policy and legal cases to be included in FLUID.



*Pew Charitable Trust Fluoridation Activities.* In seven meetings since 2009, CAPIR representatives, NFAC and Pew have had a number of opportunities to discuss issues and possible collaborations regarding support for community water fluoridation. Pew called attention to the status of fluoridation in states in its 2010 publication, "The Cost of Delay: State Dental Policies Fail One in Five Children." Most recently Dr. Kathleen O'Loughlin, ADA executive director, Dr. Leon Stanislav, former CAPIR member and NFAC chair, and other key fluoridation stakeholders attended an invitational Pew meeting on March 28, 2011, titled, "Protecting America's Fluoridated Water: From Strategy to Urgent Action." Sharing successes and obstacles, attendees focused on how best to sustain improved oral health through fluoridation now and over the long-term.

*ADA Comments on European Fluoridation Report.* The European Commission (EC) is the European Union's (EU) executive body with responsibility to manage EU policy. In 2008, the EC requested their Scientific Committee on Health and Environmental Risks (SCHER) to critically evaluate any new evidence on the hazard profile, health effects, and human exposure to fluoride. In May 2010, SCHER adopted a preliminary opinion and made the report available for public comment. The ADA, with recommendations from CAPIR, submitted comments on the report to SCHER in September 2010. While in agreement with a large portion of the report, ADA's comments focused on the benefits fluoridation affords to children and adults as well as the cost effectiveness and cost savings community fluoridation provides as a public health measure. While no timeline is available for release of a final report, NFAC will continue to monitor the SCHER activities.

**National Children's Dental Health Month (NCDHM):** The February 2011 observance of NCDHM campaign featured a two-sided, eye-catching poster with the McGrinn Twins, Flossy and Buck along with their NEW best friends and next door neighbors Den and Gen Smiley, reminding children "*A Healthy Smile? It's Easy to Find! Remember to brush & floss every day!*" On the opposite side, pre-teens/teens are excited to discover "*A Healthy Smile Looks Good Up Close*" with general oral health messages. The poster, program planning guide, poster insert and coloring/activity sheets were made available 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 appears on the ADA's website at <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 2011 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.

The program continues to increase its visibility at various annual meetings and conferences. A special edition 3D poster and glasses were designed in English and Spanish to disseminate during those meetings. The NCDHM program participated at the following meetings: National Dental Association, Hispanic Dental Association, Management Conference, GKAS Promising Practices Symposium, ADA Annual Session Volunteer Celebration Area, Arizona Student Outreach Program, and the Greater New York Dental meeting.

*NCDHM Program Survey.* For the past 60 years the NCDHM program has shipped posters and planning guides primarily to state and local dental societies and the military. In 2008, the target audience was expanded to include any oral health/public health entities doing oral health education programs for children. In addition, the poster was translated to Spanish and as a cost-saving and efficiency measure, the program planning guide was not printed and mailed but instead made available on the web as a download.

Throughout the years, the program conducted an annual satisfaction survey that was mailed to dental societies only. This survey was basic in nature and did not provide the program with much useful



information. Also, the return rate was extremely low. In 2009, the program worked with the Health Policy Resources Center (HPRC) to develop a new survey. The survey was developed to not only measure the usefulness of the current materials but seeks to understand who and how programs are using the materials and what additional materials may need to be developed.

Two surveys were developed, the first a preliminary survey which gathered baseline information about who is ordering materials and how they plan to use them in their program. The second survey examined the usefulness of the core campaign materials (posters, poster inserts, planning guide and coloring/activity sheets), online resources and materials, where materials were displayed and for how long. Based on the survey results, ADA members are the largest consumer of the NCDHM program materials, with school teachers/nurses next. Program coordinators find the NCDHM materials to be a key component to their annual oral health education programs; however, they expressed a need to have resources for parents and high school students. Moving forward, the program should redesign the website to include online games, children videos, and resources for parent and school nurses.

**National Association of School Nurses (NASN)/ADA Collaboration:** In November 2010, the NASN submitted a grant application to DentaQuest entitled “Empowering School Nurses to Change Oral Health Perceptions” and included the ADA as an external in-kind collaborator. In December 2010, NASN was notified by DentaQuest that it was awarded a \$160K grant. The grant calls for NASN to collaborate with the ADA to conduct a needs assessment to evaluate school nurses’ oral health knowledge, perceptions and practices. Based on the results of the needs assessment, NASN will convene a national advisory group to compile a list of available resources and work with ADA to tailor existing resources to meet identified needs. NASN will develop and launch an oral health website. The website will be promoted to school nurses nationally through NASN and ADA’s well-established communication channels. NASN and ADA will also encourage collaborations between oral health professionals and school nurses in local communities. The goals of the grant include: 1) to support school nurses in their efforts to keep children healthy and ready to learn; 2) to assess the knowledge, perceptions and practices of school nurses related to promoting an awareness of oral health; 3) to provide school nurses with relevant oral health resources and messages, while improving the mechanism through which these are delivered; and 4) to encourage and improve collaboration between school nurses and oral health professionals in states and communities.

**Sports Dentistry:** On May 27, 2010, the ADA issued a press release regarding the importance of mouthguards when participating in athletic activities. Additionally, the Council collaborated with *ADA News* on a story promoting the Academy for Sports Dentistry’s Annual Symposium which took on place on June 24-26, 2010, in Arlington, VA. Following a recommendation taken by the Council during its January 2011 meeting, a hyperlink was added on ADA.org to the Academy for Sports Dentistry’s “Emergency Treatment of Athletic Dental Injuries” card.

#### **Tobacco/Oral Cancer Activities:**

*Trends in Tobacco Use.* The continued importance of tobacco use prevention and cessation related activities were highlighted by the September 7, 2010, release of a *CDC Morbidity and Mortality Weekly Report (MMWR)* indicating that previous declines in smoking prevalence in the United States have stalled during the past five years with the current rate at approximately 21%. The *MMWR* also noted that the burden of cigarette smoking continues to be high, especially in persons living below the federal poverty level and with low educational attainment. The CDC urged continued efforts be aimed at teens since most adult smokers began before they turned 18. The CDC also noted there is no risk-free level of secondhand smoke exposure. Among children and youth living with smokers, more than 98% had detectable levels of cotinine, a breakdown product of nicotine, in their blood.

*New Surgeon General Report on Tobacco.* The continued importance of this and other tobacco-related activities were highlighted by the December 9, 2010, release of a new U.S. Surgeon General’s report, “*How Tobacco Smoke Causes Disease: The Biology and Behavioral Basis for Smoking-Attributable Disease.*” The report contains important new information on how tobacco smoke causes disease and explains why it is crucial to stop smoking and avoid secondhand smoke. This follows on the heels of an

October 2010 announcement by Dr. Thomas Frieden, director, CDC, who has chosen six priorities to improve the nation's health: smoking; AIDS, obesity/nutrition, teen pregnancy, auto injuries and health care infections. The CDC has also launched a new website, Communities Putting Prevention to Work, with special appeal to communities and partners that are interested in addressing obesity prevention and tobacco use locally (<http://www.cdc.gov/CommunitiesPuttingPreventiontoWork/>). The site provides tools and resources for program planning and implementing community-level change efforts, as well as brief overviews of each funded community.

*FDA Regulation of Tobacco.* With the signing of The Family Smoking Prevention and Tobacco Control Act on June 28, 2009, the FDA has the authority to regulate tobacco products. In monitoring the progress made in the past year, CAPIR noted that significant activities have included, but are not limited to enforcement of the ban on fruit, candy or clove flavored cigarettes, establishment of regulations designed to restrict that sale and distribution of cigarettes and smokeless tobacco to children and adolescents and guidance to industry restricting the use of labels such as "Light," "Mild" or "Low" that may misinform the public about the risk of the use of certain tobacco products.

*U.S. Department of Health and Human Services (HHS) Tobacco Strategic Plan.* On November 10, the HHS issued a tobacco control strategic action plan, "Ending the Tobacco Epidemic," that includes proposed new bolder health warnings including pictures on cigarette packages and advertisements. (Similar warnings for smokeless tobacco products will follow at a later date.) The FDA is scheduled to select the final nine graphic and textual warning statements by the end of June 2011. Cigarette packages must carry these new items by the end of October 2011.

*Tobacco and Major League Baseball (MLB).* In April 2011, the House Energy and Commerce Committee held a hearing calling on baseball and its players to agree to bar major leaguers from using chew, dip or similar products during games. Use of these smokeless tobacco products is already banned in all baseball leagues except the major league. During the hearing, it was noted that any ban would have to be agreed to through collective bargaining. In December 2010 with the start of baseball's winter meetings, ADA joined with a consortium of ten health agencies to send letters to the MLB commissioner and the head of the Players' Association requesting a ban on smokeless tobacco in the major league. While tobacco use has declined over the past several decades, it has been estimated that one-third of major leaguers use smokeless tobacco. In February, just as spring training for the 2011 baseball season began, ADA joined the same consortium to launch a coordinated campaign urging Major League Baseball and the Major League Baseball Players Association to ban tobacco use by players, managers, coaches and other staff at major league ballparks. Efforts included an online campaign, Knock Tobacco Out of the Park, featuring a new website with social media tools that allow fans and other members of the public to tell their hometown teams, players and Major League Baseball that continued use of smokeless tobacco at baseball games is unacceptable. The consortium includes the American Academy of Pediatrics, American Cancer Society, American Dental Association, American Heart Association, American Lung Association, American Medical Association, Campaign for Tobacco-Free Kids, Legacy, Oral Health America and Robert Wood Johnson Foundation.

*National Smokeless and Spit Tobacco Summit.* ADA co-sponsored the 6<sup>th</sup> National Smokeless and Spit Tobacco Summit in Austin, TX, on May 10-12, 2011. The theme, "The New Face of Smokeless Tobacco Addiction" was inspired by the Summit goal to raise awareness of the dangers of smokeless tobacco products and to broaden the national coalition of organizations, agencies and individuals committed to reducing and eventually eliminating the use of smokeless and spit tobacco products. Summit topics included new information on tobacco cessation, taxation, new products, priority populations and dual tobacco use. This Summit, which historically has been held biennially, provided an opportunity for collaboration with various leading medical, dental, and other organizations and agencies to discuss science transfer, policy updates and networking with others who have an interest in spit and smokeless tobacco. A venue for policy-makers, researchers, tobacco control experts, and health care providers to interact and learn from each other, the Summit is the only national conference that is designed especially for professionals and advocates working in the field of smokeless tobacco use prevention and cessation. Dr. Gerald Ciebien, CAPIR member, and a CAPIR staff member attended the Summit.

*National Consortium on Tobacco Use Prevention Through Schools.* CAPIR staff participated in the Tobacco Use Prevention through Schools Consortium through bi-monthly conference call in the first half of 2011 to update progress in pilot states and to share resources. The funding for the Consortium which was through a CDC grant to the National School Boards Association ended in May 2011. As the grant ended the Consortium focused on sustainability of the progress that had been made and the maintenance of resources that had been developed and contributed to this vital school-based effort to improve the health of children and adolescents.

*Oral Cancer Awareness Month.* On March 14, 2011, the ADA agreed to publicize and encourage dentists to participate in Oral Cancer Awareness Month in April 2011. Noting that any delay in discovery yields a later stage disease when diagnosed, increased treatment morbidity and reduced survival rates, ADA encouraged its members in an *ADA News* story to take part in Oral Cancer Awareness Month by signing up to conduct at least three hours of free public screenings in their community any time during the month of April. Organized and supported by the Oral Cancer Foundation (OCF) and its executive director, Mr. Brian Hill, the OCF provided dentists who hosted oral cancer screening events with literature, customized press releases that can be used in local community media opportunities, talking points sheets, oral cancer screening forms, patient referral forms and other support materials for office screenings.

### **School-Based Oral Health Care:**

*School-Based Oral Health Care.* CAPIR collaborated with the Illinois Department of Public Health and the Chicago Public School System at the 2011 Chicago Midwinter Meeting on a panel discussing, "Dental Sealants: Take a Bite Out of Decay." CAPIR staff highlighted information from the ADA "Evidence-Based Clinical Recommendations for the Use of Pit-and-Fissure Sealants," published in 2008 and promoted the ADA Center for EBD website.

*National Coordinating Committee on School Health and Safety (NCCSHS).* NCCSHS's annual meeting was held May 24, 2010, with a theme of "Preventing Student Obesity and Promoting School Wellness: Where Are We?" CAPIR staff joined other NCCSHS organizations in a discussion of these contemporary issues as they related to the federal, national, district and school levels.

### **Nutrition Activities:**

*Healthy, Hunger-Free Kids Act of 2010.* CAPIR provided technical assistance to the Washington Office staff as they worked to support the successful passage of the Healthy, Hunger-Free Kids Act of 2010, which reauthorized two major child nutrition programs the ADA has long supported: the National School Lunch Program and the Special Supplemental Nutrition Program for Women, Infants, and Children (the WIC program). The ADA expressed support for both the House and Senate versions, which contained nearly identical provisions to enhance breastfeeding education and improve the nutritional quality of school foods. The ADA preferred the enacted Senate version, however, because it also established a grant program for states to provide nutrition education and obesity prevention services to individuals participating in the Supplemental Nutrition Assistance Program (SNAP) (formerly known as the Food Stamp Program).

*Menu Labeling.* Section 4205 of the Affordable Care Act, signed into law in March 2010, set new federal requirements for nutrition labeling for foods sold at certain chain restaurants and similar retail food establishments. Rules for implementation of these new requirements are to be established in 2011. As the new rules are drafted, the FDA may look at local menu labeling laws that have been in effect for some time in New York City, Philadelphia and Seattle (King County). All have reported strikingly similar results. About 60% of patrons say they have seen the nutrition information (which appears on menus or ordering tables). But of that 60%, only 13-15% state the information influences their purchases and it would appear that those using the information are from higher socioeconomic groups. To date, this experience appears to have little impact on overall calorie consumption.

*Proposal to Develop ADA Policy on Sweetened Beverages.* During its regular conference calls held in 2010, the CAPIR Prevention Subcommittee discussed numerous nutrition issues including issues surrounding sweetened beverages. Members noted an increasing public awareness of the negative effects of frequent intake of sweetened beverages. However, they were stymied by a lack of a focused ADA policy on this topic. In the fall of 2010, the Prevention Subcommittee established a goal to propose an ADA policy for CAPIR's consideration regarding sweetened beverages that would provide a basis for advocacy with the intent of submitting such policy to the 2011 House of Delegates. At its January 2011 meeting, CAPIR held an extended, rich discussion on a proposed resolution noting that many types of sweetened beverages may contribute to caries risk across the life-span. The Council also noted that while ADA had a few related policies, none spoke directly to this issue which is of significant concern to ADA members. In a strong belief that collaboration among a number of ADA internal agencies would be the best approach, CAPIR forwarded a report to the April 2011 meeting of the Board of Trustees requesting the ADA Board of Trustees to establish an interagency workgroup to review the best available science related to soda and other sweetened beverage (natural and sugar-added) consumption and that the workgroup, in collaboration with other appropriate ADA agencies, develop appropriate statements and draft policies for consideration by the ADA House of Delegates. In response to CAPIR's request, the Board of Trustees recommended that the Council review the issue and seek input from other agencies, as appropriate, on the development of policies for consideration by the House of Delegates.

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

**American Indian/Alaska Native (AI/AN) Strategic Workgroup:** The AI/AN Strategic Workgroup, authorized by Resolution 27H-2008 (*Trans.*2008:456), assisted with planning the 2010 Symposium on Early Childhood Caries in American Indian and Alaska Native Children. In 2011, the Workgroup is focusing on ECC in Native American Children, refining recommendations made during the Symposium.

**Symposium on Early Childhood Caries in American Indian and Alaska Native Children:** Researchers, clinicians, tribal health and dental public health representatives gathered in the City of Presidents (SD), on October 20-22, 2010, for the second Symposium on Early Childhood Caries in American Indian and Alaska Native Children. The Symposium was co-hosted by the ADA, CAPIR and the American Academy of Pediatrics. Oral Health America co-sponsored the meeting with support from the DentaQuest Foundation. The meeting featured two full days of scientific presentations, workgroup activities and goal setting, followed by an optional field trip for participants that wound through the Badlands to meet with a variety of American Indian health and education officials on Pine Ridge Indian Reservation, about 70 miles from Rapid City. Participants evaluated the latest research in the epidemiology and microbiology of ECC; a variety of traditional and newly developing interventions, cultural and anthropological influences and barriers and more to determine how best to work collaboratively in the future to reduce or eliminate the disease in population groups that have a disproportionately higher risk. The Symposium Summary and presentations are available on ADA.org.

**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 10-12 dental students participating in the IHS extern program. For summer 2010, students are assigned to White Earth Health Center (MN). In 2010, the ADA's AI/AN Dental Placement Program placed 22 volunteers who served for 251 days at IHS/tribal clinics.

**Give Kids A Smile:** The ninth annual Give Kids A Smile (GKAS) Day took place February 4, 2011. Program participation trends continue to be impressive. In 2011, nearly 45,000 dental team members will have participated in GKAS events. That total includes more than 12,000 dentists and over 33,500 other volunteers: hygienists, dental assistants, office managers, spouses, school health nurses, dental students, etc. Some 1,750 programs signed up to participate in GKAS. It is likely that the online medium deters some from registering so the above numbers may understate program participation. Registered participants estimated that they would treat approximately 400,000 children in 2011. 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. In 2010, 51% of programs returned to the site to input actual event data. As the data is studied, the results will enable the ADA to make data-driven decisions, which in turn will improve the quality of the program delivery. By any measure, these are impressive results and indicate continued support by dental team members.

A CAPIR consultant serves on the GKAS National Advisory Board, which continues to move ahead with taking the program to “More Than Just A Day.” A major task this year has been exploring the development of a plan for a National Oral Health Education and Awareness 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. In addition, GKAS joined 3M and Henry Schein Cares to provide oral health education at the NASCAR March 12, 2011, SpeedFest in Charlotte, NC, at the Charlotte Motor Speedway. SpeedFest is a fan appreciation event targeted to children that features NASCAR drivers and cars and includes various displays, games and fan participation activities. About 7,000 families attend. The ADA’s involvement took the form of a tent at which packets containing toothpaste, brushes and oral health education were provided free to kids. Dentists and hygienists from the local area were on hand to answer questions. The more important component of the project will be an actual oral health screening event at the NASCAR race that takes place October 15, 2011, again in Charlotte. The planning for this event is in the early stages, but in addition to placement of the GKAS logo on the # 16 car (Greg Biffle) and the driver’s uniform, a number of promotional and fundraising activities are being planned.

The GKAS National Advisory Board held a strategic planning session on February 22, 2011, followed by its semiannual Board meeting on February 23. During the meetings, a proposed revised management structure for the GKAS National Advisory Board was presented so that it is more closely aligned with the vision and mission of ADA through CAPIR. The Council forwarded a report to the April 2011 meeting of the Board of Trustees on the GKAS program which included a request that the GKAS National Advisory Board become an advisory committee to CAPIR to manage ADA’s GKAS activities and programs. The ADA Board adopted the following resolution:

**B-30-2011. Resolved,** that the American Dental Association accept the transfer of the expansion program from the ADA Foundation and the responsibility for management of the entire Give Kids A Smile initiative, and that the Give Kids A Smile National Advisory Board be an advisory committee of the Council on Access, Prevention and Interprofessional Relations.

**Geriatrics and Special Needs Populations:** In continuing efforts to address the ambitious agenda of initiatives set forth by Resolution 5H-2006 (*Trans.*2006:317), the National Elder Care Advisory Committee (NECAC) serves to assist and advise the Council in efforts to improve the oral health of elders. NECAC meets twice yearly and is composed of a Council member and consultants to the Council. NECAC adopted goal statements echoing those set forth in ADA’s 2011-2014 Strategic Plan but with a specific focus on the vulnerable elderly. The activities and accomplishments of CAPIR’s Geriatric and Special Needs Populations program are described using the following goal statements as a framework: 1) equip dentists with the funding, education and delivery systems necessary to meet the needs of the elderly; 2) enable elders and/or their caregivers to be good stewards and advocates for their own health, including preventing and managing disease; 3) improve elder oral health outcomes by building national coalitions and promoting legislative and regulatory reform; and 4) build and transfer the knowledge base needed to improve the oral health of elders.

**Special Care Dentistry Act:** The Special Care Dentistry Act (SCDA) was introduced on April 15, 2011, in the House of Representatives as H.R. 1606 by Rep. Engel (D-NY) and Rep. Schakowsky (D-IL). SCDA seeks to amend Title XIX of the Social Security Act and would require states to provide an adult dental benefit for Medicaid-eligible adults who qualify as “aged, blind or disabled,” a defined class, established by the Social Security Act. The expanded coverage would be at no cost to the states as the bill calls for a 100% federal cost-share. CAPIR and the Council on Government Affairs have worked closely on the reintroduction of this bill, introduced into the 111<sup>th</sup> Congress as H.R. 5364. Establishing funding for dental care to Medicaid-eligible aged, blind and disabled adults would help support dentists’ efforts in caring for



these most vulnerable of our adult populations. Despite an unreceptive financial climate, critical education occurs as legislators are made aware that there is no dental safety net for these populations who have critical needs. H.R. 1606 is available by performing a search at the Library of Congress website ([http://thomas.loc.gov/home/bills\\_res.html](http://thomas.loc.gov/home/bills_res.html)).

**How-to Guide for the Use of Incurred Medical Expense:** A guide has been developed to “provide information to the membership about the use of Post Eligibility Treatment of Income (PETI) funds as a payment mechanism to cover dental care for nursing home residents.” Incurred Medical Expense (also known in some states as PETI funds) allow nursing facility residents enrolled in Medicaid to pay for medically necessary dental care that is NOT covered by the state’s adult Medicaid program using their Social Security or other income. The How-to Guide includes guidelines for 1) state and county Medicaid caseworkers; 2) dental professionals; and 3) nursing home residents and their representatives. ADA’s Division of Government and Public Affairs was engaged in the identification of state specific variations and information resources and will be developing a dissemination strategy for the membership and others.

**OralLongevity™:** The OralLongevity™ initiative, a joint effort of the ADA, the ADA Foundation and GlaxoSmithKline Consumer Healthcare (GSK), was launched in September 2007 and continued through December 2009. The initiative was designed to increase awareness about the oral health needs of older Americans by encouraging dental visits where patients could receive information and guidance from trusted professionals. The cornerstone of the OralLongevity outreach effort, a brochure and educational DVD on a variety of oral health topics, continues to be distributed to member dentists, dental students, health care organizations and the public. A new collaborative agreement building on the initial OralLongevity effort is pending with GSK, awaiting GSK Scientific Engagement guideline decisions. Under the new collaborative agreement, the OralLongevity™ initiative will be expanded to promote oral health for *all* adult Americans. This will be accomplished by augmenting the current agenda of improved oral health for the elderly with that of improved oral health *throughout the adult life cycle*. Proposed key issues to be addressed under the OralLongevity umbrella are oral systemic health issues of older adults, co-morbidities, polypharmacy, and mouth dryness, and caries prevention in adults. All ADA aspects of the agreement have been addressed by CAPIR, the Division of Communications and Marketing, the Division of Legal Affairs and the Accounting Department. The GSK/ADA collaboration once signed is a \$900,000 agreement over three years.

**National Coalition Consensus Conference: Oral Health Needs of Vulnerable Older Adults and Persons With Disabilities (NCCC):** This Conference was convened by the ADA in Washington, D.C., November 18, 2010. The Conference laid the groundwork for the establishment a new coalition of individuals and groups positioned to better address the oral health needs of vulnerable older adults and persons with disabilities. One hundred fifty individuals attended representing dentistry, the disability community, the aging advocacy community, the long-term care industry, geriatric medicine, and government agencies, was a first-of-its-kind working conference. Sixty percent of the attendees identified dentistry as their primary affiliation, followed by advocacy, government, long-term care, elderly services and disabilities.

Invited speakers presented on pre-determined topics, followed by reactor presentations, and audience input/discussion. Thirty percent of the Conference day was devoted to gathering input and ideas from the 150 participants via small group facilitated discussion. All the feedback was gathered and recorded on the following day by 35 Conference attendees who served as speakers, reactors, facilitators and conference planners. Written evaluation of the Conference was overwhelmingly positive with all respondents giving the conference outstanding or above average ratings. Conference proceedings are currently under development.

The recommendations will be used to develop action plans and a road map for future activity for CAPIR. Broad dissemination of the Conference proceedings and outcomes is planned through publications and will be used in policy briefs and ongoing advocacy efforts. External funding is being sought to publish a Special Supplement of *JADA* containing the five papers prepared for the Conference as well as a sixth paper summary of recommendations. Presentations on outcomes of the NCCC were

presented at several meetings including the Access to Oral Health for Individuals with Disabilities Pennsylvania, Special Care Dentistry Association and the National Oral Health Coalition. The NCCC website was repurposed as a communication tool with Conference participants. On March 2, 2011, the repurposed website went live with an e-mail announcement sent to 150 NCCC participants as well as CAPIR members about the availability of the PowerPoint presentations and pictures from the Conference [www.ada.org/nccc](http://www.ada.org/nccc). This website will serve as a repository for information sharing among the Conference participants and the public. Additional information regarding the NCCC will be provided in a supplemental report to the 2011 House of Delegates.

**Collaborative Activities Focused on Geriatric and Special Needs Populations:** CAPIR liaises with the Partnership for Health in Aging coalition whose overarching mission is “to prepare America’s formal and informal care giving workforce to provide quality care for America’s aging population, and to ensure the financial feasibility of providing that care.” Liaison led to the ADA’s endorsement of “Multidisciplinary Competencies in the Care of Older Adults at the Completion of the Entry-level Health Professional Degree” and a review of the position statement on “Interdisciplinary Team Training in Geriatrics: An Essential Component of Quality Health for Older Adults.”

CAPIR also liaises with the Association of State and Territorial Dental Directors (ASTDD) Healthy Aging Committee. This has led to CAPIR’s invitation to present at the 2011 National Oral Health Conference and an invitation to present at 2011 American Public Health Association annual meeting. CAPIR has been actively building the collaborative relationship of Special Care Dentistry Association (SCDA) and the ADA in programs and projects of mutual interest resulting in an invitation to speak to the SCDA Board of Directors about ADA elder care initiatives, facilitating a meeting between the executive directors of ADA affiliate, Dental Lifeline Network (formerly National Foundation of Dentistry for the Handicapped) and SCDA to discuss possible points of collaboration between the two organizations, presenting at 2011 SCDA annual session on ADA’s National Elder Care Advisory Committee and an invitation to participate in a consensus forum titled *Issues and Opportunities in Oral Health Care for Patients with Special Needs* hosted by the SCDA Board of Directors. CAPIR has participated in discussions of possible collaboration on Oral Health America’s Wisdom Tooth Project which closely aligns with educational initiatives outlined in Resolution 5H-2006.

**Gap Analysis and Literature Review Project:** In keeping with the Resolution 5H-2006 initiative “to develop with key stakeholders a plan to aggregate, identify, collect and synthesize existing research on the oral health of the vulnerable elderly, in order to identify knowledge gaps,” four areas of research were identified for investigation: prevention of root caries in vulnerable elderly; restoration of root caries in the vulnerable elderly; access to oral health care for the vulnerable elderly; and xerostomia and salivary hypofunction in the vulnerable elderly.

**Post-Access to Dental Care Summit:** The 2009 Access to Dental Care Summit focused on creating a common vision among diverse stakeholders to begin to improve access to oral health care for underserved people. It focused on this question: *What are we going to do, in the short and the long term, both individually and collectively, to assure optimal oral health through prevention and treatment for underserved people?* The Summit affirmed the ADA’s commitment to serve as a convener and a collaborator committed to finding common ground and shared solutions to one of the major health problems facing some of the nation’s most vulnerable people.

Summit participants prioritized key issues for action, including: developing metrics for measuring and defining access, strengthening the dental delivery system, financing models, population-based prevention strategies and strengthening the public health infrastructure, improving health literacy in dentistry through social marketing, and collaboration between the medical and dental communities.

The development of a sustainable infrastructure upon which to address the multiple determinants that comprise the access to dental care dilemma through communication and coordination reflects the vision that the House of Delegates foresaw when it called for the Access to Dental Care Summit. One of the goals of the ADA convening the Summit was to enlist the support of others in supporting collaboration.

For the two years, a Coordination and Communication (C&C) Workgroup has been developing such an infrastructure, re-engaging the participants of the original summit to initiate a U.S. National Oral Health Alliance and supporting the continued effort to develop strategies to improve access to oral health care for the underserved. This effort includes a compilation of an inventory of individual and collective efforts that have moved forward to address the topical priority areas since the completion of the 2009 Summit. A three-year timeline has been developed, which includes: incorporating the Alliance as a Massachusetts not-for-profit organization; selecting an “interim home” to house its activities; establishing joint leadership for the Alliance from organized dentistry, the dental public health community and the state dental society executive directors; and the creation of an interactive website to inform and document progress made thus far.

The DentaQuest Foundation has provided support for this Workgroup and fiscal resources to underwrite the first year’s planning and operational costs for the Alliance. The Henry Schein legal division has provided in-kind legal consultation in researching incorporation of the Alliance. The ADA has provided meeting space and staff support.

**Update on Post-Access to Dental Care Summit Activities:** On March 22, 2011, the C&C Workgroup formed the U.S. National Oral Health Alliance ([www.usnoha.org](http://www.usnoha.org)), representing a significant milestone in continuing the work of the 2009 Access to Dental Care Summit. At this meeting, the C&C workgroup formalized the U.S. National Oral Health Alliance as a Massachusetts not-for-profit organization; accepted the Bylaws, confirmed the Board members, elected the Alliance interim officers and confirmed four committees of the Board: Executive, Finance, Nominating and Membership.<sup>1</sup>

On that same day, a webinar entitled “Progress on Access to Oral Health” was presented to about half of the original Summit participants with a synopsis of the presentation shared with all participants. The meeting concluded with discussion of next steps for the Alliance, including: strategies for ongoing communication with Summit participants and other interested parties, engaging the six prioritized action areas, plans for the “launch” of the Alliance, and ongoing website development.

The following individuals have accepted the responsibility of being founding board members of the U.S. National Oral Health Alliance: Dr. Vincent Mayher (private practitioner), Dr. Ken Rich (American Dental Association), Dr. Cesar Sabates (Florida Dental Association), Dr. Leslie Grant (National Dental Association), Dr. Lindsey Robinson (CAPIR consultant), Mr. Douglas Bush (Indiana Dental Association), Mr. Steve Kess (Henry Schein, Inc.), Mr. Ralph Fuccillo (DentaQuest Foundation), Ms. Evelyn Ireland (National Association of Dental Plans), Dr. Caswell Evans (University of Illinois at Chicago), Dr. Lawrence Hill (American Association for Community Dental Programs), Ms. Wendy Frosh (Healthcare Management Strategies), Dr. Dushanka Kleinman (University of Maryland School of Public Health), Dr. David Krol (Robert Wood Johnson Foundation), and Dr. William Maas (U.S. Public Health Service, retired). Dr. Vincent Mayher, Dr. Caswell Evans and Mr. Douglas Bush have been approved as interim officers for the U.S. National Oral Health Alliance.<sup>2</sup>

Throughout the process, CAPIR has maintained transparency in its post-Summit actions through regular reports to its volunteers and Board liaison at its Council meetings; through regular reports to the ADA leadership, including April 2010, December 2010, February 2011 and April 2011 reports to the Board of Trustees; and through its annual reports to the House of Delegates. A 2010 article in the *ADA News* highlighted these post-Summit activities to increase the awareness of the general membership. At the invitation of the leadership of the state dental association executive directors, presentations were made to these executives at their July 2010 management meeting. A similar presentation was included in the January 2011 President-Elect’s Conference. Discussions have been had with Dr. Howard Koh,

<sup>1</sup> Pending the approval of its Board of Trustees to officially join, the ADA could play a continuing and vital role in the U.S. National Oral Health Alliance, through the participation and influence of both volunteers and staff for each level of the Tripartite.

<sup>2</sup> Admiral Christopher Halliday, original planning representative for the federal stakeholder group; Ms. Shelly Gehshan, original planning representative for the healthcare policy-makers stakeholder group; and Mr. Jack Bresch, C&C representative for the education and research communities stakeholder group were not considered as USNOHA founding board members due to their inability to be fully engaged with the work of the C&C Workgroup during the last two years. The Board wishes to thank Ms. Martha Phillips, Georgia Dental Association executive director, for her wisdom and guidance during the formation of the Alliance.



assistant secretary of Health, Department of Health and Human Services (DHHS), for consideration of possible alignment of the DHHS Oral Health Initiative with the collaborative efforts following the post-Access to Dental Care Summit.

Additional information regarding the post-Access to Dental Care Summit activities will be provided in CAPIR's Supplemental Report to the 2011 House of Delegates.

**HRSA/ADA Collaboration:** Building upon three face-to-face meetings of ADA and HRSA leadership to explore areas of collaboration and several conference calls, CAPIR has continued to promote the importance of perinatal oral health as the prime focus of collaboration for 2011. This effort follows up on five strategies outlined by a 2008 expert panel hosted by the HRSA Maternal and Child Health Bureau concentrating on forming national perinatal oral health guidelines. Other areas of collaboration include health literacy in dentistry, oral health for senior and special needs populations, and enhancing the local dental public health infrastructure through increasing familiarity between dentists in private practice and those working within community-based settings. Additional information regarding this collaboration will be provided in a supplemental report to the 2011 House of Delegates.

**Follow-Up to 2010 Medicaid Provider Symposium:** In response to the recommendation of the 2010 Medicaid Provider Symposium participants, CAPIR resolved to create a Medicaid Provider Advisory Committee to provide guidance and offer direction to the Council and the ADA on matters of provider participation in Medicaid. Additional information regarding the status of the Medicaid Provider Advisory Committee will be provided in a supplemental report to the 2011 House of Delegates.

**Federal Dental Public Health (DPH) Infrastructure and the IOM's Report Advancing Oral Health in America:** With the continued vacancies of the chief dental officer positions within HRSA, CMS and CDC, the report of the U.S. Public Health Service (USPHS) chief dental officer on the DHHS Oral Health Coordinating Committee to CAPIR's January 2011 meeting, raised concern as this oral health workgroup has neither fiscal nor administrative support to accomplish its work. A report of its accomplishments is still forthcoming. Likewise, the first of two reports of the two oral health committees of the Institute of Medicine, *Advancing Oral Health in America*, funded by HRSA, was released in April 2011 citing both opportunities and challenges for a "new oral health initiative." The report focuses mainly on the role the DHHS can play in shaping oral health in America, and in particular, on the ways in which DHHS can have the most impact." The Report clearly states that "Every effort needs to be made by HHS to collaborate with and learn from the private sector; other public sector entities at the local, state and nation levels; and patients themselves toward achieving the goal of improving the oral health care, and ultimately, the oral health of the entire U.S. population." As there were no private practice dentists on the committee, there is even more resonance to this finding by the IOM committee. The Report discusses the critical role the ADA plays in supporting community based interventions to improve the nation's health. It acknowledges the ADA as a leader in convening and bringing diverse stakeholders together to improve the nation's oral health. The IOM demonstrates to HHS how it can learn from the ADA on methods for engaging others in dialogue and collaboration.

The demotion of the CDC Division of Oral Health to branch status has posed a grave concern for the ADA. Despite extended advocacy on behalf of the ADA, this demotion was not able to be diverted. Efforts continue to educate DHHS authorities and congressional representatives about the potential dire ramifications of this decision. CAPIR continues to collaborate with CGA and other external oral health stakeholders to strengthen this aspect of the DPH infrastructure. Additional information regarding the status of the federal public health infrastructure and the role of public/private partnering to enhance that infrastructure will be provided in a supplemental report to the 2011 House of Delegates.

**National Health Service Corps (NHSC):** In addition to presenting at NHSC Awardee Conferences, CAPIR continues to establish an ADA presence within the NHSC by suggesting and planning new sessions to address the educational needs of oral health professional loan repayment and scholarship recipients.

**Association of State and Territorial Dental Directors (ASTDD):** CAPIR staff participates on a variety of ASTDD committees, including Leadership, Best Practices and Healthy Aging. There are numerous opportunities to encourage greater public/private collaboration at both the local and state levels. ASTDD received supplemental funding from the CDC Division of Oral Health for a one year project to update and enhance the 2000 ASTDD Infrastructure and Capacity Report.<sup>3</sup> CAPIR staff serves on this project's advisory group representing the ADA, offering additional input into the federal dental public health infrastructure chapter.

**Hispanic Dental Association Symposium:** CAPIR staff participated on a panel addressing "Improving Oral Health Access to Services for Hispanics through workforce diversity."

**ADA/ASTDD/CDC:** CAPIR is working with CDC and ASTDD representatives to plan the state dental directors' workshop to be held in August 2011 bringing private sector collaboration to the table.

**Medicaid/SCHIP Dental Association (MSDA):** CAPIR represents the ADA in advising the inaugural MSDA Best Practices Committee, whose charge is to strengthen the capacity of the current dental Medicaid and CHIP oral health financing infrastructures. The work thus far has been productive and the possibility for greater ADA/MSDA collaboration to strategically advocate for improving federal and state Medicaid guidelines and regulations is growing. Eight state dental societies have expressed interest in collaborating with MSDA in promoting their CMS "best practices" as a vehicle for greater advocacy.

**Public Health Advisory Committee (PHAC):** During its second face-to-face annual meeting in early December 2011, the PHAC was charged to create a dental public health module to serve as part of the orientation modules for the ADA Board of Trustees. This "value added" product will have many uses in addition to the orientation. A second draft is currently being reviewed.

**2011 National Oral Health Conference (NOHC):** In light of the uncertainty posed by the potential federal shutdown and issues surrounding budgetary concerns at the federal, state and local levels, a palpable sense of uncertainty permeated the 2011 meeting overshadowing the release of the IOM Report *Advancing Oral Health in America*.<sup>4</sup>

The following CAPIR organized sessions were presented at the 2011 conference: *No Longer Islands Unto Themselves—Innovative Health Centers Enhancing the Public Health Infrastructure*, and an ASTDD Healthy Aging panel offering recommendations and next steps from the November 2010 Conference on Oral Health of Vulnerable Elders and Disabled. Roundtables and posters were presented specific to the Give Kids A Smile Initiative.

Dr. Gary Davis, CAPIR chair, represented the ADA and CAPIR as a speaker at the American Board of Dental Public Health Symposium entitled *Expanding the Dental Workforce: Creating a Vision for the Future*. He emphasized that the ADA believes all Americans deserve optimal oral health, acknowledged that workforce is indeed an important determinant; while at the same time emphasizing that the fixation on workforce has been a distraction and that the shrill nature of the debate has detracted from what should be collaborative efforts between the public and private sectors in identifying areas of common ground to improve population oral health. He suggested that the sharing of experiences and building of trust needs to occur at the local and individual levels. Dr. Davis charged the attendees to actively engage organized dentistry at the grassroots level by asking them to "adopt a private practitioner" emphasizing attitudes must change at the local level first in order for change to occur elsewhere.

Organized dentistry was well represented at this conference with delegations or individuals representing the following constituent societies: California, Illinois, Pennsylvania, North Dakota, Tennessee, Virginia, New Hampshire and Wisconsin. CAPIR was a \$5,000 sponsor of the NOHC and collaborated with the Council on Membership to promote ADA programs and materials in an exhibit booth. Membership staff did an outstanding job showcasing ADA products. Having Pennsylvania Dental

<sup>3</sup> This report can be found at <http://www.astdd.org/docs/Infrastructure.pdf>.

<sup>4</sup> For additional information, see <http://www.iom.edu/Reports/2011/Advancing-Oral-Health-in-America.aspx>.

Association (PDA) staff join the ADA in the booth demonstrated the linkage between the state and national organizations and provided safety net providers in Pennsylvania the opportunity to interact with the PDA.

**2010 National Primary Oral Health Conference:** The ADA had a positive presence at this conference designed primarily for safety net oral health providers. ADA staff participated in the planning of the conference, which emphasized both clinical skills enhancement and promoting efficient management/leadership within health center oral health programs. In conjunction with the DentaQuest Foundation, CAPIR sponsored a Cybercafé to raise awareness of evidence-based dentistry through a direct connection to the ADA's evidence-based dentistry website. The ADA had a prominent display within the exhibit area with brochures promoting CAPIR activities, the Community Dental Health Coordinator, and membership within the ADA. Drs. Raymond Gist, ADA president, Kathleen O'Loughlin, ADA executive director, and Marcia Brand, HRSA deputy administrator, shared the podium for the conference's opening plenary.

The ADA had a visible presence within several continuing education sessions. These included an overview of ADA and CDC sealant guidelines and highlighting the importance of public/private partnerships within health centers to enhance the local dental public health infrastructure. The ADA's fiscal support of this conference was duly noted and appreciated by the National Network for Oral Health Access Board of Directors and the participants. It was noted that 69% of health center dentists are ADA members.<sup>5</sup>

**Federally Qualified Health Centers (FQHCs):** CAPIR continues to seek to increase awareness about FQHCs and facilitate greater familiarity among dentists working in private practice and those providing care within health centers. *The ABCs of FQHCs* will be presented for the third time at the 2011 ADA annual session with a request from the Council on ADA Sessions that it be repeated at the 2012 ADA annual session in San Francisco. Conversations have begun with Safety Net Solutions over condensing this 2.5 hour presentation down to a 45 minutes presentation that would be applicable for educating constituent and component societies, use in dental and dental hygiene schools and for educating health center boards of directors about safety net oral health programs. CAPIR staff has provided technical assistance to CGA, the Board of Trustees of the Missouri Dental Association and many others on this subject.

Efforts are underway to increase the importance of health centers as a vital foundation within state oral health programs. A continuing education session on this topic was presented at the 2011 National Oral Health Conference and this has been a repeated theme at the last several ADA lobbyist conferences.

**Constituent Dental Society Survey and Participation Within State Oral Health Coalitions:** CAPIR, in conjunction with the Department of State Government Affairs and the Council on Government Affairs, gathered additional information on the relationship between state oral health coalitions and constituent dental societies through a 2010 version of an initial survey completed in 2009. Almost 90% of constituent dental societies completed the initial survey with a similar percentage completing the sequel. With the growing interest in pursuing public/private collaboration, it is important to find out if more state dental societies are involved with their respective state oral health coalitions. The Association is interested in knowing if participation has changed over the last year or so. This information will help focus future efforts to support greater collaboration within the state dental public health infrastructure, which includes both private dental practitioners and various safety net dental organizations. The results of the survey were shared with the component and constituent societies.

**National Rural Health Association (NRHA):** CAPIR staff continues to encourage joint advocacy efforts between CGA and NRHA staff. Though NRHA was offered the opportunity to submit a report to the January 2011 CAPIR Council meeting, a report was not forthcoming. CAPIR staff will contact the NRHA executive director and encourage greater information sharing with the Council, hopefully with a report for

<sup>5</sup> Additional information can be found at [www.nnoha.org](http://www.nnoha.org).

the June Council meeting. CAPIR was invited to give the presentation, “National Plans to Improve Health Literacy,” during the NRHA annual meeting.

**National Association of Community Health Centers (NACHC):** Following up on Resolution B-223 passed by the Board of Trustees at its December 2010 meeting, a CAPIR volunteer and staff will be participating in the NACHC Annual Conference and Expo in August 2011 and in the NACHC Primary Care Association Conference in October 2011 as a means of increasing ADA presence and oral health representation within this primary advocacy association representing health centers.

**American Association of Public Health Dentistry and ADA Joint Leadership Meeting:** The ADA and AAPHD presidents emphasized the expansive “common ground” that exists between the Associations with the notable exception of mid-level providers. The recent AAPHD summit emphasized the importance of improved communication and advocacy by the dental public health community, health literacy and support for research, education and recruitment.

Several initiatives were cited as areas of greater collaboration, including ADA collaborating with Scholastic, the recent HRSA 5-year grant to AAPHD to develop DPH competencies for dental and dental hygiene schools, and recruitment and retention of dentists within DPH/community-based settings. AAPHD leaders were urged to identify a program among its current portfolio, for example, expanding student chapters within dental schools and assess whether CAPIR could/would consider building support for such in a future budget. To that end, CAPIR staff presented “Community-Based Practice Options” to AAPHD student chapters at the University of Michigan and University of Indiana dental schools.

**Dental Public Health Infrastructure Task Force:** This joint effort by ADA, ASTDD and AAPHD continues to advocate for greater coordination and communication among all components of the DPH community. It was encouraging to report that its efforts are continuing to bear fruit. Regular conference calls allow participants to share information and align efforts. It is expected that the creation of the U.S. National Oral Health Alliance will eventually subsume the work of this task force. A presentation to that effect was presented to the executive committees of ASTDD and AAPHD at the 2011 National Oral Health Conference.

**Caries Management by Risk Assessment (CAMBRA) Symposium:** CAPIR staff provided reaction at the CAMBRA Symposium, hosted by the California Dental Association Foundation (CDAF) in San Francisco in January 2011. Through a series of presentations and reactions, CDAF supported a forum to address the barriers to widespread adoption of CAMBRA and non-surgical intervention for the treatment of caries. There were four focus areas for the symposium: *Introduction to CAMBRA*, *Navigating the Paradigm Shift*, *Affects on Access to Care*, and *Making the Case to the Public and Private Payers*.

**Dental Lifeline Network (DLN):** CAPIR staff participated in the March 2011 DLN Board of Directors meeting and shared how many of CAPIR’s programs intersect with DLN: geriatrics, access, capacity, oral health literacy, prevention and GKAS (with a similar interest in continuity of care). A brief update on post-Access to Dental Care Summit activities was shared as there is the possibility that subsequent “state grants” offered post-establishing the U.S. National Oral Health Alliance could be a vehicle to support increased patient coordination at the state level.

**American Academy of Pediatrics (AAP) Chapter Advocate Training on Oral Health (CATOOH):** Following two successful CATOOH training programs in 2008 and 2009, the third and final program funded by the ADAF was held November 5-6, 2010. Former CAPIR member, Dr. Leon Stanislav, continued his role on the planning committee and served on several presentation panels, including one on fluoride modalities. Through the CATOOH program, pediatricians 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. With the last training program, all of the remaining AAP chapters had an opportunity to send representatives to be trained as oral health advocates. AAP will re-evaluate this project during the next year as this is the end of the three-year grant from ADAF. Consideration may be given to a “refresher” training program in the future where all of the trainees would come together at one

meeting to receive updates on issues covered in this original training and perhaps continue their education in other oral health areas.

**Health Literacy in Dentistry:** Health literacy in dentistry is the degree to which individuals have the capacity to obtain, process and understand basic health information and services needed to make appropriate oral health decisions. The ADA affirmed that limited health literacy is a potential barrier to effective prevention, diagnosis and treatment of oral disease, and clear, accurate and effective communication is an essential skill for effective dental practice.

*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. The Committee continues 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.

*National Plan to Improve Health Literacy.* The ADA, along with the AMA and AAP, hosted a meeting with Howard Koh, M.D., M.P.H., U.S. assistant secretary for Health, to discuss the federal *National Plan to Improve Health Literacy*. The meeting included representatives from specialty and special interest dental and medical societies. Dr. A.J. Smith, ADA first vice president, introduced participants to the Association's Action Plan to Improve Health Literacy, the five-year plan coordinated by CAPIR.

*Education and Outreach.* The Council was invited to give health literacy presentations at annual meetings for the Hispanic Dental Association, National Rural Health Association, Institute for Health Care Advancement and the American Public Health Association.

*Publications.* Partial results from the Council's health literacy survey of dental team members were published in the May 2011 issue of *The Journal of the American Dental Association* as "Dentist-patient communication techniques used in the United States."

### **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 (OU) and the University of California Los Angeles (UCLA) were launched in March 2009 with 12 trainees beginning their online training. Ten of the trainees (five from each site) have completed the CDHC program at the end of 2010. In March 2010, a second cohort of 18 students (six per site) commenced their training; this group included six new students from Temple University in Philadelphia, the urban pilot site selected for the project. Eight out of the 18 students began their six month internship in March 2011. The attrition of students in both cohorts is due to poor academic performance or personal issues.

At its December 2010 meeting, the Board of Trustees decided to end the relationship with UCLA as a part of the CDHC program. It was mutually decided that UCLA would continue to train existing Cohort 2 students through the completion of the internship. ADA initiated discussions with A.T. Still University Arizona School of Dentistry and Oral Health (ASDOH) to investigate the possibility of starting a CDHC training program in Mesa, Arizona. Soon thereafter, these discussions were formalized via an executed contract making ASDOH the new pilot training program for the American Indian site.

On March 28-30, 2011, the kick off meeting for Cohort 3 trainees took place at Rio Salado College in Tempe, Arizona. At that time, a new group of 20 students (eight from OU, six from Temple and six from ASDOH) began training as part of the last cohort in the CDHC Pilot Program.

A supplemental report regarding the CDHC project will be prepared for the 2011 House of Delegates.

## Response to Assignments From the 2010 House of Delegates

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**The American Dental Association Dental Health Program for Children:** Resolution 4H-2010 (*Trans.*2010:552) calls for the appropriate ADA agency (CAPIR) to study the policy and report back to the 2011 House of Delegates. Due to the age, complexity and how this policy interfaces with other existing children's oral health policies, it is recommended any action be deferred. Further information regarding Resolution 4H-2010 will be provided in CAPIR's supplemental report to the House of Delegates.

**School-Based Oral Health Programs:** Resolution 38H-2010 (*Trans.*2010:557) notes that school-based oral health programs can play an important role in preventing and controlling dental caries in children and adolescents and can assist in the referral of those patients to establish a dental home.

In response to Resolution 38H-2010, CAPIR identified additional content for the ADA web page called for in the resolution at its January 2010 meeting. It is anticipated that the web page will be launched in fall 2011.

**ADA Commitment to Dialogue and Engagement to Improve the Public's Oral Health:** Resolution 39H-2010 (*Trans.*2010:560) brings to life the ADA's Strategic Plan, especially its third goal of improving public health outcomes through a strong collaborative profession and through effective collaboration across the spectrum of our external stakeholders, infuses all program areas.

In response to Resolution 39H, every CAPIR programmatic area is reaching out to external stakeholders on a routine basis.

**Amendment of the Definitions of Primary Dental Care Provider and Dental Home:** Resolution 80H-2010 (*Trans.*2010:548) defines "Primary Dental Care Provider" as "A licensed dentist who accepts the professional responsibility for delivering primary dental care," and defines "Dental Home" as "The ongoing relationship between the dentist who is the Primary Dental Care Provider and the patient, which includes comprehensive oral health care, beginning no later than age one, and continuing throughout the patient's lifetime."

In response to Resolution 80H-2010 CAPIR volunteers and staff have communicated these actions of the HOD and the new definitions with key stakeholders in and outside the dental community. These changes have been incorporated in Association policy and will be added in the current edition of *Current Policies*.

**Amendment of the Definition of Primary Dental Care:** Resolution 82H-2010 (*Trans.*2010:561) defines "Primary Dental Care" as "The dental care provided by a licensed dentist, to patients beginning no later than age one and throughout their lifetime. Primary dental care is directed to evaluation, diagnosis, patient education, prevention and treatment of oral disease and injury, the maintenance of oral health, and the coordination of referral to specialists for care when indicated. Primary dental care includes services provided by allied personnel under the dentist's supervision."

In response to Resolution 80H-2010 CAPIR volunteers and staff have communicated this action of the House of Delegates and the new definition with key stakeholders in and outside the dental community. These changes have been incorporated in Association policy and will be added in the current edition of *Current Policies*.

**Support of National Dental Association Efforts Regarding Access to Care and Mid-Level Providers for Underserved Communities:** Resolution 107H-2010 (*Trans.*2010:563) acknowledges the American Dental Association support of the National Dental Association's efforts to address access for underserved communities while assuring that those communities receive the same opportunity to receive dental care as all other Americans, and acknowledges with appreciation the NDA's historical efforts in providing care for at-risk populations.

In response to Resolution 107H-2010 the ADA continues to foster a close working relationship with the National Dental Association and has engaged the NDA as active participant in the work of the National Roundtable for Dental Collaboration. The NDA has removed the position paper from its website. The current position is being reviewed and will be updated based on additional information.

**Meetings:** The Council met in the ADA Headquarters Building in Chicago on January 27-29, and again June 23-25, 2011. Dr. Maxine Feinberg, trustee, Fourth District, serves as the Board of Trustees' liaison to the Council.

**Personnel:** The close of the 2011 annual session will bring to an end the terms of four valued members of the Council: Dr. Gary S. Davis, Dr. A.J. Homicz, Dr. Melanie Lang, and Dr. David Miller. These members have given unselfishly of their time and energy on behalf of the profession. The Council acknowledges their efforts with great appreciation.

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

## Council on ADA Sessions

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**Laing, Kevin M.**, Ohio, 2011, chair  
**Bertagni, Hugo F.**, Illinois, 2013  
**Blicher, Michael M.**, Washington, DC, 2013  
**Foster, James R.**, Texas, 2014  
**Fussell, Randy G.**, North Carolina, 2012  
**Galati, James E.**, New York, 2014  
**Heier, Ronald K.**, Pennsylvania, 2011  
**Hendrickson, Gregg C.**, Nevada, 2011, *ex officio*  
**Huberty, Mark C.**, Wisconsin, 2012  
**Lee, William E.**, Kentucky, 2013  
**McCorkle, Hutson E.**, Florida, 2011  
**Miller, Keri L.**, Alabama, 2011, *ex officio*\*  
**Okano, David K.**, Wyoming, 2012  
**Peppes, Gregory J.**, Kansas, 2013  
**Percy, Kent H.**, Georgia, 2012  
**Pietrasik, John P.**, Massachusetts, 2014  
**Remes, Michael C.**, Minnesota, 2011  
**Rounsavelle, Richard K.**, California, 2012  
**Samy, S. Shane**, Oregon, 2014  
**Shinbori, Dennis D.**, California, 2012, *ex officio*  
**Mills, Catherine**, director

**The Council on ADA Sessions and the Strategic Plan of the American Dental Association:** At the May 2007 Council on ADA Sessions meeting, the Council elected to update its Vision and 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 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 focuses on its "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.

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



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.

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

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**ADA 10 Orlando:** The ADA's 151<sup>st</sup> Annual Session and Technical Exhibition was held at the Orange County Convention Center under the direction of the Council on ADA Sessions. Total actual registration for the meeting was 25,605 attendees. There were 7,652 dentists at the meeting, totaling 29.8% of all meeting registrants. Attendees registered via the following methods: 92% pre-registered online; 2% pre-registered by mail; 6% pre-registered by fax and over 1,000 attendees registered on-site.

In an effort to attract nonmembers to the annual session, the one-time reduced registration fee was continued for non-member attendees who did not take advantage of this offer from 2005-2009. 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 Orlando annual session drew 3,268 first-time attendees. The Orlando annual session featured a First-Time Attendee Orientation Center, which provided concierge-style service to nonmembers and first-time attendees at the meeting.

The Florida Dental Association was helpful in making the meeting a success by hosting the 2010 Committee on Local Arrangements (CLA) micro site, which helped the Central Florida District Dental Association through the CLA in the recruitment and management of close to 380 volunteers. Of these volunteers 90% were from Florida and 10% were from other states; 177 were ADA member dentists.

The American Dental Assistants Association (ADAA) again met in conjunction with the ADA annual session and 1,922 dental assistants registered for the annual session. The Rosen Centre served as headquarters for the ADAA House of Delegates, which met October 10–11. Other highlights of the ADAA meeting included their silent auction and President's Gala.

### **2010 Education Overview:**

*Attendance Review.* There were 243 courses available to the 25,605 attendees of the meeting: 61 (25%) of the courses were hands-on workshops; six were live-patient Education in the Round; and 176 were lectures. Specifically, details of attendance include:

- 35,972 CE seats were occupied during the week
- Each dental professional took an average of 2.8 courses

- Of the 35,972 reserved seats, 26,297 (73%) were for no-fee lectures, 7,744 (22%) were for fee courses, and 1,431 (4%) were for fee workshops
- 88% of all seats in workshops were sold

*Education in the Round.* This was the second year of the virtual meeting connection at the meeting in conjunction with the live-patient courses. A live web cast was made available for free to all North American dental students and faculty as well as all ADA members who could not attend the meeting. Attendees could watch the six courses and interact live with the speakers in Orlando, or watch a recorded version of it for six months afterward. Over 1,000 individuals took advantage of the opportunity.

*The LOC (Learn, Optimize, Connect).* The year 2010 marked the third year of the ADA's LOC, where attendees could earn up to 30 hours of free continuing education (CE) on the exhibit floor. This high tech environment was 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 in an educational format that embraced adult learning principles. This cutting edge, live-patient center was divided into distinct educational disciplines, including: The Laser Pavilion, CBCT Imaging Center, Technology Expo and Open Science Forums. In the Open Science Forums alone, over 3,000 people earned free CE without leaving the exhibit floor.

*ADA 365.* The annual session online networking community, ADA 365, expanded opportunities for attendees of the 2010 meeting. New for 2010, attendees were able to enter a proposal to speak at the New Speaker Stage at the annual session. Sixteen new speakers were chosen out of over 140 entrants. In addition, ADA 365 provided attendees the ability 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 2010 educational tracks were developed specifically for new dentists and dental assistants. In addition, tracks were developed on topics including: esthetic dentistry; team building; prevention; geriatric dentistry; and professional development. Leadership Day also launched in 2010 in partnership with the ADA's Department of Dental Society Services.

*Programs.* Workshops on topics included pediatric dentistry, occlusion/TMD, dental assisting, endodontics, and prosthodontics. Practice management courses included career transitions, customer relations (presented by the Disney Institute), social media and Web marketing, health and wellness, career/life planning and diet/fitness.

Courses were presented in collaboration with ADA Divisions and Councils, including: ADA Business Enterprises, Inc., Council on Access, Prevention and Interprofessional Relations, Council on Dental Benefit Programs, Council on Dental Practice, Council on Dental Education and Licensure, Center for Continuing Education and Lifelong Learning, Center for International Development and Affairs, Council on Members Insurance and Retirement Programs, New Dentist Committee, 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 51<sup>st</sup> anniversary in Orlando at the 2010 annual session, is conducted annually by the Council on ADA Sessions and is financially supported by DENTSPLY International, Inc., York, Pennsylvania.

On Saturday, October 9, at the Orange County Convention Center, the American Dental Association and DENTSPLY International hosted the 51<sup>st</sup> Annual Student Clinician Research Program. Fifty-seven U.S. student clinicians representing 56 dental schools and 14 international student winners of the DENTSPLY International Program presented their poster presentations from 1:00–4:00 p.m. at the Orange County Convention Center.

This is the second year that DENTSPLY International partnered with the American Dental Hygienists' Association (ADHA) and developed a new program aimed at promoting dental hygiene research. The program entitled, the DENTSPLY/ADHA Graduate Student Research Award Program sponsors one graduate level dental hygiene student from a U.S. Dental Hygiene Program which offers a Master's of Science Degree in Dental Hygiene to present their research at the ADA's annual session meeting.

The winners of the 2010 ADA/DENTSPLY Student Clinician Research Competition were:

*Winning Students in Category I: Clinical Science/Public Health Research.* First place, Robert Lawrence Trujillo, Arizona School of Dentistry & Oral Health; Second place, Mindy S. Gil, Harvard University School of Dental Medicine; Third place, Hanna Elizabeth Lindskog, University of Texas Health Science Center at San Antonio Dental School.

*Winning Students in Category II: Basic Science Research.* First place, Insoon Chang, University of California at Los Angeles School of Dentistry; Second place, Anne Ziegler, University of Michigan School of Dentistry; Third place, Samin Nawaz, University of Medicine & Dentistry of New Jersey, New Jersey Dental School.

The judges of the 2010 ADA/DENTSPLY Student Clinician Research Competition were:

*Judges for Category I: Clinical Science/Public Health Research.* Dr. Steven Andreus, Raleigh, NC; Dr. Shirley A. Austin, Mesa, AZ; Dr. Stephen Corbin, Rockville, MD; Dr. Janet L. Harrison, Memphis, TN; Dr. Keith V. Krell, West Des Moines, IA; 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; Dr. Albert Whitehead, Ft. Lauderdale, FL.

*Judges for Category II: Basic Science Research.* Dr. Robert A. Augsburger, Tulsa, OK; Dr. Carmen Yolanda Bonta, Somerset, NJ; Dr. Gareth R. Brock, England; Dr. Tadasha Culbreath, Alexandria, VA; Dr. Christopher Cutler, Stony Brook, NY; Dr. Lisa P. Deem, Blue Bell, PA; 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. Angella Tomlinson, Tampa, FL; Dr. Thomas Van Dyke, Boston, MA; Dr. Hans-Jurgen Wenz, Germany.

**Exhibition:** The ADA Marketplace featured 1401 booths from more than 550 companies during a three-day exhibition period. The exhibition took place in the Exhibit Level of the Orange County Convention Center which was opened from 9:00 a.m.–5:30 p.m. each day.

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

- The LOC (see Education Overview for features of the LOC).
- The International Pavilion, which clustered 15 international manufacturers together into one area of the hall.
- The annual session tote bags sponsored by Procter & Gamble 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 2011 annual session in Las Vegas. 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 ADA Photo Souvenir Stage featured a green screen backdrop of various theme park rides. There were approximately 1,300 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.

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

*ADA General Sessions Featuring the Distinguished Speaker Series.* The 2010 General Session and Distinguished Speaker Series (DSS) took place on Saturday, October 9, 2010, at the Orange County Convention Center.

The opening General Session helped highlight the accomplishments of the ADA in 2010. During the General Session, a special recognition and a moment of silence were observed in memory of Dr. Thomas Grams. The Dental Lifeline Network (DLN), formerly the National Foundation of Dentistry for the Handicapped, was also recognized. DLN was celebrating its 25<sup>th</sup> anniversary.

Dr. Ronald Tankersley, ADA president, gave highlights of ADA initiatives:

- The first-ever Diversity in Dentistry Summit
- The Roundtable for Dental Collaboration
- The Volunteer Celebration Area in the Exhibit Hall
- The Honda Motor Company program with its donation to the ADA Foundation's Give Kids a Smile program
- The Adopt a Practice in Haiti campaign in collaboration with the Health Volunteers Overseas organization with a goal of \$350,000 by the end of 2010

Dr. Raymond F. Gist was introduced as the next President of the ADA. Dr. Gist gave brief remarks.

Dr. Tankersley recognized the cohort of students in the Community Dental Health Coordinator pilot program from the University of Oklahoma and UCLA. Henry Schein's was recognized as an entity supporting the program. Stan Bergman, CEO from Henry Schein, spoke of the company's support for the ADA's mission to expand access to dental care.

Dr. Terry Dickinson was recognized at this year's recipient of the ADA's Humanitarian Award. Dr. Dickinson conceived an idea that would enable dentists in Virginia to bring free oral healthcare to the impoverished populations of rural Virginia. He began the Missions of Mercy project. The International College of Dentists also recognized Dr. Dickinson during the General Session.

The distinguished speaker was Mr. Malcolm Gladwell who delivered a thought provoking message. Attendance was close to 6,000 people who gave Mr. Gladwell a great welcome and standing ovation. Over 500 people participated in the book signing that followed his presentation. The addition of CE credit for this tailored presentation was well received.

*Evening Entertainment/151<sup>st</sup> Celebration Event.* The featured entertainment for 2010 was the ADA Night at Universal's Islands of Adventure. The event took place on Sunday, October 10, 2010, in which ADA attendees had exclusive access to the park. The hours of the event were 7:00 to 11:00 p.m. The evening included unlimited rides, entertainment throughout the park, unlimited free play on all video games and pinball machines in the Marvel Super Hero Island, specialty shops and restaurants. A limited number of rides were closed at 10:00 p.m. due to a noise ordinance. The evening was enhanced with ADA logos which were projected on highly visible buildings, custom signage and banners and each guest received a customized program booklet and park map upon entry. A red carpet was provided for attendees as they entered through the gates.

Adult and children's tickets were sold through the annual session registration system, on-site at the convention center and at the park the evening of the event. In total, 7,134 tickets were sold. Shuttle service to and from all official ADA hotels was included in the ticket price. A ten dollar food coupon was also included in the ticket price and was distributed to each guest upon entry to the park. This coupon could be used at any concession stand during the ADA event including the gift shops.

*ADA Presidential Gala.* The Presidential Gala honored ADA President Dr. Ronald Tankersley. In addition to the dinner for 637 attendees, the event featured Lisa Z and Funhouse Extreme, Orlando's premier entertainment band. Guests enjoyed the expansive repertoire of hits while dancing and visiting with friends and colleagues throughout the evening.

*Related Events.* Meetings and social events were sponsored by 31 dental school alumni groups, one dental fraternity, two military organizations and 36 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 Saturday, October 9, Tuesday, October 12 and Wednesday, October 13, at the Hilton Orlando. The Reference Committees convened on Sunday, October 10, at the Hilton Orlando. 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 34 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 offered the Association's latest products and publications along with branded gift items
- Publicity for upcoming regional and national meetings
- ADA Pavilion promoted ADA benefits and services
- Four special *ADA News Convention Dailies* highlighted each day's events

Registration and housing for the 2011 annual session in Las Vegas was made available in Orlando and over 800 attendees pre-registered. Dr. Gregg C. Hendrickson, CLA chair, and members of the 2011 Committee on Local Arrangements were on hand to answer questions and promote the Las Vegas meeting.

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## **152<sup>nd</sup> Annual Session, Las Vegas, Nevada, October 10–13, 2011**

**ADA11 Las Vegas:** The 152<sup>nd</sup> Annual Session will take place at the Mandalay Bay Hotel & Convention Center in Orlando. The schedule of events will be:

Opening General Session: October 10  
 Continuing Education: October 10–13  
 World Marketplace Exhibition: October 10–12  
 House of Delegates: October 10–14

The Mandalay Bay Hotel & Convention Center and MGM Grand Hotel 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. The House of Delegates and its activities will be held in the MGM Grand.

**ADA World Marketplace Exhibition:** The Council left Orlando with 69% of the show floor for Las Vegas rented. Over the past five years, the Council has averaged between 52%–89% in selling the future year's

hall. The remainder of the space will need to be sold to companies who are purchasing smaller booths as the companies who bought the larger spaces participated in the space draw. Companies that downsized in 2009 and 2010 are still 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 our smaller exhibitors as well as market to new exhibitors.

**General Sessions and Distinguished Speaker Series:** One General Session and keynote address (ADA Distinguished Speaker Series) is scheduled for Monday, October 10. 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 Dr. Condoleezza Rice, current professor of political economy in the Stanford Graduate School of Business, Thomas and Barbara Stephenson Senior Fellow on Public Policy at the Hoover Institution, professor of political science at Stanford University, and former Secretary of State of the United States.

**2011 Education Overview:** Over 245 courses will be a part of the 2011 Scientific Program. Some highlights include:

*Education in the Round (EIR).* 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 2011, all six of the EIR courses will be available as a live webcast 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 Webpage and earn continuing education (CE) credit for these courses.

*The LOC (Learn, Optimize, Connect).* For the fourth 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 Las Vegas, 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.

*Competition Hub.* In 2011, 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; the Education Exchange Competition; 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 2011, 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 2011 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 the Council on Scientific Affairs. Additional tracks include: ones for new dentists, federal dentists and dental assistants; as well as tracks based on esthetic dentistry, team building, and 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 ADA Business Enterprises, Council on Access, Prevention and Interprofessional Relations, Council on Dental Benefit Programs, Council on Dental Practice, Council on Dental Education and Licensure, Center for Continuing Education and Lifelong Learning, Center for International Development and Affairs, Council on Members Insurance and Retirement Programs, New Dentist Committee, Council on Scientific Affairs, and ADA Insurance Plans.

**ADA/DENTSPLY Student Clinician Research Program:** 2011 marks the 52<sup>nd</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 Las Vegas, the students will make their poster presentations to the public on Monday, October 10, from 1:00 to 4:30 p.m., on the first day of the annual session meeting.

Complete annual session information including continuing education, registration, housing and entertainment, is available online at [www.ada.org](http://www.ada.org).

**Meetings:** The Council met at the MGM Grand in Las Vegas, Nevada, Thursday, from February 10 to Saturday, February 12, 2011, and at the ADA Headquarters Building in Chicago, from Thursday, May 19 to Saturday, May 21, 2011.

**Personnel:** Dr. Kevin M. Laing has served as council chair for the 2010-2011 terms with Dr. Kent H. Percy serving as 2011 program chair.

**Acknowledgments:** The Council wishes to express its appreciation to Dr. Gregg C. Hendrickson, general chair of the 2011 Committee on Local Arrangements for his assistance in the planning and production of the 2011 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 2011 annual session. Most importantly, the 2011 Committee on Local Arrangements for their valuable assistance in the production of the annual session: Dr. James G. Kinard, vice chair; Dr. Rick B. Thriot and Dr. Jonathan E. Rothbart, hospitality co-chairs; Dr. William G. Pappas and Dr. Michael C. Lloyd, program co-chairs; Dr. Brad A. Wilbur and Dr. George F. Rosenbaum, registration co-chairs.

The Council also expresses its sincere appreciation to the entire Southern Nevada and Nevada Dental Associations for their support of this year's ADA annual session. Without the assistance and cooperation of these individuals and organizations, the Las Vegas 2011 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 2011 annual session: Dr. Ronald K. Heier, Dr. Kevin M. Laing, Dr. Hutson E. McCorkle and Dr. Michael C. Remes.

The Council also would like to recognize the contributions made by Dr. Charles L. Steffel, Board of Trustees liaison, Dr. Keri L. Miller, New Dentist Committee liaison and Mr. Daniel A. Hammer, ASDA liaison to the Council on ADA Sessions during 2011. The Council will miss all of them and wishes them all the best in their future endeavors.

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

# Council on Communications

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**Kolling, Josef N.**, Michigan, 2011, chair  
**Brown, W. Carter**, South Carolina, 2012, vice chair  
**Campbell, Jeffrey A.**, Ohio, 2014  
**Chesser, William, E.**, Alabama, 2014  
**Elliott, Anita W.**, Arizona, 2012  
**Gellert, Jonathan R.**, New York, 2011  
**Giannini, Eugene T.**, District of Columbia, 2011  
**Jenkins, James F.**, Nebraska, 2014  
**Johnson, J. Michael**, Kentucky, 2013  
**Jones, Krista M.**, Oklahoma, 2013  
**Nase, John B.**, Pennsylvania, 2013  
**Niewald, Matt**, Missouri, *ex officio*\*  
**Olinger, Thomas J.**, California, 2012  
**Ray, Pamela S.**, Texas, 2012  
**Shenkin, Jonathan D.**, Maine, 2013  
**Starsiak, Mary A.**, Illinois, 2011  
**Watts, Renee E.**, Oregon, 2014  
**Wunderlich, Hugh T.**, Florida, 2012  
**MacLachlan, Janine**, director  
**Hall, Lydia**, manager

**The Strategic Plan of the American Dental Association:** In accordance with the Council on Communications' *Bylaws* duties, the Council identifies, recommends, and maintains a strategic communications plan for the ADA in support of the current ADA strategic plan. The Council will discuss an outline of the 2011-2014 Strategic Communications Plan at its June meeting, and further information will be provided in the Council's supplemental report.

## Response to Assignments From the 2010 House of Delegates:

*ADA Public Relations Campaign.* The 2010 House of Delegates adopted Resolution 29H-2010 (*Trans.*2010:611):

**Resolved**, that the ADA through the state public affairs program collect existing data, multi-media and collateral material, messaging and best practices from the states on the issue of workforce and make this material available to constituent societies for use in their efforts to educate policymakers and like-minded special interest groups on that topic.

In response to Resolution 29H-2010, State Public Affairs (SPA) program staff is collecting data and the Division of Communications and Marketing is creating a communications strategy that includes advertising, talking points, media story placements and sample legislation. The Division repurposed staff and assigned a project manager to focus on the coordination and implementation of this process working with SPA and members of the tripartite to ensure effective distribution. This information is currently posted on the "Loop," a password-protected web library for state dental societies.

*Dental Access Barriers.* Resolution 121H-2010 (*Trans.*2010:566) states:

**Resolved**, that the ADA, in communications regarding dental access issues, emphasize barriers to care including, but not limited to:

- a. financial barriers
- b. geographic barriers

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



- c. governmental policy barriers
- d. personal barriers
- e. cross-cultural barriers
- f. language barriers

In response to both Resolution 29H-2010 and Resolution 121H-2010, the ADA in February 2011 published the first in a series of papers entitled, “Breaking Down Barriers to Oral Health for All Americans: The Role of Workforce.”

The Council took a leadership role in developing the ADA paper “Breaking Down Barriers to Oral Health for All Americans: the Role of Workforce” in order to provide a platform for ADA advocacy communications. The paper was shared with the Council’s Access Communications Workgroup for comment and then with numerous councils including the Council on Access, Prevention and Interprofessional Relations (CAPIR), the Council on Dental Practice (CDP), and the Council on Government Affairs (CGA). The ADA Board of Trustees approved the paper at its February 2011 meeting.

The main purposes of the paper were to: dispel the notion of so-called “midlevel providers” as a cure-all by putting workforce into perspective relative to other barriers mentioned in the resolution; clarify the ADA’s position on various workforce proposals, i.e., support for such concepts as Expanded Function Dental Assistants and Community Dental Health Coordinator (CDHC), and opposition to models that would allow non-dentists to perform surgical/irreversible procedures; and make clear that the ultimate solutions to oral health disparities are education and prevention.

This paper is the first in what is intended to be a series of papers to raise awareness of the multiple barriers to oral health and to help the ADA attain its core commitment to help Americans attain the optimal oral health they deserve. The second paper, “The Tattered Safety Net,” is expected to be published in July 2011. The Council has established an Access Communications Workgroup to provide oversight and guidance on all of these issues.

The Access Communications Workgroup is composed of Council vice chair Dr. W. Carter Brown and Council members Dr. Krista M. Jones, Dr. Eugene T. Giannini and Dr. Jonathan D. Shenkin.

**Council on Communications Liaison Program:** The Council’s liaison program, established as an ongoing program with the adoption of Resolution 30H-2008 (*Trans.*2008:490), enables the Council’s representatives to attend meetings of CAPIR, CDP, Council on Membership (CM), Council on Scientific Affairs (CSA) and CGA. Council on Communications liaisons serve as a resource to the host council, identifying strategic communications issues and providing communications recommendations to host councils on their projects, programs or issues that have the potential to impact the reputation of the ADA.

The Council on Communications formalized and submitted to the Board of Trustees a set of guidelines for the Council’s liaison program. The guidelines outline the program’s purpose, how the liaisons are selected, and the role of the liaisons and the host councils.

Over the past year, the Council has grouped the issues raised at host Council meetings into one of three categories: barriers to optimal oral health for all Americans (including issues such as workforce); oral health initiatives for the public (such as Give Kids A Smile); and issues that can affect the reputation of the ADA and of dentistry (such as dental amalgam). With strategic oversight from the Council, the Division of Communications and Marketing staff facilitates tactical communications efforts in support of the communications for these three categories.

The 2010-2011 Council liaisons are Dr. Mary A. Starsiak for CAPIR, Dr. Thomas J. Olinger for CDP, Dr. Eugene T. Giannini for CGA, Dr. Jonathan R. Gellert for CM and Dr. Jonathan D. Shenkin for CSA.

**CDHC Communications Programs:** The Division of Communications and Marketing, with strategic guidance from the CDHC Communications Committee, developed 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. Council members Dr. Mary A. Starsiak and Dr. Krista M. Jones serve on the CDHC Communications Committee, a subgroup of the CDHC Workgroup, which is under the purview of CAPIR.

The CDHC Communications Committee provided input and oversight to the creation and implementation of the CDHC ambassador program which involves ADA volunteer leaders in each district to provide peer-to-peer presentations about the CDHC pilot project, answer members' questions, and help dispel myths about the pilot project. The CDHC Communications Committee will continue the ambassador program, updating their districts on the current status and future direction of the CDHC program.

**Public Outreach:** In support of oral health initiatives, and in support of ADA strategic plan goal #2 to help the public become good stewards of their own oral health, the Council adopted a resolution to the Board supporting the ADA's involvement in Sharecare, a new consumer health website and business venture founded by Dr. Mehmet Oz, Mr. Jeff Arnold, founder of WebMD, and investor Ms. Oprah Winfrey.

The ADA Board in April 2011 approved that the ADA enter into a multi-year contractual agreement with Sharecare, Inc., to provide intellectual property in the form of consumer information, online content from ADA.org, video and original answers to public questions to this major new online health website as its preferred oral health information resource. The Sharecare.com website is designed as a robust question-and-answer platform to provide the public with health information from unbiased experts in a manner that is intuitive and user friendly.

The ADA will participate as the primary provider of oral health information. Sharecare will repurpose existing ADA content into the desired format at their sole expense. The ADA will offer its members who meet ADA-developed criteria to become part of the "expert" community of dentists featured on Sharecare. The ADA will have final approval over all ADA-provided content. Sharecare is a unique and financially attractive method of providing ADA-branded oral health information to the public; and, by creating a mechanism for selective member participation, it will build recognition of the essential role of the dentist in meeting the oral health needs of the country.

The Council at its January 2011 meeting adopted a resolution that the Council will assist in the development of a comprehensive strategy for the rollout of the caries classification system by developing a communications plan for the profession, the public and other stakeholders, when authorized to proceed by the ADA House of Delegates. Implementation of the communications plan will be contingent on appropriate funding.

In addition, at the June meeting, the Council will consider a communications plan for the tenth anniversary of Give Kids A Smile in 2012. Further information on oral health initiatives will appear in the Council's supplemental report.

**State Public Affairs (SPA) Program Oversight Committee:** Communications plays a critical role in the SPA Program, which was established by Resolution 41H-2006. 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 creates metrics to measure the effectiveness of the SPA program; reviews proposals from numerous national public affairs firms interested in working with the ADA on the SPA program, and reviews annual dental society applications for the SPA program. Council member Dr. Anita W. Elliott was appointed to serve on the committee for 2010-12, and is scheduled to serve as chair next year.

Workforce issues were the focus of most of the states that participated in the SPA program in 2010. The SPA program administrators are developing advocacy tools for the ADA Tripartite, drawing upon legislative language, case studies and research findings conducted in a number of SPA states that can be used to support workforce strategies in other states.

**Evidence-Based Dentistry (EBD) Advisory Committee:** The EBD Advisory Committee was established to assure the ADA that the entire spectrum of research, dental practice and education are taken into account as the Association moves forward on any given activity related to EBD. Council member Dr. John B. Nase serves on the committee.

The Council is providing strategic oversight to a marketing and communications plan currently under development for the Center for EBD. The objectives of the plan include increasing awareness of EBD and evidence-based clinical guidelines among dentists working in private practice, public health and academia; developing effective messages that will improve the perception of EBD; encouraging dentists to accept and adopt evidence-based clinical guidelines into practice; and increasing the utilization of EBD tools, including the website.

Marketing Department staff is conducting market research to gather baseline information on general awareness and current perceptions of EBD; current level of acceptance/embrace of EBD and evidence-based clinical guidelines; favorability to adopt evidence-based clinical guidelines into practice; and current use and planned future use of the EBD website. Once the data is collected by the due date of June 6, division staff will work with Dr. Nase to develop a strategic marketing communications plan.

**Give Kids A Smile (GKAS) and National Children's Dental Health Month (NCDHM):** The ADA Board of Trustees re-appointed Council member Dr. Hugh T. 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 representatives from CAPIR to review the program's poster artwork and slogan each year.

**Impact of Information Technology on the Profession or Practice of Dentistry Social Media Workgroup:** As the body designated to develop a social media strategy for the ADA, the Council, through its Social Media Workgroup, provided strategic input to the Division of Communications and Marketing to conduct research with dentists and the public in 2010 to help shape the ADA's social media strategy. In April 2011, the ADA Board of Trustees approved the proposed social media strategy and implementation plan for the ADA.

Social media offer tools and resources that can be integrated with existing communications and leveraged to help achieve the ADA strategic plan goals. Social media use can directly impact attainment of goals 1, 2 and 3 of the strategic plan, since emerging technology can help members build and market their practices and more effectively engage with patients. Social media also provide the opportunity to greatly improve our communication with the public and are essential methods of collaboration with diverse stakeholders. There is a risk to reputation and perception in social media. However, the demand for relevance, the need for transparency and the power of the ADA's credibility are such that to ignore the reach and influence of social media is an even greater risk.

The Council's Social Media Workgroup collaborated with the Council on ADA Sessions to develop and implement a social media strategy for the 2010 ADA annual session that included a Facebook Group page, a Twitter Feed for subscribers and integrated mobile applications.

The Facebook page served as an online community where members could read news and other session-related posts, as well as post their comments, photos and video to the group page. The Twitter feed pushed news and event information to those individuals following the feed, allowing them to forward (re-Tweet) the information to their friends and networks. The mobile phone application offered maps of the exhibit hall, a schedule of events, and a direct link to the Twitter feed on attendee smart phones. In addition, the 2010 annual session registration software included a supplemental service that allowed registered attendees to search for and connect with dentists/friends on various social media websites.

The Council's Social Media Workgroup is collaborating with the Council on ADA Sessions to develop and implement a social media strategy for the 2011 annual session as well as the New Dentist Committee (NDC) to develop and implement a social media strategy for its 2011 New Dentist Conference.

The Social Media Workgroup members are Dr. James F. Jenkins, Dr. John B. Nase, Dr. Renee E. Watts, Dr. Hugh T. Wunderlich, Dr. Matt Niewald, and Ms. Colleen Green, American Student Dental Association representative to the Council.

**Reputation Management Workgroup:** The Council is the primary ADA agency responsible for advising on reputation management, providing strategic oversight and advising the Association on the image and brand implications of Association plans, programs, services and activities. The definition of reputation management is the protection, preservation and promotion of the perception and understanding of the Association across a diverse audience of stakeholders. These include members, leadership, the tripartite, non-member dentists and professionals, the dental industry, legislators, regulators and the public. The task of safeguarding the reputation of the Association crosses all divisions and the strategic management of issues requires the collaboration with every functional area.

In 2010, the Council created a Reputation Management Workgroup to offer guidance on the development and implementation of an issues management approach for the ADA and to provide on-going oversight and recommendations. The presentation and coverage of the Association in the media directly influences stakeholder perception. Media relations is an essential function necessary both to respond quickly and appropriately and to provide access and outreach for the messaging of the Association. Effective reputation management includes integrating media outreach, risk assessment messaging and responsiveness within the over-arching goals for reputation management.

The Reputation Management Workgroup members are Council vice chair Dr. W. Carter Brown and Council members Dr. Jeffrey A. Campbell, Dr. Eugene T. Giannini and Dr. Jonathan D. Shenkin.

**Brand Management Workgroup:** Brand management is the consistent delivery of the brand imagery and messaging across all communications. The true impact of effective brand management is enhancing the value of the brand. The ADA is a highly respected and trusted professional health organization, and each time the brand is presented to the diverse stakeholders who influence that perception, there is the opportunity to both enhance and reinforce the brand.

The Council created the Brand Management Workgroup in 2010 to offer strategic guidance on the use of the ADA brand including the oversight of brand standards, the integration of the brand into collaborative ventures and the presentation of the brand across all ADA and non-ADA media channels. Since then, the Workgroup has evaluated requests from external organizations seeking permission to use the ADA logo and related intellectual property on their materials. This work has provided the foundation for *de minimis* guidelines that are in development and scheduled for upcoming consideration by the Board of Trustees.

The Brand Management Workgroup members are Dr. W. Carter Brown, Dr. Jonathan R. Gellert, Dr. J. Michael Johnson and Dr. William E. Chesser.

**Council Meeting Evaluation Survey:** The Council participated in a survey of its January 2011 meeting 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 84.2%, with 16 respondents.

Nearly all respondents reported being "very satisfied with staff support" they received to help them prepare for the January meeting. Respondents reported a high level of satisfaction with communication between the June 2010 and January 2011 Council meetings as well as the opportunity for agency volunteers to provide input during the meeting.

**Awards:** The Council selected the Massachusetts Dental Society's "Children's Oral Health Awareness Campaign" in the constituent category as the winner of the 2010 Golden Apple Award for Excellence in

Dental Health Promotion to the Public. Nominations for the 2011 awards will be considered at the Council's June meeting.

**Personnel:** The Council expresses appreciation to retiring members Dr. Jonathan R. Gellert, Dr. Eugene T. Giannini and Dr. Mary A. Starsiak. The Council is grateful to Dr. Josef N. Kolling for his thoughtful leadership as chair. The Council thanks Dr. Charles R. Weber, Third 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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**Joondeph, Donald R.**, Washington, 2011, chair, American Association of Orthodontists  
**Tonelli, J. Steven**, Massachusetts, 2012, vice chair, American Dental Association  
**Biermann, Michael E.**, Oregon, 2013, American Dental Association  
**Buchanan, Richard**, Utah, 2012, American Dental Education Association  
**Burr, Kristi**, Ohio, 2014, Public Member  
**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  
**Dulde, Ryan**, Wisconsin, 2011, American Dental Education Association and American Student Dental Association  
**Gagliardi, Lorraine**, California, 2012, American Dental Assistants Association  
**Giasolli, Robert**, California, 2014, Public Member  
**Greenwell, Henry**, Kentucky, 2014, American Academy of Periodontology  
**Hardesty, W. Stan**, North Carolina, 2011, American Association of Dental Boards  
**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  
**Marinelli, Charles**, Michigan, 2013, American Association of Dental Boards  
**Messura, Judith**, North Carolina, 2013, American Association of Hospital Dentists and American Dental Education Association  
**Mueller-Joseph, Laura**, New York, 2011, American Dental Hygienists' Association  
**Neville, Brad Wesley**, South Carolina, 2014, American Academy of Oral and Maxillofacial Pathology  
**Pelot, Reuben N., III**, Tennessee, 2011, American Dental Association  
**Ray, Robert G.**, Washington, D.C., 2012, American Association of Dental Boards  
**Rivera-Nazario, Yilda M.**, Puerto Rico, 2013, American Dental Education Association  
**Schonfeld, Steven E.**, California, 2014, American Dental Association  
**Sims, Paul G.**, Montana, 2014, American Association of Dental Boards  
**Wenckus, Christopher**, Illinois, 2012, American Association of Endodontists  
**West, Karen**, Nevada, 2011, American Dental Education Association  
**White, B. Alexander**, Massachusetts, 2012, American Association of Public Health Dentistry  
**Williams, John**, Indiana, 2014, American Dental Education Association  
**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 August 2010 through February 2011 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 August 2010 and February 2011 meetings, for a total of 514 accreditation actions. Applications for initial accreditation of education programs were reviewed. During this time, three predoctoral dental education programs, five advanced specialty education programs, four postdoctoral general dentistry programs, 12 dental hygiene education programs, and seven dental assisting education programs were granted the accreditation status of "Initial Accreditation." As indicated

in Table 2, the total number of educational programs accredited is 1,412. This represents an increase of 47 programs from the previous reporting period. Of the 1,412 accredited programs, 60 (4.2%) hold the status of "Initial Accreditation." One thousand three-hundred and fifteen (1,315) programs (93.1%) are in compliance with all requirements and have been awarded "Approval *Without* Reporting Requirements." During this reporting period, 37 programs (2.6%) were found to have deficiencies or areas of noncompliance and hold the status of "Approval *With* Reporting Requirements." Each of the 37 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 11 complaints against programs during this time.

During this reporting period, one advanced specialty education program had accreditation withdrawn and appealed the Commission's decision to the Appeal Board. 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 affirm, amend, remand, or reverse the adverse actions of the Commission. For the advanced specialty education program that had accreditation withdrawn, the Appeal Board affirmed the decision of the Commission.

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, 10 programs voluntarily discontinued their participation in the Commission's accreditation program.

**Table 1. Selected Accreditation Actions: Two Meetings, August 2010 and February 2011**

	Dental	Specialty	Advanced General Dental	Dental Assisting	Dental Hygiene	Dental Laboratory Technology	Total
Initial Accreditation Granted	3	5	4	7	12	0	31
Initial Accreditation-- Continuing	1	3	1	1	10	0	16
Approval Without Reporting Requirements	16	153	68	54	69	4	364
Approval With Reporting Requirements	5	5	19	29	18	2	78
Accreditation Denied	0	1	0	0	0	0	1
Discontinued Programs	0	4	3	3	0	0	10
Intent to Withdraw	0	0	2	7	3	0	12
Accreditation Withdrawn	0	1	0	0	0	0	1
Decision Appealed	0	1	0	0	0	0	1
Number of Accreditation Actions	25	173	97	101	112	6	514

**Table 2. Total Number of Accredited Programs as of February 2011**

	Dental	Specialty	Advanced General Dental	Dental Assisting	Dental Hygiene	Dental Laboratory Technology	Total
Initial Accreditation	5	14	10	7	24	0	60
Approval Without Reporting Requirements	54	429	257	262	294	19	1,315
Approval With Reporting Requirements	2	2	9	16	7	1	37
Number of Accredited Programs	61	445	276	285	325	20	1,412

**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);
- United States Department of Education (USDE) regulations regarding accreditation recognition renewal petitions;
- Trends in the National Advisory Committee on Institutional Quality and Integrity (NACIQI) evaluation of accreditors for USDE recognition; and
- 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 2011 Commission meeting:

- Intent statement to Accreditation Standards 2-4 of the Accreditation Standards for Advanced Specialty Education Programs in Endodontics;
- New Accreditation Standards on monitoring board certification for the Accreditation Standards for Advanced Specialty Education Programs in Orthodontics and Dentofacial Orthopedics; and
- A revised accreditation standard on eligibility requirements for admission into Advanced General Dentistry Education Programs in Oral Medicine and Advanced General Dentistry Education Programs in Orofacial Pain. In addition, the Commission directed that a new accreditation standard on eligibility requirements for admission into General Practice Residencies, Advanced General Dentistry Education Programs, and Advanced General Dentistry Education Programs in Dental Anesthesiology be added to Standard 4 (Educational Support Services) of each discipline's Accreditation Standards.

The Commission held open hearings on the proposed revised standards at the October 2010 ADA annual session and the March 2011 American Dental Education Association annual session.

The Commission approved the circulation of proposed revised standards to the communities of interest in the following areas for review at the February 2012 Commission meeting:



- Accreditation Standards for Dental Hygiene Education Programs, including revisions to the Initial Application document;
- Accreditation Standards for Advanced Specialty Education Programs in Oral and Maxillofacial Surgery;
- Accreditation Standards for Clinical Fellowship Training Programs in Oral and Maxillofacial Surgery; and
- Comprehensive revision of the Accreditation Standards for Advanced Specialty Education Programs in Pediatric Dentistry.

The Commission held open hearings on the proposed revised standards at the March 2011 American Dental Education Association annual session and will hold open hearings on the proposed revised standards at the October 2011 ADA annual session.

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

- Accreditation Standards for Dental Education Programs, for implementation July 1, 2013, with programs having the option of review under the revised standards or the current standards from January 1, 2012 through June 30, 2013. All programs will be reviewed using the revised standards as of July 1, 2013;
- Accreditation Standards for Clinical Fellowship Training programs in Craniofacial and Special Care Orthodontics Educational Programs (editorial revisions to Standards 3-9 and 6-2.2) for immediate implementation;
- Language common to all specialty education programs (specialty boilerplate language) Standard 1 (formal system of quality assurance) and Standard 4 (learning experiences in evidence-based practice). In addition, revisions were made to the preface of the specialty boilerplate language, along with revisions in the definition of terms used in advanced specialty education program accreditation standards, with immediate implementation. Revision of discipline-specific standards to be in congruence with the revisions in boilerplate language is to be completed no later than January 1, 2014;
- Accreditation Standards for Advanced General Dentistry Education Programs in Dental Anesthesiology regarding program director qualifications, for immediate implementation; and
- Language on the topic of ethics and professionalism for each discipline under the Commission's purview, as a new discipline-specific accreditation standard. The ethics and professionalism accreditation standard will be placed within the accreditation standards for each discipline according to the recommendation of the relevant Review Committee, with implementation time-frame as recommended by each Review Committee.

**New Standing Committee Structure:** The Commission adopted a revised Standing Committee structure and charge for each committee: Quality Assurance and Strategic Planning; Documentation and Policy Review; Nomination; Finance; and Communication and Technology. The restructuring of the Standing Committees will enhance the Commission's ability to conduct strategic planning; to efficiently and effectively address ongoing technology and communication issues; and to monitor outside influences on the accreditation program.

**Revised Policies:** The Commission adopted a combined *Evaluation Policies and Procedures (EPP)* and *Operational Policies and Procedures (OPP)* manual, which will be called the *Evaluation and Operational Policies and Procedures (EOPP)* manual. Date of implementation of the combined manual with new policies was January 1, 2011 (with the exception of the revised policy on nomination criteria). Revisions were made to achieve clarity of information, elimination of redundancy, and uniformity of policy and procedures. Substantive changes were made in the following policies:

- Enrollment Increases in Advanced Dental Specialty Programs—A request for an increase in enrollment with all supporting documentation must be submitted in writing to the Commission at least one month prior to a regularly scheduled semiannual Review Committee/Commission meeting. A program must receive Commission approval for an increase in enrollment prior to publishing or announcing the additional positions or accepting additional students/residents. The

Commission will not retroactively approve enrollment increases without a special focused site visit. Special circumstances may be considered on a case-by-case basis.

- **Changes in Policy Regarding the Accreditation and Visitation of Off-Campus Sites—**CODA must be informed if a program accredited by the Commission plans to initiate an off-campus site (distance site and/or additional training site not located on the main campus). The Commission must be informed in writing six months prior to the anticipated initiation of educational experiences at the off-campus site. Generally, only programs without reporting requirements will be approved to initiate educational experiences at off-campus sites.
- **Role of Observers on a Site Visit—**A description of the role of observer was added so that all individuals who attend a site visit are included in this section of the manual.
- **Conflict of Interest Policy—**As the differentiation between direct and indirect conflict of interest is confusing and unnecessary, the revised policy redefines what constitutes a conflict of interest and carries that policy through to all policies and procedures that have conflict of interest implications.
- **Criteria for Granting Accreditation—**Increased the time period that a dean or program director must be employed prior to an initial accreditation site visit from three months to at least six months prior to the anticipated date of the site visit.
- **Policy Statement on Consultant/Site Visitor Training—**Revised policy to require site visitors/consultants who have not been on a site visit during the previous two years to receive additional training.
- **Nomination Criteria for Review Committee Members and Commissioners—**Individuals may now serve a maximum of eight years on any combination of Review Committee and/or Commission without a hiatus. Policies related to the appointment term on Review Committees and the Commission still apply.
- **Review Committee Structure and Guidelines on Requirements for Review Committee Members—**Revised policy to require that all Review Committee members observe at least one site visit. Additionally, revised the policy to require that the chairperson of the Review Committee reschedule the Review Committee meeting if an adequate number of content experts are not available for the meeting.

*Operational Effectiveness Assessment Plan.* The Commission reviewed the Operational Assessment Effectiveness Plan (OEAP), and determined that all Commission goals had been met in 2010. The Commission adopted an updated OEAP for 2011.

**Request to Accredit Educational Programs for New Dental Team Members:** The Commission reviewed the Report of the Workgroup on New Dental Team regarding requests from the Minnesota Board of Dentistry, the University of Minnesota, the Minnesota Dental Association, and the Metropolitan State University of the Minnesota and State Colleges and Universities System to accredit the Dental Therapy and Advanced Dental Therapy Educational programs in the state of Minnesota. In addition, the Commission reviewed the Report of the Workgroup on New Dental Team regarding a request from Dental Quality Assurance Commission of the State of Washington Department of Health to accredit Expanded Function Dental Auxiliary (EFDA) education programs. In response to these requests, the Commission adopted a new policy, "The Criteria and Principles for Determining Eligibility of Educational Programs for Accreditation." This policy outlines the criteria and principles for determining whether educational programs for proposed new members of the dental team are eligible for accreditation by CODA. At the August 2010 meeting, the Commission determined that the requests from Minnesota concerning the dental therapy and advanced dental therapy education programs did not include sufficient information and evidence to warrant establishing an accreditation program and standards at this time. In response to the request from the State of Washington, Department of Health, the Commission directed the Dental Assisting Review Committee to begin the process of reviewing and updating the Standards for Dental Assisting Educational Programs to provide for review of programs with an Expanded Function Dental Auxiliary (EFDA) component.

**Responses to Assignments From the House of Delegates:** As directed by Resolution 37H-2008, the Commission provided a progress report to the 2010 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 CODA Subcommittee met twice at the ADA Headquarters Building in 2010. At the first meeting on February 4, 2010, the CODA Subcommittee provided input to the Joint Workgroup on Commission Structure and Finances. In addition, implementation status of the ADA recommendations was reviewed. At its second meeting on August 5, 2010, the CODA Subcommittee made recommendations to the Commission on implementation of the following ADA Task Force on CODA recommendations: 1, 2, 3, 6, 10, 13, 17, 19 and 23. At its August 6, 2010, meeting, the Commission directed that the implementation strategies proposed by the CODA Subcommittee be adopted. The CODA Subcommittee met jointly with the ADA Monitoring Committee following the August 6, 2010, Commission meeting. To date, of the 34 ADA recommendations, 28 have been implemented or are in the process of being implemented. Several ADA recommendations require ongoing Commission review and evaluation. The majority of the remaining six ADA recommendations that have not been implemented require funding that is currently not available. The Commission acknowledged that there will be an ongoing need for guidance and communication with ADA and supported Resolution 78H-2010 to the ADA House of Delegates regarding the continuation of a small ADA Monitoring Committee.

In accord with Resolution 15H-1995 (*Trans.*1995:660), the Commission reviewed current ADA policies to determine whether any policies were redundant, irrelevant, or needing revision. Based on this review, the Commission recommended the ADA policy on Advanced Educational Programs in General Dentistry (*Trans.*1979:613) be rescinded, as the current policy is no longer relevant. The Commission recommended the following ADA policies be revised: Urging the Commission on Dental Accreditation to Communicate with Local Communities of Interest (*Trans.*2003:367) and Single Accreditation Program (*Trans.*1996:696). The 2010 ADA House of Delegates concurred with the Commission recommendations (65H-2010 and 67H-2010).

Two resolutions were adopted by the 2010 ADA House of Delegates that directly affected the Commission. The first, Resolution 75H-2010 (*Trans.*2010:577) on the structure of the Commission, reaffirmed that the Commission retain its current structure in conjunction with implementation of changes in functionality that have already been initiated through the ADA Task Force on CODA recommendations. The second, Resolution 77H-2010 on the Commission Funding Model, directed that the Commission and ADA adopt a funding model in which total expenses, direct and indirect, are shared equally by ADA and the Commission. The Commission is to make annual adjustments to its accreditation fees over the next six years to achieve this balance, decreasing ADA support from approximately 60% to 50% of total direct and indirect expenses.

**Enhanced New Commissioner Training:** In response to ADA Task Force on CODA recommendation #11, the Commission's Outcomes Assessment Committee recommended, and the Commission adopted, a six-month training period ("redshirt year") in 2012 for all new Commissioners whose appointments begin in 2013—this includes attendance at a Commission meeting, at the discipline-specific Review Committee meeting, and at an appropriate site visit. The Commission will include all expenses associated with six-month training in its annual budget. The sponsoring organizations with new Commissioner terms starting in 2013 will be asked to identify trainees for 2012 by June 1, 2011. Both the ADA Monitoring Committee and the 2010 ADA House of Delegates (Resolution 76H-2010) supported the concept of the "redshirt year."

**Revisions to the *Rules of the Commission*:** The 1973 ADA House of Delegates approved the establishment of the Commission on Dental Accreditation as the agency responsible for the profession's accreditation program with sufficient autonomy to develop and approve educational standards, policies and procedures affecting the accreditation program (*Trans.*1973:695). The Commission was granted operational independence as it relates to accreditation affairs. The *Constitution and Bylaws* of the American Dental Association provides for the Commission to develop rules for the conduct of its business, contingent on approval by the House of Delegates. Since the approval of the *Rules of the Commission on Dental Accreditation* by the House of Delegates in 1973, revisions were approved in 1982, 1987, 1997 and 2002.

As the Commission is the nationally recognized accrediting agency by the United States Department of Education (USDE) for the accreditation of predoctoral dental education programs, advanced dental education programs, and allied dental education programs, the Commission monitors changes in USDE policies and criteria for recognition with assistance from ADA government affairs staff on a regular basis; this ensures that the Commission remains in compliance with USDE policies and criteria. In October 2009, USDE published amended Rules and Regulations on institutional eligibility under the Higher Education Act of 1965, resulting from enactment of the Higher Education Reconciliation Act of 2005 (HERA) and the Higher Education Opportunity Act of 2008 (HEOA). (*Federal Register/Vol. 74, No. 206/Tuesday October 27, 2009/Rules and Regulations.*) In particular, changes in the Secretary's Recognition of Accrediting Agencies, Subpart B—The Criteria for Recognition, Section 602.25 Due Process required amendments in the Commission *Rules* in Article IV, Section 4 (Appeal Procedures).

At its August 6, 2010, meeting, the Commission adopted the proposed amendments to the *Rules*, including several editorial corrections. The following is a summary of the *Rules* revisions:

- Article 2, Section 2 (Composition of the Commission)—revised language on ADA appointments to reflect the language in the ADA *Bylaws*. This is an editorial change required as a result of the action of the ADA House of Delegates in 2008 to revise its *Bylaws*.
- Changed references from American Association of Dental Examiners (AADE) to American Association of Dental Boards (AADB). This is an editorial change to reflect the new name of this appointing organization.
- Article 4, Section 4 (Appeal Procedures)—Added language regarding the one-time presentation of new financial information during the appeals process and decision-making ability of the Appeal Board. This change is made to conform with new policies and criteria from the USDE, the Secretary's Recognition of Accrediting Agencies, Subpart B—The Criteria for Recognition, Section 602.25 Due Process.
- Article 5, Section 2 (Duties of the Officers)—Added vice-chair duties to provide for continuity in the volunteer leadership; changes do not conflict with ADA *Bylaws*.

The 2010 ADA House of Delegates approved the proposed *Rules* changes (Resolution 72H-2010).

**Meetings:** The Commission conducted meetings on August 5-6, 2010, and February 4, 2011, at ADA Headquarters. The Commission's discipline-specific review committees met prior to these meetings. Approximately 70% 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. Russell I. Webb, trustee, Thirteenth District, and Dr. Roger L. Kiesling, trustee, Eleventh District attended the August 2010 and February 2011 meetings, respectively. The next meeting of the Commission is August 4-5, 2011.

**Acknowledgments:** The Commission acknowledges with appreciation the many significant contributions made by those members who will complete their terms in 2011: Dr. Paul Casamassimo, Mr. Ryan Dulde, Dr. W. Stan Hardesty, Dr. Donald Joondeph, Dr. Mel Kantor, Dr. Karen Kershenstein, Dr. Laura Mueller-Joseph, Dr. Reuben N. Pelot, III, and Dr. Karen West. The Commission acknowledges the service of Dr. Charles Marinelli, who was unable to complete the full term and resigned this past year from the Commission. In addition, the Commission acknowledges the service of Ms. Anna Nelson, who passed away unexpectedly in January 2011.

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

# Council on Dental Benefit Programs

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**Smiley, Christopher J.**, Michigan, 2011, chair  
**Klemmedson, Daniel J.**, Arizona, 2011, vice chair  
**Coggin, C. Celeste**, Georgia, 2012  
**Enos, Jennifer**, Arizona, *ex officio*\*  
**Eversman, Philip J.**, Indiana, 2011  
**Futrell, Harry C.**, Florida, 2011  
**Harrell, Gavin G.**, North Carolina, 2014  
**Jurkovich, Mark W.**, Minnesota, 2014  
**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  
**Toy, Bruce G.**, California, 2013  
**Ura, Stephen C.**, New Hampshire, 2012  
**Vorrasi, Andrew G.**, New York, 2014  
**Wood, C. Rieger, III.**, Oklahoma, 2014  
**Dycus, Richard W.**, Tennessee, 2013\*\*  
**Preble, David M.**, director  
**Avalos, Rocio**, 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: 2011-2014, particularly with the following goals: Goal 1. Provide support to dentists so they may succeed and excel throughout their careers; Goal 2. Be the trusted resource for oral health information that will help people be good stewards of their own oral health; and, Goal 3. Improve public health outcomes through a strong collaborative profession, including effective collaboration across the spectrum of stakeholders outside of dentistry.

The Council annually reviews the strategic plan to assure that its activities and programs remain effective and relevant.

## Dental Codes Maintenance and Development:

*Code Revision Committee (CRC)/Code on Dental Procedures and Nomenclature (Code).* 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 review and revision cycle that leads to a new version of the *Code* effective on January 1, 2013, is underway. There are two CRC meetings in 2011 (February and August) and one in February 2012. The CRC's work for this review and revision cycle will be complete in May 2012. This activity supports the Council's development of technical content for the suite of *Code*-related salable products: *CDT*, *CDT Companion* and *Code Workshop*.

*CDT.* The eighth edition of the manual, titled *CDT 2011/2012*, incorporates changes to the *Code* that became effective January 1, 2011. This edition of the *CDT* manual includes additional technical content prepared by the Council on Dental Benefit Programs, which is in expanded sections containing questions & answers and the glossary.

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

\*\* Resigned as of April 9, 2011.

*CDT Companion.* The third edition of this publication contains updated and additional technical content prepared by the Council. There are updates to the section on coding scenarios that reflect changes to the Code effective January 1, 2011, as well as additional exercises adapted from the Code Workshop.

*Code Workshop—Presentation.* This revenue generating program, offered through the Center for Continuing Education and Lifelong Learning, has been further updated by inclusion of new coding exercises developed by the Council. To emphasize that this is an updated and enhanced program, the title has been changed to “Optimize Your Practice: Understanding the Code.” The workshop is a scheduled event on the 2011 ADA annual session agenda.

*Code Workshop—CE Online.* The Council has developed its second online educational program on procedure coding and claim submission. Titled “The Code: Changes Published in *CDT 2011/2012*,” this program’s target audience is dentists and practice staff who are not able to attend the full Code Workshop presentation. This program is posted by CELL as a revenue generating CE Online offering. The Council is proceeding with development of additional online continuing education programs.

*ADA Dental Claim Form.* The current version of this form is undergoing Council review. The Council has reactivated its Dental Claim Form Advisory Committee to solicit suggestions on changes from other dental communities of interest. The next version of the HIPAA standard electronic dental claim (837D) must be in use by January 1, 2012, and this version supports reporting ICD-9-CM and ICD-10-CM diagnosis codes. Guidance to the Council on form changes is provided by ADA policy, “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*).”

*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.

*ADA Glossary of Dental Terms—Revisions.* The Council maintains this glossary that is published in the printed *CDT* manual and electronically on ADA.org. Online publication enables the Council to provide immediate guidance to members and the dental community when it is necessary to add or revise definitions. These additions and revisions are incorporated into the *CDT* manual when a new version is printed every two years.

*Revisions.* As part of its ongoing review of *CDT* manual content, the Council identified three terms whose published definitions are unclear or incomplete. The revised definitions follow, with added text underlined and deleted text stricken through.

***abutment crown:*** Artificial crown ~~attached to a tooth, root or implant body~~ also serving for the retention or support of a dental prosthesis. ~~See crown; retainer (prosthodontic).~~

***artificial crown:*** Restoration covering or replacing the major part, or the whole of the clinical crown of a tooth, or implant.

***prosthodontic retainer:*** A part of a ~~fixed partial denture prosthesis~~ prosthesis that attaches a ~~pontic restoration~~ restoration to the abutment tooth, implant abutment, or implant.

The Council also reviewed the definition of onlay, included in the *CDT* manual glossary by permission of the American College of Prosthodontists. The revised definition follows, with deleted text stricken through.

***onlay:*** A dental restoration made outside the oral cavity that covers one or more cusp tips and adjoining occlusal surfaces ~~or the entire occlusal surface~~, but not the entire external surface. It is retained by luting cement.

These revised definitions have been posted to the online glossary at ADA.org and will be incorporated into the *CDT* manual glossary when the next version (“CDT-2013-2014”) is printed.

**Definition of Dental Assessment.** During the weeks leading to the February 2011 CRC meeting, there were a series of conversations concerning additions to the *Code* that would enable reporting dental screening and dental assessment procedures. These conversations involved the CRC’s representative from the Centers for Medicare and Medicaid Services (CMS) and the CRC’s ADA representatives. The ADA’s representatives are current and past members of the Council on Dental Benefit Programs’ Subcommittee on the Code, appointed by the ADA President.

On February 11, 2011, the CRC accepted *Code* changes developed by the ADA and CMS. The changes are additions of two new procedure codes for screening of a patient and for assessment of a patient that would be in a new “Pre-Diagnostic” subcategory within the “Diagnostic” section of the *Code*. CRC work on these two codes is continuing.

Details of the activity leading to the CRC’s acceptance of these requested additions are contained in a memorandum sent by the Council Chair to the ADA’s Officers and Members of the Board of Trustees dated February 14, 2011. This memorandum is attached as Appendix 1.

After the CRC accepted these additions Council volunteers engaged in continuing discussions on how to best define the terms “screening” and “assessment” so that the procedures’ scopes are clear and that the dentist’s role as team leader is not abridged. These discussions included feedback from other ADA agencies (e.g., CAPIR, CDP, CGA) and external dental organizations (e.g., AAPD, AGD).

Council research established that the term “screening” is defined in the Comprehensive Policy Statement on Allied Dental Personnel (*Trans.*1996:699; 1997:691; 1998:713; 2001:467; 2002:400; 2006:307; 2010:494):

**screening:** Identifying the presence of gross lesions of the hard or soft tissues of the oral cavity.

Therefore, the Council focused its attention on a developing a definition of “dental assessment.” This effort drew upon a variety of sources including state statute, the ADA Statement “Breaking Down Barriers to Oral Health for All Americans: The Role of Workforce,” suggestions from other CDBP subcommittees and from other ADA Councils—CAPIR, CDP, CGA and COC. The work led to development of the following definition.

**dental assessment:** A limited clinical observation of a patient with collection and recording of data for identification of oral disease or health.

This definition has been proposed to the CRC as the descriptor for the new procedure code for assessment of a patient. CRC action on this is expected during the Committee’s scheduled meeting in either August 2011 or February 2012.

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

**Direct Reimbursement (DR) Promotional Co-Op Program.** The DR promotional co-op program was 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 2010, 10 state dental societies participated in the program (AL, CA, FL, IN, IA, MN, OH, TX, VA and WI) and \$151,735 was spent by those dental societies to support local DR promotional efforts. The DR promotional co-op program was sunsetted as of December 31, 2010, and this was the best year ever in terms of dollar utilization. The funding structure of the program included 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 2010 annual session in Orlando for offering a direct reimbursement

dental program to their employees. The recognition included special exhibit hall signage, customized booth signage, special badge ribbons, acknowledgment in the official program guide, an *ADA News* article, recognition in “Shuttlevision” programs on annual session buses and hotel in-room messaging.

*National Dental Benefits Conference 2011.* The National Dental Benefits Conference 2011 is scheduled for August 5 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 dentists and their staff, constituent and component dental society staff and consultants. The registration fee has been increased to \$50 this year to help offset operating costs of the Conference and once again dentists will be eligible to receive continuing education credits for attendance at this meeting.

*Meetings With Dental Benefit Carriers.* In 2010, the DBIS Subcommittee met with representatives from: 1) Blue Cross Blue Shield Michigan, Dental Network of America (DNOA) and Regence; and 2) Aetna on Thursday, August 19 (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 quite productive. For these reasons, the Council approved the DBIS Subcommittee’s recommendation that these meetings with dental benefit carriers continue, facilitated by the Subcommittee and held immediately before the National Dental Benefits Conference. This year’s meeting is scheduled for August 4 with the carriers. Topics of concern are yet to be determined; and it was suggested that the Subcommittee consider inviting a dental consulting firm (these firms are typically retained by large employers with self-funded dental programs).

*Non-Orthodontic Procedures Subject to Orthodontic Lifetime Maximums.* The Council discussed a dental office’s concerns over a carrier’s adjudication of extractions necessary for orthodontic treatment. Basically, the carrier considered the extractions (D7140) as part of the orthodontic lifetime maximum and applied the allowance for these procedures to the orthodontic lifetime maximum and not the plan’s annual maximum. Thus, there were fewer dollars available in the orthodontic lifetime maximum for the patient and the claim was paid at a lower percentage (50% instead of 80%). The Council believes that third-party payers and administrators should not intentionally change a procedure code’s category of service in order to reduce available reimbursement amounts that are subject to benefit plan limitations and exclusions.

There is no current ADA policy that addresses this issue. The Council, therefore, recommends adoption of the following resolution. This resolution supports the ADA strategic plan goal to support member success.

**1. Resolved,** that claim adjudication and reimbursement be guided by a procedure code’s category of service as specified in the *Code on Dental Procedures and Nomenclature*.

*Definitions of Usual and Customary Fees.* The Council reviewed the ADA policy on Definitions of Usual and Customary Fees (*Trans.2010:545*) with a goal of amending the policy to be consistent with other policies that contain language referencing fees and maximum allowable/maximum plan benefits, and felt that the term “customary fee” should be replaced with the term “maximum plan benefit.” The Council believes the term “customary” is misleading, as a “customary fee” is arbitrarily determined by individual insurance companies using proprietary information and algorithms. The Council, therefore, recommends adoption of the following resolution. This resolution supports the ADA strategic plan goal to support member success.

**2. Resolved,** that the ADA policy, Definitions of Usual and Customary Fees (*Trans.2010:545*), be amended as follows (additions are shown by underscoring; deletions are shown by strikethroughs):



### Definitions of “Usual Fee” and “Maximum Plan Benefit Customary” Fees

**Resolved**, that the following definitions of “usual fee” and “maximum plan benefit 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.

~~*Maximum plan benefit 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.~~

*Statement on Determination of Customary Fees by Third Parties.* The Council reviewed the ADA policy on Statement on Determination of Customary Fees by Third Parties (Trans.1991:633; 2010:545), as amended by Resolution 1H-2010. Based on recent activities concerning terminology relating to “customary fees” the Council reviewed existing ADA policies that make reference to this term and recommends substituting the term “maximum plan benefit” for the term “customary fee.” The Council believes the term “customary” is misleading, as a “customary fee” is arbitrarily determined by individual insurance companies using proprietary information and algorithms. The Council, therefore, recommends adoption of the following resolution. This resolution supports the ADA Strategic Plan Goal to Support Member Success.

**3. Resolved**, that the Statement on Determination of Customary Fees by Third Parties (Trans.1991:633; 2010:545) be amended by deleting the word “customary” (except in the title of the Statement to facilitate search capabilities) and adding the words “Maximum Plan Benefit” (additions are shown by underscoring; 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 Maximum Plan Benefit (Customary) Fees by Third Parties

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 Maximum Plan Benefit Customary Fee Screens
- Require carriers to use sufficient data when determining Maximum Plan Benefit 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

*Limitations in Benefits by Dental Insurance Companies.* The Council reviewed the ADA policy on Limitations in Benefits by Dental Insurance Companies (*Trans.*1997:679). Using the term “maximum plan benefit” is consistent with recent changes to existing ADA policy and the Council recommends that this term replace “maximum plan allowance.” The Council, therefore, recommends adoption of the following resolution. This resolution supports the ADA Strategic Plan Goal to Support Member Success.

**4. Resolved**, that the policy, Limitations in Benefits by Dental Insurance Companies (*Trans.*1997:680), be amended in the first resolving clause by replacing the term “maximum plan allowance” with the term “maximum plan benefit” (additions are shown by underscoring; deletions are shown by strikethroughs):

**Resolved**, that since the term “usual, customary and reasonable” is often misunderstood by patients and tends to raise distrust of the dentist in the patient’s mind by suggesting the dentist’s fees are excessive, the American Dental Association urges all third-party payers employing this terminology to substitute the term “maximum plan benefit” ~~“maximum plan allowance”~~ in all patient communications and explanations of benefits, and be it further

*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; 2010:548), as amended by Resolution 2H-2010. Based on recent activities concerning terminology relating to “customary fees” the Council reviewed existing ADA policies that make reference to this term and recommends substituting the term “maximum plan benefit” for the term “customary fee.” The Council believes the term “customary” is misleading, as a “customary fee” is arbitrarily determined by individual insurance companies using proprietary information and algorithms. The Council, therefore, recommends adoption of the following resolution. This resolution supports the ADA Strategic Plan Goal to Support Member Success.

**5. Resolved**, that the Definitions of Fraudulent and Abusive Practices in Dental Benefit Plans and Claims (*Trans.*1998:701; 2001:428; 2010:548) be amended in the second paragraph under the definition of “Inappropriate Fee Discounting Practices” by deleting the word “customary” and inserting in its place the words “maximum plan benefit” (additions are shown by underscoring; 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, but are not limited to: 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 maximum plan benefit customary fees as established by the plan.

**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 17, 2011. The Subcommittee made recommendations to the Council for the April 2011 meeting on: Peer Review and Affiliate Membership, Orientation for Peer Review, Peer Review Survey, QA&I Resources on ADA.org, CE online courses and Dental Practice Parameters.

*Dental Practice Parameters.* It was requested that the Quality Assessment and Improvement Subcommittee review the Dental Practice Parameters for possible deletion as part of its new responsibility to monitor the parameters for accuracy and clinical relevance in response to Resolution 7H-2010 (*Trans.*2010:546); Resolution 7H-2010 directs the Council to monitor the parameters and recommend removal of any parameters that become too outdated to be useful. Each Committee member was assigned a set of parameters to review in such a way that each parameter is reviewed independently by two Subcommittee members. The Council decided that no parameters needed to be deleted at this time.

*Dental Quality Alliance (DQA).* The DQA is a multi-stakeholder group formed by the ADA in conjunction with the Centers for Medicare and Medicaid Services (CMS) to develop quality measures in dentistry. The DQA met on October 29, 2010, in Washington, D.C. The members of the DQA are: Academy of General Dentistry; Agency for Healthcare Research and Quality; American Academy of Oral and Maxillofacial Pathology; American Academy of Oral and Maxillofacial Radiology; American Academy of Pediatric Dentistry; American Academy of Periodontology; American Association of Endodontists; American Association of Oral and Maxillofacial Surgeons; American Association of Orthodontists; American Association of Public Health Dentistry; American College of Prosthodontists; American Dental Association's Board of Trustees; American Dental Education Association; American Dental Hygienists' Association; American Medical Association; America's Health Insurance Plans; Centers for Medicare and Medicaid Services; ADA Council on Access, Prevention and Interprofessional Relations; ADA Council on Dental Benefit Programs; ADA Council on Dental Practice; ADA Council on Government Affairs; Delta Dental Plans Association; Health Resources and Services Administration; Medicaid and SCHIP State Dental Directors Association; National Association of Dental Plans; and The Joint Commission.

The DQA charged its Executive Committee with selecting the final nominees to staff the DQA Advisory Committee on Research and Development of Performance Measures. All nominees' CVs/resumes were to be submitted via e-mail to the ADA's Office of Quality Assessment and Improvement. It was decided that the Executive Committee would hold a conference call to decide the five nominees to staff the Committee.

Also discussed at the DQA meeting was future funding for 2011 and 2012. It was noted that the ADA will help fund 2011 meetings. The members discussed grant applications and other sources of funding for 2012 and beyond, including implementing a dues structure for all participating member groups to help fund the DQA.

The Executive Committee held a conference call on December 2, 2010, to choose nominees to staff the DQA Advisory Committee on Research and Development of Performance Measures. The Executive Committee clarified the following key attributes to provide guidance in selecting members of the Advisory Committee:

- Experience with performance/quality measure development
- Experience working with demographic data
- Clinical experience with Medicaid programs
- Administrative experience
- Understanding of diverse application of measures
- Ability to work cooperatively in a small group

The following individuals were selected for membership on the Advisory Committee on Research and Development of Performance Measures:

1. Dr. James Crall, chair
2. Dr. Craig Amundson
3. Dr. Robert Compton
4. Ms. Christine Farrell
5. Dr. Jed Jacobson

The Executive Committee Liaison is Dr. Christopher Smiley.

The DQA Advisory Committee on Research and Development of Performance Measures held its initial conference call on Thursday, March 3, 2011. The purpose of the conference call was to review current oral health care parameters in pediatric dentistry, and discuss how the Committee will come up with a set of recommended measures for an accurate assessment of pediatric oral health care. It was decided that a face-to-face meeting should be scheduled before the June 28, 2011, DQA meeting takes place. Also, monthly conference calls were scheduled to keep the Committee on track in performing its tasks.

The Executive Committee held a second conference call on Thursday, March 17, 2011, to select members of the DQA Advisory Committee on Implementation, Maintenance & Outcomes and the DQA Advisory Committee on Education & Communication. The Executive Committee clarified the following key attributes to provide guidance in selecting members of the Advisory Committees.

#### Implementation:

- Identify and analyze current use of performance measures in dentistry
- Monitor and evaluate the appropriateness and effectiveness of the use of DQA performance measures
- Evaluate a process for ongoing updating of performance measures
- Identify desirable outcomes of performance measures/measurement
- Plan and implement outcomes assessment of performance measures/measurement

#### Education:

- Identify objectives for educating and communicating with the dental profession and other interested parties regarding performance measures and performance measurement
- Develop a plan and methods (articles, announcements, courses, workshops, presentations, etc.) for meeting objectives of education and communication
- Identify regular sites and forums (journals, newsletters, websites, meetings, etc.) for education and communication
- Review and produce educational information and communication regarding performance measures, performance measurement, and DQA organization and activities

Therefore, the following individuals were selected for membership on each Committee:

#### Implementation:

1. Dr. Jane Grover, chair
2. Dr. Susan Griffin

3. Dr. Jay Anderson
4. Dr. Robert Isman
5. Dr. Man Wai Ng

The Executive Committee liaison is Dr. Shawneequa Harris.

Education & Communication:

1. Dr. Janet Leigh, chair
2. Dr. Bill Kohn
3. Dr. David Schirmer
4. Dr. Marie Schweinebraten
5. Dr. Allen Moffitt

The Executive Committee liaison is Dr. Ron Hunt.

**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 4,469 contracts, 104 of those contracts in 2010, and 55 contracts in 2011 as of May 10, 2011.

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 Contract*
- *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, go to ADA.org (<http://www.ada.org/1308.aspx>).

## Response to Assignments From the 2010 House of Delegates:

*Amendment of the Statement on Determination of Usual, Customary and Reasonable Fees.* Resolution 1H-2010 (*Trans.*1991:633; 2010:545). A response to Resolution 1H-2010 is discussed under the DBIS section of this report.

*Amendment of the Definitions of Fraudulent and Abusive Practices in Dental Benefit Plans.* Resolution 2H-2010 (*Trans.*1998:701; 2001:428; 2010:548). A response to Resolution 2H-2010 is discussed under the DBIS section of this report.

*Amendment of the Standards for Dental Benefit Plans.* Resolution 3H-2010 (*Trans.*1988:478; 1989:547; 1993:696; 2000:458; 2001:428; 2008:453; 2010:546) amended ADA policy to reflect that the methodology used by plan administrators to set reimbursement schedules no longer makes reference to UCR. This revised policy will be added to the next edition of *Current Policies*.

*Amendment to the Policy, "American Dental Association Dental Health Program for Children."* Resolution 4H-2010 (*Trans.*1966:179, 306; 1967:336, 2010:552) amended ADA policy to reflect that reimbursement for professional services should be given on the doctor's "full fee" basis and not on the usual and customary basis. This revised policy will be added to the next edition of *Current Policies*.

*Statement on Dental Consultants.* Resolution 5H-2010 (*Trans.*2010:553) combined three prior ADA policies on dental consultants into one easier to understand policy on dental consultants. This revised policy will be added to the next edition of *Current Policies*.

*Legislation to Require Dental Benefit Plans to Provide Dental Consultant Information.* Resolution 6H-2010 (*Trans.*2010:546) became ADA policy to pursue federal legislation or regulation to require federally regulated dental benefit plans to provide dental consultant information in the explanation of benefits statement. In addition, the policy requested that constituent and component dental societies pursue state legislation or regulation to require the same. The Council on Government Affairs (CGA) will address this in a supplemental report to the 2011 House of Delegates.

*Dental Practice Parameters.* A response to Resolution 7H-2010 (*Trans.*2010:546) is discussed under the Office of Quality Assessment and Improvement section of this report.

*Amendment of the Definitions of Usual and Customary Fees.* A response to Resolution 8H-2010 (*Trans.*2010:545) is discussed under the Dental Benefit Information Service section of this report.

*Support of Current Medicaid Law and Regulations Regarding Dental Services.* In a follow-up to Resolution 97H-2010 (*Trans.*2010:603), the Council provided its expertise and guidance on this topic to CGA, which will address this in a supplemental report to the 2011 House of Delegates.

*Supporting Quality Related Performance Measures in Health Centers.* Resolution 120-2010 (*Trans.*2010:605) was referred to the appropriate agencies, which included the Council on Dental Benefit Programs as the lead agency. The resolution reads as follows:

**Resolved**, that the ADA advocate aggressively for HRSA to define and direct a RVU oral health performance measure aligned with grant performance reporting (UDS), and be it further

**Resolved**, that the ADA advocate aggressively for HRSA defined and directed DTPC rate oral health performance measure aligned with grant performance reporting (UDS).

The Council on Dental Benefit Programs, in consultation with CGA and CAPIR, has reviewed Resolution 120-2010 and recommends that it not be adopted.

The Council, taking into consideration the consultation with CGA and CAPIR, provides a suggested alternative in this report. The Council believes that relative value units (RVU) are not appropriate as a measure of quality, although they may have some value in tracking more accurately how a provider's time

is spent in clinical settings, as opposed to tracking encounters alone. Dental treatment plan completion (DTPC) rates may be useful in measuring quality, but the Council believes it would be more appropriate to vet this concept through the Dental Quality Alliance (DQA) than to aggressively advocate for the Health Resources and Services Administration (HRSA) to develop this concept on its own.

It is important that the stakeholder groups work within the DQA and especially that the ADA advocate for the DQA to be the mechanism for the development of quality measures for dentistry. CMS, HRSA and the Agency for Healthcare Research and Quality (AHRQ) are all participants in the DQA.

- *Background.* In November 1991, prior to the implementation of Medicare's new physician payment system, the American Medical Association (AMA) and the national medical specialty societies formed the AMA/Specialty Society RVS Update Committee, commonly referred to as the RUC. The cornerstone of this payment system is the resource-based relative value scale (RBRVS).

The RBRVS is a list of physician services ranked according to value. Each service on the RBRVS is divided into three components: physician work (52%), practice expense (44%), and professional liability insurance costs (4%). To determine the payment for a service, the relative value is multiplied by a monetary conversion factor. Also, payments are adjusted to reflect geographical differences in resource costs.

The RUC is composed of physician members from the major national medical specialties and AMA staff. The Advisory Committee is the major source of specialty society input into the updating process. In 1995, the ADA was appointed a seat on the Advisory Committee by the AMA. This Committee serves as a resource to the RUC by giving advice on work values and practice expense inputs relevant to the advisor's specialty. This appointment is advisory in nature and no voting privileges are attached to this appointment.

This Committee was charged with the responsibility for recommending physician work relative values to the Health Care Financing Administration (HCFA), which is now known as the Centers for Medicare and Medicaid Services (CMS), for new and revised codes in *Current Procedural Terminology (CPT)*.

The function of the RUC is to develop physician work relative values for procedure codes that are added or revised by the CPT Editorial Panel. In addition, two member dentists from AAOMS represent both AAOMS and the ADA on the RUC.

- *Relative Value Units and Dentistry.* Defining and directing a relative value unit oral health performance measure to be used by HRSA could prove to be a major problem for the profession of dentistry. The Council believes that a reimbursement system based on procedures, as outlined in the *Code on Dental Procedures and Nomenclature*, is more suitable than RVUs to be the authoritative determinant for recording and reimbursing dental care.

RVUs can be arbitrary in nature and are best suited as internal tools to improve efficiency and effectiveness within individual practice settings. Relative value units are most useful when viewed within the context of appropriate staffing and adequate number of operatories, as well as treatment planning that aims for completion of comprehensive primary oral health care services within a timely manner using quadrant dentistry routinely. Comparison of RVUs must take into account the experience and skill set of the providers. The Council's opinion is that RVUs are not suitable as the basis for determining reimbursement for dental services.

In addition, other reasons why an inappropriate usage of RVUs may be problematic include:

- 1) The use of the term "relative value unit" could precipitate a review of all the work of the resource-based relative value scale from Harvard and all the refinement of that work done over

the last 20 years by the American Medical Association's Relative Value Scale (RVS) Update Committee.

2) If RUC methodology enters into the dental field, the resulting impact on reimbursements could be catastrophic; for example, a 50% reduction in reimbursement for the second procedure done on the same patient on the same date of service could easily become the norm.<sup>1</sup> The application of an RVU system when providing care for the same patient at the same visit would take into account the impact of many fixed expenses that cannot be accounted for individually on a procedure by procedure basis. Although one can envision appropriate examples of when resources are used only once, even for multiple procedures, dental reimbursement has already been designed to take these into account. The following three examples would seem to indicate that reimbursement should be reduced for additional procedures performed using these same resources, but that would ignore the fact that dentistry isn't reimbursed for these things at all:

- One mandibular block injection for a quadrant of restorations would reduce the fees because each procedure did not need an individual injection.
- The room needs to be prepared for one patient only regardless of how many procedures are being done.
- Similarly, the room needs to be cleaned once regardless of the amount of procedures.

3) In a hospital setting, the hospital, not the provider, is reimbursed for all of the incidentals to a procedure. In dentistry these costs are considered to be factored into the fee for the procedure. Although there is a code for local anesthesia, dentists are not generally reimbursed for this, even though it is a separate procedure with distinct technique, armamentarium and consequences.

4) Using the term "relative value unit" as a performance measure would be using the term in a way which contradicts the use within the insurance industry, especially since many private medical payers currently base their fee schedules on the Medicare fee schedule and utilize RVUs in calculating fees.

5) Establishing RVUs to quantify dental provider productivity may catch the attention of CMS, which may then request surveyed data capturing the dentists' work, time, and practice expense associated with dental procedures in order to establish reimbursement for those dental procedures covered by Medicare and Medicaid. Currently, reimbursement for covered dental procedures is arbitrarily determined by individual carriers. If dental procedure codes are brought into the RBRVS, the codes would be "relatively valued" to other procedures experiencing the same dentist work, time and practice expense.

6) Dentistry would have to have tight control over the entire process (with the appropriate stakeholder input and participation) as opposed to any other governing bodies. That entails three issues: 1) the ADA has clear and unequivocal ownership of the codes (which it does); 2) dentistry would not allow anyone else to develop RVUs; and 3) there would be no other code sets, presumably owned by other entities, which could be substituted for this purpose.

*Additional Considerations.* According to the American Medical Association, although the establishment of the RBRVS has been a significant achievement for all of medicine, it has been very challenging and has demonstrated certain flaws. The greatest threat facing the AMA is the declining value of the conversion factor due to the sustainable growth rate (SGR) formula. Other Congressionally mandated payment policies that add to the detrimental effect on reimbursement include negative geographic adjustments, imaging cuts due to the Deficit Reduction Act, budget neutrality adjustments and changes in the calculation of practice expenses.

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<sup>1</sup> "Medicare Claims Processing Manual. Chapter 12—Physicians/Nonphysician Practitioners," pages 107–109.



Since 2003, the AMA has halted annual cuts of 4%–5% to the conversion factor. Through the AMA's advocacy efforts, physicians have instead received increases of 1.1%–1.5% to the conversion factor or freezes for the past six years. These efforts have been victories for medicine; however, averting the cuts has only been a temporary fix. Congress has not agreed to replace the flawed SGR. The 2009 Medicare Trustees report shows projected cumulative Medicare physician payment cuts of 38% by 2016 while practice costs will increase by 20% in the same time period. As of December 2009, Congress passed legislation to apply a zero percent update to the conversion factor through February 28, 2010. The AMA believes that short-term fixes to the annual conversion factor have exacerbated the problem. This belief was evident when in 2005, the Congressional Budget Office said that freezing physician payments would cost \$48.6 billion over the next 10 years; and in 2009, the CBO estimated the cost at \$210 billion, with the removal of physician administered drugs from the SGR formula. Therefore, to address this dire situation, the AMA supports a permanent repeal of the SGR from the Medicare payment formula as a key component of comprehensive reform to improve the health system for patients and physicians.

The AMA continues to advocate for changes in this payment update formula and opposes the use of spending targets in determining annual updates to Medicare payments for physicians' services. The AMA favors replacing the current payment update formula with a new system that appropriately reflects increases in practice costs, including changes in patient need for medical services, changes in technology and other relevant information and factors. Only through such changes will the payment update system adequately reflect the costs of practicing medicine so that Medicare patients' access to care is not undermined.<sup>2</sup>

The AMA's annual battle to halt or limit cuts to the conversion factor is something that organized dentistry needs to take under consideration during discussions on relative value units.

Also, even if the intent of the resolution is for limited development of RVUs for very restricted applications (i.e., just for a few grants in the public health sector), this effort could likely evolve into a RUC-like project over a period of time. Consideration should be given to the cost this will likely entail and who will have control over how the information will be used.

The bottom line is that an RVU system already exists, courtesy of HRSA Region II and the Indian Health Service. It is defined as appropriate, when utilized as part of an overall quality improvement program to determine efficiency, effectiveness, productivity and profitability. It is only one metric in an arsenal designed to improve the delivery of dental care in the most efficient manner possible.

*Recommendation.* Resolution 120-2010 seeks to develop performance measures for dental procedures in order to measure quality and value. CMS has developed a Physician Quality Reporting System (PQRS) designed to eventually reimburse based on quality and efficiency of care and not volume of services. This may be a better option for HRSA to consider the measurement of quality and value.

Insurance carriers such as Aetna, Humana, CIGNA and BCBS are testing similar programs. The American Dental Association supports HRSA's commitment to quality improvement; however, substituting the term "quality" in lieu of RVU may be a much safer choice of terminology to use and also follows industry trends. In addition, it is highly recommended that relative value units not be linked to reimbursement at all and the role of developing quality measures for dentistry be entrusted to the DQA.

**Meetings:** The Council met in the ADA Headquarters Building on April 22-24, 2010, November 4-6, 2010, and April 15-16, 2011. The Council is scheduled to meet again on November 17-19, 2011. Dr. Samuel B. Low, Seventeenth District trustee, serves as the Board of Trustees liaison to the Council and Mr. Stephen Boss serves as the ASDA liaison to the Council.

<sup>2</sup> "Medicare RBRVS: The Physician's Guide 2010," pages xv-xvi.

**Chair and Vice Chair:** Dr. James G. Richeson was nominated as chair of the Council for the 2011-2012 term at the April 2011 meeting. Dr. Stephen C. Ura was elected vice chair of the Council for the 2011-2012 term at the April 2011 meeting.

**Personnel:** The close of the 2011 annual session brings to an end the terms of four valued members of the Council: Dr. Philip J. Eversman, Dr. Harry C. Futrell, Dr. Daniel J. Klemmedson and Dr. Christopher J. Smiley. 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 claim adjudication and reimbursement be guided by a procedure code's category of service as specified in the *Code on Dental Procedures and Nomenclature*.

**2. Resolved,** that the ADA policy Definitions of Usual and Customary Fees (*Trans.*2010:545) be amended as follows (additions are shown by underscoring; deletions are shown by strikethroughs):

### Definitions of "Usual Fee" and "Maximum Plan Benefit Customary" Fees

**Resolved,** that the following definitions of "usual fee" and "maximum plan benefit 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.

*Maximum plan benefit 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.

**3. Resolved,** that the Statement on Determination of Customary Fees by Third Parties (*Trans.* 1991:633; 2010:545) be amended by deleting the word "customary" (except in the title of the Statement to facilitate search capabilities) and adding the words "Maximum Plan Benefit" (additions are shown by underscoring; 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 Maximum Plan Benefit (Customary) Fees by Third Parties

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 Maximum Plan Benefit ~~Customary Fee Screens~~
- Require carriers to use sufficient data when determining Maximum Plan Benefit ~~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

**4. Resolved**, that the policy, Limitations in Benefits by Dental Insurance Companies (*Trans.*1997:680), be amended in the first resolving clause by replacing the term “maximum plan allowance” with the term “maximum plan benefit” (additions are shown by underscoring; deletions are shown by strikethroughs):

**Resolved**, that since the term “usual, customary and reasonable” is often misunderstood by patients and tends to raise distrust of the dentist in the patient’s mind by suggesting the dentist’s fees are excessive, the American Dental Association urges all third-party payers employing this terminology to substitute the term “maximum plan benefit” ~~“maximum plan allowance”~~ in all patient communications and explanations of benefits, and be it further

**5. Resolved**, that the Definitions of Fraudulent and Abusive Practices in Dental Benefit Plans and Claims (*Trans.*1998:701; 2001:428; 2010:548) be amended in the second paragraph under the definition of “Inappropriate Fee Discounting Practices” by deleting the word “customary” and inserting in its place the words “maximum plan benefit” (additions are shown by underscoring; 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, but are not limited to: 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 maximum plan benefit ~~customary~~ fees as established by the plan.

**Appendix 1**

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Date: February 14, 2011  
 To: ADA Officers and Members, Board of Trustees  
 From: Christopher J. Smiley, D.D.S., Chair, Council on Dental Benefit Programs



Subject: Codes for Screening and Assessment

The February Code Revision Committee (CRC) ended this Saturday and during that meeting, codes for “assessment” and “screening” were passed, with the full support of the ADA CRC members. Because this was a contentious issue, not only with the third-party payers, but also to some extent with some segments of the dental profession, we thought it would be beneficial for you to have a complete understanding of the issue in case you receive inquiries.

**BACKGROUND**

At its meeting on April 22-24, 2010, the CDBP discussed a request by Dr. Conan Davis, Chief Dental Officer, Centers for Medicare and Medicaid Services (CMS), to work with them to address a “gap in the code” that is creating hardship for Medicaid programs. CMS has expressed a need for a dental code for “initial oral assessments” and that Medicaid currently has “*mechanisms through federal regulation to reimburse for many oral health services provided by dental hygienists and other mid-level providers, however, (they) are not able to bill for initial oral assessment even where their license allows.*” (Attached is a list compiled by ADA-DSGA indicating the states that allow dental hygienists to directly bill for Medicaid services). In discussing this gap in the code, the CMS further noted that such a code is needed to allow for billing on the standard HIPAA claim transaction for dental services (837D) and they raised further concerns they have about the responsiveness of the ADA-CDT to rapidly emerging treatment and technology needs in the field.

Although CMS indicated that they would attempt to resolve their billing issue in the short term by creating a HCPCS code for these services to allow billing on the 837-P, recognizing that this is not the preferred approach. They also noted that this was a concern for the Office of eHealth Standards and Services (OEHS) within CMS. It was the opinion of the Council that these issues must be taken very seriously as they could have substantial impact going forward.

The ADA CDBP/Subcommittee on the Code became concerned that failure to adopt codes directed to the CMS concerns would hold up under appeal. As noted in past reports to the BOT and covered through articles in *ADA News*. In May of 2010 the ADA exercised its right, for the first time ever, to appeal codes defeated in the code revision process. The ADA had great success in having the appealed codes adopted. Central to our prevailing argument was that the Code must be for both “recording” and “reporting.” It was agreed that if a provider is delivering a legally acceptable service, they must have a code that allows recording and reporting of that service. That being the case, members of the Subcommittee on the Code believe that the CMS requested codes would have a significant chance of succeeding on appeal, and our working to defeat them could impact the ADA’s relationship with CMS and our credibility in future appeal processes.

## CODE SUBMISSION

The Subcommittee on the Code began working informally with CMS in May of 2010 to develop code language that addressed their needs and is consistent with the mandate to provide codes for legally provided services. It was equally important to the ADA CRC members that the codes protect the position that the dentist is the only provider who can appropriately perform a complete diagnosis. Words such as “evaluation” and “examination” were specifically negotiated out of the code language and agreement with CMS was reached this past Thursday (February 10, 2011). The compromise included two codes that were to be housed in the Diagnostic section of the Code on Dental Procedures and Nomenclature under a new subcategory entitled “Pre-Diagnostic Procedures.”

The first submission was:

**assessment of a patient by a licensed health care professional  
(no descriptor)**

The second submission was:

**screening of a patient by a legally authorized health care professional**

With the descriptor:

**A screening, including state or federally mandated screenings, to determine an individual's need to be seen by a dentist for diagnosis.**

The National Association of Dental Plans and the payer community also introduced two code submissions to address the needs outlined by CMS in their April 16, 2010 letter.

Their first submission was:

**limited evaluation by a mid-level provider**  
(no descriptor)

Their second submission was:

**screening by a mid-level provider, hygienist, physician, physician's assistant,  
nurse or other authorized personnel**

With the descriptor:

**A state or federally mandated screening to determine whether a child needs to be seen  
by a dentist for immediate care.**

The ADA and NADP had two proposals each for assessment and screening. The CRC representatives believed the ADA proposals were much better than the NADP's and therefore worked to pass the ADA submissions as amended (DIA-003 and DIA-004) rather than the NADP submissions (DIA-006, DIA-007), particularly in light of the desires of CMS to move their agenda forward at this meeting and the risks associated with an “appeal” on these submissions. It is important to note that the CRC is governed by a specific set of rules that call for decisions to be made by an equal number of ADA and non-ADA members, who are charged with maintenance of the Code. The six non ADA members are composed of representatives from the private payer community, CMS and a representative from the benefit purchaser community. Although the Code is the intellectual property of the ADA, its maintenance is subject to this process and ADA representatives to the CRC are guided by the Association through the CDBP, the Board of Trustees and the House of Delegates, but they must act in good faith as stewards of the Code.

## **ACTIONS OF THE CRC**

The CRC adopted the negotiated codes and the new subcategory on Friday February 11, 2011. Following adoption of the first submission, the payers made a motion to table the second, create a third submission and create a workgroup to create code language to define these terms (assessment and screening).

The ADA's representatives supported the motion to create a workgroup so that potentially better nomenclature could come forward, however, the CRC did defeat the motion to table consideration of the second code. That code was subsequently adopted and the third submission by NADP was defeated.

ADA representatives supported adoption of both the assessment and screening codes rather than tabling because it preserves the best language they could achieve by having them adopted, but if a better submission comes forward in batch 2 or 3, it can replace these codes. It should also be noted that the term "screening" is currently defined in ADA policy as "identifying the presence of gross lesions of the hard or soft tissues of the oral cavity" and "assessment" is currently undefined. The ADA CRC representatives believe that it would be appropriate for CDBP, in conjunction with the appropriate ADA agencies, to define assessment.

## **CDP VOICES CONCERNS**

The Subcommittee on the Code recognized early on that definition of the terms "assessment" and "screening" would be crucial. It is the intent of the CDBP to house these definitions within the ADA-CDT's Glossary, where it retains complete editorial control. The CDBP is concerned that if the definitions were to be included within the adopted codes, they would be developed by the CRC and the ADA would have to share editorial control of the definitions with the payer community and CMS. It is also important to realize that state practice acts may define these terms as they see fit, regardless of definitions that are developed by organized dentistry.

CDBP intends to involve CDP, CGA, CAPIR and Communications for input as these definitions are developed. Once approved, they can be included in the on-line Glossary immediately, rather than waiting for the publishing of the new codes in 2013. On Tuesday, February 8, 2011, CDBP staff and CDP staff discussed the codes under consideration by the CRC and the intent of the CDBP to involve CDP in defining terms once the codes were approved. CDP then elected to publish the proposed codes on its SiteScape for discussion and input prior to the CRC meeting.

On Thursday evening, February 10, 2011, the ADA CRC representatives and CDP held a conference call to discuss concerns they had with these codes. Although the ADA CRC representatives believe there is no conflict between the presence of these codes in the Code on Dental Procedures and Nomenclature and ADA policy, their intent in involving CDP was to try to diffuse any misunderstanding about the role of the Code as the sole means of reporting dental procedures, and to clarify that the Code is not a means to promote any given opinion about what ADA policy should be on contentious workforce issues. The discussion provided the following explanations:

1. The ADA CRC representatives took into consideration many of the concerns expressed by individual CDP members. They believe they have arrived at language that supports Association policy and is acceptable to CMS while allowing us to circumvent more aggressive language introduced by third-party payers. If the ADA CRC representatives

had withdrawn their submissions, NADP's submissions would have remained for consideration and they would potentially remain in play during an appeal.

2. The ADA CRC representatives thought long and hard about the language of these codes, and believe they have performed a valuable service to dentistry by obtaining passage of these codes, particularly the passage of a subcategory of "Pre-diagnostic Procedures," under which these codes are listed. Although there will be the opportunity to submit an alternative code or modify these in batch 2 and 3, it will be difficult for those with agendas contrary to the ADA to replace what has already passed with language that the ADA does not support.
3. We retain editorial control to define screening and assessment in the Glossary and this can be posted immediately "on line" prior to the code release date in 2013.
4. This compromise language supports what the ADA is advancing with the CDHC initiative, that through billing of Medicaid for their services, that program would be self sustaining. To record and report, these services need a code to fulfill that objective.
5. This language preserves the role of the dentist as the head of the dental team. Screenings will identify issues for referral to a dentist and both codes can be used by a dentist and other licensed professionals as defined in each individual state in their practice act.
6. The federal government has identified the Code as a HIPAA standard and this designation is of great value as it mandates use of the Code in electronic dental claims. The ADA must not risk the HIPAA Standard designation of the Code through failure to act in good faith in its maintenance. It would be irresponsible to jeopardize our intellectual property and a primary source of "non-dues revenue" by not acting as good stewards of the Code.
7. State and federal laws supersede association policy. Non-dentist providers are providing services in specific jurisdictions of our nation. Also, some states have laws that allow hygiene screening or assessment. A code is a necessity to allow for reporting and recording of procedures delivered.

## **THE AGD VOICES CONCERNS**

At the morning meeting between the Specialty Organizations and the ADA CRC representatives on Thursday February 10, 2011, representatives from AGD voiced their displeasure with the codes under consideration. A chief complaint was that the new codes were to be housed in the Diagnostic section of the ADA-CDT and that diagnosis must remain the purview of the dentist.

It was explained that these services will be designated into a subcategory of "pre-diagnostic procedures" within the diagnostic section. As such these codes are recognized to be "information gathering" much like other codes in the diagnostic section such as radiographs and saliva collection. By designation under this subcategory, this does not surrender the role of the dentist as the complete diagnostician through development of these codes.

Later that afternoon, at a conference call with AGD leaders and the Chair of CDBP; Chair of the Subcommittee of the Code and the Chair of the CRC, many of the same issues discussed on the CDP conference call were reviewed.

On Friday February 11, following adoption of the compromise codes by the CRC, an AGD observer came to the microphone and expressed concerns that the codes do not define “assessment” and “screening” and that these codes compromise the dentist’s duty to diagnose. He lamented that we did not take the opportunity to table the discussion, when offered, to develop a better submission to address these concerns.

ADA representatives to the CRC would like to note that when the motion by a Delta Dental member of the CRC to table these revised submissions was made, only the “screening” code remained under consideration. The assessment code had been passed at that point. The screening code is the most complete and it addresses the concerns being voiced in that it calls for determination of “an individual’s need to be seen by a dentist for diagnosis.”

It is agreed that these terms must be properly defined; however, as previously stated the ADA currently has defined “screening.” Also, such definition should not be included in the code itself, but in the CDT’s Glossary. The CDBP/ADA has complete editorial control of the content in the Glossary and thus would retain control of how these terms are defined.

## **SUMMARY**

The ADA representatives to the CRC found themselves in a difficult position. CMS had identified a gap in the code that would require the creation of codes for “assessment” and “screening” that may be used by providers other than dentists.

It is evident that these services are currently legally provided by direct billing hygienists and other non-dentist providers in specified jurisdictions of our nation.

This past May, the ADA won an important appeal based on the position that if a service is legally provided, a code must exist for its recording and reporting. This can be seen as the responsibility of the Code as the sole HIPAA approved standard for reporting electronic dental claims.

ADA representatives to the CRC act in good faith and not out of self interest. Moreover, the CRC is composed of an equal number of non-ADA representatives and if we failed to act, they would have potentially adopted a less favorable option or won one on appeal.

By the CRC’s adoption of these codes, the ADA’s representatives to that body succeeded in adopting sound language, addressed the needs of the public, maintained a consistent argument for the purpose of the Code and protected the interests of the Association and our profession.

CJS:DMP:abh

cc: CDBP members

Dr. Kathleen O’Loughlin

Dr. Joseph McManus

Dr. Dave Preble



# Council on Dental Education and Licensure

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**Kennedy, Brian T.**, New York, 2011, chair, American Dental Association  
**Kinney, George J., Jr.**, Minnesota, 2012, vice chair, American Association of Dental Boards  
**Antoon, James W.**, Florida, 2012, American Dental Association  
**Dolan, Teresa**, Florida, 2014, American Dental Education Association  
**Edwards, Michael D.**, Alabama, 2013, American Dental 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  
**Lloyd, Patrick M.**, Minnesota, 2012, American Dental Education Association  
**Meyerowitz, Cyril**, New York, 2011, American Dental Education Association  
**Miller, Jade A.**, Nevada, 2014, American Association of Dental Boards  
**Perkins, David**, Connecticut, 2011, American Association of Dental Boards  
**Robinson, William F.**, Florida, 2013, American Association of Dental Boards  
**Schmidt, James L.**, Maine, 2011, American Dental Association  
**Stenberg, Donna J.**, Minnesota, 2014, American Dental Association  
**Vakil, Shamik S.**, North Carolina, *ex officio*\*  
**Venezie, Ronald D.**, North Carolina, 2014, 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 18-19, 2010, and April 28-29, 2011. Dr. Charles H. Norman, III, Sixteenth 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 Measurement and Testing
- Committee on Recognition of Specialties and Interest Areas in General Dentistry
- Committee on Anesthesiology
- The ADA/ADEA/CODA Liaison Committee

**Strategic Planning and Operational Effectiveness:** The Council continued to develop and implement action plans and strategies which complement the ADA Strategic Plan: 2011-2014 and are relevant to its mission and duties. The Council's strategic priorities for 2010-2011 included the Student Ambassador Program, the CERP Program, Periodic Review of Dental Specialty Education and Practice, Emergency Airway Management Course, the Academic Dentistry Workshop, monitoring licensure activities/initiatives and the Golden Apple Award for Inspiring Careers in Dental Education.

In November 2010, the Council's Mega Issue Discussion focused on existing and emerging models of dental education. In April 2011, the Council devoted considerable time to discussing Resolution 87-2010, Resolution 112-2010, the 2011 Periodic Review of Dental Specialty Education and Practice, and the proposed 2012 budget. The Council also had a strategic discussion on communication technology and its implications for dental education and associations.

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

**Collaborating With Councils, Agencies and Associations:** Members of the Council served on a number of interagency committees and subcommittees in 2010-2011, including the Council on Dental Benefit Program's Subcommittee on Quality Assessment and Improvement, Advisory Committee on Evidence-Based Dentistry, SNODENT Editorial Panel, Practice Management Initiative Advisory Group, Workgroup on Resolution 42H-2010 (RFP for portfolio style exam), Caries Classification System Stakeholder Workgroup and the AAOS-ADA Antibiotic Prophylaxis for Patients With Permanent Orthopedic Implants Workgroup. Also, a member of the Council served as a liaison to the CSA Expert Panel on Topical Fluoride Caries Preventive Agents.

CDEL and the American Dental Education Association (ADEA) co-sponsored the American Association of Dental Boards' (AADB) April 2011 Mid-Year Meeting.

During the ADA 2010 annual session, CDEL and ADEA co-sponsored workshops for practitioners interested in becoming dental faculty and members interested in mentoring dental students.

### **Dental Education and Accreditation**

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**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 2011 meeting, the Council chose Dr. William C. Forbes as the recipient of the 2011 Golden Apple Award, Inspiring Careers in Dental Education. The prestigious Golden Apple Trophy has been presented to Dr. Forbes along with funding to attend ADA's 2011 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 reports and proposed changes to Commission on Dental Accreditation standards.

*Review of CODA's Informational Report on Frequency of Citing of Accreditation Standards for Dental Education Programs.* The Council reviewed this report which contains information regarding areas of non-compliance with Accreditation Standards cited during site visits conducted by CODA between January 2007 and October 2009. The Council noted that during this time, CODA visited 27 dental education programs and assessed their compliance with 86 areas in the Standards. Of the 86 areas requiring compliance, each of the following was cited three times: Standard 2-25m, measurement of student competency in malocclusion and space; Standard 3-1, number and distribution of faculty and staff; and Standard 5-1b, review of patient records to assess patient care. Standard 6, Research Program, was the only standard whereby all programs have been in compliance. This Standard's lack of citations raised questions among the Council members regarding the rigor of the standard. However, they were pleased to learn that the requirements for the conduct of a research program have been strengthened in the newly revised Accreditation Standards for Dental Education Programs.

*Ethics and Professionalism.* The Council members fully supported the addition of the Proposed Ethics and Professionalism Standard to the curriculum section for all programs under CODA's purview.

*Proposed Revision to Statement of Intent to Standards 2-4 of the Accreditation Standards for Advanced Specialty Education Programs in Endodontics.* The Council reviewed the Commission's rationale for changing the intent statement to clarify who qualifies as attending faculty. The revised intent statement identifies attending faculty as an "educationally qualified" endodontist or an "endodontist with equivalent experience, as determined by the program director and institution." This interpretation of attending faculty includes faculty members who would fall under the American Board of Endodontics' category, Educationally Qualified. It would also include internationally trained endodontists who would be

eligible for teaching/supervising endodontic residents, based upon equivalent experience as determined by the program director and the institution. The Council supported the revision.

*Proposed New Standard to the Accreditation Standards for Advanced Specialty Education Programs in Orthodontics and Dentofacial Orthopedics.* The Council agreed that the orthodontic accreditation standards should include language that addresses preparation for and monitoring of board certification as do five other dental specialty standards' documents (Endodontics, Oral and Maxillofacial Surgery, Pediatric Dentistry, Periodontics and Prosthodontics). The Commission maintains that these changes would not drive the curriculum by requiring orthodontic programs to teach to the precepts of the American Board of Orthodontics or to be accountable for having their students/residents take/pass the Board examination as a program outcomes assessment measurement. The Council supported the revision.

*Proposed Additions/Revisions to the Accreditation Standards for Advanced Education Programs in General Practice Residency, General Dentistry, Dental Anesthesiology, Oral Medicine and Orofacial Pain.* The Council noted that the proposed changes will standardize the qualifications to be eligible to enter one of the programs. The Council supported the changes.

*Proposed Revisions to Accreditation Standards for Advanced General Dentistry Education Programs in Dental Anesthesiology.* The Council members noted that the changes to Standard 3-2, Faculty and Staff, regarding the educational and training requirements of dental anesthesiology program directors were editorial in nature and did not represent a change in the intent of the standard. The Council agreed that qualifications were appropriate for a program director.

*Proposed Revisions to Standard 5, Advanced Education Students/Residents Evaluation.* The Council members noted that the proposed revisions to Standard 5 will be applied to all Advanced Dental Education Programs. The terminology and processes for evaluation and advancement have been changed to reflect the educational protocols and practices related competency-based education. Specifically, student/resident assessment must be ongoing, use multiple methods of evaluation and assess both the process and end-product.

*Proposed Revisions to the Accreditation Standards for Dental Hygiene.* The Council noted the majority of the proposed changes were found in Standard 2—Educational Program. The standard on Ethics and Professionalism was separated into two standards, one addressing ethics and the other addressing legal and regulatory concepts. Other changes clarified intent statements and others expanded examples of evidence in several standards. The Council also reviewed the proposed revision to the Initial Accreditation Application for Dental Hygiene Program which encourages sponsoring institutions to "include within their application for accreditation documentation demonstrating the conduct of a formal needs assessment." The Council supported these proposed changes.

*Proposed Revisions to the Accreditation Standards for Clinical Fellowship Training Programs in Oral and Maxillofacial Surgery.* Many of the proposed revisions to the Clinical Fellowship Standards are editorial in nature. The term "cases" will be replaced with "procedures." Several of the fellowship categories are to be renamed to more accurately reflect the nature of the fellowship. Maxillofacial Trauma, listed as a category of fellowship since 2000, has had no programs apply for accreditation and therefore is being removed as a category. The Council had no concerns with these proposed changes.

*Proposed Revisions to the Accreditation Standards for Advanced Specialty Education Programs in Oral and Maxillofacial Surgery.* The Council noted that throughout the document, the term "student/resident" has been changed to "resident." Standard 1-1 Ethics and Professionalism was added under Standard 1—Institutional Commitment/Program Effectiveness. The Council noted the addition of two new requirements for demonstrating program effectiveness, e.g., graduates' success in obtaining board certification by the American Board of Oral and Maxillofacial Surgery (ABOMS) and participation in the Oral and Maxillofacial Surgery In-Training Examination (OMSITE). OMSITE is an examination offered by ABOMS for OMS residents. It is an examination of knowledge, not a self-assessment or a study tool. Data from the OMSITE can be used to document resident progress, remediate residents, identify areas of strengths and weaknesses, and assess program performance.

The Council also noted the number of required anesthesia procedures increased from 100 to 300 and the number of required major surgical procedures increased from 75 to 175. The increases in anesthesia administrations have been proposed to more accurately reflect the educational experience of the residency programs and to demonstrate that anesthesia training is an intense component of the educational programs. Because many cases include more than one procedure, the experience of the resident is more accurately reflected in a count of procedures rather than patients.

The Council supported all of the proposed changes with the exception of Standard 1.3, Participation in the OMSITE. The Council sought additional information from CODA questioning whether it is appropriate to mandate in the standards residents' participation in the OMSITE as a measure of student achievement.

*Proposed Revision to the Accreditation Standards for Advanced Specialty Education Programs in Pediatric Dentistry.* The Council noted that revisions to the Accreditation Standards for Advanced Specialty Education Programs in Pediatric Dentistry are extensive, but the changes are not substantive. The majority of the changes appear in Standard 4—Curriculum and Program Duration. The changes are a result of the replacement of the Relative Value Units (RVU) rating system with a competency-based approach/system. This change eliminates the option of substituting “comparative experiences” to “required experiences,” strengthening the educational experiences by ensuring residents achieve competency in all procedures outlined in the standards. The Council also noted that most of the additions to the Standards found on pages 8-13 are current CODA policies. The Council supported the changes.

**Response to Resolution 87-2010—Study of Impact on Existing and Emerging Models of Dental Education:** The ADA 2010 House of Delegates referred Resolution 87 to the Council on Dental Education and Licensure for study.

**87. Resolved,** that the ADA Council on Dental Education and Licensure study the short and long term impact (positive and negative) of existing and emerging models of dental education in resolving the challenge of preservation of the profession as a learned profession while meeting the changing needs of oral health for diverse patient groups in a time of economic challenge, and be it further

**Resolved,** that relevant stakeholders be invited to participate in the discussion at their expense or the sponsoring organization's expense and that recommendations include collaborative new strategies for working together as a profession to resolve these important issues through partnerships, and be it further

**Resolved,** that the Council on Dental Education and Licensure report its findings to the 2011 ADA House of Delegates.

The Council chair appointed Council members with wide-ranging backgrounds and expertise to an ad hoc committee to address this resolution. Committee members included Dr. Cyril Meyerowitz, chair, Dr. Teresa Dolan, Dr. Michael Edwards, Mr. Corwyn Hopke, Dr. Tariq Javed, Dr. David Perkins and Dr. William Robinson. The Ad Hoc Committee met by telephone conference on February 21 and March 22, 2011. Noting that Resolution 87 was submitted by the Sixth and Seventh Trustee Districts, the chair invited comment from Dr. W. Ken Rich, Sixth District trustee and Dr. Charles L. Steffel, Seventh District trustee.

In April 2011, the Council reviewed the ad hoc committee's report, including an extensive list of references about dental education matters and noted that the ADA's Health Policy Research Center and Survey Center publish annually numerous reports on dental education programs; these reports are posted in the “members only” section of the ADA website at <http://www.ada.org/1443.aspx>. Some of the most relevant data reviewed by the Council is highlighted in Appendix 1. Based on discussions, meetings and background materials, the Council carefully studied the issues and reports the following to the House of Delegates.

**National Meetings Discussing New Dental Schools:** In addition to the House of Delegates' interest in this topic, the Council identified that the subject of new dental schools and emerging models of dental education was discussed at numerous national dental meetings in 2010 and 2011:

November 2010, American Dental Education Association (ADEA) Council of Deans Meeting:  
Changing Relationships, Implications of Interprofessional Education

November 2010, ADA Council on Dental Education and Licensure Mega Issue Discussion:  
Existing and Emerging Dental Education Models

- Dr. Eugene Anderson, associate executive director and director, Center for Educational Policy and Research, ADEA
- Dr. Lex MacNeil, dean, College of Dental Medicine, Northwestern University, IL
- Dr. Phillip Marucha, associate dean of research and director of graduate studies, College of Dentistry, University of Illinois at Chicago

January 2011, ADA President-elects' Conference:  
Dental Education/New Models for Dental Schools

- Dr. Laura Neumann, senior vice president, Education and Professional Affairs
- Dr. Anthony Ziebert, director, Commission on Dental Accreditation
  - Change and innovation in dental schools (existing)
  - New dental schools
  - New accreditation standards for dental schools/predoctoral education
  - Impact of above on organized dentistry

March 2011, ADEA Annual Session:

- Presidential Symposium—The Profession Should/Should Not Encourage the Establishment of New Dental Schools
- Joint American Association of Dental Research (AADR)/ADEA Symposium—Will Dental Institutions Lead Dental and Craniofacial Research in the Future?

April 2011, American Association of Dental Boards (AADB) Mid-Year Meeting:  
New Dental Schools and Their Impact on the Future of the Profession

- The Expanding and Shrinking American University: Understanding Why Colleges Open and Close Major Programs—Dr. Bryan Cook, DC, associate director, Center for Policy Analysis, American Council on Education
- Update on New Dental Schools—Dr. Eugene Anderson, associate executive director and director, Center for Educational Policy and Research, American Dental Education Association
- The Northwestern University Model—Dr. Lex MacNeil, IL, dean, Northwestern University
- The Standards That All Dental Education Programs Must Meet—Dr. Anthony Ziebert, director, Commission on Dental Accreditation

April 2011, ADA Board of Trustees:  
Mega Issue Discussion

- Dr. Jack Dillenberg, dean, Arizona School of Dentistry and Oral Health, A.T. Still University
- Dr. Ira Lamster, dean, School of Dental and Oral Surgery, Columbia University, NY

**Closed, Current and New Dental Schools:** As of February 2011, 61 dental education programs (DDS/DMD programs) were accredited by the Commission on Dental Accreditation. These programs, located in 35 states and Puerto Rico, are all sponsored by regionally accredited higher education institutions. The programs are posted on ADA.org at <http://www.ada.org/267.aspx>. Thirty-eight of the programs are sponsored by public universities, 19 by private not-for-profit universities and four by private/state-related universities. None are sponsored by a for-profit institution. The definitions below describe types of higher education institutions.



Seven dental schools were closed by their sponsoring institutions between 1985 and 1996 (Table 1). The reason commonly cited was that the costly dental programs did not align with the overall mission of the sponsoring universities. All seven were housed in private universities. Also during the 1980s there was a perceived diminished need for dentists nationwide.

**Table 1. Dental School Closings**

		Year	Graduates	Total Enroll	US Pop
	Location	Closed		Last Full Yr	
Oral Roberts University Private - Not for Profit	Tulsa, OK	1986	20	84 (1984)	240,133,000
Emory University Private - Not for Profit	Atlanta, GA	1987	90	341 (1984)	242,289,000
Georgetown University Private - Not for Profit	Washington, DC	1990	140	587 (1985)	249,470,539
Fairleigh Dickinson University Private - Not for Profit	Rutherford, NJ	1990	90	294 (1988)	249,470,539
Washington University Private - Not for Profit	St. Louis, MO	1991	60	260 (1985)	252,208,537
Loyola University Private - Not for Profit	Maywood, IL	1992	110	331 (1989)	255,104,027
Northwestern University Private - Not for Profit	Chicago, IL	2001	105	304 (1997)	285,049,647
<b>Totals</b>			<b>615</b>	<b>2,201</b>	

Between 1997 and 2011, nine dental schools have opened at both public and private/not-for-profit accredited universities (Table 2). Two of the new dental schools (University of Nevada-Las Vegas and East Carolina University, NC) are sponsored by public universities. The remaining seven new schools are in private/not-for profit institutions. Eight of nine schools have been granted "Initial Accreditation" by the Commission on Dental Accreditation. At the time this report was prepared, the Roseman University (formerly the University of Southern Nevada) was pursuing accreditation.

**Table 2. Dental School Openings**

1986–2011	Location	Opened	2009	Per Class	2009–2010	US Pop
Nova Southeastern University Private - Not for Profit	Davie, FL (Ft. Lauderdale-Miami)	1997	101	108	430	267,846,741
University Of Nevada-Las Vegas Public	Las Vegas, NV	2002	73	80	318	287,745,630
A.T. Still University of Health Sciences, Arizona School of Dentistry and Oral Health Private - Not for Profit	Mesa, AZ (Phoenix)	2003	56	67	249	290,242,027
Midwestern University Private - Not for Profit	Glendale, AZ (Phoenix)	2008	N/A	111	*444	304,177,401
Western University Private - Not for Profit	Pomona, CA (Los Angeles)	2009	N/A	64	*256	306,656,290
Midwestern University Private - Not for Profit	Downers Grove, IL (Chicago)	2011	N/A	125	**500	313,232,000
East Carolina University Public	Greenville, NC	2011	N/A	50	**200	313,232,000
Lake Erie College of Osteopathic Medicine-School of Dental Medicine Private - Not for Profit	Bradenton, FL (Tampa)	2011	N/A	100	**400	313,232,000
Roseman University Site Visit Spring 2011, No Status Yet Private - Not for Profit	South Jordan, UT (Salt Lake City)	2011	N/A	64	**256	313,232,000
<b>Totals</b>			<b>230</b>	<b>769</b>	<b>3,053</b>	

\*Total enrollment projected for full program

\*\*Enrollment figures estimated

Six of the nine universities sponsoring new dental schools also sponsor colleges of osteopathic medicine. According to the American Association of Colleges of Osteopathic Medicine, osteopathic physicians, also known as DOs, are licensed to practice the full scope of medicine in all 50 states. They practice a holistic approach to patient care in a variety of settings and constitute 7% of all U.S. physicians. Today, nearly one in five medical students in the United States is attending an osteopathic medical school.

The universities sponsoring new schools cite their need for a dental program to be an integral component to their academic health science center, to provide all health professions students with an



interprofessional learning environment and to address the need for more dentists to practice in their communities. In addition to the new schools cited in Table 2, the following universities and organizations also may be contemplating the expansion of current, or establishment of new, dental education programs:

- A.T. Still University, AZ (adding branch campuses in Missouri and California)
- University of New England College of Dental Medicine, Maine
- University of New Mexico
- Eastern Tennessee State University
- Texas Tech, El Paso
- University of Utah
- Marshfield Clinics, Wisconsin
- University of Central Florida

**Accreditation of Dental Education Programs:** The Commission on Dental Accreditation is the nationally recognized accrediting agency for dental, advanced dental and allied dental education programs in the United States. Accreditation standards are routinely reviewed and revised by the profession to ensure that dental education programs are preparing competent practitioners who are ready for unsupervised practice and to meet the oral health needs of the public. The Accreditation Standards for Dental Education Programs underwent a major revision over the past two years. Adopted in August 2010, the new Accreditation Standards will be fully implemented by July 2013 and are available on ADA.org at <http://www.ada.org/316.aspx>.

The Council reviewed the current and newly adopted standards in light of concerns expressed that the majority of developing dental schools appear to be sponsored by institutions of higher education that are not research intensive. Since 2007, all dental education programs have been in compliance with the requirements of current Standard 6 Research Program. The Council was pleased to learn that the new standards have an increased research emphasis, noting the need for and value of scientific discovery and the integration of knowledge. Each of the six new Accreditation Standards, as well as the components of the standards document relating to research, include:

#### **Revised Introductory Narrative:**

*Scientific Discovery and the Integration of Knowledge.* The interrelationship between the basic, behavioral, and clinical sciences is a conceptual cornerstone to clinical competence. Learning must occur in the context of real health care problems rather than within singular content-specific disciplines. Learning objectives that cut across traditional disciplines and correlate with the expected competencies of graduates enhance curriculum design. Beyond the acquisition of scientific knowledge at a particular point in time, the capacity to think scientifically and to apply the scientific method is critical if students are to analyze and solve oral health problems, understand research, and practice evidence-based dentistry.

*Evidence-Based Care.* Evidence-based dentistry (EBD) is an approach to oral health care that requires the judicious integration of systematic assessments of clinically relevant scientific evidence, relating to the patient's oral and medical condition and history, with the dentist's clinical expertise and the patient's treatment needs and preferences. EBD uses thorough, unbiased systematic reviews and critical appraisal of the best available scientific evidence in combination with clinical and patient factors to make informed decisions about appropriate health care for specific clinical circumstances. Curricular content and learning experiences must incorporate the principles of evidence-based inquiry, and involve faculty who practice EBD and model critical appraisal for students during the process of patient care. As scholars, faculty contribute to the body of evidence supporting oral health care strategies by conducting research and guiding students in learning and practicing critical appraisal of research evidence.

## Accreditation Standards That Address Research:

### *Standard 1—Institutional Effectiveness.*

- 1-1 The dental school **must** develop a clearly stated purpose/mission statement appropriate to dental education, addressing teaching, patient care, research and service.
- 1-2 Ongoing planning for, assessment of and improvement of educational quality and program effectiveness at the dental school **must** be broad-based, systematic, continuous, and designed to promote achievement of institutional goals related to institutional effectiveness, student achievement, patient care, research, and service.
- 1-6 The sponsoring institution **must** ensure that support from entities outside of the institution does not compromise the teaching, clinical and research components of the program.

### *Standard 2—Educational Program.*

#### *Ethics and Professionalism*

- 2-20 Graduates **must** be competent in the application of the principles of ethical decision making and professional responsibility.

#### *Clinical Sciences*

- 2-21 Graduates **must** be competent to access, critically appraise, apply, and communicate scientific and lay literature as it relates to providing evidence-based patient care.

### *Standard 3—Faculty and Staff.*

- 3-4 A defined evaluation process **must** exist that ensures objective measurement of the performance of each faculty member in teaching, patient care, scholarship and service.

### *Standard 4—Educational Support Services. Student Services.*

- 4-6 Student services must include the following:
  - a) personal, academic and career counseling of students;
  - b) assuring student participation on appropriate committees;
  - c) providing appropriate information about the availability of financial aid and health services;
  - d) developing and reviewing specific written procedures to ensure due process and the protection of the rights of students;
  - e) student advocacy; and
  - f) maintenance of the integrity of student performance and evaluation records.

### *Standard 5—Patient Care Services.*

- 5-2 Patient care **must** be evidenced-based, integrating the best research evidence and patient values.
- 5-3 The dental school **must** conduct a formal system of continuous quality improvement for the patient care program that demonstrates evidence of:
  - a) standards of care that are patient-centered, focused on comprehensive care and written in a format that facilitates assessment with measurable criteria;
  - b) an ongoing review and analysis of compliance with the defined standards of care;
  - c) an ongoing review of a representative sample of patients and patient records to assess the appropriateness, necessity and quality of the care provided;
  - d) mechanisms to determine the cause(s) of treatment deficiencies; and
  - e) implementation of corrective measures as appropriate.

### *Standard 6—Research Program.*

- 6-1 Research, the process of scientific inquiry involved in the development and dissemination of new knowledge, **must** be an integral component of the purpose/mission, goals and objectives of the dental school.
- 6-2 The dental school faculty, as appropriate to meet the school's purpose/mission, goals and objectives, **must** engage in research or other forms of scholarly activity.
- 6-3 Dental education programs **must** provide opportunities, encourage, and support student participation in research and other scholarly activities mentored by faculty.

The Council noted that Standard 6 Research Program directly addresses the requirement that program goals along with faculty engagement in research be present in each program to ensure students have the opportunity to participate in research and other scholarly activities. These concepts are reinforced and expanded in the other five standards. Dental education programs and their sponsoring institutions will continue to provide students with the skills, abilities and knowledge needed for dentistry to remain a learned professional.

During its discussion about the term, “research-intensive universities,” the Council considered factors that may be used to identify such institutions, i.e., the amount of annual funding received from federal agencies such as of National Institutes of Health (NIH), National Institute of Dental and Cranial Research (NIDCR), state and local governments, private industry and foundations. For example, in 2010, 48 dental schools received NIDCR grants ranging from a high \$11,583,534 to a low of \$135,000 (Appendix 2).

**ADA Policy Related to Dental Education and Dental Schools:** The Council also noted the following policy statements which reflect the Association’s current position on dental education and dental schools. (The citation in parenthesis following the title of the policy indicates the year of adoption and the page number from that year’s *Transactions of the American Dental Association*.) Members of the Council believed that the intent of Resolution 87 complements these policies.

**Support for the Continued Existence of Private and Public Dental Schools in the United States (1989:522)**

**Resolved**, that the American Dental Association strongly supports the continued existence of the private and public dental schools in the United States and the need for dental education to remain an integral part of the university community and an inviolate part of the higher education system, and be it further

**Resolved**, that the American Dental Association through the Council on Dental Education and Licensure and Commission on Dental Accreditation and other appropriate Association agencies, communicate its position and, when requested, make its resources available to work with the state and local governments, and with foundations, the business community and other groups identified by an institution in ensuring the continued operations of all existing private and public dental schools in the United States, and be it further

**Resolved**, that Resolution 8-1967-H (*Trans.*1967:287) be rescinded.

**Mission of a Dental School (1995:640)**

**Resolved**, that the policy of the American Dental Association be that the mission of a dental school is to educate students competent to practice the art and science of dentistry, and be it further

**Resolved**, that research is important to the mission of a dental school, and be it further

**Resolved**, that patient care is important in the mission of educating dental students.

**Curricular Changes to Maintain Dentistry as an Autonomous Independent Health Profession (1996:696)**

**Resolved**, that the American Dental Association urge the Commission on Dental Accreditation, in cooperation with the American Dental Education Association and individual dental schools, to stimulate curricular changes that will integrate appropriate medical knowledge into the dental curriculum in such a manner that dentistry remains an autonomous independent health profession.

**Association Activities to Address Problems in Dental Education (2002:400)**

**Resolved**, that the Association continue to monitor the problems facing dental education and facilitate discussions with all appropriate communities of interest with the goal of finding and implementing solutions to the crisis, particularly those related to the cost of education, student debt and faculty shortages.

### **Innovative Models of Clinical Teaching (2002:405)**

**Resolved**, that the Association urge the dental practice and dental education communities to work together to develop innovative models of clinical teaching.

### **Evaluation of Dental Programs (1983:558)**

**Resolved**, that all parties responsible for funding and administration of dental education be urged to evaluate the size and quality of their programs on an ongoing and periodic basis, and be it further **Resolved**, that periodic evaluations by the ADA be based on a continued assessment of resources, enrollment levels, manpower projections, disease trends and demand for dental services.

The Council agreed with the intent of Resolution 87 that the Association should monitor and analyze current and future dental education models and concluded that given all of the changes occurring in dental education, a comprehensive study of dental education, similar to the Gies Report, should be done in the long-term. However, the Council believes that the collection and analysis of data on both existing and new schools is the first step; convening a meeting at this time would be premature. The Council plans to collaborate with the ADA's Health Policy Resources Center (HPRC), the Survey Center and Health Policy Analysis Departments, and other appropriate ADA agencies, to identify and analyze relevant data and make the findings available on a routine basis to the profession and the House of Delegates.

**Response to Resolution 112-2010—A Viable Mid-Level Solution: Improving Access by Reinventing Dentists' Education:** The ADA 2010 House of Delegates referred Resolution 112-2010 to the Council for further study.

**112. Resolved**, that the ADA invite to a conference of appropriate stakeholders and leaders, to include, but not be limited to representatives of CAPIR, CDEL, CGA, ASDA, CODA, ADEA, AADB, CMS and the Kellogg Foundation to consider development of dental education models that facilitate fourth- and fifth-year dental students and residents to provide care in underserved and unserved settings, and be it further

**Resolved**, that the conference agenda will include, but not be limited to, the following:

- Utilization of pre-doctoral dental students as an alternative to mid-level providers for improved access to care and maintaining a high quality single tier delivery system
- Consideration of conversion of some basic science curricula to undergraduate prerequisites
- Education cost-reduction through provision of services by both students and faculty
- Alternative faculty/student supervisory models to reduce barriers to access in remote locations
- Concurrent loan forgiveness programs and stipends for pre-doctoral practice in remote locations
- Statutory consideration of utilizing dental students in alternative settings
- Testing and licensing considerations in alternative educational models
- Applications for teledentistry and distance education via interactive links
- Funding needs for pilot projects and transition to new models
- Accreditation considerations for alternative educational models
- Limitations of public funding and subsidies as educational clinic revenue sources

and be it further

**Resolved**, that the appropriate Association agencies provide a report on the conference with a recommended action plan to the 2011 House of Delegates.

The Council chair appointed an Ad Hoc Committee to address this resolution. Committee members include: Dr. James Antoon, chair, Dr. Teresa Dolan, Dr. Jade Miller, Dr. Donna Stenberg, Dr. Shamik Vakil, and Dr. Ron Venezie. The Ad Hoc Committee met by telephone conference on January 5, February 8, and February 15, 2011. The Ad Hoc Committee discussed the resolution, the intent of the makers and how to gather information relevant to the committee charge. The chair, staff and Ad Hoc Committee members submitted information they felt would be valuable in evaluating issues related to

Resolution 112. Appendix 3 is an extensive list of references considered. In addition, the Ad Hoc Committee heard presentations from Dr. James Williamson (UT), co-author of the resolution, and Dr. Ana Karina Mascarenhas, professor, Public Health Dentistry, Nova Southeastern University (FL). Ad Hoc Committee members were given a chance to ask questions and both speakers offered to address any follow-up questions by e-mail.

In April 2011, the Council considered the Ad Hoc Committee's report and supported its conclusions. The Council reports the following to the House in response to referred Resolution 112-2010:

- The primary mission of a dental school is to ensure that students possess the knowledge, skills and values to practice general dentistry independently at the time of graduation. Using dental students to provide care to the underserved must be balanced with this primary goal. While community-based clinical experiences are an important part of dental students' education, the provision of continuous and comprehensive general dental care on-campus under the direct supervision of faculty is also very important. The comprehensive care experiences, both on- and off-campus, must be adequate to ensure competency in all components of general dentistry practice, as required by the Commission on Dental Accreditation's Accreditation Standards for Dental Education Programs.
- According to the ADA Survey Center's 2010-11 Survey of Dental Education, Volume 4 data, 54 out of 59 schools required students to complete community-based patient care hours. Dental students at 41 schools spend 1%-10% (24 spend 1%-5%, and 17 spend 6%-10%) of their time in community-based settings, 10 schools reported 11%-19% (eight spend 11%-15%, two spend 16%-20%), and three schools reported that students spend 20% or more of their time in community-based settings.
- While some studies have demonstrated that students are slightly more productive in a community-based setting than in a dental school clinic, the overall delivery of patient care by a dental student, (typically no more than four to six patients per day), is much less than that of an experienced practitioner in a public health clinic or private practice.
- Most dental school clinics provide discounted care for the underserved and many are Medicaid providers. The dependence of dental schools on clinic revenues and the move to community-based clinics can create a financial burden on schools and ultimately students. The data were mixed on whether delivering care in off-campus facilities is more cost effective than in on-campus dental clinics. Further, the net gain of patients treated in community settings versus dental schools clinics appears to be minimal.
- Best practices in community-based service learning have been promulgated by the ADA, ADEA, and by dental education projects funded by the Robert Wood Johnson Foundation and the Macy Foundation. The Robert Wood Johnson Foundation has provided funding to at least 23 dental schools to study and implement programs "for increased access to dental care in underserved areas by enhancing the knowledge of students through community-based education" (<http://www.ada.org/news/2280.aspx>). The Josiah Macy, Jr., Foundation funded a study of new models of dental education, recognizing the financial and other challenges facing dental education institutions. Study findings were published in the February 2008 *Supplement of the Journal of Dental Education*.
- The Council considered the resolution's proposal for a three-year dental school model that would present the basic sciences content in the undergraduate curriculum, allowing for community-based clinical training in the final year of the predoctoral dental curriculum. Council members learned that some dental schools have considered requiring basic science courses solely as prerequisites to dental school, but that the result is insufficient background knowledge in the sciences for dentistry. This is especially important given rapid advances in the biomedical sciences and the recognition of oral health as being an essential component of overall health and well-being.
- The Council noted that Resolution 112 calls for utilization of fourth- and fifth-year dental students and residents to provide care in underserved and unserved settings. In 2008, the ADA conducted an opinion survey on the Dental Education Experience to investigate perceptions of need for reforming the current dental education model by adding a fifth year. Those surveyed included students, recent graduates, faculty, directors of accredited advanced education programs and practitioners. Results were mixed, but the majority of respondents did not support a fifth year of

dental school. “Potential financial burden to students” and “the current predoctoral model is sufficient to produce competent dental graduates” were reasons cited for not extending dental school by one year. Additionally, when asked reasons why the curriculum *should* be extended by one year, directors of advanced education programs were the only group where a slight majority selected, “Potential to increase access to care for underserved populations” (51.4%).

- According to the 2010 U.S. Census Bureau’s Current Populations Report, *Income, Poverty and Health Insurance Coverage in the United States*, in 2009, the poverty rate for children under the age of 18 was 20.7% and for people between the ages of 18-64 it was 12.9%. For those over the age of 65, 8.9% were at the poverty level. A total of 43.6 million people were in poverty in 2009. The Council believed that the total impact of sending approximately 5,000 fourth-year dental students and 1,600 postdoctoral general dentistry students into the community would be very small, given that most of these students already treat patients at or below the poverty level within the dental school clinics. The number of patients 6,600 students can treat annually is very limited, regardless of the treatment setting.

The Council was unanimous in complimenting the makers of Resolution 112 for their efforts in attempting to further address and reduce barriers to care. The Council respects the intent and direction of the resolution and supports many of its proposed concepts. Council members also recognized the need for some states and regions to offer different solutions for their local situations. Members questioned the cost of implementing Resolution 112 at this time and if using the same ADA resources to promote prevention and education programs might be more successful in reducing barriers to access and improving oral health more quickly. The cost to implement Resolution 112-2010 could range from \$35,000-\$75,000 (number attending, travel, food costs, honorarium for speakers, reception, meeting materials etc.); the Council believes this would not be the best use of ADA’s resources at this time.

After reviewing and discussing an extensive amount of data and information available on this subject, the Council concluded that many dental education and advanced dental education programs include off-campus community-based experiences for students. The dental education institutions are doing their share to address this multi-faceted issue. Community-based service learning plays an important role in educating dental students and can be part of the solution to the access crisis. Yet, the profession must be cautious in sending less experienced people into community-based facilities to treat patients with some of the most challenging oral and general medical conditions. The Council believes that convening stakeholders to further explore the use of fourth- and/or fifth-year dental students and postdoctoral general dentistry residents in lieu of proposed mid-level provider models for providing care to the underserved and unserved would be an expensive activity, with limited benefit or advancement in addressing the access to care issue. Accordingly, the Council presents these findings and concludes that no further action should be taken by the Council or the House of Delegates at this time.

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

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 and state dental boards, encouraging them to undertake initiatives to implement ADA policies related to licensure and freedom of movement. For example, this year the Council encouraged state associations and state boards of dentistry to work together to promote and adopt ADA policy regarding specialty licensure and specialty licensure by credentials.

**Clinical Licensure Examinations:** Currently, five regional dental testing agencies administer their own clinical licensure examinations. Each regional testing agency is made up of member states that utilize that examination for the purposes of initial licensure. The five regional 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). Additionally, there are four independent state testing agencies: Delaware, Florida, Nevada and Virgin Islands.

The American Board of Dental Examiners (ADEX) is an examination development agency for dentistry and dental hygiene consisting of state and U.S. territory licensing jurisdictions, organized in districts throughout the nation, whose member representatives provide for the ongoing development of the ADEX Dental and Dental Hygiene Examinations. Approximately 24 states are members of ADEX. Only the NERB, Hawaii and Nevada administer the ADEX Examinations, though nearly 40 states accept results of the examinations for licensure. Florida has discontinued the Florida clinical examination and approved the use of the ADEX Examinations. At the time this report was prepared, the bill was awaiting the governor's signature. The remaining four regional testing agencies, Delaware and the Virgin Islands all administer their own examinations. California administers its own examination but also accepts results of the WREB examination.

Less than 10 state dental licensing agencies accept successful completion of a clinical licensure examination administered by any recognized regional or independent testing agency for the purpose of licensure in their state.

**States' Alternatives to the Clinical Licensure Examination:** Several states have adopted alternatives to the clinical licensing examination for initial licensure.

*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. Delaware also requires a one-year residency, but is the only state that requires both the one-year residency *and* a clinical examination. California, Connecticut, Minnesota and Washington offer candidates the option of completing a residency (PGY-1) or taking a clinical examination. However, each state has its own rules and regulations for licensure by PGY-1. In California, the candidate must complete a residency in general dentistry (GPR or AEGD). In Minnesota, the candidate has to be a graduate of Minnesota-based GPR or AEGD program after January 1, 2004. In Connecticut, the candidate must complete a program accredited by CODA, provided that the supervising dentist attests to the resident dentist's competency in all areas tested on the North East Regional Board Examination. In Washington, the requirement is a postdoctoral dental residency program approved by the Dental Quality Assurance Commission, of one to three year's duration, in a community health clinic that serves predominantly low-income patients or is located in a dental care health professional shortage area in this state and that includes an outcome assessment evaluation.

*Canadian NDEB 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 initial 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.

*Portfolio System.* Effective January 1, 2011, dental students in California have a new pathway for obtaining initial licensure. In addition to the PGY-1, and the clinical examination options, dental students have the option of taking a school-based portfolio examination. The portfolio examination requires students to complete specific clinical experience benchmarks in seven categories and pass a final assessment in each area whenever they and the dental school faculty feel they are ready. Once all experience benchmarks and assessments have been completed, the students submit their finished portfolio to the Dental Board for final approval and licensure. The Dental Board is still in the process of developing regulations for implementation of this new system.

**Licensure by Credentials:** There have been no changes in state laws regarding licensure by credentials since the Council's 2010 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.

**Joint Commission on National Dental Examinations National Board Dental Examinations:** In 2010, the Joint Commission on National Dental Examinations (JCNDE) established a Committee on the Integrated Examination (CIE) to develop and validate a new integrated examination that will replace NBDE Part I and Part II. This is a long-term project expected to take a minimum of five years.

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

**Annual Meeting With Dental Specialty Certifying Boards and Organizations:** In August 2010, the Council hosted its annual meeting with the ADA-recognized dental specialty certifying boards and sponsoring organizations at ADA Headquarters in Chicago. Representatives from all nine specialty boards and organizations attended the meeting. The agenda included updates on ADA activities and the proposed resolutions to the 2010 House of Delegates, a report from the Royal College of Dentists of Canada, updates on recent activities and topics of interest from each board and organization and a variety of topics submitted by some boards and organizations for discussion. The Council chair provided an update on Council activities of interest to the specialty groups.

The meeting participants requested assistance from the Council/ADA on several issues related to the specialties including:

- The ADA consider amending language in reference to dental specialties in the *Principles of Ethics and Code of Profession Conduct* to be consistent with language in the Council's *Bylaws* and to help avoid confusion between dental specialties and interest areas in general dentistry,
- The Council encourage state associations and state boards of dentistry to work together to promote and adopt ADA policy regarding specialty licensure and specialty licensure by credentials,
- The ADA/Council help promote the dental specialties and the value of dental specialty board certification to the public, and
- The CDEL request the Council on Membership to consider revisions to its specialist logo to eliminate a date and add language reflecting diplomate status.

The Council, in collaboration with other appropriate ADA agencies, is addressing each of these requests.

**Report of the ADA-Recognized Dental Specialty Certifying Boards:** As part of its *Bylaws* responsibilities, the Council annually surveys the ADA-recognized dental specialty certifying boards. The 2011 Report of the ADA-Recognized Dental Specialty Certifying Boards is available on ADA.org at <http://www.ada.org/494.aspx>. The 2011 report shows that all nine specialty certifying boards certified diplomates and eight recertified diplomates in 2010. The report also reflects changes that some boards made to their eligibility requirements, application and registration procedures, re-examination 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 alternative pathway to certification for internationally trained dental specialists; however, none reported certifying individuals via this pathway in 2010.



## 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. The studies consider factors such as changes in technology, changes in dental specialty education, 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.

In preparation for the 2011 Periodic Review, the Council reviewed the proposed format for 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 were submitted.

At its November 2010 meeting, the Council reviewed the reports and was impressed with the extensive, innovative and groundbreaking research the dental specialties have undertaken in the past 10 years. Without exception, each dental specialty is creating new knowledge and new ways to apply this knowledge to enhance patient care.

The Council did raise a concern regarding the specialty organizations whose membership categories appeared to permit non-dentists and/or non-specialists to be members in a myriad of categories. Similar concerns were raised by the Illinois State Dental Society regarding the membership categories and numbers of dental public health dentists/specialists who are members of the American Association of Public Health Dentistry. The Council discussed the potential implications to these specialties and whether they continue to meet the conditions set out in Requirement 1(a) of the Requirements for Recognition of Dental Specialties:

- (1) In order for an area to be recognized as a specialty, it must be represented by a sponsoring organization: (a) whose membership is reflective of the special area of dental practice; and (b) that demonstrates the ability to establish a certifying board.

The Council then directed that all of the dental specialty organizations be requested to submit supplemental information on their membership categories and numbers, strategic planning efforts and research initiatives for review by the Council at its spring 2011 meeting.

In January 2011, the letters were mailed to each of the nine recognized dental specialty organizations requesting a list and definition of all membership categories, the number of members and the privileges (voting and holding office) corresponding to each category. Each specialty organization was asked to provide the total number of dentists in the specialty in the United States, the total number of members, the number of members who are dentists in the specialty and the total number of dental specialist members who are diplomates.

In April 2011, the Council carefully reviewed the additional information on membership categories and corresponding privileges. The Council believes that each of the sponsoring organizations continues to meet the conditions set out in Requirement 1(a) of the Requirements for Recognition of Dental Specialties.

The Council directed that the 2011 Periodic Review of Dental Specialty Education and Practice be transmitted to the 2011 ADA House of Delegates (Appendix 4). The Council also considered two policies related to the Periodic Review and concluded that the 2001 policy, Comprehensive Study of Dental Specialty Education and Practice, should be modified to reflect the recommendation that these reviews continue on a 10-year basis. The Council believes that the 1992 policy, Periodic Review of Dental Specialty Education and Practice, is redundant and recommends rescission.

**6. Resolved**, that the policy, Comprehensive Study of Dental Specialty Education and Practice (*Trans.*2001:468), be amended as follows (proposed deletions are ~~stricken~~; proposed additions are underlined):

**Comprehensive Study-Periodic Review of Dental Specialty Education and Practice**

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

**Resolved**, that the Council report the results of the reviews ~~next periodic review of dental specialty education and practice be presented to the 2014 ADA House of Delegates.~~

**7. Resolved**, that the following policy, Periodic Review of Specialty Education and Practice (*Trans.*1992:620), be rescinded:

**Resolved**, that the concept of the Association maintaining a mechanism for the periodic review of specialty education and practice be endorsed, and be it further

**Resolved**, that beginning in 2001, the Council on Dental Education and Licensure forward recommendations from this review to the House of Delegates for its consideration.

### **Request to Recognize Dental Anesthesiology as a Dental Specialty**

In June 2011, the American Society of Dentist Anesthesiologists submitted to the Council an application for recognition of dental anesthesiology as a dental specialty. The Council and its Committee on Recognition of Dental Specialties and Interest Areas in General Dentistry will seek comments on the request from the communities of interest during the fall of 2011. The Council will report its findings and recommendations to the 2012 House of Delegates.

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

In October 2010, The House of Delegates adopted Resolution 12H-2010 (*Trans.*2010:579), Criteria for Recognition of Interest Areas in General Dentistry. Subsequently, the Council established a process and application for considering requests for recognition. Modeled after the Application for Recognition as a Dental Specialty, the Council approved the Application for Recognition as an Interest Area in General Dentistry at its April 2011 meeting. The application includes the process by which interest areas in general dentistry will be recognized and the criteria that must be satisfied in order to achieve recognition by the ADA.

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

**National Board for Certification in Dental Laboratory Technology:** One of the duties of the Council is to approve or disapprove national certifying boards for allied dental personnel. 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 Council approved NBC's 2010 Annual Report as complete and providing required annual information. From the information provided, NBC's finances appear to the Council to be stable. NBC expanded its Board of Trustees from seven to nine members. An at-large ballot of all Certified Dental Laboratory Technicians (CDLT) will elect the new trustees. The Council expressed concern regarding the 18% decline in number of certified dental laboratory technicians between 2008 and 2010 and its impact on dental practice in the United States and the ability to monitor the quality of outsourced laboratory cases. The loss of certified dental laboratory technicians also has financial implications for NBC.

**Dental Assisting National Board:** The Dental Assisting National Board (DANB), as the recognized certifying board for dental assistants, 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. In November 2010, the Council reviewed DANB's Annual Report and found it complete and noted that the organization appears to be financially stable. The Council also noted the ongoing development of the DALE Foundation (Dental Auxiliary Learning and Education), a DANB-affiliated, incorporated foundation. Its mission is to benefit the public by providing quality education and conducting sound research to promote oral health.

Also, at its November 2010 meeting, the Council noted DANB's intention to solicit feedback from the communities of interest regarding a waiver for its proposed pilot study for a new eligibility pathway for the Certified Dental Assistant/General Chairside (CDA/GC) certification. ADA's *Criteria for Recognition of a Certification Board for Dental Assistants* (Section IV-Criteria) permits DANB to establish waivers for candidates who do not meet the established eligibility criteria on educational training to sit for the exam. However, to obtain the waiver, DANB must make a formal request to CDEL that includes a description of how the proposed change was circulated to communities of interest, and provide documentation that the change was justified and supported by the organizations represented on its board.

DANB's proposed new eligibility pathway would permit graduates of one-year, non-CODA-accredited dental assisting programs to substitute their year of education for one of the two years of continuous full-time or two of four years of continuous part-time work experience as a dental assistant, which is currently required for eligibility to sit for the DANB examination. Graduates of a CODA-accredited program are eligible to sit for the DANB exam upon graduation and without work experience.

The Council concluded that it should work with the Council on Dental Practice (CDP) to consider the issues before forwarding any comments to DANB. Accordingly, the Councils appointed a joint ad hoc committee to study the proposed pilot program pathway and to provide feedback and recommendations to the Councils at their April 2011 meetings.

The Joint Ad Hoc Committee's Report expressed concern that under the proposal, the DANB would be "approving" the non-CODA accredited dental assisting programs to be accepted as substitutes for the year of work experience. DANB is a credentialing agency and does not have the expertise or authority to "approve" dental assistant training programs. CODA is the programmatic accrediting agency recognized by the United States Department of Education to accredit dental assisting education programs. At its April 2011 meeting, the Council agreed with recommendations of the Joint Ad Hoc Committee to oppose the proposed pathway.

In July 2010, DANB began pretesting qualified candidates for its Certified Preventive Dental Assistant (CPDA) examination. Candidates who were eligible for pretesting work in states in which all four functions, i.e., coronal polishing, application of sealants, application of topical anesthetic and application of topical fluoride, are allowed or not expressly prohibited. As of April 1, 2011, the CPDA examination is available to qualified candidates. According to DANB's website, 35 states now allow or do not expressly prohibit dental assistants from performing all four functions.

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## Anesthesiology

**ADA Course Recognition and Management of Complications During Minimal and Moderate Sedation:** In 2008, the ADA Foundation (ADAF) awarded a grant to the American Dental Society of Anesthesiology (ADSA) to develop a course to train the dentist using minimal and moderate sedation in the proper recognition and management of respiratory complications. The course, Recognition and Management of Complications During Minimal and Moderate Sedation, has been licensed by the ADAF to the ADA. Part 1 of the course is available on [www.adaceonline.org](http://www.adaceonline.org) and must be completed prior to participation in Part 2. Part 2 is a hands-on workshop consisting of a pre-assessment, four task training sessions followed by high fidelity activities on a simulator and a post-assessment.

The Council administered Part 2 of the course for the first time in October 2010 at the ADA Headquarters. Thirty-four individuals participated in the workshop, and the course evaluations showed a high level of satisfaction with the workshop and workshop faculty. (See *ADA News* article, November 15, 2010 at <http://www.ada.org/news/5059.aspx>.) The workshop will be offered again at the ADA Headquarters from October 27-28, 2011.

**Safety Awareness Campaign:** The Council approved its Committee on Anesthesiology's recommendation to develop a communications campaign promoting routine dental equipment safety checks in dental offices/clinics that include nitrous oxide equipment, x-ray equipment, automated external defibrillators, dental unit water lines, sterilization equipment, amalgam recovery protocols, and medications and equipment in medical emergency kits. The Council established an Ad Hoc Committee to assist in this activity consisting of representatives from CDEL, the Council on Membership, the Council on Communications, the Council on Scientific Affairs and the Council on Dental Practice. The Ad Hoc Committee will report its progress to the appropriate Councils in fall 2011.

### **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 424 ADA CERP nationally recognized providers. Providers are distributed in the following self-reported categories: 22% dental education companies; 17% dental/medical schools, universities and colleges in the United States and Canada; 15% dental specialty organizations or societies; 9% constituent dental societies; 9% pharmaceutical/dental equipment companies; 4% study clubs; 4% consulting companies; 3% hospitals; 3% component dental societies; 3% communications/publishing companies; 2% insurance companies; 1% federal agencies; and 8% 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 applies for ADA CERP recognition 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 131 component dental societies and specialty component organizations have ADA CERP recognition through the EAP. (These are in addition to the 424 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 ADA members and nonmembers.

**Operational Effectiveness 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 2011 decision cycle indicate that overall respondents found the application instructions clear and complete, organization of the application appropriate and logical, and the questions clear. Approximately one-third 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. Almost half of the survey respondents 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 workshops held during the 2008 and 2010 ADA annual sessions, as well as checklists and additional information for applicants posted online.

**Activities Related to Commercialism and Conflicts of Interest in Continuing Education:** As reported in 2010, 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 and undermine public trust. In response to calls for stronger firewalls between commercial interests and providers of continuing education, the Council has proposed revising the ADA CERP Eligibility Criteria to stipulate that "commercial entities" (defined by CERP as companies that produce, market, re-sell or distribute health care goods or services consumed by, or used on, patients) would no longer be eligible for ADA CERP recognition. The proposed change is designed to promote independence from commercial influence in continuing dental education, and to bring ADA CERP into alignment with current accreditation guidelines in the health professions community related to managing commercial conflicts of interest. The Accreditation Council for Continuing Medical Education, the American Nurses Credentialing Center, and the Accreditation Council for Pharmacy Education do not consider commercial entities eligible to become accredited providers of continuing education. The CDEL has circulated the proposed revisions to the CERP Eligibility Criteria to the communities of interest for comment. The document can be found online at [http://www.ada.org/sections/EducationAndCareers/pdfs/call\\_for\\_comments.pdf](http://www.ada.org/sections/EducationAndCareers/pdfs/call_for_comments.pdf). The Council will consider all comments received at its November 2011 meeting.

**Changes to ADA CERP Recognition Standards and Policies:** The [ADA CERP Recognition Standards and Procedures](#) (ADA CERP Standards) 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.

At its November 2010 meeting, the Council approved revisions to the ADA CERP Recognition Standards and Procedures designed to strengthen requirements that continuing dental education courses have a sound scientific basis in order to adequately protect the public. In finalizing these revisions, the Council considered comments from the communities of interest, including the ADA Council on Scientific Affairs, and reviewed policies related to content validation established by other accrediting agencies for continuing health care education. The revised criteria now require ADA CERP approved providers of continuing dental education to adopt and operate in accordance with *written* policies, guidelines or procedures designed to ensure that all clinical and/or technical CE activities they offer include the scientific basis for the program content as well as an assessment of the benefits and risks associated with that content. In cases where the scientific basis for a clinical and/or technical CDE activity is evolving or uncertain, presentations must describe the level of scientific evidence that is currently available and what is known of any associated risks and benefits.

**ADA CERP and AGD PACE Mutual Recognition:** In 2009 the Council and the CERP Committee, working in conjunction with the Academy of General Dentistry Program Approval for Continuing Education (AGD PACE), completed a side-by-side comparison and revision process of the CERP Standards and the PACE Guidelines. The revisions were made in order to establish consistent guidelines for quality continuing dental education, and to move towards mutual recognition between the programs. Over the last year, PACE and CERP have also worked to remove a remaining barrier to mutual recognition by separately taking preliminary steps to improve oversight of the CERP Extended Approval Process (EAP) and the PACE local approval process in order to ensure that providers at both the national and the local levels maintain consistent standards. However, CERP and PACE are now separately considering revisions to the CERP Standards and PACE Guidelines related to the role of commercial entities as CE providers and the use of product training for continuing education that may introduce substantive differences between the programs. The Council has therefore deferred further discussions of mutual recognition until any emerging differences between the two programs are better understood.

**ADA CERP Provider Workshop at 2011 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 2011 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. Similar workshops offered in 2008 and 2010 were well received.

## Continuing Education Matters

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The Council and its Committee on Continuing Education are responsible for oversight of ADA CE Online and other aspects of continuing education as appropriate. Chaired by CDEL member Dr. Tariq Javed, the Committee includes representatives from the Council on Scientific Affairs, Council on ADA Sessions, Council on Dental Practice, Council on Membership and the New Dentist Committee.

**The Current State of ADA CE Online:** ADA CE Online, now in its fifth year, is delivered by a vendor through a revenue sharing model. The number of registered users continues to grow, increasing in 2010 by more than 30%. New dentists comprised 37% of the users in 2010 and non-members were 35%. The international user base has also increased in 2010 by 711 to 1,358, from more than 100 countries.

A 2011 Online CE Members Survey revealed that nearly a quarter of all respondents have participated in a CE offering through the ADA and, of those, 18% have taken a course through ADA CE Online. On average, respondents took 36.5 hours of CE in 2010, including 11.2 hours online.

**Library of Courses and Content Development:** Currently, 118 courses are featured on ADA CE Online. The peer review process, a strength of the program, is overseen by the editor-in-chief, Dr. Jeffrey Sameroff. All new courses are approved by the Editorial Board and existing courses are reviewed periodically. The ADA CE Online Editorial Board members are nominated through CDEL and its Committee on Continuing Education.

To encourage content experts to write new online courses for ADA CE Online, the 2010 House of Delegates adopted Resolution 63H calling for the development of up to six online continuing education courses for addition to the ADA CE Online library. The Council has directed staff to pursue the development of proposed online courses utilizing funds allocated by Resolution 63H-2010. Up to six online continuing education courses will be added to the ADA CE Online library in late 2011.

**Review of the Policy Statement on Continuing Dental Education and the Request of the Council on Ethics, Bylaws and Judicial Affairs to Classify Ethics as a Clinical Subject for Continuing Education Purposes:** In November 2010, the Council reviewed a request from the Joint ADA Subcommittee on Ethics and Integrity in Dental Education and Practice that ethics be classified as a clinical subject for purposes of continuing education. The Council supported the concept that ethics-related continuing education should be, when appropriate, classified as “clinical” continuing education and also that clinical continuing education courses may include ethical education; however, the Council recognized that the recognition of such CE classifications for licensure renewal purposes rests with the licensing jurisdictions.

Subsequently, the Council received correspondence from the Council on Ethics, Bylaws and Judicial Affairs (CEBJA) noting that, “ethics is not simply a matter of management of practice but rather an inseparable component of virtually all clinical treatment decisions.”

The Council reviewed the request, the Association’s Policy Statement on Continuing Dental Education and the Association’s 2009 Continuing Education Regulatory Summary, noting that:

- 13 states allow CE credit for ethics courses
- 37 states allow self-instructional activities, although some have limitations such as no more than half of the CE requirement
- Required courses for many states include CPR and infectious diseases
- Many states do not accept CE credit for instruction in finances, personal health and practice management or money management

The Council concluded that the Association's Policy Statement on Continuing Dental Education should be amended to reflect the changing nature of continuing education and support ethics as continuing education. Accordingly, the Council forwards the following resolution to the House of Delegates:

**8. Resolved,** that the Association's Policy Statement on Continuing Dental Education (*Trans.2006: 331*) be amended as follows (proposed additions are underlined; proposed deletions are ~~stricken~~):

### **Policy Statement on Continuing Dental Education**

**Definition of Continuing Dental Education:** Continuing dental education consists of educational activities designed to review existing concepts and techniques, to convey information beyond the basic dental education and to update knowledge on advances in scientific, clinical, and non-clinical ~~practice~~ related subject matter, including evidence-based dentistry and ethics. The objective is to improve the knowledge, skills and ability of the individual to provide the highest quality of service to the public and the profession. All continuing dental education should strengthen the habits of critical inquiry, ~~and~~ balanced judgment and ethics that denote the truly professional and scientific person and should make it possible for new knowledge to be incorporated into the practice of dentistry as it becomes available.

Continuing education programs are designed for part-time enrollment and are usually of short duration, although longer programs with structured, sequential curricula may also be included within this definition. In contrast to accredited advanced dental education programs, continuing dental education programs do not lead to eligibility for ethical announcements or certification in a specialty recognized by the American Dental Association. Continuing dental education should be a part of a lifelong continuum of learning.

**Acceptable Subject Matter:** In order for specific course subject material to be acceptable for credit, the stated course objectives, overall curriculum design or topical outlines should be clearly stated. The information presented should enable the dental professional to enhance the dental health of the public, either directly or through improved effectiveness of operations in dental practice, or through expansion of present knowledge through research. The dental professional should be able to apply the knowledge gained within his or her professional capacity.

**Acceptable Activities:** Continuing education activities are conducted in a wide variety of forms using many methods and techniques which are sponsored by a diverse group of institutions and organizations. State boards and/or legislatures may specify acceptable activities or content. The Association urges the state boards to allow maximum flexibility for an individual to choose content and learning activities based on individual preferences, needs, interests and resources. Additionally, clinical credit should be awarded for all activities related to the delivery of dental procedures including those with ethical components and self study activities.

Acceptable forms might include but are not limited to:

- attendance at and/or delivery of a formal continuing education course (a didactic and/or participatory presentation to review or update knowledge of new or existing concepts and techniques)
- general attendance at a multi-day convention type meeting (a meeting held at the national, state or regional level which involves a variety of concurrent educational experiences)

- authorship of publications (e.g., a book, a chapter of a book or an article or paper published in a professional journal)
- completion of self study activities ~~individualized continuing education instruction such as online courses and research, webinars, journal articles and downloadable books~~ (a individualized course of study which is structured and organized, but is available on an unscheduled and unsupervised basis; a method of providing feedback to the learner on performance or comprehension must be incorporated into the self-study activity)
- enrollment in a preceptor program (an independent course of study with a formally structured, preplanned and prescheduled curriculum where the participant observes and provides patient treatment using criteria and guidelines provided by the instructors; this type of study does not lead to an academic degree)
- academic service (e.g., instruction, administration or research related to undergraduate, postgraduate or graduate dental or allied dental training programs)
- presenting posters or table clinic
- participation on a state dental board, a board complaint investigation, peer review or quality care review procedures
- successful completion of Part II of the National Board Dental Examination, a recognized dental specialty examination or the National Board Dental Hygiene Examination if taken after initial licensure
- test development for written and clinical dental, dental hygiene and dental specialty examinations
- volunteering pro bono dental services or community oral health activities through instruction at a public health facility
- participation in dental research as a principal investigator or research assistant

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

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**Student Ambassador Program:** The 2010 Student Ambassador Program, was held on October 10, 2010 at the Westin Imagine Hotel, Orlando, FL, in conjunction with the 2010 ADA annual session. The program, *Collaboration of National Dental School Programs for a Common Goal: Increasing Diversity in the Dental Profession*, had the highest number of participants (70) and the greatest number of dental schools (46) participating. This resulted in a 30% increase in participants over last year with a corresponding 35% increase in dental school participation. 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 Committee and Council are grateful to GlaxoSmithKline (GSK) for generously contributing funding to support the 2010 event.

The 2010 program continued to build on the focus and spirit in reaching out and partnering with admissions offices by highlighting model collaborative ambassador/admissions liaisons along with furthering strategies to collaborate with prehealth advisors across the country. The College Assistance Migrant Program (CAMP) was featured as a potential partner and the recipients of the first-ever Ambassador Awards Program for exemplary outreach efforts were honored.

The 2010 program featured the UMKC School of Dentistry's Admissions Office/Ambassador collaborations presented by Dr. John Killip, assistant admissions director, University of Missouri Kansas City School of Dentistry (UMKC). UMKC's ambassadors partner with several community organizations including the Missouri Area Health Education Centers (M-AHEC) whose goal is to improve the distribution of health care professionals to enhance the health of communities. Dr. Killip also presented information regarding the UMKC admissions/ambassador liaisons at the NAAHP national meeting in June 2010. The University of Illinois at Chicago School of Dentistry (UIC), University of Alabama (UAB) and the West Virginia University (WVU) ambassador outreach programs were also highlighted for their collaborations with admissions offices.



The first 2010 Ambassador Awards Program recognized three programs for their excellence in designing and implementing student-driven recruitment programs in their schools and communities to promote dentistry as a career among historically underrepresented groups.

Beginning in 2009, the ambassadors were grouped into Ambassador Regional Team's using NAAHP's regional breakdown. This year, the ambassadors selected Ambassador Regional Coordinators. One of the main roles of the ARCs is to keep in touch with their team members. A total of nine regional areas selected ambassadors to act as ARCs for their teams at the 2010 program.

A team building (get acquainted) event was held on October 9, 2010, with funding from ASDA, ADEA, HDA, NDA and SAID to develop team spirit and camaraderie prior to the day-long Ambassador Program.

The Student Ambassador Program again will be held during the 2011 annual session at the MGM Grand Hotel in Las Vegas on October 9. The theme is *Increasing the Diversity in the Dental Profession: For You By You*. Highlights of this student-initiated program include Ambassador outreach efforts, cultural competency issues, and collaborations with prehealth advisors and dental school admission offices. Students from over 80% of dental schools will participate.

**2010 Predental Day at the ADA:** The first Predental Day was held in conjunction with the 2010 ADA annual session. This collaboration among CDEL's Career Guidance Department, ADA Conference and Meeting Services and the American Student Dental Association, provided an opportunity for local predental students to experience dentistry. Twenty-five students viewed live patient procedures (Education in the Round), saw the latest in dental technology and networked with annual session dental professionals. The event will be replicated at the 2011 annual session targeting local predental underrepresented minority students.

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

- 2010 Hispanic Dental Association (HDA) annual meeting, Chicago, IL
- 2010 Give Kids A Smile Events (Sullivan-Schein Dental supported the inclusion of 2,500 dentistry career posters in the promotional kits)
- 2010 UIC Predental Consortium Conference, Chicago, IL
- 2010 ADA Take Our Sons and Daughters to Work Day, Chicago, IL

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### Dental Admission Testing Program (DAT)

The DAT continues to be administered exclusively on computer at Prometric Testing Centers throughout the United States and its territories. The post-test survey results for 2010 indicate that the majority of 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 scores are transmitted to dental school admission officers through the ADA secure score site. Examinees receive an unofficial report of scores upon completing the DAT at a Prometric Testing Center. Prehealth advisors receive printed score listings of examinees who indicated their desire to have their results communicated to their prehealth advisor. Beginning in 2010, DAT score information was reported electronically to schools through ADEA's Associated American Dental Schools Application Service (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.

In 2010, the Commission on Dental Accreditation, Joint Commission on National Dental Examinations, and Council on Dental Education and Licensure continue to use a unique identification number, DENTPIN™, for applicants and students in dental or advanced dental education programs and for candidates taking the National Board Dental and Dental Hygiene Examinations. The DENTPIN™

enhances the privacy of applicants and students by eliminating the use of Social Security and Reference Numbers to identify them.

At its meeting in April 2011 the Council, through its Committee on Educational Measurement and Testing, reviewed a plan for replacing Quantitative Reasoning Test (QRT) with a critical thinking test. After the review and discussion of the plan with budget information and validation procedures, the Council approved the proposed changes to the current QRT specifications, as well as the proposed validity study plan as presented.

A summary report of the DAT Program activities for 2010 included trends in the number of the administrations delivered to examinees (including gender and ethnicity ratios), the performance of examinees (all and first-time) on each test on the DAT battery, the mean academic averages and the mean perceptual ability scores of examinees accepted into dental schools. The summary also included test score reliability and the names and affiliations of the test construction committee members. The following information regarding the DAT Program activities for the five-year period from 2006 through 2010 was highlighted:

- Comparing 2006 with 2010 suggests an overall increase of 118 administrations or an increase of 0.9%. The number of administrations of the DAT slightly decreased from 13,993 to 13,406, i.e., a decrease of 587 administrations from 2009 to 2010.
- Comparing 2006 with 2010 shows an overall decrease of 349 examinees, or 3.9% decrease, taking the DAT for the first time.
- The gender ratios have changed since 2006; i.e., percentages of administrations of the DAT to males declined from 51% to 49.4% while the percentage of females taking the DAT increased from 49% to 50.6%.
- Less than 2% of the administrations of the DAT were to American Indian examinees; between 5% and 10% of the administrations of the DAT were to Black and Hispanic examinees; between 20% and 30% of the administrations of the DAT were to Asian examinees; and between 50% and 60% of the administrations of the DAT were to White examinees. For Asian and Hispanic examinees, the numbers were higher in 2009 and 2010 when compared to 2006 through 2008. For White examinees, the number gradually decreased each year since 2006.
- The percentage of examinees taking the DAT more than once was the highest at 37.6% in 2009.
- The fluctuations in the reported averages for each test on the DAT battery are statistically and practically insignificant.
- The performance of students matriculating in dental schools is superior to the test performance of first-time and all examinees.
- The reliability of the score achieved on each test on the DAT battery is either excellent, i.e.,  $\geq 0.90$  (the Survey of the Natural Sciences and Perceptual Ability Test), or acceptable, i.e., 0.88 and 0.87 for the Reading Comprehension Test and Quantitative Reasoning Test, respectively.

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### **Response to Assignments From the 2010 House of Delegates**

**Amendment of the ADA Bylaws Regarding the Name of CDEL's Standing Committee on Dental Education:** Resolution 9H-2010 amended the Name of CDEL's Standing Committee on Dental Education. Appropriate ADA documents have been corrected to reflect this change.

**Amendment of the ADA Bylaws to Update Terminology in the Duties of the Council on Dental Education and Licensure:** Resolution 10H-2010 updated the ADA Bylaws to accurately reflect the current terminology in the Duties of the Council on Dental Education and Licensure. Appropriate ADA documents have been updated.

**Amendment of the ADA Bylaws, Duties of the Council on Dental Education and Licensure Relating to the Recognition of Interest Areas in General Dentistry:** Resolution 11H-2010 amended the duties of the Council on Dental Education and Licensure to include the recognition of interest areas in general dentistry. The ADA Bylaws and other appropriate ADA documents have been updated.

**Criteria for Recognition of Interest Areas in General Dentistry:** Resolution 12H-2010 approved the *Criteria for Recognition of Interest Areas in General Dentistry* for the Council to use when considering a request for recognition of an interest area in general dentistry. As noted previously in this report, the Council has developed a protocol and an application form for implementing the new recognition process should a general dentistry interest area seek recognition by the ADA.

**Acceptance of Formal Continuing Medical Education Courses Offered by ACCME Accredited CE Providers:** Resolution 13H-2010 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). The ADA president sent correspondence to the presidents and executive directors of the state boards of dentistry urging their consideration of this new ADA policy.

**Participation in Dental Outreach Programs:** Resolution 31H-2010 urges that students in U.S. dental schools and pre-dental programs who participate 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*; be directly supervised by dentists licensed to practice or teach in the United States; and perform only procedures for which the volunteer has received proper education and training. The Chair of the Council and the Chair of the Committee on International Programs and Development transmitted a joint letter to dental school deans, ASDA, pre-dental societies and groups, and international volunteer groups urging their consideration of this new ADA policy. A news article also appeared in *ADA News*.

**Online Continuing Education Courses for 2011:** Resolution 63H-2010 approved the development of online continuing education courses for addition to the ADA CE Online library. The Council has directed staff to pursue the development of proposed online courses utilizing funds allocated by Resolution 63H-2010. Up to six online continuing education courses will be added to the ADA CE Online library in late 2011.

**Study Impact of Existing and Emerging Models of Dental Education:** The 2010 House of Delegates referred Resolution 87 to the Council for study. The Council's detailed response to Resolution 87 is presented elsewhere in this report. The Council agreed with the intent of Resolution 87 that the Association should monitor and analyze current and future dental education models and concluded that given all of the changes occurring in dental education, a comprehensive study of dental education, similar to the Gies Report, should be done in the long-term. However, the Council believes that the collection and analysis of data on both existing and new schools is the first step. The Council will collaborate with the ADA's Health Policy Resources Center (HPRC), the Survey Center and Health Policy Analysis Departments, and other appropriate ADA agencies, to identify and analyze relevant data and make the findings available on a routine basis to the profession and the House of Delegates.

**Examinations for Allied Dental (Non-Dentist) Personnel:** Resolution 106H-2010 strongly urges state dental boards and regional clinical testing agencies to examine candidates for dental licensure separately from candidates for allied dental (non-dentist) licensure. The ADA president sent correspondence to the presidents and executive directors of the state boards of dentistry and regional clinical testing agencies urging their consideration of this new ADA policy.

**A Viable Mid-Level Solution: Improving Access by Reinventing Dentists' Education:** The House of Delegates referred Resolution 112-2010 to the Council for study. The Council's detailed response to Resolution 112 is presented elsewhere in this report. The Council concluded that many dental education and advanced dental education programs include off-campus community-based experiences for students. The dental education institutions are doing their share to address this multi-faceted issue. The Council believes that convening stakeholders to further explore the use of fourth- and/or fifth-year dental students and postdoctoral general dentistry residents in lieu of proposed mid-level provider models to provide care to the underserved and unserved would be an expensive activity, with limited benefit or advancement in addressing the access to care issue. The Council concluded that no further action should be taken by the Council or the House of Delegates at this time.

**Chair and Vice Chair for 2011-2012:** The Council forwarded the name of Dr. George J. Kinney to the Board of Trustees for approval as the Council's chair for the upcoming term. Dr. Ronald D. Venezie was elected vice chair for the 2011-2012 term.

**Personnel:** At the 2011 annual session, Dr. Brian T. Kennedy, Dr. Cyril Meyerowitz, Dr. David Perkins, Dr. James L. Schmidt and Dr. Shamik Vakil complete their terms as Council members. Mr. Corwyn Hopke completes his term as the American Student Dental Association's consultant 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. Charles H. Norman, III.

## Summary of Resolutions

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**6. Resolved**, that the policy, Comprehensive Study of Dental Specialty Education and Practice (*Trans.*2001:468), be amended as follows (proposed deletions are ~~stricken~~; proposed additions are underlined):

### ~~Comprehensive Study~~ Periodic Review of Dental Specialty Education and Practice

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

**Resolved**, that the Council report the results of the reviews ~~next periodic review of dental specialty education and practice be presented~~ to the 2014 ADA House of Delegates.

**7. Resolved**, that the following policy, Periodic Review of Specialty Education and Practice (*Trans.*1992:620), be rescinded:

**Resolved**, that the concept of the Association maintaining a mechanism for the periodic review of specialty education and practice be endorsed, and be it further

**Resolved**, that beginning in 2001, the Council on Dental Education and Licensure forward recommendations from this review to the House of Delegates for its consideration.

**8. Resolved**, that Association's Policy Statement on Continuing Dental Education (*Trans.*2006.331) be amended as follows (proposed additions underlined; proposed deletions ~~stricken~~):

### Policy Statement on Continuing Dental Education

**Definition of Continuing Dental Education:** Continuing dental education consists of educational activities designed to review existing concepts and techniques, to convey information beyond the basic dental education and to update knowledge on advances in scientific, clinical, and non-clinical ~~practice~~ related subject matter, including evidence-based dentistry and ethics. The objective is to improve the knowledge, skills and ability of the individual to provide the highest quality of service to the public and the profession. All continuing dental education should strengthen the habits of critical inquiry, and balanced judgment and ethics that denote the truly professional and scientific person and should make it possible for new knowledge to be incorporated into the practice of dentistry as it becomes available.

Continuing education programs are designed for part-time enrollment and are usually of short duration, although longer programs with structured, sequential curricula may also be included within this definition. In contrast to accredited advanced dental education programs, continuing dental education programs do not lead to eligibility for ethical announcements or certification in a specialty recognized by the American Dental Association. Continuing dental education should be a part of a lifelong continuum of learning.

**Acceptable Subject Matter:** In order for specific course subject material to be acceptable for credit, the stated course objectives, overall curriculum design or topical outlines should be clearly stated. The information presented should enable the dental professional to enhance the dental health of the public, either directly or through improved effectiveness of operations in dental practice, or through expansion of present knowledge through research. The dental professional should be able to apply the knowledge gained within his or her professional capacity.

**Acceptable Activities:** Continuing education activities are conducted in a wide variety of forms using many methods and techniques which are sponsored by a diverse group of institutions and organizations. State boards and/or legislatures may specify acceptable activities or content. The Association urges the state boards to allow maximum flexibility for an individual to choose content and learning activities based on individual preferences, needs, interests and resources. Additionally, clinical credit should be awarded for all activities related to the delivery of dental procedures including those with ethical components and self study activities.

Acceptable forms might include but are not limited to:

- attendance at and/or delivery of a formal continuing education course (a didactic and/or participatory presentation to review or update knowledge of new or existing concepts and techniques)
- general attendance at a multi-day convention type meeting (a meeting held at the national, state or regional level which involves a variety of concurrent educational experiences)
- authorship of publications (e.g., a book, a chapter of a book or an article or paper published in a professional journal)
- completion of self study activities individualized continuing education instruction such as online courses and research, webinars, journal articles and downloadable books (a individualized course of study which is structured and organized, but is available on an unscheduled and unsupervised basis; a method of providing feedback to the learner on performance or comprehension must be incorporated into the self-study activity)
- enrollment in a preceptor program (an independent course of study with a formally structured, preplanned and prescheduled curriculum where the participant observes and provides patient treatment using criteria and guidelines provided by the instructors; this type of study does not lead to an academic degree)
- academic service (e.g., instruction, administration or research related to undergraduate, postgraduate or graduate dental or allied dental training programs)
- presenting posters or table clinic
- participation on a state dental board, a board complaint investigation, peer review or quality care review procedures
- successful completion of Part II of the National Board Dental Examination, a recognized dental specialty examination or the National Board Dental Hygiene Examination if taken after initial licensure
- test development for written and clinical dental, dental hygiene and dental specialty examinations
- volunteering pro bono dental services or community oral health activities through instruction at a public health facility
- participation in dental research as a principal investigator or research assistant

## **Appendices**

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Appendix 1: References From the 2008-2009 Survey of Dental Education

Appendix 2: NIDCR Grants to U.S. Dental Institutions, FY 2010

Appendix 3: Listing of Resources Considered by Resolution 112 Ad Hoc Committee

Appendix 4: 2011 Periodic Review of Dental Specialty Education and Practice

## Appendix 1

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### Council on Dental Education and Licensure Ad Hoc Committee on Resolution 87

April 2011

#### REFERENCES FROM THE 2008–2009 SURVEY OF DENTAL EDUCATION

The American Dental Association's *Survey of Dental Education* provides statistical information from dental schools regarding academic programs, admissions, enrollment, attrition, graduates, educational expenses and financial assistance, patient care, advanced dental education and faculty positions. Requests to complete the surveys are sent annually to all United States dental schools and Canadian dental schools. All U.S. schools are required to complete the survey in order to maintain accreditation by the Commission on Dental Accreditation (CODA).

Excerpts from Volumes 1 through 5 of the 2008–2009 Survey of Dental Education may be useful to the Resolution 87 Ad Hoc Committee. Complete volumes are available at: <http://www.ada.org/1621.aspx>.

#### **Volume 1: Academic Programs, Enrollment, and Graduates**

- Figure 1: Classification of US Dental Schools – Page 5
- Table 2: Description of Academic Program in US and Canadian Dental School – Page 6
- Figure 15: Outcomes Assessment for Class of 2007 – Page 52
- Table 22: United States Dental School Graduates, 1999 to 2008 – Page 46
- Table 29: Patient Care Provided by United States and Canadian Dental School Students During the Recent Year – Page 64

#### **Volume 2: Tuition, Admission, and Attrition**

- Table 1: Resident and Non-Resident Tuition by Class, 2008–09 – Page 6
- Table 3: United States Dental Schools Ranked by the Ratio of Non-Resident First-Year Tuition and Fees to Resident First-Year Tuition and Fees, 2008–09 – Page 10
- Table 22: Average DAT Scores of First-Year Students, 2008–09 – Page 45
- Table 23: Average Pre-Dental GPA1 of First-Year Students, 2008–09 – Page 47

#### **Volume 3: Faculty and Staff Support**

- Table 1: Enrollment, Biomedical Science and Dental/Clinical Science Faculty 2007–08 – Page 3
- Table 6: Total Full-Time Equivalent Support Personnel, 2007–08 – Page 13-14

#### **Volume 4: Curriculum**

- Table 3: Dental Schools Order by Total Clock Hours of Instruction – Page 10
- Table 7: Clock Hours by Type of Instruction in Dental/Clinical Sciences – Page 15
- Figure 15b: Average Number of Dental School-Based and Community-Based Patient Care Clock Hours in Dental/Clinical Science Major Teaching Areas, 2008–09

#### **Volume 5: Finances**

- Figure 1: Total Revenue and Total Expenditures at All Dental Schools, FYE 1999 to 2008 – Page 2
- Table 11a: Schools Rank Ordered by Percentage of Total Revenue From Research and Sponsored Training Programs Recovery of Direct Cost, FYE 2008 – Page 49
- Table 12: Schools Rank Ordered by Percentage of Total Revenue From Financial Aid Revenue, FYE 2008 – Page 52

**Appendix 2**

**Council on Dental Education and Licensure  
Ad Hoc Committee on Resolution 87**

**April 2011**

<b>NIDCR Grants to U.S. Dental Institutions, FY 2010 In Rank Order of Amount Funded</b>		
<b>Rank</b>	<b>Institution</b>	<b>FY 2010 Amount</b>
1	FORSYTH INSTITUTE	11,583,534
2	UNIVERSITY OF CALIFORNIA SAN FRANCISCO	11,213,948
3	UNIVERSITY OF ROCHESTER	9,072,198
4	UNIVERSITY OF MICHIGAN AT ANN ARBOR	8,602,362
5	NEW YORK UNIVERSITY	7,748,432
6	UNIVERSITY OF WASHINGTON	7,670,778
7	UNIVERSITY OF FLORIDA	7,193,425
8	UNIVERSITY OF NORTH CAROLINA CHAPEL HILL	7,078,650
9	UNIVERSITY OF CALIFORNIA LOS ANGELES	7,055,633
10	BOSTON UNIVERSITY MEDICAL CAMPUS	6,604,296
11	UNIVERSITY OF ALABAMA AT BIRMINGHAM	5,614,303
12	UNIVERSITY OF PITTSBURGH AT PITTSBURGH	4,694,478
13	UNIVERSITY OF SOUTHERN CALIFORNIA	4,539,756
14	STATE UNIVERSITY NEW YORK STONY BROOK	4,222,774
15	UNIVERSITY OF MARYLAND BALTIMORE	4,048,214
16	UNIVERSITY OF LOUISVILLE	3,804,017
17	UNIVERSITY OF CONNECTICUT SCH OF MED/DNT	3,716,236
18	UNIVERSITY OF IOWA	3,517,544
19	UNIVERSITY OF PENNSYLVANIA	3,442,469
20	UNIVERSITY OF MINNESOTA TWIN CITIES	2,985,358
21	UNIVERSITY OF TEXAS HLTH SCI CTR SAN ANT	2,879,184



22	UNIVERSITY OF COLORADO DENVER	2,584,870
23	OHIO STATE UNIVERSITY	2,231,169
24	STATE UNIVERSITY OF NEW YORK AT BUFFALO	2,201,476
25	UNIVERSITY OF ILLINOIS AT CHICAGO	2,148,232
26	UNIV OF MED/DENT OF NJ - NJ DENTAL SCHOOL	1,603,937
27	CASE WESTERN RESERVE UNIVERSITY	1,506,956
28	HARVARD UNIVERSITY (MEDICAL SCHOOL)	1,488,410
29	TEXAS A&M UNIVERSITY HEALTH SCIENCE CTR	1,477,053
30	MEDICAL UNIVERSITY OF SOUTH CAROLINA	1,326,153
31	TUFTS UNIVERSITY BOSTON	1,312,570
32	UNIVERSITY OF MISSOURI KANSAS CITY	1,132,641
33	UNIVERSITY OF TEXAS HLTH SCI CTR HOUSTON	1,051,494
34	VIRGINIA COMMONWEALTH UNIVERSITY	1,046,947
35	INDIANA UNIV-PURDUE UNIV AT INDIANAPOLIS	890,652
36	MEDICAL COLLEGE OF GEORGIA (MCG)	705,323
37	LOUISIANA STATE UNIV HSC NEW ORLEANS	702,900
38	COLUMBIA UNIVERSITY HEALTH SCIENCES	702,051
39	UNIVERSITY OF PUERTO RICO MED SCIENCES	680,718
40	NOVA SOUTHEASTERN UNIVERSITY	630,285
41	OREGON HEALTH AND SCIENCE UNIVERSITY	534,899
42	UNIVERSITY OF MISSISSIPPI MEDICAL CENTER	507,116
43	UNIVERSITY OF OKLAHOMA HLTH SCIENCES CTR	362,588
44	UNIVERSITY OF NEBRASKA MEDICAL CENTER	352,910
45	MARQUETTE UNIVERSITY	310,707
46	HOWARD UNIVERSITY	272,301
47	UNIVERSITY OF TENNESSEE HEALTH SCI CTR	152,202
48	UNIVERSITY OF KENTUCKY	135,000
	<b>Grant Total:</b>	155,339,149

### Appendix 3

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#### **Council on Dental Education and Licensure Ad Hoc Committee on Resolution 112**

**April 2011**

#### **REFERENCE LIST**

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<http://www.newsobserver.com/>. The fix that ECU's med school is in. 2011/01/22.

## Appendix 4

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### Council on Dental Education and Licensure 2011 Periodic Review of Dental Specialty Education and Practice to the ADA House of Delegates

**Background:** In 1992, the ADA House of Delegates adopted Resolution 144H-1992 directing the periodic (every 10 years) review of dental specialty education and practice beginning in 2001. In 2001, the Council on Dental Education and Licensure conducted the review and forwarded its recommendations to the House of Delegates. The 2001 House of Delegates accepted the report and adopted the following resolutions:

**20H-2001. Resolved,** that the appropriate Association agency continue to conduct a periodic review of dental specialty education and practice at 10-year intervals, and be it further

**Resolved,** that the next periodic review of dental specialty education and practice be presented to the 2011 ADA House of Delegates.

**21H-2001. Resolved,** that the sponsoring dental specialty organizations and ADA recognized dental specialty certifying boards be urged to continue to monitor the number of specialists who are board certified and identify ways to increase the percentage of specialists who seek and achieve board certification in light of dental specialty faculty shortages and the Commission on Dental Accreditation's standard requiring that program directors of advanced dental specialty education programs be board certified.

In carrying out the House directive for such periodic reviews, the Council hopes to gather strategic information that will be of value to the Association, the dental specialty organizations, the profession and the public. This review focuses on changes occurring within the specialty education and practice environments, e.g., disease trends, technology, scope of practice, program enrollments, and demographics. It addresses the current environment as well as potential trends for the future and how these may impact the public and the profession. The Council believes that the input and self-assessment presented by each of the specialty organizations was essential in providing this report to the House of Delegates.

**CDEL Activities:** For the 2011 Periodic Review, members of the Council and its Committee on Recognition of Specialties and Interest Areas in General Dentistry began by reviewing with the leadership and staff of the recognized dental specialty organizations and certifying boards the purpose of the 2011 Periodic Review of Dental Specialty Education and Practice. They shared the template used by the Council in the conduct of the 2001 Review and indicated that a similar format would be followed for the 2011 Review. Representatives of the specialty organizations had few comments on the review process and were pleased to learn that the format used in 2001 would be repeated.

The following dental specialty organizations submitted reports: American Association of Public Health Dentistry (AAPHD), American Association of Endodontists (AAE), American Academy of Oral and Maxillofacial Pathology (AAOMP), American Academy of Oral and Maxillofacial Radiology (AAOMR), American Association of Oral and Maxillofacial Surgeons (AAOMS), American Association of Orthodontists (AAO), American Academy of Pediatric Dentistry (AAPD), American Academy of Periodontology (AAP) and American College of Prosthodontists (ACP).

At its November 2010 Meeting, CDEL conducted a preliminary analysis of the reports. The Council noted that overall membership in the dental specialty organizations has increased in the last 10 years. The increase appears to be due to several reasons, including growth in the number of advanced specialty education programs and increase in the number of program graduates. However, the increase also may be due to the establishment of new membership categories within the dental specialty organizations. The Council noted that some of the organizations have a myriad of membership categories for non-dentists and non-specialists. The Council considered the potential implications of the organizations' broad

membership eligibility categories in relation to Requirement 1(a) of the Requirements for Recognition of Dental Specialties (appended), i.e., the specialty “must be represented by a sponsoring organization (a) whose membership is reflective of the special area of dental practice...”

The Council also considered a letter from Dr. Robert Bitter, president-elect of the Illinois State Dental Association. Dr. Bitter raised several questions about the membership categories and numbers of dental public health dentists who are members of the American Association of Public Health Dentistry.

In January 2011, CDEL contacted each specialty organization requesting additional information by February 28, 2011. The Council requested definitions of each membership category, privileges (voting and holding office) of each category and the number of members in each category. The Council asked that each organization provide information on the total number of practitioners of the specialty in the United States, the total number of members in the specialty organization who are specialists and the total number of specialty members who are diplomates in the specialty (Table 5). Lastly, the Council urged the organizations to review their initial reports related to strategic planning and research and submit any updates, as appropriate.

In April 2011, the Council carefully reviewed the supplemental information submitted by the organizations. The Council approved the following 2011 Periodic Review of Dental Specialty Education and Practice and directed its transmission to the 2011 House of Delegates.

## **I. GENERAL INFORMATION AND DEMOGRAPHIC DATA OF THE SPECIALTIES**

**History of Dental Specialties:** As noted in Table 1, in 1947, the ADA formally recognized five dental specialties, oral and maxillofacial surgery, orthodontics (now known as orthodontics and dentofacial orthopedics), pedodontics (now known as pediatric dentistry), periodontics and prosthodontics. Oral and maxillofacial pathology was recognized shortly after in 1949, followed by dental public health in 1950. Endodontics was recognized in 1963; oral and maxillofacial radiology in 1999.

**Table 1. History of ADA-Recognized Dental Specialties and Dental Specialty Certifying Boards**

	Date Specialty Recognized by ADA	Date Specialty Re-Recognized by ADA	Date Specialty Board Recognized (by CDEL)	Founding Date of Certifying Board
Public Health Dentistry	1950	1986	1951	1950
Endodontics	1963	1989	1964	1964
Oral and Maxillofacial Pathology	1949	1987	1950	1948
Oral and Maxillofacial Radiology	1999	N/A	2000	1979
Oral and Maxillofacial Surgery	1947	1988	1947	1946
Orthodontics and Dentofacial Orthopedics	1947	1989	1950	1929
Pediatric Dentistry	1947	1990	1948	1942
Periodontics	1947	1988	1948	1940
Prosthodontics	1947	1987	1948	1946

*Source: ADA Annual Reports and Transactions 1947-2000.*

**Professionally Active Dental Practitioners:** Since the 1940s, the dental profession has recognized the value of dentists who seek advanced education, specializing in one area of dentistry. Today, approximately 20% of dentists identify themselves as dental specialists. Based on ADA Survey Center data, there has been little change from 1991 - 2008 in the percentage distribution of all professionally active dentists in the U.S., as illustrated in Table 2. The data reflects that the ratio of general dentists to specialists has remained constant over the last two decades. The number of specialists most likely will increase, but not dramatically, in the near future.

**Table 2. Percentage Distribution in U.S. of All Professionally Active Dentists\***

GP/SPECIALISTIST	1991	1998	2008
	N=150,762	N=149,337	N=181,774
General Practice	79.4%	79.4%	78.9 %
Public Health Dentistry	0.82%	0.7%	0.8%
Endodontics	2.0%	2.3%	2.6%
Oral and Maxillofacial Pathology	0.25%	0.2%	0.2%
Oral and Maxillofacial Radiology			0.1%
Oral and Maxillofacial Surgery	4.2%	4.0%	3.9%
Orthodontics	5.9%	5.8%	5.6%
Pediatric Dentistry	2.4%	2.5%	3.2%
Periodontology	2.9%	3.0%	2.8%
Prosthodontics	2.2%	2.0%	1.8%

Source: ADA Survey Center—"Distribution of Dentists in the U.S. by Region and State"—1991, 1998 and 2008.

\*Includes private practitioner, dental school faculty or staff, armed forces dentist, government-employed dentist, graduate student, intern or resident, or other health and dental organization staff member. Further, the distributions reported in this table reflect dentists' self-reported area of practice rather than whether they were specialists in an ADA-recognized special area of practice by virtue of meeting licensure, education, diplomate or grandfather requirements.

**Specialty Membership and Certification:** Overall, membership in the specialty organizations increased from 42,264 members in 2001 to 53,422 members in 2009, representing an overall increase of 26% in membership. Four of the nine organizations require their dentist-members to be members of the American Dental Association:

Organization	ADA Membership Required?
AAPHD	No
AAE	Yes Active, Associate, Educator
AAOMP	No
AAOMR	No
AAOMS	No
AAO	Yes
AAPD	Yes
AAP	Yes Active, Associate, Educator
ACP	No

Several of the organizations have redefined the criteria for membership to include residents, retired specialists and various dentist, non-dentist or non-specialist categories. These changes have expanded each specialty's base and strengthened each organization. Table 3 reflects the nine recognized specialty organizations' general membership figures over the last 10 years, as reported by the organizations.

**Table 3. Overview of Membership in Dental Specialty Organizations**

	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2000-09 Change
<b>AAPHD</b>	616	605	761	713	917	809	901	911	1113	1265	100%
<b>AAE</b>	5,337	5,718	6,204	6,468	6,586	6,665	6,947	7,008	7,063	7,219	35%
<b>AAOMP</b>	640	642	632	632	634	630	598	575	593	586	(8%)
<b>AAOMR</b>	345	347	335	312	328	319	274	294	301	317	(8%)
<b>AAOMS</b>	7,622	7,757	7,965	8,163	8,192	8,290	8,476	8,583	8,805	9,008	18%
<b>AAO</b>	13,649	13,678	13,811	14,372	14,732	14,907	15,261	15,437	15,594	15,972	17%
<b>AAPD</b>	4,528	4,620	4,841	5,724	5,905	6,311	6,547	7,007	7,374	7,665	69%
<b>AAP</b>	6,970	7,290	7,342	7,619	7,745	7,804	7,856	8,014	8,085	8,098	16%
<b>ACP</b>	n/a	2,718	2,499	2,641	2,535	2,779	2,812	3,025	3,141	3,292	21%

Three of the specialty organizations, AAPHD, AAE and AAPD experienced significant increases in membership. Membership in AAPHD has doubled in the last 10 years and the organization attributes its increase to the establishment of student chapters. AAPHD's "primary" membership category, open to any qualified dental health professional with a primary commitment to dental public health practice, may also be a contributing factor. AAE cites the increase in advanced specialty education programs in endodontics and the creation of new membership categories as reasons for its membership growth. The growth in AAPD's membership is attributed to its merger with the American Society of Dentistry for Children (ASDC) as well as expanded membership categories that include predoctoral students and non-dental professionals.

Two associations have experienced a decrease in membership, AAOMP and AAOMR. AAOMP explains the decline in membership as a result of lost academic positions due to dental school closings and lack of funds to hire faculty who are oral pathologists. However, the AAOMP believes the trend will end as more new dental schools open in the next five years. AAOMR did not offer an explanation for the decrease in its membership.

The Council requested information on the gender and ethnicity of the membership in each of the specialty organizations. Six of the nine specialty organizations provided gender information (Table 4). Males represent the majority of members in the specialty organizations ranging from a low of 58% in AAPD to a high of 96% in AAOMS. Very little data was available related to ethnicity of each specialty organization's membership and not worthy of including in this report. The ADA is committed to increasing diversity in its membership, in dental education and in the profession as a whole. Accordingly, CDEL will encourage the dental specialty organizations to routinely track and report gender and ethnicity data.

**Table 4. Gender of the Membership in the Dental Specialty Organizations**

2009	Gender	
	Male	Female
<b>AAPHD</b>	NA	NA
<b>AAE</b>	80%	20%
<b>AAOMP</b>	73 %	37%
<b>AAOMR</b>	NA	NA
<b>AAOMS</b>	96%	4%
<b>AAO</b>	NA	NA
<b>AAPD</b>	58%	42%
<b>AAP</b>	81%	19%
<b>ACP</b>	81%	19%

The Council monitors ADA recognized specialty certifying boards' compliance with the ADA Requirements for Recognition of National Certifying Boards for Dental Specialists through annual reports provided by each recognized certifying board. The Council provided each specialty organization with certification trend data collected via these annual reports. Each specialty organization was requested to review the certification data and provide comment on significant trends.

**Table 5. Active Diplomates From 2000–2010**

	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2000-10 Change
<b>ABPHD</b>	141	144	146	152	152	157	155	157	157	160	159	13%
<b>ABE</b>	725	744	707	739	762	776	792	788	815	831	846	17%
<b>ABOMP</b>	268	265	272	276	289	295	296	301	302	306	313	17%
<b>ABOMR</b>	95	95	95	93	94	96	97	98	100	106	110	16%
<b>ABOMS</b>	4,220	4,245	4,224	4,399	4,506	4,552	4,417	4,620	4,616	4,904	4,983	18%
<b>ABO</b>	1,933	1,922	202	2,008	1,994	2,640	3,111	5,139	5,164	5,034	4,858	151%
<b>ABPD</b>	1,177	1,221	1,278	1,337	1,355	1,404	1,668	2,056	2,383	2,726	3,100	163%
<b>ABPerio</b>	1,384	1,432	1,492	1,569	1,710	1,915	2,111	2,267	2,381	2,506	2,544	84%
<b>ABProsth</b>	720	717	715	724	724	736	1,068	1,056	1,085	1,141	1,147	59%
<b>Total Diplomates</b>	10,663	10,785	9,131	11,297	11,586	12,571	13,715	16,482	17,003	17,714	18,060	70%

Source: CDEL's Annual Reports of the ADA-Recognized Dental Certifying Boards 2000-2010.

While not all specialists seek board certification, this number is increasing. The number of active diplomates grew from 10,663 in 2000 to 17,003 in 2008, representing a 59% increase. Four specialties, orthodontics and dentofacial orthopedics, pediatric dentistry, periodontics and prosthodontics have had significant increases due to changes in their board certification processes (Table 5).

In general, eligibility for board certification is based on the completion of an advanced specialty education program accredited by the Commission on Dental Accreditation (CODA) and experience in the field. To achieve diplomate status, all certifying boards require successful completion of a written examination; all but the American Board of Oral and Maxillofacial Pathology (ABOMP) require successful completion of an oral exam; six of the boards require either a case history presentation or clinical examination.

Specialty certifying boards are committed to increasing the number of specialists who are board certified and have made a number of changes in the eligibility pathways. Several boards have developed pathways to assist those specialists who have been in practice for many years to pursue diplomate status. All boards have made changes to make the certifying process more appealing to new graduates. In addition, the following boards have certification pathways for internationally trained specialists who are not graduates of CODA-accredited advanced specialty education programs: American Board of Dental Public Health (ABDPH), ABOMP, American Board of Oral and Maxillofacial Surgery (ABOMS) and American Board of Pediatric Dentistry (ABPD).

Maintaining the highest standards of practice is a goal of all nine dental specialty boards. Recertification of diplomates provides a mechanism to assure these standards are maintained throughout the specialist's career. Today, all of the certifying boards require recertification with each specialty certifying board determining its own process.

The Council believes positive steps have been taken by specialty organizations and certifying boards to increase the number of board certified diplomates in response to Resolution 21H-2001. All of the certifying boards have taken steps to make the certification process more user friendly. Further, all dental specialty certifying boards have policies in place requiring recertification.

After considering the overall membership and certification data, the Council then requested each organization to provide supplemental information on membership categories, membership privileges



(voting and holding office) for each category and the number of members in each category. The Council asked that each organization provide information on the total number of practitioners of the specialty in the United States, the total number of members in the specialty organization who are specialists and the total number of specialty members who are diplomates in the specialty. Table 6 provides an overview of data collected. Table 7 notes that almost all of the organizations have non-specialist/non-dentist membership categories. Two organizations, the AAPHD and AAOMR, permit non-specialists/non-dentists to vote and hold office.

**Table 6. Overview of Professionally Active Specialists, Members of Organizations and Diplomates**

	Estimated Number of Specialists in US*	Total Membership of the Specialty Organization	Number of Members Who Are US Specialists	Percentage of Members Who Are US Specialists	Total Number of Members Who Are Diplomates	Percentage of Members Who Are Diplomates
AAPHD	1,391	1,265	520	41%	168	32%
AAE	4,757	7,219	4,625	64%	1,082	23%
AAOMP	369	582	352	60%	285	81%
AAOMR	106	317	147	46%	93	63%
AAOMS	7,015	9,008	8,988	99%	5,146	57%
AAO	10,108	15,972	9,525	94%	4,858	51%
AAPD	5,800	7,665	5,239	68%	2,635	50%
AAP	5,136	8,098	5,058	62%	2,140	42%
ACP	3,293	3,292	2,685	82%	955	36%

\*ADA Survey Center, Table 3a, Distribution on Dentists, 2008.

**Table 7. Membership Categories and Privileges**

	Non-Specialist Membership Categories	Non-Dentist Membership Categories	Are Non-Specialists/Non-Dentists Eligible to Vote?	Are Non-Specialists/Non-Dentists Eligible to Hold Office?
AAPHD	Yes	Yes	Yes	Yes
AAE	Yes	Yes	No	No
AAOMP	Yes	Yes	No	No
AAOMR	Yes	Yes	Yes	Yes
AAOMS	Yes	No	No	No
AAO	No	No	No	No
AAPD	Yes	Yes	No	No
AAP	Yes	No	No	No
ACP	Yes	Yes	No	No

The Council believes that the supplemental information provided by the dental specialty organizations and presented in Tables 6 and 7 indicates that the sponsoring organizations considered continue to meet the conditions set out in Requirement 1(a) of the Requirements for Recognition of Dental Specialties:

- (1) In order for an area to be recognized as a specialty, it must be represented by a sponsoring organization: (a) whose membership is reflective of the special area of dental practice; and (b) that demonstrates the ability to establish a certifying board.

The Council noted that while 46% of AAOMR's membership is comprised of oral and maxillofacial radiologists and 41% of AAPHD's membership is comprised of dental public health dentists, AAOMR and AAPHD meet the spirit of the requirement. They are the sponsoring organizations representative of the specialties of oral and maxillofacial radiology and dental public health, respectively.

**Strategic Planning:** In order to understand what each specialty area envisions as its future role in improving and providing oral health services to the public, each ADA-recognized specialty was requested to provide its organization's mission statement, goals and strategic plan. The organizations were also requested to include a brief summary highlighting the specific areas and efforts undertaken to promote quality in the discipline over the last 10 years.

The Council found each specialty organization's plan well conceived, providing direction for continued growth and development. The focus of the strategic plans is the promotion of education with the goal of increasing the quality of patient care. In addition, each specialty organization has unique goals related to its current practice environment, expanding technology and growing knowledge base.

The Council commends the dental specialty organizations for the leadership they have shown in their strategic planning efforts. Each of the specialties demonstrated that it has a process in place to secure its future viability. The Council urges the sponsoring organizations to continue these efforts.

## **II. MAJOR RESEARCH CHANGES AND TECHNOLOGY ADVANCES**

Each specialty organization was requested to examine the impact of major dental research and new technology on the specialty over the last decade. Specifically, each organization was requested to list major research changes and major technology advances over the last 10 years and provide an overview comment on how these changes and advances have affected the practice of the specialty. A summary of each specialty organization's response follows.

### **American Association of Public Health Dentistry**

- Research on oral health disparities has resulted in the creation of multiple consortia with the aim of addressing high disease levels in numerous populations within the United States.
- There have been important developments in the integration of surveillance data at the national and state levels. At the national level, oral health data is continuously obtained through National Health and Nutrition Examination Survey (NHANES). At the state level, the Center for Disease Control (CDC) and the Association of State and Territorial Dental Directors (ASTDD) developed the National Oral Health Surveillance System (NOHSS) that monitors eight indicators of oral health. The national and state data supported the Surgeon General's Report on Oral Health, Healthy People National Objectives and documentation of disparities and inequalities in oral health status in the nation.
- There has been, and continues to be, an increase in research correlating oral health and systemic health.
- Genome-wide Association Studies (GWAS) of large populations has permitted rapid advances in identifying genetic disease risk.

### **American Association of Endodontists**

- The AAE provided more than \$2.7 million in research grants over the past decade--the major contributing factor to the growth in research related to endodontics.
- The major research changes allow for more predictable endodontic clinical procedures, better outcomes for endodontic surgical and reparative procedures and better pain management.
- Probably no endodontic material has generated as much interest world-wide as mineral trioxide aggregate (MTA). Its uses were recognized from the beginning - root end fillings, perforation repairs, apical plugs and vital pulp protection; however, the properties and characteristics have only recently been more clearly understood. Recognized now as a bioinductive material, its role in stimulating hard tissue development (bone, cementum, dentin) has been elucidated with more clarity. Its application in vital pulp therapy is gaining momentum, to the extent that previous concepts regarding the pulp's ability to recover from bacterial exposure (e.g. carious and accidental exposures) is being re-evaluated.
- Significant data has emerged with respect to pain management and the value of supplemental intraosseous anesthesia and use of articaine.

- Growing understanding of endodontic microbiology has resulted in more effective biomechanical debridement protocols with expectations of improved clinical outcomes.
- Research has shown that the nature of organisms populating infected root canal apices is more diverse than expected.
- Research is ongoing in the areas of regenerative endodontics, revascularization and dental trauma.

#### **American Academy of Oral and Maxillofacial Pathology**

- Major research changes and technology advances can be categorized as:
  - a. Those related to applied and basic science aspects of oral and maxillofacial pathology;
  - b. Those related to the clinical management aspects of the specialty; and
  - c. Those related to the diagnostic histopathology aspects of the specialty.
- Molecular genetic studies are providing valuable understanding of oral soft tissue pathology.
- New and more effective pharmacologic agents are being developed to limit and in some cases eliminate a wide range of potentially debilitating autoimmune disease.
- Research has identified several new histopathologic lesions in the oral and perioral regions.

#### **American Academy of Oral and Maxillofacial Radiology**

- 2D imaging has had improvements in sensor technology, image processing and image enhancement software.
- 3D imaging—The greatest technologic advance of the last decade in oral and maxillofacial imaging came with the introduction of cone-beam computed tomography (CBCT).
- Current areas of research include image-guided surgical planning and treatment for the implant patient, image segmentation and registration, and CBCT image fusion with 3D photography.
- Systemic disease detection research during the last decade has demonstrated correlation of trabecular and cortical jaw architecture with the presence of systemic diseases such as osteoporosis and sickle cell anemia.

#### **American Association of Oral and Maxillofacial Surgery**

- Oral and Maxillofacial Foundation has funded more than 200 awards and projects, totaling \$9,100,000 between 1985-2010.
- Convened a significant number of research programs, included three Research Summits (2005, 2007, 2009) with a fourth scheduled in 2011; one Young Investigators' Program (2009), with a second planned in 2011; two Clinical Trials Workshops at the University of Michigan (2008, 2010).
- Funded and participated in a major research study investigating the necessity of removing third molars and the affect on overall health.
- The Outcomes Assessment Project, initiated by AAOMS, was created to validate the quality and appropriate care provided by oral and maxillofacial surgeons.

#### **American Association of Orthodontists**

- Use of temporary anchorage devices (TADs) for control of tooth movement is one of the most significant changes in treating malocclusion.
- Improved availability of three-dimensional CBCT is providing orthodontists with “better eyes” to plan treatment for severely impacted canines and supernumerary teeth as well as better prediction of skeletal changes needed in craniofacial challenges of all types.
- American Journal of Orthodontics and Dentofacial Orthopedics (AJO-DO) has continued to improve its Impact Factor, while increasing the number of articles published.
- AAO is a specialty determined to be known by its recognition and understanding of “evidence-based practice.” AAO participates regularly in ADA's Evidence-Based Dentistry (EBD) workshops, published editorials regarding evaluation of studies and speakers at AAO-sponsored programs are invited to give evidence-based presentations only.

### **American Academy of Pediatric Dentistry**

- Advances in adhesive dental technology have radically changed restorative dentistry. New materials offer the possibility of improved esthetics, more conservative bonded restorations, less intrusive/aggressive preparation designs, fluoride releasing materials used for disease treatment, prevention and restoration.
- Chlorhexidine rinses and varnishes, fluoride varnishes, and remineralizing agents have been found to facilitate more conservative, cost-effective approaches to caries management through microbial control and remineralization.
- Data supporting the safety of conscious sedation with proper monitoring as well as research into numerous sedative agents and combinations of agents have produced a broader array of modalities and supported evidence-based decisions in choosing the proper agent for a given clinical situation.
- Genetic testing and counseling is now part of management of children with multiple missing teeth, enamel and dentin disorders and craniofacial conditions.
- Microbial mechanisms in early caries development and the importance of the transfer of oral flora from care-taker to child has led to research on more focused early prevention.
- Dramatic caries reductions seen in permanent teeth over the past four decades are not matched by caries reduction in primary teeth.

### **American Academy of Periodontology**

- Research has demonstrated that a more significant relationship exists between the periodontal diseases and many systemic conditions than was ever conceived of previously.
- Research advances in bone metabolism (particularly osteoclastogenesis) and in the immunological/inflammatory fields and the recognition of their relationship (osteoimmunology) has led to a paradigm shift in understanding the pathogenesis of the periodontal diseases.
- Significant research and technological advancement has occurred in tissue regeneration.
- Major research and technological advancements include the area of tooth replacement with root form endosseous dental implants.
- Evidence is accumulating that periodontal disease can be viewed as one of many chronic diseases of aging that share inflammation as a common denominator.

### **American College of Prosthodontists**

- The major research and technologic advances over the last 10 years that affect prosthodontics include remarkable changes in 1) (bio) informatics, 2) materials science, 3) imaging technology and 4) digital technology.
- CBCT of osseous structures, video-based imaging of soft tissues, and visible wavelength (and x-ray) based scanning technologies together permit the integrated three dimensional imaging of patients and related study casts.
- The ability to perform guided surgery using stereolithographic surgical guides made from CBCT images is one example of technologies that have the opportunity to improve tooth replacement therapies.
- An international consensus conference has identified the mandibular implant supported overdenture as the standard of care for management of the edentulous mandible.
- ACP sponsored in April 2010 a conference entitled "The Art and Science of Modern Dental Ceramics 2010" where 20 expert clinicians offered scientific fact and expert opinion regarding these matters.

The Council was impressed with the extensive, innovative and ground-breaking research the dental specialties have undertaken in the past 10 years. Without exception, each dental specialty is creating new knowledge and new ways to apply this knowledge, resulting in better patient care. All of the specialty organizations reported that they publish journals and/or newsletters containing information on the practice of the specialty as well as scientific, research and educational articles.

### III. TRENDS IN SPECIALTY EDUCATION

The Council requested that each specialty organization review summary data collected over the last 10 years regarding the number of advanced specialty education programs, program enrollments, and faculty and provide overview comments on past or future education trends. Additionally, based on information provided by CODA regarding specialty education standards, the specialty organizations were requested to provide overview comments on future trends regarding this information.

#### Programs and Enrollments

**Table 8. Number of Dental Specialty Education Programs**

	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	Range
<b>Public Health</b>	18	15	14	13	13	13	13	12	10	10	10 – 18
<b>Endodontics</b>	48	50	51	52	52	53	53	53	53	54	48 – 54
<b>Pathology</b>	12	12	13	14	14	13	13	15	15	14	12 – 15
<b>Radiology</b>	4	4	4	5	5	5	5	5	5	5	4 – 5
<b>Oral Surgery</b>	101	100	102	100	100	100	99	100	100	102	99 – 102
<b>Orthodontics</b>	56	58	58	58	60	61	62	63	63	64	56 – 64
<b>Pediatric Dentistry</b>	57	61	65	65	65	67	69	73	74	74	57 – 74
<b>Periodontics</b>	52	52	52	52	53	53	53	54	54	54	52 – 54
<b>Prosthodontics</b>	48	48	48	47	46	46	44	45	45	45	44 – 48
<b>Total # Programs by Year</b>	396	400	407	406	408	411	411	420	419	422	

Source: ADA Survey Center, Survey of Advanced Dental Education, 2001-2010.

According to the ADA Survey Center's 2009-2010 Survey of Advanced Dental Education, two-thirds of the 422 specialty programs are housed in dental schools while one-third are housed in facilities such as medical centers, hospitals and Veterans' Administration facilities. The overall number of dental specialty programs increased 7% between 2001 and 2010 from 396 to 422. Six of the specialties saw a small increase in the number of programs, and advanced specialty education programs in pediatric dentistry experienced a 29% increase in programs. Prosthodontics programs experienced a 7% decrease and dental public health experienced a 44% decrease in the number of programs in the specialty. The Council found the decline in dental public health programs concerning. However, enrollment has increased slightly. On the other hand, the renewed interest in training dentists to address access to care issues may lead to a resurgence and potential increase in the number of programs and subsequent specialists in dental public health.

**Table 9. Enrollment in Dental Specialty Education Programs**

	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	Range
<b>Public Health</b>	35	41	43	46	41	42	35	38	43	44	35 – 46
<b>Endodontics</b>	406	415	406	420	430	432	445	443	444	433	406 – 445
<b>Pathology</b>	31	34	31	37	36	38	33	34	37	40	31 – 38
<b>Radiology</b>	5	12	13	22	23	24	19	24	27	31	5 – 24
<b>Oral Surgery</b>	937	939	942	923	964	960	965	1012	1008	1040	923 – 1012
<b>Orthodontics</b>	714	722	736	785	818	859	912	911	903	931	714 – 931
<b>Pediatric Dentistry</b>	442	480	509	543	579	621	658	686	710	733	442 – 686
<b>Periodontics</b>	476	496	507	497	509	514	512	517	535	541	476 – 517
<b>Prosthodontics</b>	378	377	392	398	401	407	425	431	445	451	377 – 431
<b>Total Per Year</b>	3424	3516	3579	3671	3801	3897	4004	4096	4152	4244	

Source: ADA Survey Center, Survey of Advanced Dental Education, 2001-2010.

The total number of advanced specialty education programs did not increase significantly, but enrollment in all specialty programs increased by almost 24% between 2001 - 2010 from 3,424 to 4,244 residents. While program enrollments tend to fluctuate slightly from year to year, each specialty's enrollment in 2010 was greater than its enrollment in 2001. Notable is the over 500% increase in enrollment in oral and maxillofacial radiology programs and 65% increase in enrollment in pediatric dentistry programs. AAPD expects the number of pediatric dentistry programs and enrolled residents to increase over the next 10 years, assuming federal and local funding continues. Like all the specialty organizations, AAPD is concerned about the continued ability to establish programs needed to meet public demand for services when faculty shortages continue and funding availability is tentative.

### Program Directors

Related to the faculty shortages is the need for full-time and board certified program directors as seen in Tables 10 and 11. Existing and projected faculty shortages have and continue to plague all advanced dental specialty programs. With the potential of eight to 10 new dental schools in the next five years, the number of specialty programs is likely to grow, increasing the projected shortage of qualified faculty for both predoctoral and advanced specialty education programs.

**Table 10. Percentage of Program Directors That Are Full-Time**

	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	Mean % Directors FT	Range
<b>Public Health</b>	94%	94%	93%	93%	92%	92%	92%	92%	100%	100%	<b>93%</b>	92 – 94
<b>Endodontics</b>	98%	98%	96%	98%	96%	94%	94%	100%	94%	94%	<b>97%</b>	94-100
<b>Pathology</b>	92%	92%	100%	100%	100%	100%	100%	100%	100%	100%	<b>98%</b>	92 -100
<b>Radiology</b>		100%	100%	100%	100%	80%	100%	100%	100%	100%	<b>97%</b>	80 -100
<b>Oral Surgery</b>	95%	98%	98%	100%	99%	99%	96%	100%	98%	99%	<b>98%</b>	96 – 100
<b>Orthodontics</b>	52%	52%	50%	59%	52%	54%	54%	58%	89%	92%	<b>54%</b>	50-59
<b>Pediatric Dentistry</b>	83%	88%	88%	85%	83%	78%	84%	85%	86%	89%	<b>84%</b>	78 – 88
<b>Periodontics</b>	92%	90%	90%	90%	91%	92%	92%	94%	96%	98%	<b>91%</b>	90 – 94
<b>Prosthodontics</b>	91%	92%	96%	89%	96%	93%	89%	93%	93%	93%	<b>81%</b>	89 – 96

Source: ADA Survey Center, Survey of Advanced Dental Education, 2001-2010.

**Table 11. Percentage of Program Directors That Are Board Certified**

	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	Mean % Directors Certified	Range
<b>Public Health</b>	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	<b>100%</b>	100
<b>Endodontics</b>	81%	86%	86%	87%	87%	83%	93%	87%	87%	91%	<b>86%</b>	81 – 91
<b>Pathology</b>	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	<b>100%</b>	100
<b>Radiology</b>		100%	100%	100%	100%	100%	100%	100%	100%	100%	<b>100%</b>	100
<b>Oral Surgery</b>	98%	100%	95%	95%	96%	92%	100%	100%	100%	100%	<b>97%</b>	92 -100
<b>Orthodontics</b>	71%	70%	79%	83%	80%	75%	90%	97%	98%	98%	<b>80%</b>	70 – 98
<b>Pediatric Dentistry</b>	78%	75%	81%	83%	80%	76%	87%	90%	89%	91%	<b>81%</b>	75 – 91
<b>Periodontics</b>	87%	92%	94%	92%	85%	89%	94%	94%	96%	93%	<b>91%</b>	85 – 96
<b>Prosthodontics</b>	89%	90%	91%	88%	83%	89%	98%	98%	98%	100%	<b>91%</b>	83-100

Source: ADA Survey Center, Survey of Advanced Dental Education, 2001-2010.

The Council recognized the challenges facing the dental specialties in meeting faculty shortages in its 2001 Report to the House of Delegates. This crisis will continue, particularly as new dental schools are established. Several specialty organizations cited their concerns about faculty shortages that could ultimately result in a decrease in the number of specialty programs and a shortage of qualified, board certified program directors and faculty and predoctoral program directors and faculty. The Council urges

the ADA as well as the dental specialty organizations to continue to monitor these trends and the ultimate impact they may have on accredited advanced specialty education programs.

#### **IV. CHANGES IN SCOPE OF PRACTICE**

The Council requested that each specialty organization highlight recent epidemiological data or studies that establish the incidence and/or prevalence of major conditions routinely diagnosed and/or treated by practitioners in the specialty and describe how these changes have affected the practice of the specialty. Information regarding referral patterns and how they may have changed over the past 10 years was also requested.

##### **American Association of Public Health Dentistry**

For dental public health specialists, “patients” served are defined as populations and communities rather than individual patients. Services provided by public health dentists include programs that emphasize primary prevention and oral health education as well as those that extend care to the underserved. Dental public health specialists continue to work with community leaders and stakeholders interested in preventing oral diseases and/or extending dental care to a broader base of their constituencies. Most dental public health specialists work for the government (44%) or in academic settings (36%). Issues facing public health dentistry include the erosion of state Medicaid programs, increased interest in mid-level provider models, high profile tragedies related to poor access to oral health services and recently enacted health care reform legislation.

##### **American Association of Endodontists**

The conditions treated routinely in clinical practice by endodontists continue to be pulpal and periapical disease. Patients on IV bisphosphonates are at greater risk for complications with oral surgical procedures making endodontic treatment the procedure of choice for this patient group. The increased use of surgical microscopes has provided greater understanding of root anatomy, leading to better treatment planning and treatment results. Research on and the use of mineral trioxide aggregate (MTA) has improved treatment outcomes. The number of teeth treated by endodontists has increased by about 3% in the last decade. New materials are allowing for treatment of more complex disease and anatomical problems.

##### **American Academy of Oral and Maxillofacial Pathology**

The principal services provided by oral and maxillofacial pathology include clinical diagnosis, management of oral abnormalities, as well as the microscopic diagnosis of oral and maxillofacial surgical tissue/cytology specimens. Oral cancer and bisphosphonate-related osteonecrosis of the jaw (BRONJ) and conditions associated with older patients such as lichen planus, burning mouth/tongue syndrome, and even oral squamous cell carcinoma, will likely become more numerous as the aging U.S. population grows.

Slightly more than 63% of all surgical pathology specimens originate from oral and maxillofacial surgeons. There has not been a significant change in the settings where the services of an oral and maxillofacial pathologist are customarily provided - 54.8% in dental schools, 21.4% in hospital/medical centers; 4.8% in medical schools, 2.4% in government facilities. However, the specialty is entering a new phase in its development, namely a substantial expansion of participation in private, independent practice settings.

##### **American Academy of Oral and Maxillofacial Radiology**

Most oral and maxillofacial radiology services have been provided through dental school radiology departments, medical school radiology departments, and hospital radiology departments. Recent technological advances (for example, CBCT and tele-radiology) have increased the opportunities for oral and maxillofacial radiologists to operate outside of the academic health center. As technologies improve and the costs decrease, private practice will become a destination for oral and maxillofacial radiologists, which in turn, will improve public access to these vital diagnostic services.

During the past 10 years, perhaps the greatest opportunity for referrals and changes in scope of practice for oral and maxillofacial radiologists has been the dramatically increased need for implant site

assessment and post-operative imaging. Oral and maxillofacial radiologists are frequently involved in the diagnostic assessment of patients with obstructive sleep apnea. CBCT is having a significant impact on the three-dimensional analysis necessary for orthodontics and in evaluating osseous pathology, e.g., cysts, benign and malignant tumors, inflammatory conditions, para-nasal sinus disorders, and soft-tissue calcifications. Specialty-level services, provided by oral and maxillofacial radiologists, are helpful when traditional services (intra-oral and panoramic radiographs) are inadequate. Imaging studies are a critical component of assessment of temporomandibular joint (TMJ) disease.

Most referrals are made by general dentists, followed by oral and maxillofacial surgeons and orthodontists, primarily for implant site assessment (40%), pathology (24%) and for TMJ analysis (16%). The AAOMR anticipates that referral patterns will grow at a significant pace over the next decade as the specialty continues to evolve.

### **American Association of Oral and Maxillofacial Surgeons**

The principal health services provided to the public by oral and maxillofacial surgeons are dentoalveolar surgery, implants, anesthesia with an increase in management of pathology, genioplasty and obstructive sleep apnea. Epidemiologic studies showed an increased demand for anesthesia, obstructive sleep apnea and oral cancer. Placement of dental and cranio-maxillofacial implants is increasing.

Oral and maxillofacial surgery services continue to be provided in outpatient and inpatient facilities. Medically compromised patients and select oral and maxillofacial surgical procedures are provided in hospitals.

### **American Association of Orthodontists**

Orthodontists provide diagnosis and comprehensive orthodontic care for patients of all ages, with the largest number in the adolescent age group. Adult treatment has continued to increase in the last 10 years. An emphasis has continued to be placed on early diagnosis and treatment of functional problems that may reduce future treatment needs. Advanced craniofacial training is an important change in practice with its link to the dental specialties of oral and maxillofacial surgery and pediatric dentistry. Increasing numbers of consumers are using the American Board of Orthodontic's website to find a board certified orthodontist. Education materials for general dentists and other health care providers have increased referrals from other healthcare professionals.

Most orthodontic care is provided in private, individual or group practice settings; some in company-owned offices and some in orthodontic education program clinics.

### **American Academy of Pediatric Dentistry**

As an age-defined specialty, the services provided by pediatric dentists relate primarily to populations rather than specific procedures. The very young, the developmentally disabled and medically-compromised patients, and children with complex dental, medical, or communication needs form the basis for pediatric dental practice. The condition most routinely diagnosed and treated by pediatric dentists is dental caries. Dental caries rates in children are still on the rise and caries is still the most common chronic disease of childhood. Nationally, nearly 30% of all child health expenditures are devoted to children's oral health care.

Pediatric dental care continues to be offered in private and public clinics as well as in hospital outpatient clinics and operating rooms. There is an increasing trend for deep sedation or general anesthesia for children to be performed in freestanding surgical centers and/or in clinics served by anesthesiologists and anesthesiologists.

The main sources of referrals to pediatric dentists are general dentists, pediatricians and other health care providers. In 2007, AAPD entered into a contract with the Office of Head Start to partner at the national, state and local levels to develop a national network of pediatric and general dentists to link Head Start children to establish dental homes.



### **American Academy of Periodontology**

The principal health services provided to the public by periodontists include evaluation and diagnosis of oral conditions and assessment of risk for future disease; non-surgical treatment and the management of periodontal diseases, oral mucosal diseases, and periodontal inflammation associated with systemic conditions; surgical care to correct oral hard and soft tissue defects; and surgical placement/management of dental implants. Periodontal disease is now viewed as a critical inflammatory disease in the body. Links between periodontal diseases and systemic conditions have been strengthened by research on inflammatory conditions, such as diabetes and cardiovascular disease.

Four recent reports have suggested that the prevalence of periodontitis in the United States may be declining. An individual's susceptibility to periodontal disease may be more important than their age as a risk factor for the disease. Race and ethnicity are social constructs that can strongly influence socioeconomic status, access to health care, educational levels, and frequency of dental visits. There is a well established and documented relationship between smoking and development and/or severity of periodontitis. The AAP believes that the specialty of periodontics needs to place increasing emphasis on early diagnosis, early and appropriate treatment of periodontitis, and education of the profession and public regarding potential associations between chronic oral inflammation and systemic complications.

General dentists provide most of the referrals to periodontists, followed by patient self-referrals and patient-to-patient referrals. Periodontists historically have provided the majority of their services in the clinical office setting.

### **American College of Prosthodontists**

Prosthodontists replace missing teeth and the structures that support them. The scope of services provided by prosthodontists has remained similar during the past 10 years but the frequency of certain services has shifted during this timeframe. The six procedures requiring the largest percentage of the prosthodontist's time include fixed prosthodontics, implant services, complete dentures, operative care, diagnosis and partial dentures. The increased demand for referral based services in the area of maxillofacial prosthodontics, temporomandibular disorders and sleep apnea have all impacted prosthodontic practices.

The data related to tooth loss and tooth retention will have a significant impact on the specialty of prosthodontics. Based on the data related to edentulism, tooth loss and the condition of remaining teeth, as well as other factors such as abrasion, attrition, erosion, and the need for esthetic improvement (Douglass, 1992) coupled with the increase in the adult population, there is an increased need for complex prosthodontics services. NHANES III data also indicates that 20% of adults between the ages of 18 and 74, representing 35.7 million civilian, non-institutionalized Americans, wear some type of removable prosthesis. Selected indicators on denture use among persons 18-74 years reveal no differences in patterns of denture use between 1981 and 1991. The need for complete dentures would decline more slowly than the rate of edentulism due to the replacement needs for existing edentulous persons. The number of patients who are partially edentulous will increase significantly. Therefore, the need for more complex fixed prostheses, implant prostheses and removable partial dentures will increase. The need for complex prosthodontics will increase substantially in the adult population. As the population continues to grow, the need for prosthodontic services will also grow, at least for the next 25 years. A significant increase in referral based demand for sleep disorders, maxillofacial prosthodontics and temporomandibular disorders has been noted in practice.

The ACP notes increased demand for services because of innovative technology, shifting demographics, changing epidemiology and emerging diseases. Examples of each include a) the evidence based merit of implants for all edentulous patients, b) the aging population who are partly dentate and likely to lose more if not all teeth, c) increasing prevalence of root caries, erosive disorders affecting enamel, and the static level of oral cancers in the U.S. and d) polypharma-induced xerostomia, sleep apnea and bisphosphonate osteonecrosis of the jaws. These changes reflect matters that may be best managed by specialists for diagnosis and treatment, as well as life-long care and prevention.

The largest source of patient referrals to prosthodontists is patients, followed by general practitioners (18%), periodontists (14%), patient self-referrals (13%) and oral surgeons (13%). The primary setting for prosthodontic services has predominately been in and will continue in private practice.

Overall, the scope of practice for each recognized dental specialty has not changed dramatically. Advances in technology and science have provided specialists with the knowledge and skills to provide patients with a better diagnosis and treatment plan and a greater array of treatment modalities. Each dental specialty has adapted to new and changing environments and continues to define itself within its scope of practice.

The Council noted several trends that have impacted specialty practice and will continue into the next decade. Some of these trends affect multiple specialties while others directly impact just one or two particular specialties. These trends include but are not limited to disparities in oral health, tooth retention awareness, the aging population, expansion in prescription drug therapy, a shift in health care delivery from a hospital setting to an ambulatory/office facility, continued high dental caries rates in some children and the link between periodontal disease and other systemic conditions. These changes have also led to an expansion in the scope of practice of some specialties. Such changes are appropriately reflected in the education and training requirements for the specialties.

**Conclusions:** In reviewing all of the information submitted by each specialty for the 2011 Review comparing it with the 2001 Review, the Council concluded that each specialty is unique. However, the information submitted demonstrates that the specialties also share common issues and concerns. An overview of these issues follows.

*Faculty Shortage.* Unfilled faculty positions, resignations, projected retirements, and the shortage of students being prepared for the faculty role pose a threat to the dental workforce in the coming years. Faculty shortages at dental schools across the country may compromise student learning at a time when the public need for dentists continues to grow. Every specialty organization is concerned about the growing faculty shortage and is looking to find ways to assist dental and advanced specialty education programs in recruiting and supporting potential faculty members. The Council commends the dental specialty organizations for their leadership in addressing issues related to dental specialty faculty shortages.

*Movement to Increase Number of Board Certified Diplomates.* As noted elsewhere in this report, most of the specialties have experienced an increase in the number of board certified, active diplomates over the last 10 years. The Council believes that this demonstrates the specialty organizations' commitment to increasing the number of individuals who achieve board certification and to maintaining competency levels for specialty practice. Further evidence of this commitment is the establishment over the last 10 years of recertification policies by all dental specialty certifying boards. More attention is also being directed to making the certification process more candidate-friendly. Some specialty certifying boards offer educational consultants and mentors to assist candidates as they work through the examination process. Some boards have adjusted the examination process and others continue to identify innovative approaches to recruit new applicants into the board certification process.

*Lack of Significant Changes in Referral Patterns.* The Council noted that referral patterns over the last 10 years for most of the specialties have changed only slightly with the source of most referrals continuing to come from general dentists, patients and/or their families, other specialists and physicians. An exception exists for dental public health where the referral pattern is often reversed. Patients identified in screening programs are often referred by DPH dentists to private general and specialty dental practitioners. It was also noted that Periodontists anticipate a change in the future in their referral patterns. The Council continues to believe that if stronger links are established between periodontal disease and systemic conditions, more referrals might come from physicians and other health care providers.

*Membership Categories and Privileges.* Membership in the specialty organizations increased 26% over the last 10 years. The number of new specialty programs as well as an increase in class size has contributed to the membership increases. In addition, specialty organizations have redefined the

membership eligibility criteria to include residents, retired specialists and various dentist and non-dentist categories. The Council carefully reviewed the membership categories and corresponding privileges (voting and right to hold office), and concluded that all of the sponsoring organizations have memberships reflective on their respective specialties, continuing to meet Requirement 1(a) of the Requirements for Recognition of Dental Specialties.

**Final Comments:** The Council wishes to acknowledge the cooperation, participation and contributions of the dental specialty organizations and the national certifying boards for dental specialists in providing critical information for CDEL's 2011 Periodic Review of Specialty Education and Practice.

After thoroughly reviewing all of the information submitted by the dental specialties, the Council believes that all of the recognized specialties have documented evidence that they continue to be in a healthy and viable state. From information provided related to each discipline's scope of practice, the Council has concluded that there continues to be a need and demand by the public for the recognized specialties' oral health services. The Council believes that over the last two decades, the recognized dental specialties have demonstrated ongoing efforts to improve the quality of advanced specialty education, research and practice. Further, they are committed to continuing to deliver quality oral health care services.

The dental specialty organizations and recognized certifying boards provided for this study valuable information that is highly beneficial to the entire profession. The format of the study served to facilitate each sponsoring organization's internal review by highlighting specific areas of growth and accomplishments over the last decade and provided the opportunity for each organization to note ongoing and future challenges. In broader terms, the format of the review allowed the organizations to note past and future trends, new research and crosscutting issues such as faculty shortages, potential membership and program enrollment increases/decreases and efforts to increase the number of board certified specialists.

The Council believes the format used was effective and not overly burdensome to the specialty organizations and certifying boards. As a result of the overall benefits derived from this review, the Council believes that this periodic review of the ADA-recognized dental specialties and certifying boards continues to be valuable to the profession. The periodic review should continue to be provided to the ADA House of Delegates at ten-year intervals.

## APPENDIX

### **Requirements for Recognition of Dental Specialties**

Approved by the ADA House of Delegates, October 2001

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

- (1) In order for an area to be recognized as a specialty, it must be represented by a sponsoring organization: (a) whose membership is reflective of the special area of dental practice; and (b) that demonstrates the ability to establish a certifying board.
- (2) A specialty must be a distinct and well-defined field which requires unique knowledge and skills beyond those commonly possessed by dental school graduates as defined by the predoctoral accreditation standards.\*
- (3) The scope of the specialty requires advanced knowledge and skills that: (a) are separate and distinct from any recognized dental specialty or combination of recognized dental specialties; and (b) cannot be accommodated through minimal modification of a recognized dental specialty or combination of recognized dental specialties.

- (4) The specialty must document scientifically, by valid and reliable statistical evidence/studies, that it: (a) actively contributes to new knowledge in the field; (b) actively contributes to professional education; (c) actively contributes to research needs of the profession; and (d) provides oral health services for the public; all of which are currently not being met by general practitioners or dental specialists.
- (5) A specialty must directly benefit some aspect of clinical patient care.
- (6) Formal advanced education programs of at least two years beyond the predoctoral dental curriculum as defined by the Commission on Dental Accreditation's Standards for Advanced Specialty Education Programs must exist to provide the special knowledge and skills required for practice of the specialty.

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

## Council on Dental Practice

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**Glenn, Stephen O.**, Oklahoma, 2011, chair  
**Zust, Mark R.**, Missouri, 2012, vice chair  
**Armstrong, Craig S.**, Texas, 2013  
**Cole, Jeffrey M.**, Delaware, 2013  
**D'Aiuto, Charles W.**, Florida, 2012  
**Dawley, Joanne**, Michigan, 2014  
**Dowd, Brendan P.**, New York, 2014  
**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  
**Newman, Roger K.**, Montana, 2012  
**Schwab, Brian M.**, Pennsylvania, *ex officio*\*  
**Sessa, Kevin, D.**, Colorado, 2014  
**Sledd, Jamie L.**, Minnesota, 2012  
**Tippett-Whyte, Judee**, California, 2012  
**Torbush, Douglas B.**, Georgia, 2010  
**Willey, James L.**, director  
**Porembski, Pamela M.**, senior manager  
**Furlong, Arlene M.**, manager  
**Siwek, Alison M.**, manager

**The Strategic Plan of the American Dental Association (ADA):** The activities of the Council on Dental Practice (CDP) are consistent with and continue to support the ADA Strategic Plan 2011-14. In keeping with Goal 1: Provide support to dentists so they may succeed and excel throughout their careers, the CDP manages all aspects of the ADA Hillenbrand Fellowship Program. Further, the CDP added practice management content to its Dental Practice Hub site on ADA.org. CDP also added a health and well-being resource section and Going Green landing page to ADA.org. One health and well-being newsletter is distributed quarterly, and weekly health and well-being updates are sent to constituent well-being program directors. Additionally, the CDP maintains the *Directory of Dental Practice Management Consultants* and the *Directory of Dental Practice Appraisers and Brokers*. *The ADA Practical Guide to Frequently Asked Legal Questions* and *The Power of Internal Marketing* were revised and are available for purchase in the *ADA Catalog*.

The Council supports Goal 2: Be the trusted resource for oral health information that will help people be good stewards of their own oral health. The CDP does this by collaborating with the Department of Product Development and Sales (DPDS) to develop oral health brochures. Nineteen were produced in 2010.

The Council fulfills Goal 3: Improve public health outcomes through a strong collaborative profession and through effective collaboration across the spectrum of our external stakeholders, by attending annual meetings held by national organizations representing members of the dental team. These include the American Dental Assistants Association (ADAA), the American Dental Hygienists' Association (ADHA), the American Association of Dental Office Managers (AADOM), the National Association of Dental Laboratories (NADL) and the Lab Summit. Staff attended annual meetings of the American Academy of Dental Group Practice (AADGP) and the New Dentist Committee (NDC) to develop an enhanced expertise and knowledge base and identify emerging issues related to dental practice management. The CDP also maintains its commitment to providing leadership in disaster planning and emergency planning by fulfilling voting member responsibilities to the American Medical Association by attending National

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

Disaster Life Support Education Consortium (NDLSEC™) meetings and also attending the annual Illinois Public Health Emergency Preparedness Summit.

To satisfy Goal 4: Ensure that the ADA is a financially stable organization that provides appropriate resources to enable operations and strategic initiatives, the CDP contributes to non-dues revenues with its collaboration on the aforementioned oral health brochures and practice management publications and maintains a modest revenue provided from advertising revenues derived from its *Directories*.

## Emerging Issues and Trends

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**Trends in Dental Group Practice:** At its November 2010 meeting, the CDP formed the Subcommittee on Practice Patterns and Transitions to study changing trends in practice models and transitioning from one dental practice model to another. Two CDP staff members attended the American Academy of Dental Group Practice Conference from January 26-29, 2011, to learn more about emerging trends in group practice and about group practice models.

**Dental Team Workforce Issues:** The CDP staff took the lead to form an interagency staff work group, the Workforce Oversight Work Group (WOW), which meets monthly to aid internal communication between all ADA agencies involved in workforce issues. The CDP reviewed *Breaking Down Barriers to Oral Health for All Americans: The Role of Workforce*, A Statement from the American Dental Association, before it was posted online at ADA.org. Also, an analytical review of the Pew Report entitled, "It Takes a Team," and the accompanying productivity and profit calculator were collaboratively drafted by the CDP and the Council on Government Affairs (CGA) and posted on ADA.org. The Subcommittee on Workforce Issues is investigating the development of a Dental Workforce Resource Center on ADA.org. The CDP staff produced and facilitated an engaging dialogue for the Board of Trustees at its April 2011 meeting regarding Dental Workforce 2030—New Models and Where the Profession of Dentistry Is Headed.

**Going Green in the Dental Office:** The ADA and the ADAA collaborated to have a "Going Green in the Dental Office" course available on both the ADAA website and the ADA's "Going Green" website. Also, the Council agreed to investigate the possibility of, and is discussing with ADA agencies the feasibility of, promoting the recycling program of TerraCycle, Inc., with respect to a collection program to recycle oral care products.

**Impact of Information Technology on Dentistry:** The CDP reviews the work products of the Standards Committee on Dental Informatics (SCDI). The Electronic Health Record (EHR) Work Group met by conference call on March 14. The CDP developed and approved an EHR Primer, which will be forwarded for consideration to the EHR Work Group.

**Standards Administration:** In 2010, the Council's *Bylaws* duties were amended to include, as an addition to the duties of the Council: "Encourage and coordinate the development and improvement of national and international standardization programs for dental informatics." The amendment formalizes the Council's role of oversight of the ADA's informatics standards program.

The Department of Standards Administration conducted successful meetings of the Standards Committee on Dental Informatics (SCDI) on February 24, 2010, October 8, 2010, and February 23, 2011. The meetings included a digital imaging forum, in which major issues in digital imaging that will affect future standards development were discussed and a strategic planning session, which covered ways to improve participation in informatics standards activities.

The SCDI reviewed proposed revisions of the ADA Vision Statement, Mission Statement and Scope for SCDI approval. According to the ADA Standards Program Operating Procedures, the CDP shall recommend the scope of a standards committee to the ADA Board of Trustees. The CDP approved the revised SCDI Scope as amended:

The ADA SCDI shall develop informatics standards, specifications, technical reports, and guidelines and interact with other entities involved in the development of health informatics standards aimed at implementation across the dental profession.

At the SCDI February 2011 meeting, Dr. Kenneth Aschheim, chairman, SCDI Joint Working Group 10.12 on Forensic Odontology Informatics, informed the ADA SCDI that two national services that assist in cases of missing and unidentified persons, NamUs (U.S. Department of Justice National Missing and Unidentified Persons System) and NCIC (FBI National Crime Information Center), plus Interpol, the international police organization, have requested permission from the ADA for implementation of *ANSI/ADA Specification No. 1058 for Forensic Dental Data Set*. Their goal is to utilize ADA Specification No. 1058 on a worldwide basis by creating a standardized electronic coding and workflow for exchange of the specified data.

The CDP recommended forwarding to the appropriate ADA leadership the distribution of ANSI/ADA Specification No. 1058 for use by appropriate entities without licensing fees for non-commercial use.

The following new informatics technical reports and a white paper were approved by the SCDI:

- Revised ANSI/ADA Specification No. 1000 for Standard Clinical Data Architecture;
- Revised ANSI/ADA Specification No. 1027 for an Implementation Guide to ADA Specification No. 1000;
- ANSI/ADA Specification No. 1058 for Forensic Dental Data Set;
- ADA Technical Report No. 1048 for Attachment of DICOM Datasets Using E-Mail in Dentistry;
- ADA Technical Report No. 1055 for Hardware and Software Guidelines;
- ADA Technical Report No. 1060 for the Secure Exchange and Utilization of Digital Images in Dentistry; and
- ADA White Paper No. 1070 for Implementation of the Electronic Prescription Standard for Dentistry.

The following new work items were approved by the SCDI:

- Proposed ADA Specification No. 1068 for ANSI HITSP Data Dictionary Crossmap to ANSI/ADA Specification 1000 Data Elements;
- Proposed ADA Specification No. 1069 for SCDI Standard Terms, Acronyms and Definitions;
- Proposed ADA Specification No. 1070 for a Recommended Electronic Prescription Standard for Dentistry; and
- Proposed ADA Specification No. 1071 for Testing Procedures to Ensure Comparability of 2D and 3D Cephalograms, Cone Beam CTs and Facial Scans.

The SCDI status report on Resolution 83H-2009 (*Trans.2009:415*), Development of a Standard for Secure Electronic Transmission of Digital Radiographs, was forwarded to the House of Delegates as a report from the Council on Scientific Affairs. Resolution 83H reads as follows.

**Resolved,** that the ADA Standards Committee on Dental Informatics develop a standard for the secure electronic transmission of digital radiographs and photographs and promote this standard for use by practitioners as well as third-party payers, and provide a status report to the 2010 House of Delegates.

The SCDI began development of solutions to the House request with the publication of ADA Technical Report No. 1048 for Attachment of DICOM Datasets Using E-Mail in Dentistry and ADA Technical Report No. 1060 for the Secure Exchange and Utilization of Digital Images in Dentistry.

Work progressed on development of Proposed ANSI/ADA Specification No. 1067 for Electronic Dental Record System Standard Functional Requirements, an important component of the collaborative work with Health Level 7 in development of the Dental Functional Profile.

The ADA continues to participate in the Digital Imaging and Communications in Medicine (DICOM) Standards Committee and DICOM Working Group 22 for Dentistry.

In April 2010, the Board of Directors of Integrating the Healthcare Enterprise (IHE) accepted ADA as a member organization. In October, IHE formally accepted the ADA as Secretariat of the IHE Dental Domain. IHE is a non-profit health informatics standards organization that brings together users and developers of healthcare information technology in a process that improves interoperability of health information systems, digital radiography and other electronic medical devices. On February 22, 2011, the IHE Dental Domain Kickoff Meeting was held. Participants discussed potential subjects for initial IHE dental profiles, which include the secure exchange of dental digital data and images; and digital radiography dose capture, recording and exchange.

**Practice Management Initiative (PMI):** The Council participated in the PMI Advisory Group meeting held on January 14-15, 2011, and also with a conference call held on March 24. Dr. Stephen Glenn and Dr. Jon Johnston serve as the CDP representatives on this interagency advisory group. The objective of this initiative is to develop a proposed business plan to meet the needs of ADA members for education related to practice management.

**Dental Quality Alliance (DQA):** Dr. Mark Zust, representing the CDP, serves on the DQA Steering Committee. The DQA met in person on October 29, 2010. A conference call was conducted with the Executive Committee on December 2. A conference call with the DQA Advisory Committee on Research and Development of Performance Measures was held on March 3, 2011. The Steering Committee met on March 17, 2011. The DQA met on June 28, 2011, in Chicago.

**Comparative Effectiveness Research (CER):** Also known as Patient-Centered Outcomes Research (PCOR), the Council formed a Subcommittee on CER at its May 2010 meeting that met by conference call on March 1, 2011. The Subcommittee organized an interagency PCOR Work Group in March 2011 to develop ADA Policy on PCOR/CER. A supplemental report proposing ADA policy on PCOR/CER will be forwarded to the 2011 House of Delegates for consideration.

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### Response to Assignments From the 2010 House of Delegates

**Amendment to the Policy, “Dentist Administered Dental Assisting and Dental Hygiene Education Programs”:** Resolution 44H-2010 (*Trans.*2010:542) directed that the ADA policy on Dentist Administered Dental Assisting and Dental Hygiene Education Programs (*Trans.*1992:616) be amended by the deletion of the first resolving clause, and the addition of a new second resolving clause. These changes have been incorporated in Association policy and will be added in the current edition of *Current Policies*.

**Amendment to the Policy, “Diagnosis or Performance of Irreversible Dental Procedures by Nondentists”:** Resolution 46H-2010 (*Trans.*2010:542) directed that the ADA policy on Diagnosis or Performance of Irreversible Dental Procedures by Nondentists (*Trans.*2004:328) be amended. These changes have been incorporated in Association policy and will be added in the current edition of *Current Policies*.

**Amendment to the Policy, “Support of the Dental Laboratory Technician Certification Program and Continuing Education Activities”:** Resolution 68H-2010 (*Trans.*2010:547) directed that the ADA policy on Support of the Dental Laboratory Technician Certification Program and Continuing Education Activities (*Trans.*1997:682) be amended. These changes have been incorporated in Association policy and will be added to the current edition of *Current Policies*. Continuing education for dentists and dental laboratory technicians taught by a certified dental technician will be available at ADA annual session beginning in 2011.

**Statement to Encourage U.S. Dental Schools to Interact With U.S. Dental Laboratories:** Resolution 69H-2010 (*Trans.*2010:547) directed that the ADA encourage U.S. dental schools to utilize U.S. dental



laboratories and to use their own in-house dental laboratories wherever possible. Also, the ADA encourages U.S. dental schools to combine dental education programs with dental laboratory technology programs wherever dental laboratory technology programs are located within commuting distance of the school. These changes have been incorporated in Association policy and will be added in the current edition of *Current Policies*.

**Amendment of the ADA Bylaws Regarding the Duties of the Council on Dental Practice:**

Resolution 70H-2010 (*Trans.*2010:547) directed that the Council's *Bylaws* duties be amended by the adoption of a new letter j. Encourage and coordinate the development and improvement of national and international standardization programs for dental informatics. This amendment to the *Bylaws* was made to reflect current Council activities related to SCDI. For further information on Resolution 70H-2010, see the section of this report titled, "Standards Administration."

**Amendment to the Policy, "Opposition to Pilot Programs Which Allow Nondentists to Diagnose Dental Needs or Perform Irreversible Procedures":**

Resolution 92H-2010 (*Trans.*2010:542) directed that Resolution 24H-2004 (*Trans.*2004:291), item number 13 in the policy, Strategy to Assure Access to Quality Health Care for Native Alaskans, be amended. It also directed that Resolution 93H-2005 (*Trans.*2005:343) on opposing pilot programs that are in violation of the existing ADA policy be rescinded. It further adopted language related to dental workforce issues or models or oral health care delivery issues and the resulting effects on the dental profession and the protection of the public's oral health. These changes have been incorporated in Association policy and will be added in the current edition of *Current Policies*.

**Advocating for Victims of Addictive Disease:** Resolution 110H-2010 (*Trans.*2010:564) directed that the CDP, through its Dentist Well-Being Advisory Committee (DWAC), develop strategies to communicate the value and importance of confidential treatment and monitoring for dental team members suffering from addiction. It also directed that the CDP assign a task force to consider addiction issues and, with the assistance of the DWAC, submit a report and action plan with recommendations to the 2011 House of Delegates. A Well-Being Task Force was formed, comprised of four CDP members and four constituent well-being committee members. The Task Force distributed a survey to all well-being directors at the constituent level in February and met in March to discuss the survey results. The CDP approved the preliminary goals of the Task Force and the concept of a three-year action plan. A supplemental report on Resolution 110H-2010 will be submitted to the 2011 House of Delegates.

**Amendment to the "Comprehensive Policy Statement on Allied Dental Personnel":** Resolution 132H-2010 (*Trans.*2010:542) directed the new ADA policy "Comprehensive Policy Statement on Allied Dental Personnel" (*Trans.* 2010:494) be adopted and that the "Comprehensive Policy Statement on Allied Dental Personnel" (*Trans.*1996:699; 1997:691; 1998:713; 2001:467; 2002:400; 2006:307) be rescinded. These changes have been incorporated in Association policy and will be added in the current edition of *Current Policies*.

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## Council Activities

**Dental Team Advisory Panel (DTAP):** The Council's DTAP met on March 25, 2011, at the ADA Headquarters Building in Chicago. Topics discussed included social media, practice management and dental career resources, workforce, environmental sustainability and the health and well-being of the dental team.

**Team Building Series:** The 16th Annual Team Building Series, jointly sponsored by the CDP and the Council on ADA Sessions, will be held on October 10-13, during the 2011 ADA annual session in Las Vegas. In addition to a roster of daily courses, the head coach of the U.S.A. Water Polo Men's Senior National Team will conduct a 90-minute program on team building. The course will be held on a stage in the exhibit hall and webcast to all ADA members to watch, free of charge.

**Liaison With the American Dental Hygienists' Association (ADHA):** The ADHA president, executive director and director, Government Affairs, met with the CDP at its November 2010 meeting. Their presentation included an overview of dental hygiene education program proliferation and for-profit programs, which may have negatively affected the dental hygiene employment outlook, and the efforts of the ADHA's newly created Diversity Committee. CDP staff attended the ADHA annual session in June 2011.

**Liaison With the American Dental Assistants Association (ADAA):** The ADAA was invited to the CDP's November 2010 meeting. The ADAA executive director and director, Education and Professional Relations, submitted a proposal to the CDP to collaborate on the creation and implementation of a program of basic knowledge for On-the-Job Trained (OJT) dental assistants. The Council then formed a Subcommittee on Dental Assistant Training at its November 2010 meeting to assess the current state of on-the-job training for dental assistants. The purpose of this Subcommittee is to report back to CDP on the potential value of forming an ADA/ADAA task force to study the feasibility of developing a program of basic training for dental assistants. The CDP received a report from Dr. Julie Kim, a University of Iowa doctoral graduate student, at its May 2011 meeting, which assessed the potential value and need for a program of basic knowledge for OJT dental assistants. The CDP approved referring the findings of the report and an ADA survey related to the report to the Council on Dental Education and Licensure for evaluation and feedback.

**Dental Laboratory Industry Activities:** The CDP attended the NADL annual meeting held January 20-22 in Las Vegas in keeping with its *Bylaws* responsibility to encourage and develop satisfactory relations with the various organizations representing the dental laboratory industry. A CDP member and staff from various ADA agencies attended the Seventh Annual Laboratory Technology Summit held prior to the Chicago Midwinter Meeting on February 23, 2011. Concerned stakeholders discussed challenges facing the dental laboratory industry. The NADL addressed the Council at its May 2011 meeting and shared its concerns regarding changing laboratory market dynamics.

**Liaison With the National Board of Certification in Dental Laboratory Technology (NBC):** Dr. Charles "Bill" D'Aiuto, member, CDP, started his three-year term as trustee of the NBC in January 2011. Dr. D'Aiuto participated in an NBC conference call held in March 2011.

**Council Publications:** The Council is working with the DPDS to update *Dental Office Design*, *Associateships* and *Valuing a Practice*. *The Power of Internal Marketing* (third version) was published with the addition of a new chapter on social media marketing. The update of the *Employee Office Manual* will go to print in 2011.

**The Dental Practice Hub:** One new consultant article was posted to the Hub. The quarterly Economic Confidence Surveys from the Health Policy Resources Center continue to be posted to the Hub. The CDP intends to further enhance the Hub based on qualitative and quantitative survey results generated under the auspices of the PMI Work Group.

**Dentist Health and Wellness:** The DWAC and the Ergonomic Disability and Support Advisory Committees (EDSAC) held a joint meeting March 11, 2011, at the ADA Headquarters Building in Chicago. The CDP and its advisory committees developed the program schedule for the 2011 Conference on Dentist Health and Well-Being, "Empowering Healthy Lifestyles," scheduled for August 18-19, and coordinated seminars on addictive disorders and general health issues, including physical activity and nutrition, stress and burnout, and ergonomic issues. Staff develops and circulates a quarterly health and wellness newsletter for state well-being directors. Staff and two members of the DWAC attended the 2011 University of Utah School on Alcoholism and Other Drug Dependencies meeting which took place on June 19-24, 2011, in Salt Lake City. The CDP supported the American Society of Addiction Medicine and American Academy of Addiction Psychiatry's grant applications to manage the Substance Abuse and Mental Health Services Administration's Prescriber's Clinical Support System for the Appropriate Use of Opioids in the Treatment of Pain and Opioid-Related Addiction.

**Developing ADA Policy on Hearing Loss:** At their March 11, 2011, joint meeting, the DWAC and the EDSAC discussed hearing loss prevention educational materials and suggested contacting audiology experts to discuss the focus of hearing loss materials and develop resources to prevent noise induced hearing loss in the dental profession. The CDP approved this recommendation at its May 2011 meeting.

**Dentistry's Role in Emergency Preparedness and Disaster Response:** The ADA serves as a voting member of the National Disaster Life Support Education Consortium (NDLSEC™). The CDP staff attended the annual NDLSEC meeting held in Chicago on July 20, 2011.

**The Hillenbrand Fellowship Program:** The Board of Trustees transferred the administration of this program from the ADA Foundation to the CDP at its June 2010 meeting. The CDP formed a Hillenbrand Fellowship Selection Committee and held conference call meetings on February 18 and March 16, 2011, to select semi-finalists. The Committee interviewed the semi-finalists on April 8 and selected Dr. Elizabeth "Betsy" Shapiro of Waterman, IL, to serve as the Hillenbrand Fellow for the program year of 2011-12. Dr. Shapiro's fellowship will commence in September 2011 and conclude in August 2012.

**Meetings:** The Council met at the ADA Headquarters Building in Chicago on November 11-13, 2010, and May 12-14, 2011. The CDP would like to thank the following individuals for their service to the Council during 2010-11: Dr. R. Wayne Thompson, Twelfth District trustee, Board of Trustees' liaison to the Council; Dr. Thomas J. Olinger of La Mesa, CA, Council on Communications' liaison to the Council; and Mr. Alex Mellion, a student at the Case Western Reserve University, American Student Dental Association's consultant to the Council.

**Personnel:** At the May 2011 meeting of the Council, Dr. Mark R. Zust was unanimously nominated as chair for 2011-12 and Dr. Jonathan B. Knapp was elected vice chair for 2011-12. The 2011 ADA annual session will mark the retirement from the Council of Dr. Stephen O. Glenn, chair; Dr. H. Lee Gardner, Jr.; Dr. Michael H. Halasz; and Dr. Christopher C. Larsen. The Council wishes to express its appreciation to these individuals for their thoughtful, determined leadership and for the many contributions during their tenure.

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

## Council on Ethics, Bylaws and Judicial Affairs

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**Wentworth, Rodney B.**, Washington, 2011, chair  
**Lantz, Marilyn S.**, Michigan, 2012, vice chair  
**Brooks, Dwyte E.**, Nevada, 2013  
**Chinoy, Walter I.**, New Jersey, 2013  
**Esterburg, Jeffrey C.**, Ohio, 2013  
**Foy, Patrick J.**, Minnesota, 2012  
**Gamba, Thomas W.**, Pennsylvania, 2011  
**Henner, Kevin A.**, New York, 2013  
**McCarley, David H.**, Texas, 2012  
**Ortego, L. Stephen**, Louisiana, 2012  
**Palcanis, Kent G.**, Alabama, 2012  
**Pansick, Ethan A.**, Florida, 2014  
**Reynolds, Elizabeth C.**, Virginia, 2014  
**Rosato, Richard J.**, New Hampshire, 2014  
**Ruskin, Danielle**, Illinois, *ex officio*\*  
**Sebelius, Carl L., Jr.**, Tennessee, 2011  
**Senseny, Charlotte L.**, California, 2014  
**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 19-20, 2010, and April 14-15, 2011, at the ADA's Headquarters in Chicago. Dr. Donald L. Seago, trustee of the Fifth District, served as the Board of Trustees' liaison to the Council. Mr. Andy Bohnsack, a student at the University of Minnesota School of Dentistry, served as the American Student Dental Association's consultant to the Council.

**The Strategic Plan of the American Dental Association:** So that the activities of the Council are current and continue to be consistent with the 2011-2014 ADA Strategic Plan, the Council's subcommittee on Visionary and Strategic Planning reviewed the Association's plan to identify activities the Council may wish to accomplish in furtherance of the plan's goals. Among the activities suggested by the subcommittee, the Council agreed that it will work with the Survey Center to revise and conduct a second member ethics survey and develop a method to determine the level of utilization by member dentists of the Patient Rights and Responsibilities Statement. These activities will support Goal 1, Outcome/Objective 1—Professional competency and ethical standards and Goal 2, Outcome/ Objective 2—Shared responsibility. In furtherance of Goal 1, Outcome/Objective 4—Positive public image of the profession, the Council will propose a topic related to the impact of outside agencies on professionalism in dentistry and the public's perception of the dental profession to the House of Delegates mega topic workgroup for its consideration in relation to the 2012 House of Delegates meeting.

During this term, the Council contributed to the Association's 2007-2010 Strategic Plan with the development of the concept and material for the mega topic discussion conducted at the 2010 annual session. The mega topic discussion centered around seven ethics-based scenarios. Tables of participants then discussed the scenarios with the aid of facilitators armed with questions to stimulate thought and discussion about the ethical issues presented by the scenarios. The mega topic discussion was well received—over 96% of the participants rated the discussion at least somewhat valuable. Ninety-two percent indicated that it is very important for dentists to be aware of and to understand how to manage the ethical issues they encounter in their day-to-day practice. It was very important for 81% of the participants responding that the ADA respond to the ethical issues facing the profession in the next three to five years; an additional 18% believing that it was somewhat important for the ADA to do so. Another positive outcome of the discussion was that more than half of the participants responding stated

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

that they heard something during the discussion that enhanced or changed their understanding of the key issues that face the Association or the profession.

The Council during 2011 also established the ADA.org Ethics Resources web page, which includes direct access to: (a) a compilation of the *JADA* Ethical Moment features authored by Council members, indexed according to the sections of the ADA *Principles of Ethics and Code of Professional Conduct* (ADA Code) treated in each article; (b) the ADA Code; and (c) 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*.

Through the Joint Subcommittee on Ethics and Integrity in Dental Education and Practice (the Joint Subcommittee), the Council developed and delivered an ethics presentation designed to inform ADA councils, commissions and other agencies of the importance of ethics and professionalism, culminating with an overview of the accomplishments of the Joint Subcommittee (discussed more fully in a following section of this report). These Council activities supported the 2007-2010 goals of: To lead in advancement of standards, and To create and transfer knowledge.

## 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.

During the current term, the Council recognized two areas which it believes are of critical importance and may have a significant impact on the decision-making processes within the Association and on the public's perception of individual dentists and the profession as a whole. The first area focuses on the ethical implications of certain advertising strategies proliferating in the marketplace. Most recently, the Council has seen an increase in various marketing tactics that include potential forms of fee splitting, such as referral services that promote "pay-per-lead" or "pay-per-referral." Another marketing tactic that has recently developed is the offering of substantial discounts for dental services, treatments or procedures through internet marketing services such as Groupon. The Council has established a workgroup to investigate these programs and report its findings at the November 2011 Council meeting. Also brought to the Council's attention during this term are solicitations sent to Association members inviting membership in organizations that grant an assortment of honorary titles for use in communications to the public simply upon payment of an enrollment fee. Because of the potential legal ramifications, this matter has been turned over to the Association's Division of Legal Affairs. Finally, the Council hopes to work with specialty organizations and dental trade associations to ensure that their advertisements, published communications and, in the case of manufacturers of dental devices or therapeutic methods, contracts are monitored for violations of ethics codes or professional conduct regulations.

To facilitate members' and employees' familiarity with the professional and ethical expectations of the Association, the Council established a subcommittee to review all of the Association's written policies on ethics and professionalism that encompass interactions with and between Association members, staff, volunteers and the public, with the goal of organizing these into an easily accessible and cohesive collection of documents. The subcommittee will present its collection of documents at the Council's meeting in November 2011. It is anticipated that the resulting compilation may be included on the Ethics Resources page of ADA.org.

**Reclassification of Ethics Continuing Education Courses:** The Council received a request from the American College of Dentists (ACD) to join them in recommending reclassification of ethics courses as clinical subjects for continuing education purposes. Currently, ethics courses are classified under the category of "Ethics and Law" by the ADA and under "practice management" by many state regulatory agencies. The Council agreed with the ACD's opinion that ethics "is an inseparable component of virtually all treatment decisions" and that ethics should not be viewed simply as a matter related to

practice management. The potential benefits to this change in classification suggested by the ACD include:

1. Encouraging state regulatory agencies to adopt similar stances on how they treat ethics courses for purposes of continuing education credit;
2. Encouraging state regulatory agencies to remove the limitations on how many ethics courses can apply to overall continuing education requirements;
3. Encouraging other dental organizations that administer continuing education to adopt similar positions on how ethics is treated for purposes of continuing education; and
4. Leading the effort to remove ethics from its association with continuing education categories that are commercial in nature.

The Council considered some of the possible issues associated with reclassifying ethics courses for continuing education. However, the Council unanimously agreed with the advantages identified by the ACD and forwarded a statement in support of the recommendation to the ADA Council on Dental Education and Licensure, the Council with oversight of the Association's Continuing Education program.

**Ethics and Integrity in Dental Education and the Profession:** The Joint Subcommittee, established in 2008 and made up of members from the Council on Dental Education and Licensure (CDEL), the Council on Dental Practice (CDP) and this Council, in collaboration 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, has, as of its last meeting in July 2010, essentially accomplished the majority of its goals initiated to advance ethics and professionalism in both the academic and practice environments. The subcommittee's achievements are summarized below.

*Dental Education Environment.*

1. Disseminated the Proceedings of the June 2007 Symposium on Integrity and Ethics in Dental Education online at ADA.org
2. Revised the Preamble to the ADA *Principles of Ethics and Code of Professional Conduct* the (ADA Code) to include aspirational statements respecting expectations of student integrity
3. Enhanced, expanded and revised the ethics scenarios used in the ADA Success Programs
4. Included the ADA Code and additional ethics information in the New Student Welcome Packet
5. Secured ASDA support of and collaboration with Student Professionalism and Ethics Club (SPEC) in the establishment of ethics club chapters at dental schools
6. Obtained wider distribution of ADEA's Dental Faculty Code of Conduct via its website
7. Assisted in the development of ADEA's Statement on Professionalism in Dental Education, which has been published and is available online to the entire dental community and the public
8. Continued monitoring of the testing of the Mini-Multiple Interview process to assess applicants' propensities toward professionalism for use during the dental school admission process
9. Assisted in the development of the ASDA Code of Ethics pledge with the policy of reciting the pledge at the opening of its annual meetings
10. Reviewed, commented on and made available on ADA.org the ASDA published White Paper on Ethics and Professionalism in Dental Education
11. Encouraged the amendment of ASDA's Code of Ethics to require reporting of unethical activity and violations of its honor code
12. Assisted in the development of revisions to dental school accreditation standards to specify ethics and professional standards, including periodic evaluation of students' and residents' ethical conduct

### *Dental Practice Environment.*

1. Developed an Ethical Statement for recitation at each opening session of the House of Delegates and for publication within the *Manual of the House of Delegates*
2. Expanded continuing education ethics offerings at annual session
3. Secured House of Delegates support for the Professional Ethics Initiative, including the Program for Ethical Assessment and Development and the Ethics Resource Clearinghouse
4. Amended the ADA *Code* to strengthen its focus on reporting suspected violations of the *Code*
5. Enhanced availability of ethics course offerings by securing permission to include ACD-developed online ethics courses offered via the ADA online website and the Ethics Resources section of ADA.org
6. Developed the concept and material for the ethics-based Mega Topic Discussion conducted at the 2010 annual session
7. Developed an ethics presentation for delivery at ADA council, committee and other agency meetings

Four initiatives are still in various stages of development:

1. Completion of the Practice Ethics Assessment and Development program
2. Promoting the exchange of disciplinary information among authorized agencies
3. Completion of the Ethical Impact Analysis project
4. Publication of Joint Subcommittee accomplishments

At this juncture, members of the Joint Subcommittee as well as the three ADA Councils involved have recommended that the Joint Subcommittee be sunset and the four remaining initiatives be distributed by the Council to the appropriate agencies for completion. The Council will pursue appropriate actions to accomplish these results.

### **Response to Assignments From the 2010 House of Delegates**

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**Annual Revision of the ADA *Constitution and Bylaws* and ADA *Principles of Ethics and Code of Professional Conduct*:** The current editions of the ADA *Constitution and Bylaws* (ADA *Bylaws*) and the ADA *Code*, revised to January 1, 2011, reflect amendments that were approved by the 2010 House of Delegates. Current electronic versions of these documents are available on ADA.org.

**Report on Resolutions Referred by 2010 House of Delegates:** The Council was charged by the 2010 House of Delegates with reviewing the following resolutions and reporting to the 2011 House of Delegates with the Council's recommendations for action:

- Resolution 15H-2010 – Process to Address Violations by Candidates for Current Officers
- Resolution 16H-2010 – Enforcement Procedures for ADA Member Code of Conduct
- Resolution 88H-2010 – Review of Nomination and Election Procedures for Office of Speaker of the House of Delegates
- Resolution 102H-2010 – Review of ADA *Bylaws* regarding Meeting Sessions of ADA Governing Bodies
- Resolution 108H-2010 – Delineation of Delegate Fiduciary Duties
- Resolution 118-2010 – Investigating Breaches of Confidentiality – ADA *Bylaws* Changes

At the Council's November 2010 meeting, each member was assigned to one or more subcommittees formed to conduct reviews of the resolutions referred to the Council by the 2010 House of Delegates and to report their recommendations to the Council at its April 2011 meeting. Each of the subcommittees did so; the results and recommendations resulting from the Council's deliberations are set forth below.

*Resolutions 15H-2010, 16H-2010 and 118-2010.* The Council considered a subcommittee report regarding its consideration of the referrals of Resolutions 15H-2010, 16H-2010 and 118-2010. While the

subcommittee's report contained a comprehensive approach to integrating the Member Conduct Policy of 16H-2010 with the disciplinary and enforcement proposals of 15H-2010 and 118-2010, the Council requested the subcommittee consider a number of additional issues with respect to the matters raised by the referrals. Consequently, the Council referred these matters back to the subcommittee with instructions to consider the matters raised by the Council and report back to the Council with an amended report and recommendations on a schedule that will allow the Council to consider the revised report and act on the recommendations contained therein and forward the report to the Board of Trustees and the 2011 House of Delegates via a supplemental report.

*Resolution 88H-2010.* The Council received an assignment from the House of Delegates to study and report to the 2011 House of Delegates in regard to Resolution 88H-2010:

**Resolved**, that the Council on Ethics, Bylaws and Judicial Affairs review the nomination and election procedures for the Office of Speaker of the House of Delegates and report back to the 2011 House of Delegates.

The Council's deliberations and study of the nomination process for the office of Speaker of the House of Delegates focused on the areas of allowing candidacies for the office of Speaker to be voted on by the House of Delegates and allowing the qualifications of candidates to be communicated to the House of Delegates so those qualifications can be objectively considered by the House of Delegates in advance of the election for Speaker of the House. Under the current ADA *Bylaws*, nominated candidates are voted upon by the House of Delegates in accordance with the procedures set forth in Chapter V. HOUSE OF DELEGATES, Section 150, ELECTION PROCEDURE.

During the course of the Council's deliberations, members of the Council expressed the sentiment that the selection process should give the House of Delegates the right to select the Speaker from all candidates that have announced for the position. However, the Council strongly believes that the House of Delegates should have ample opportunity to review the credentials for the candidates for the office of Speaker to allow that office to be filled by an individual who has experience and skill in matters of parliamentary procedure and organization. For this reason, a review of each candidate's curriculum vitae and statement of qualifications should be presented to the House of Delegates. The timetable proposed by the Council allows the candidates' materials to be forwarded to delegates for their consideration at least 60 days prior to the convening of the House of Delegates.

The Council also considered whether the revised nomination procedure should allow candidates who had not previously announced their candidacy for the office of Speaker of the House of Delegates to be nominated from the floor of the House of Delegates. The Council carefully considered this question, but respectfully recommends against the process as it considers the office of Speaker too critical to the functioning of the meetings of the House of Delegates to permit candidates to announce their candidacy at the eleventh hour and bypass the thorough and thoughtful vetting process allowed by the nomination and election procedures.

The Council consequently recommends the adoption of the following resolution:

**9. Resolved**, that the ADA *Bylaws*, CHAPTER VIII., ELECTIVE OFFICERS, Section 30, NOMINATIONS, Subsection A. be amended as follows (additions underscored, deletions stricken):

- A. Nominations for the offices of President-elect, and Second Vice President ~~and Speaker of the House~~ shall be made in accordance with the order of business. Candidates for these elective offices shall be nominated from the floor of the House of Delegates by a simple declaratory statement, which may be followed by an acceptance speech not to exceed four (4) minutes by the candidate from the podium, according to the protocol established by the Speaker of the House of Delegates. Seconding a nomination is not permitted.

and be it further



**Resolved**, that the ADA *Bylaws*, CHAPTER VIII., ELECTIVE OFFICERS, Section 30, NOMINATIONS, be amended by adding a new subsection C as follows:

- C. Nominations for the office of Speaker of the House shall be made in accordance with the order of business. The search for Speaker of the House shall be announced in an official publication of the Association in January. Candidates for the office of Speaker of the House shall apply by submitting a curriculum vitae along with a statement supporting their qualifications to the Executive Director at least one hundred twenty (120) days prior to the convening of the House of Delegates. The Executive Director shall provide all members of the House of Delegates, at least sixty (60) days prior to the convening of the House of Delegates, with each candidate's curriculum vitae and statement of qualifications for the office of Speaker of the House. Only those candidates shall be nominated from the floor of the House of Delegates. The nominations may be followed by an acceptance speech not to exceed four (4) minutes by each candidate from the podium, according to the protocol established by the Speaker of the House of Delegates. Seconding a nomination is not permitted. No further nominations for the office of Speaker of the House shall be accepted from the floor of the House of Delegates. If there are no eligible candidates for the office of Speaker of the House when the House of Delegates meets, the office of Speaker of the House shall be filled in the same manner as provided in Chapter VIII, Section 80 of these *Bylaws*.

The recited Sections of the ADA *Bylaws* as amended appear in Appendix 1 appended to this report. A timeline of the process outlined in this report appears in Appendix 2.

*Resolution 102H-2010.* The Council received an assignment from the House of Delegates to study and report to the 2011 House of Delegates in regard to Resolution 102H-2010:

**Resolved**, that the Council on Ethics, Bylaws and Judicial Affairs reviews the *Constitution and Bylaws* and parliamentary procedure with legal counsel and report to the House of Delegates in 2011 with a detailed description of the different types of sessions (e.g., open sessions, closed/executive sessions, and attorney-client sessions) held during meetings of the ADA government bodies and their committees and councils, including a description of who can be present during each type of session, what information can be discussed during each type of session, what the recording obligations are with respect to each type of session, how the minutes should be prepared for each type of session, and under what conditions can the minutes of one government body be shared with another. The report should also include a risk assessment of the different types of sessions and the process obligations related thereto, with a focus on balancing the need for transparency against the potential for liability.

In response to the referral, a comprehensive review of ADA governance material was undertaken, including a focused review of the following material:

ADA *Constitution and Bylaws* (revised January 1, 2011) (the *Bylaws*),  
 The *2010 Manual of the House of Delegates and Supplemental Information (HOD Manual)*,  
 The *Organization and Rules of the Board of Trustees* (revised through December 2010) (Board Rules),  
 The ADA *Standing Rules for Councils and Commissions* (amended to February 2010) (*Standing Rules*), and  
 The *Standard Code of Parliamentary Procedure* (4<sup>th</sup> edition), by Alice Sturgis (*Standard Code*).

The Council then prepared a report detailing its review of the types of meetings for the two governing bodies of the ADA, namely the House of Delegates (legislative) and the Board of Trustees (administrative and managerial), and the committees and/or councils of each. The report contains, for each type of session identified, a description of who can be present, what categories of information can be discussed, the recording obligations that exist, how minutes of each session should be prepared, and under what conditions the minutes of sessions of one body can be shared with the other. The report also speaks to

the Council's consideration and assessment of the risks inherent in each type of session and process obligations related thereto.

The full report of the Council respecting its deliberations on the issues referred to it by 102H-2010 is appended to this annual report as Appendix 3. The report is informational in nature; no actions are recommended by the Council.

*Resolution 108H-2010.* The Council received an assignment from the House of Delegates to study and report to the 2011 House of Delegates in regard to Resolution 108H-2010:

**Resolved**, that the Council on Ethics, Bylaws and Judicial Affairs consider and delineate the fiduciary responsibilities and duties of individual delegates to the ADA House of Delegates, and be it further  
**Resolved**, that the Council be encouraged to consult additional resources including, but not limited to, current delegates, comparable associations and the American Institute of Parliamentarians, and be it further  
**Resolved**, that a report, including recommended bylaws changes, if necessary, be presented to the 2011 House of Delegates.

In considering the referral of Resolution 108H-2010 the Council researched material prepared by the Association respecting the concept of fiduciary duty. It was discovered that a comprehensive study of the fiduciary responsibilities and obligations imposed upon individuals elected to the position of trustee was completed in December 2010. This study resulted in an educational module being prepared for the Board of Trustees as part of an eight module educational onboarding process that has recently been commenced.

Because of the comprehensive nature of the work leading up to the preparation of the module reviewed by the Council, and the fact that the module appeared to the Council to have a thorough explanation of the concept of fiduciary duty in the context of the business of the Association, the Council used the Board of Trustees' educational module as the primary basis for the delineation of the fiduciary duties owed by individuals elected to the position of delegate to the Association. Use of this resource has the benefit of adding consistency to the discussions of the obligations imposed on members of both governing bodies of the Association—the House of Delegates as the legislative and governing body and Board of Trustees as the managing and administrative body. Secondary sources referenced by the Council during the course of its work on this referral include the *ADA Constitution and Bylaws* and the *2010 Manual of the House of Delegates and Supplemental Information*.

The full report of the Council respecting its deliberations on the issues referred to it by 108H-2010 is appended to this annual report as Appendix 4. The report is informational in nature; no actions are recommended by the Council.

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## Judicial Affairs

**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 conducted one appellant hearing in the matter of a member dentist disciplined by a state dental society. The decision of that hearing will be summarized in the Council's next annual report. A second scheduled appeal was conditionally dismissed, as the dentist involved is no longer a current member in good standing of the Association, as is required by the *ADA Bylaws*.

**Surveys of Constituent Societies Regarding Ethics Judicial Procedures:** The Council completed its survey of constituent dental societies to ascertain the procedures used in acting on complaints of ethics

violations received by the constituent societies. The Council will use the information obtained to assist in the revision of the manual of judicial procedures the Council maintains. The Council is also surveying state societies to determine their interest in participating in an ethics judicial procedures seminar. Once all states have responded, the Council will determine if, when and where the seminar will be held—on-site, at ADA headquarters or online.

### **Matters Relating to the ADA Constitution and Bylaws and ADA Principles of Ethics and Code of Professional Conduct**

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**ADA Bylaws:** In addition to the recommendations for amendments to the ADA *Bylaws* discussed above, the Council reviewed a request from the Division of Global Affairs to revise references to the Fédération Dentaire Internationale (FDI) in the ADA *Bylaws* to the brand name “FDI World Dental Federation.” The Council noted that “Fédération Dentaire Internationale” is the FDI’s legal name as recorded in its current constitution. As a result, the Council voted to retain the legally recognized name of the Fédération Dentaire Internationale as it is currently written in the ADA *Bylaws* and sought the input of the FDI on how it wishes to be referred in the ADA *Bylaws*.

**ADA Code:** The Council convened several subcommittees to review portions of the ADA *Code* and upon deliberation concurred with their recommendations for amendments as follows:

*Amendment to ADA Code, Section 2 – Principle: Nonmaleficence.* At the request of the Evidence-Based Advisory Committee (EBD), representative councils were asked to consider establishing EBD goals related to their council activities. One of the Council’s goals is to address the ethical concerns of EBD by increasing the visibility of EBD through a series of ethics related articles on EBD. Thus far, two such articles have been published as part of the Ethical Moment feature in *JADA*. The Council also believed that it would be appropriate to add an aspirational statement in the ADA *Code* encouraging dentists to incorporate the ADA principles of evidence-based dentistry into their practices. To this end, the Council recommends the adoption of the following resolution:

**10. Resolved**, that Section 2 – Principle: Nonmaleficence of the ADA *Principles of Ethics and Code of Professional Conduct* be amended as follows (additions underscored):

**SECTION 2 — Principle: Nonmaleficence (“do no harm”).**

The dentist has a duty to refrain from harming the patient.

This principle expresses the concept that professionals have a duty to protect the patient from harm. Under this principle, the dentist’s primary obligations include keeping knowledge and skills current, knowing one’s own limitations and when to refer to a specialist or other professional, and knowing when and under what circumstances delegation of patient care to auxiliaries is appropriate. The dentist should incorporate the ADA principles of evidence-based dentistry in patient care.

*Amendment to ADA Code, Section 5.H. Announcement and Limitation of Practice, and Revision of Advisory Opinion 5.I.1. General Practitioner Announcement of Credentials in Non-Specialty Interest Areas.* In response to a request from the Council on Dental Education and Licensure (CDEL), the Council discussed the need to revise certain ADA *Code* sections to reflect terminology currently in use such that the term “dental specialties” replaces “special areas of dental practice” and the term “interest areas in general dentistry” replaces “non-specialty interest areas.” The Council agreed to amend Section 5.H. Announcement and Limitation of Practice and Advisory Opinion 5.I.1., and therefore recommends adoption of the following resolution:

**11. Resolved**, that Section 5.H., Announcement of Specialization and Limitation of Practice, of the ADA *Principles of Ethics and Code of Professional Conduct* be amended as follows (additions underscored, deletions stricken):

**Section 5.H. Announcement of Specialization and Limitation of Practice.** This section and Section 5.I are designed to help the public make an informed selection between the practitioner who has completed an accredited program beyond the dental degree and a practitioner who has not completed such a program. The ~~special areas of dental practice~~ dental specialties approved by the American Dental Association and the designation for ethical specialty announcement and limitation of practice are: dental public health, endodontics, oral and maxillofacial pathology, oral and maxillofacial radiology, oral and maxillofacial surgery, orthodontics and dentofacial orthopedics, pediatric dentistry, periodontics and prosthodontics. Dentists who choose to announce specialization should use “specialist in” or “practice limited to” and shall limit their practice exclusively to the announced special area(s) of dental practice, provided at the time of the announcement such dentists have met in each approved specialty for which they announce the existing educational requirements and standards set forth by the American Dental Association. Dentists who use their eligibility to announce as specialists to make the public believe that specialty services rendered in the dental office are being rendered by qualified specialists when such is not the case are engaged in unethical conduct. The burden of responsibility is on specialists to avoid any inference that general practitioners who are associated with specialists are qualified to announce themselves as specialists.

The Council unanimously voted to amend Advisory Opinion 5.I.1. General Practitioner Announcement of Credentials in Non-Specialty Interest Areas, as shown below (additions underscored; deletions stricken):

**Advisory Opinion 5.I.1. General Practitioner Announcement of Credentials in ~~Non-Specialty Interest Areas~~ Interest Areas in General Dentistry.** A general dentist may not announce to the public that he or she is certified or a diplomate or otherwise similarly credentialed in an area of dentistry not recognized as a specialty area by the American Dental Association unless:

1. The organization granting the credential grants certification or diplomate status based on the following: a) the dentist’s successful completion of a formal, full-time advanced education program (graduate or postgraduate level) of at least 12 months duration; and b) the dentist’s training and experience; and c) successful completion of an oral and written examination based on psychometric principles;
2. The dentist discloses that he or she is a general dentist; and
3. The announcement includes the following language: [Name of announced area of dental practice] is not recognized as a specialty area by the American Dental Association.

The Council did not believe it appropriate to revise, as requested by CDEL, Advisory Opinion 5.H.2. Specialist Announcement of Credentials in Non-Specialty Interest Areas, as this advisory opinion relates specifically to dental specialists and the new terminology “interest areas in general dentistry” does not apply.

*Addition of Advisory Opinion 3.F.1. Disruptive Behavior in the Workplace.* With the recent ADA Code addition of 3.F. Professional Demeanor in the Workplace, wherein the obligation to provide a workplace environment conducive to providing professional care to patients is expressed, the Council believed that an Advisory Opinion was warranted to give emphasis to the individual dentist’s obligation to contribute toward such a practice environment so as to optimize patient care. The Council unanimously voted to add Advisory Opinion 3.F.1. Disruptive Behavior in the Workplace, as shown below:

**3.F.1. Disruptive Behavior in the Workplace.** Dentists are the leaders of the oral healthcare team. As such, their behavior in the workplace is instrumental in establishing and maintaining a practice environment that supports the mutual respect, good communication, and high levels of collaboration among team members required to optimize the quality of patient care provided. Dentists who engage in disruptive behavior in the workplace risk undermining professional relationships among team members, decreasing the quality of patient care provided, and undermining the public’s trust and confidence in the profession.

*Revision of Advisory Opinion 5.B.6. Unnecessary Services.* The Council engaged in lengthy deliberations regarding cases of overtreatment, treatment not within the acceptable standard, upcoding and altered treatment planning that sometimes occur. This topic was addressed as a result of a request of an ADA member dentist who allegedly experienced these situations while working in a corporate dental office. Upon discussion, the Council concluded that, because the motivation for these types of activities is usually to improve the financial situation of a practice, the concern should not be limited to corporate settings. Although it was agreed that ADA Code 3.F., Professional Demeanor in the Workplace, and Advisory Opinion 5.B.6. Unnecessary Services, addressed these behaviors, the Council agreed that Advisory Opinion 5.B.6. could be strengthened to clarify the Association's position as it relates to the individual dentist regardless of the type of organization or workplace in which he/she may practice. For this reason, the Council unanimously agreed to amend ADA Code Advisory Opinion 5.B.6. Devices and Therapeutic Methods, as follows (additions underscored):

**5.B.6. Unnecessary Services.** A dentist who recommends and performs unnecessary dental services or procedures is engaged in unethical conduct. The dentist's ethical obligation in this matter applies regardless of the type of practice arrangement or contractual obligations in which he or she provides patient care.

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## Council Activities

**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 2010 Golden Apple award went to the Michigan Dental Association. The deadline for submissions this year is Wednesday, June 1, 2011. The Council will vote upon nominations submitted for the 2011 award by confidential mail ballot.

**Ethics Articles Authored by Council Members:** 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*. During this term, subjects addressed included website ethics, EBD and unsubstantiated treatments, overtreatment and ethical considerations when approaching retirement. The Council welcomes questions from members. Suggestions should be sent to [ethics@ada.org](mailto:ethics@ada.org). The Council also renewed its commitment to prepare articles for the Ethics Corner segment in the ASDA journal, *MOUTH*.

**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 a confidential opinion letter that is strictly advisory and not binding on either the Council or the society that made the request. To avoid any appearance of bias should the matter proceed to a disciplinary hearing that results in an appeal to the Council, Council members are not informed of its contents and the members of the subcommittee who participated in the advisory opinion will have ceased to be Council members by the time the appeal is heard. Constituent societies may contact the Council staff for further information.

**Student Ethics Video Contest:** The Council's student ethics video contest is in its fifth 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 or more of the principles, code sections or advisory opinions found in the ADA Code. To be eligible, videos must be submitted by July 31, 2011. Winners will be selected by Council members. Depending on the quality of submissions

received, the winning videos will be aired at the 2011 annual session in Las Vegas, Nevada and subsequently displayed on ADA.org. Monetary prizes will be awarded including \$2,000 to the first place winner.

During the 2010 term, the Council awarded two prizes: a \$2,000 grand prize for the video entitled, "Dentethics," submitted by students from the University of Washington School of Dentistry; and an honorable mention prize of \$1,000 for the video, "Once Upon a Time There Was a Poor Dentist," by students of the Columbia University College of Dental Medicine. Both videos were displayed during the 2010 annual session in Orlando. The videos are also available for viewing on ADA.org at <http://www.ada.org/4064.aspx>.

Details about the 2011 contest may be obtained by request at [sewelle@ada.org](mailto:sewelle@ada.org).

**Council Satisfaction Survey:** Following each meeting, Council volunteers are asked to complete a meeting satisfaction survey to assist the staff in assessing its performance and 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 is evaluating later survey data and summaries of the results will be forwarded to the Council membership.

**Council 2011-2012 Budget:** As with all Association agencies, the Council prepared its budget in such a way as to allow more precise tracking of direct and indirect costs on a project by project basis and to better ensure that funds are being used to achieve the goals of the Association's strategic plan. With a view to being fiscally prudent, the Council will continue to reduce its expenses to the extent possible.

**Chair and Vice Chair for 2011-2012:** For the 2011-12 term, the Council forwarded the name of Dr. Marilyn S. Lantz to the Board of Trustees for approval as the Council's chair and elected Dr. Kevin A. Henner as Council vice chair.

**Personnel:** The Council welcomed four new members this term: Dr. Ethan A. Pansick, Dr. Elizabeth C. Reynolds, Dr. Richard J. Rosato and Dr. Charlotte L. Senseny. The 2011 annual session will mark the completion of the terms of service of four Council members: Dr. Rodney B. Wentworth, Dr. Thomas W. Gamba, Dr. Carl L. Sebelius, Jr. and Dr. Terri S. Tiersky. 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 Association and the profession as a whole. The Council also wishes to express its gratitude to Dr. Donald L. Seago for his valuable insights, participation and advice over the course of his year as Board of Trustees Liaison to the Council, and Mr. Andrew Bohnsack as the representative from the American Student Dental Association and Dr. Danielle Ruskin from the New Dentist Committee for generously providing the most welcome perspectives of the new and student dentists during their tenure.

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## Summary of Resolutions

**9. Resolved**, that the ADA *Bylaws*, CHAPTER VIII., ELECTIVE OFFICERS, Section 30, NOMINATIONS, Subsection A. be amended as follows (additions underscored, deletions stricken):

- A. Nominations for the offices of President-elect, and Second Vice President ~~and Speaker of the House~~ shall be made in accordance with the order of business. Candidates for these elective offices shall be nominated from the floor of the House of Delegates by a simple declaratory statement, which may be followed by an acceptance speech not to exceed four (4) minutes by the candidate from the podium, according to the protocol established by the Speaker of the House of Delegates. Seconding a nomination is not permitted.

and be it further

**Resolved**, that the ADA *Bylaws*, CHAPTER VIII., ELECTIVE OFFICERS, Section 30, NOMINATIONS, be amended by adding a new subsection C as follows:

- C. Nominations for the office of Speaker of the House shall be made in accordance with the order of business. The search for Speaker of the House shall be announced in an official publication of the Association in January. Candidates for the office of Speaker of the House shall apply by submitting a curriculum vitae along with a statement supporting their qualifications to the Executive Director at least one hundred twenty (120) days prior to the convening of the House of Delegates. The Executive Director shall provide all members of the House of Delegates, at least sixty (60) days prior to the convening of the House of Delegates, with each candidate's curriculum vitae and statement of qualifications for the office of Speaker of the House. Only those candidates shall be nominated from the floor of the House of Delegates. The nominations may be followed by an acceptance speech not to exceed four (4) minutes by each candidate from the podium, according to the protocol established by the Speaker of the House of Delegates. Seconding a nomination is not permitted. No further nominations for the office of Speaker of the House shall be accepted from the floor of the House of Delegates. If there are no eligible candidates for the office of Speaker of the House when the House of Delegates meets, the office of Speaker of the House shall be filled in the same manner as provided in Chapter VIII, Section 80 of these Bylaws.

**10. Resolved**, that Section 2 - Principle: Nonmaleficence of the ADA *Principles of Ethics and Code of Professional Conduct* be amended as follows (additions underscored):

**SECTION 2 — Principle: Nonmaleficence (“do no harm”).**

The dentist has a duty to refrain from harming the patient.

This principle expresses the concept that professionals have a duty to protect the patient from harm. Under this principle, the dentist's primary obligations include keeping knowledge and skills current, knowing one's own limitations and when to refer to a specialist or other professional, and knowing when and under what circumstances delegation of patient care to auxiliaries is appropriate. The dentist should incorporate the ADA principles of evidence-based dentistry in patient care.

**11. Resolved**, that Section 5.H. Announcement of Specialization and Limitation of Practice, of the ADA *Principles of Ethics and Code of Professional Conduct* be amended as follows (additions underscored; deletions stricken):

**Section 5.H. Announcement of Specialization and Limitation of Practice.** This section and Section 5.I are designed to help the public make an informed selection between the practitioner who has completed an accredited program beyond the dental degree and a practitioner who has not completed such a program. ~~The special areas of dental practice~~ dental specialties approved by the American Dental Association and the designation for ethical specialty announcement and limitation of practice are: dental public health, endodontics, oral and maxillofacial pathology, oral and maxillofacial radiology, oral and maxillofacial surgery, orthodontics and dentofacial orthopedics, pediatric dentistry, periodontics and prosthodontics. Dentists who choose to announce specialization should use “specialist in” or “practice limited to” and shall limit their practice exclusively to the announced special area(s) of dental practice, provided at the time of the announcement such dentists have met in each approved specialty for which they announce the existing educational requirements and standards set forth by the American Dental Association. Dentists who use their eligibility to announce as specialists to make the public believe that specialty services rendered in the dental office are being rendered by qualified specialists when such is not the case are engaged in unethical conduct. The burden of responsibility is on specialists to avoid any inference that general practitioners who are associated with specialists are qualified to announce themselves as specialists.

## **Appendix 1**

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### **Referral of Resolution 88H-2010 Nomination and Election Procedures for Speaker of the House of Delegates Recommended Bylaws Revisions**

#### **CHAPTER VIII., ELECTIVE OFFICERS, Section 30, NOMINATIONS, Subsection A:**

A. Nominations for the offices of President-elect and Second Vice President shall be made in accordance with the order of business. Candidates for these elective offices shall be nominated from the floor of the House of Delegates by a simple declaratory statement, which may be followed by an acceptance speech not to exceed four (4) minutes by the candidate from the podium, according to the protocol established by the Speaker of the House of Delegates. Seconding a nomination is not permitted.

#### **CHAPTER VIII., ELECTIVE OFFICERS, Section 30, NOMINATIONS:**

C. Nominations for the office of Speaker of the House shall be made in accordance with the order of business. The search for Speaker of the House shall be announced in an official publication of the Association in January. Candidates for the office of Speaker of the House shall apply by submitting a curriculum vita along with a statement supporting their qualifications to the Executive Director at least one hundred twenty (120) days prior to the convening of the House of Delegates. The Executive Director shall provide all members of the House of Delegates, at least sixty (60) days prior to the convening of the House of Delegates, with each candidate's curriculum vita and statement of qualifications for the office of Speaker of the House. Only those candidates shall be nominated from the floor of the House of Delegates. The nominations may be followed by an acceptance speech not to exceed four (4) minutes by each candidate from the podium, according to the protocol established by the Speaker of the House of Delegates. Seconding a nomination is not permitted. No further nominations for the office of Speaker of the House shall be accepted from the floor of the House of Delegates. If there are no eligible candidates for the office of Speaker of the House when the House of Delegates meets, the office of Speaker of the House shall be filled in the same manner as provided in Chapter VIII, Section 80 of these Bylaws.



## Appendix 2

### Referral of Resolution 88H-2010 Nomination and Election Procedures for Speaker of the House of Delegates Proposed Nomination Timeline

Timing	Event
January	Speaker of the House of Delegates search announced in official ADA publication
120 Days Prior to Convening of House of Delegates	Curriculum vitae and supporting statements of qualifications from all candidates for the office of Speaker of the House of Delegates due to be submitted to the ADA Executive Director by this date
60 Days Prior to Convening of House of Delegates	Curriculum vitae and statements of qualifications for all candidates for the office of Speaker of the House of Delegates due to be provided to Delegates and Alternate Delegates by the ADA Executive Director by this date

## Appendix 3

### Report on the Referral of Resolution 102H-2010 Regarding Review of the ADA *Constitution and Bylaws* Regarding Meeting Sessions of ADA Governing Bodies

**Background:** The Council on Ethics, Bylaws and Judicial Affairs (the Council) received an assignment from the House of Delegates to study and report to the 2011 House of Delegates in regard to Resolution 102H-2010:

**Resolved,** that the Council on Ethics, Bylaws and Judicial Affairs reviews the *Constitution and Bylaws* and parliamentary procedure with legal counsel and report to the House of Delegates in 2011 with a detailed description of the different types of sessions (e.g., open sessions, closed/executive sessions, and attorney-client sessions) held during meetings of the ADA government bodies and their committees and councils, including a description of who can be present during each type of session, what information can be discussed during each type of session, what the recording obligations are with respect to each type of session, how the minutes should be prepared for each type of session, and under what conditions can the minutes of one government body be shared with another. The report should also include a risk assessment of the different types of sessions and the process obligations related thereto, with a focus on balancing the need for transparency against the potential for liability.

This report from the Council provides the information requested by the Resolution. No action is requested.

**Discussion:** In response to Resolution 102H-2010 the Council has conducted a focused review of the following governance material:

ADA *Constitution and Bylaws* (revised January 1, 2011) (the *Bylaws*),  
The 2010 *Manual of the House of Delegates and Supplemental Information* (HOD Manual),

The *Organization and Rules of the Board of Trustees* (revised through December 2010) (*Board Rules*),  
 The *ADA Standing Rules for Councils and Commissions* (amended to February 2010) (*Standing Rules*), and  
 The *Standard Code of Parliamentary Procedure* (4<sup>th</sup> edition), by Alice Sturgis (the *Standard Code*).

The answers to the inquiries asked by the resolution are contained within each summary of the respective types of meetings of the governing bodies of the ADA, the House of Delegates, the ADA's legislative body (the House), the Board of Trustees, the ADA's administrative or managing body (the Board), and their respective committees and councils (together, councils). Instances of differing language among the governance material dealing with the House, the Board and councils are rare and noted only where it is perceived by the Council that the language differences signal a material change. Where appropriate, the Council also consulted with members of the ADA Division of Legal Affairs.

The information presented in this report is available to all delegates and alternate delegates of the House in the referenced documents in print and/or digital formats. Nonetheless, the Council has summarized and collated the data here as requested in 102H-2010. The descriptions contained in this document are meant to be summary responses to the questions raised in the resolution and not a comprehensive presentation of all the relevant information contained in the referenced materials. Specific detailed information on any particular subject rests within the text of the ADA's original governance documents.

## A. Types of Meetings

It is noted at the outset that the inquiries posed in 102H-2010 are assumed to focus on the content of each type of session noted in the governance documents of the Association and who may attend those meetings. In its review, the Council noted that there are also two different types of meetings discussed in the governance documents, namely "regular" and "special" meetings. Although not specifically requested by the resolution, information concerning these two types of meetings is also summarized in this report for purposes of completeness.

### 1. Regular Meetings

Regular meetings are those meetings of an organization at which any business of the organization not requiring special notice may be conducted. The time and place of such meetings require whatever notice is set forth in the bylaws of the organization (the *Standard Code*, p. 106).

House of Delegates. The regular meeting of the House is the annual session; Chapter V, Section 70 of the *Bylaws* states that the House "shall meet annually." Chapter V, Section 90.A of the *Bylaws* states that notice of each annual session shall be sent to each member of the House at least thirty (30) days before the opening of the session, as well as being published in *The Journal of the American Dental Association*.

Board of Trustees. Chapter VII, Section 110 of the *Bylaws* sets forth the minimum frequency at which Board meetings shall be held, stating that the Board shall hold 3 regular sessions at a minimum annually, and specifies that the number of additional meetings of the Board to be held for the ensuing year shall be determined in advance by the Board. Present practice is to hold seven Board meetings per year, with one meeting being designated a Board retreat.

Councils. Chapter X, Section 80 of the *Bylaws* states that each council shall hold at least one meeting annually, provided that funds are available in the budget for that purpose. The *Standing Rules* provide that unless otherwise directed by the Board of Trustees, council meeting dates are to be determined at least six months in advance and reported to the Association's Executive Director. The *Standing Rules* also provide that with the exception of the Council on Ethics, Bylaws and Judicial Affairs and the Council on ADA Sessions, no official meeting shall be held

during the Association's annual session, and that no council meeting shall be held the week prior to a Board meeting, with exceptions to these rules subject to the approval of the Executive Director. This information is found at page 10 of the *Standing Rules*. The council meeting shall be held at the call of the chair or on written motion of a majority of the council's members, with notice being provided in advance by the council's chair or director (*Standing Rules*, p. 11).

House Committees. Chapter V, Section 140 of the *Bylaws* identifies the standing committees of the House; no specific information on committee meetings is provided. In practice, these committees meet during annual session to assist the House in the conduct of business (see, generally, HOD Manual, p. 17).

Board Committees. The New Dentist Committee of the Board meets twice a year as set forth on page 23 of the *Board Rules*.

The remaining standing committees of the Board meet as follows:

Audit Committee: At least quarterly in conjunction with Board meetings and otherwise as deemed necessary by the committee (*Board Rules*, p.16).

Budget and Finance Committee: At least quarterly in conjunction with Board meetings and otherwise as deemed necessary by the committee (*Board Rules*, p.19).

Committee on International Programs and Development: At least once annually (*Board Rules*, p. 21).

Compensation Committee: Twice each year (*Board Rules*, p.18).

Diversity Committee: At least once per year (*Board Rules*, p.19).

Information Technology Committee: At least three times per year (*Board Rules*, p. 26).

Pension Committee: At least twice annually (*Board Rules*, p. 24).

Strategic Planning Committee: At least twice annually, with additional meetings called at the discretion of the Board (*Board Rules*, p. 26).

Commissions. Chapter XIV, Section 80 of the *Bylaws* states that each commission shall hold at least one meeting annually, provided that funds are available in the budget for that purpose.

## 2. Special Meetings

Special meetings are defined by the *Standard Code* as meetings convened to consider specific proposals (the *Standard Code*, pp. 104, 107).

House of Delegates. *Bylaws* Chapter V, Section 80 states that a special session of the House is called by the President on a 3/4 affirmative vote of the Board or on written request of delegates representing 1/3 of the constituent societies and 1/5 the number of certified delegates of the last House, with the business of the special session being limited to that stated in the special call except as may be agreed to by unanimous consent. Chapter V, Section 90.B of the *Bylaws* indicates that the official call is sent to the certified delegates and alternates of the last House at least fifteen (15) days prior to the opening of the special session.

Board of Trustees. Pursuant to *Bylaws* Chapter VII, Section 110.B, special sessions of the Board may be called at any time by the President or five voting members of the Board. Notice of the special meeting must be given to each member of the Board in advance.

Councils. Provided budgeted funds are available, special meetings of councils are to be held in accordance with the rule on official call, which states that a special meeting shall be held at the call of the chair or on written request of a majority of the members of the council, with notice of the meeting being sent to members in advance by the chair or council director (Standing Rules, p.10).

### 3. Electronic Conferencing

Regular or special meetings of the Board of Trustees from multiple remote locations may be held by telephone conference or other communications equipment pursuant to Chapter VII, Section 110.C of the ADA *Bylaws*. Meetings of councils and commissions via telephone conference or other communications equipment are permitted pursuant to the ADA *Bylaws*, Chapter X, Section 80 and Chapter XIV, Section 80, respectively.

## B. Types of Meetings and What Can Be Discussed at Each

The resolution requests that a detailed description of open, closed or executive and attorney-client sessions be provided. With one exception, there is no provision in the governance material reviewed by the Council that describes sessions or meetings of the ADA governing bodies as “open.”\* Closed and attorney-client sessions are discussed in the governance material, however, so for purposes of its review of Resolution 102H-2010, the Council considered the reference to “open” sessions to mean those meeting sessions other than closed or attorney-client sessions. The Council also notes that the term “open” as used to describe meetings, is often used to refer to the meeting being open to members of the public (i.e., open meeting laws). As is discussed below, there are restrictions on all meetings held by the governing bodies of the Association, their councils and, with one exception, their committees. Consequently, so as to not engender confusion, this report shall refer to sessions of meetings other than closed or attorney-client sessions as “normal sessions.”

### 1. Normal Sessions

As indicated above, regular meetings of an organization are meetings at which any business of the organization may be conducted (the *Standard Code*, p. 106). By definition, meetings in the *Standard Code* are open to all members of an organization (“A meeting is an official assembly of the members of an organization . . .”) (the *Standard Code*, p.106).

For normal sessions of regular meetings, the House, Board and their councils and committees may validly discuss, deliberate and decide on all matters that are within the scope of their defined powers and duties that are not treated in closed or attorney-client sessions. Too voluminous to list here, the powers and duties of each body may be found as follows:

House powers and duties are enumerated in Sections 40 and 50 of Chapter V of the *Bylaws*.

The duties of the standing committees of the House are defined in Section 140 of Chapter V of the *Bylaws*.

Board powers and duties are enumerated in Sections 90 and 100 of Chapter VII of the *Bylaws*.

The duties of the councils are enumerated in Chapter X, Section 120 of the *Bylaws*.

The duties of the standing committees of the Board are enumerated in the *Board Rules* with the exception of the New Dentist Committee, whose duties are enumerated in Chapter VII, Section 140 of the *Bylaws*.

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\* The one exception relates to the open hearings conducted by reference committees, referenced in Chapter V, Section 140.D.b of the *Bylaws* and on page 20 of the House Manual. This is discussed below.

The duties of the ADA commissions are enumerated in Chapter XIV, Section 130 of the *Bylaws*.

## 2. Closed Sessions

Under the *Standard Code*, a closed session is a meeting open only to members of the organization holding the meeting in which sensitive or confidential matters are discussed and acted upon. According to *Standard Code* a motion to move into a closed session is a privileged one, and is adopted by a majority vote. Boards and committees typically operate in closed session. Closed sessions are sometimes referred to as “executive” sessions (the *Standard Code*, p. 108).

Under the standing rules of the House, a closed session may be called to consider matters of a highly confidential nature. No official action may be taken nor business conducted during a closed session of the House (*House Manual*, p. 14). With respect to Reference Committees, the *House Manual* states that following the holding of hearings on proposed resolutions referred to it, a reference committee retires to a closed session to reach its decisions and prepare its report to the House on those decisions (*House Manual*, p. 20).

The *Board Rules* contain rules similar to those of the House for the conduct of closed sessions of Board and Board committee meetings, except that the *Board Rules* create an exception for the Compensation Committee, which is allowed to take actions in closed session concerning certain enumerated matters relating to the Executive Director (*Board Rules*, p. 11).

The *Standing Rules*, discussing closed sessions for councils, states that closed sessions may be called in “extraordinary circumstances” to discuss “very sensitive matters” (*Standing Rules*, p. 11). A council calls a closed session on majority vote of the members present at the meeting at which the closed session would be held and is to be conducted in the presence of either the Executive Director, ADA legal counsel, senior management team member assigned to the council, or the council director. No official action may be taken nor business conducted during a closed session of a council meeting.

## 3. Attorney-Client Sessions

As the *House Manual* indicates, an attorney-client session is a species of closed session during which an attorney acting in a professional capacity provides legal advice, or a request is made of the attorney for legal advice. During attorney-client sessions legal advice given by the attorney may be discussed at length, and such discussion is “privileged.” The requests, advice and any related discussion are protected, which means that opponents in litigation, media representatives, or others cannot legally compel their disclosure. The purpose of the privilege is to encourage free and frank discussions between an attorney and those seeking or receiving legal advice. The privilege can be lost (waived) if details about the attorney-client session are revealed to third parties. Once the privilege has been waived, there is a danger that all privileged communications on the issues covered in the attorney-client session, regardless of when or where they took place, may become subject to disclosure. Unlike a closed session, the rules governing an attorney-client session are determined and imposed by long established legal principles rather than by the Association’s *Bylaws* or policies. Attorney-client privilege may vary from state to state. For attorney-client sessions, the Speaker and Secretary shall consult with the Chief Legal Counsel regarding attendance during the session. No official action may be taken nor business conducted during an attorney-client session (*House Manual*, p. 14).

In accordance with the above information concerning the attorney-client privilege and the potential waiver of that privilege, all those participating in an attorney-client session shall refrain from disclosing information about the discussion held during the attorney-client session. In certain cases, a decision may be made to come out of the attorney-client session for purposes of conducting a non-privileged discussion of the same or related subject matter. The difference will

be that during the non-privileged session there will be no discussion of any legal advice requested by attendees during the attorney-client session or about any of the legal advice given by legal counsel (*House Manual*, p. 14).

The *Board Rules*, at pages 11-12 and *Standing Rules*, at page 11, contain similar provisions governing attorney-client sessions at Board and council and commission meetings, respectively.

## C. Attendance at Normal, Closed and Attorney-Client Sessions

### 1. Normal Sessions

House of Delegates. Pursuant to Chapter V, Section 30, the executive director or equivalent chief executive officer of each constituent society, the ranking administrative officer of each federal dental service, and the secretary of the American Student Dental Association shall file with the Executive Director of this Association, at least sixty (60) days prior to the first day of the annual session of the House of Delegates, the names of the delegates and alternate delegates designated by the society, service or association. The Executive Director of this Association shall provide each delegate and alternate delegate with credentials which shall be presented to the Committee on Credentials, Rules and Order of the House of Delegates.

For normal sessions of annual sessions and any special House session at which topics that are not highly confidential and do not involve the requesting of legal advice or receiving legal advice from an attorney for the Association, anyone who has registered for annual session and has received an annual session badge may be seated in the visitors section of the HOD. Only delegates, elected and appointed officers, former presidents, council and commission chairs and select others may be seated on or have access to the House floor. Alternate delegates, former officers and former trustees sit in a designated reserved section (*House Manual*, p. 6).

For House Reference Committees, hearings on assigned reports and resolutions are categorized as “open” hearings. All ADA members are welcome to attend and have a right to participate in reference committee hearings. Non-ADA members may also attend, but must identify themselves to the chair prior to the session. Non-ADA member attendees at reference committee hearings may only participate at the invitation of a majority of the reference committee (*House Manual*, p. 20).

Board of Trustees. One trustee elected from each of the 17 trustee districts, the President-elect, and two Vice Presidents constitute the voting membership of the Board. In addition, the President, the Treasurer and the Executive Director are *ex officio* members of the Board without the right to vote (*Bylaws*, Chapter VII, Section 10). When the Board is in a normal session of a meeting, the Board members, the Speaker of the House of Delegates, and, on the invitation of the President, designated council and staff members shall be privileged to be in attendance. Others may be privileged to attend for consultation on the invitation of the President. No action shall be taken by the Board of Trustees until such consultants have retired. Candidates for the position of President-Elect may attend in non-voting, non-speaking capacities at the invitation of the President provided that they have signed confidentiality agreements relating to information that becomes known to them by reason of such attendance (*Board Rules*, p. 10). This is in keeping with the *Standard Code*, which indicates that “[b]oards and committees normally operate in closed session, although they may invite members of the organization to attend as observers” (the *Standard Code*, p. 108).\*

Councils and Commissions. For normal sessions of councils and commissions and any special session involving topics that are not highly confidential and which do not involve the requesting of legal advice or receiving legal advice from an attorney for the Association, their members and

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\* The governance documents reviewed do not specifically discuss attendance at meetings of the committees of the Board. In such circumstances, it is understood that Board committees generally follow the protocols and procedures adopted by the Board.

appropriate members of the BOT and staff may attend. Others may attend when the council so requests (*Standing Rules*, p.11).

## 2. Closed Sessions

House of Delegates. In a closed session of the House of Delegates, attendance is limited to officers of the House, delegates and alternate delegates, and the elective and appointive officers, trustees and chief legal counsel of the Association. In consultation with the Secretary of the House, the Speaker may invite other persons with an interest in the subject matter to remain during the closed session. In addition to senior management, this is likely to include members and staff of the council(s) or commission(s) involved with the matter under discussion and executive directors of constituent societies and the American Student Dental Association. No official action may be taken nor business conducted during a closed session. Immediately after a closed session, the Speaker will inform the delegates that they may present a motion to request permission to review information which was discussed in the closed session, with the information being discussed only with those members present at the session (*House Manual*, p. 14).

Following the receipt of evidence at an open hearing, a reference committee will retire to a closed session to reach its decisions. Members of Association staff designated by the Executive Director shall be available to assist the committee; such staff may attend the closed meeting of the reference committee at the pleasure of the committee. The reference committee may also invite others to the closed session to provide resource information. When it wishes, the reference committee may exclude from its closed session everyone but committee members (*House Manual*, p. 20).

Board of Trustees. Attendance at closed sessions of Board meetings are limited to Board Members, elective officers, the Executive Director, Chief Legal Counsel, and other staff as the Board may decide; provided, however, that the Board may hold a closed session(s) without the Executive Director if the sole purpose is to evaluate the duties and quality of performance of the Executive Director and/or establish compensation for the Executive Director for the ensuing year. The Board reserves the right to designate the legal counsel present during closed sessions (*Board Rules*, p. 11).

Councils and Commissions. Members and the trustee liaison are permitted to remain in attendance at a closed session of a council or commission. The Executive Director, ADA legal counsel, the senior management team member assigned to the council or commission and/or the director of the council or commission shall also be permitted to remain in attendance at the determination of the chair (*Standing Rules*, p. 11).

## 3. Attorney-Client Session

As indicated above, attorney-client sessions are a form of closed sessions. They are based on established legal principles, not Association *Bylaws* (see, *Board Rules*, p. 11); attorney-client privilege may vary from state to state. Thus, in order to protect and maintain the attorney-client privilege, the procedures adopted by the Association for the conduct of attorney-client sessions must conform to those established legal principles.

House of Delegates. The Speaker and the Secretary of the House shall consult with the Chief Legal Counsel to determine who should be present for their respective attorney-client sessions (*House Manual*, p.14).

Board of Trustees. The President shall consult with the Chief Legal Counsel to determine who should be present for an attorney-client session of a Board meeting (*Board Rules*, p. 12).

Councils and Commissions. The chair of the council or commission shall consult with ADA legal counsel respecting who should be present for an attorney-client session of a council or commission meeting (*Standing Rules*, p. 11).

## **D. Minutes and Recordation of Meetings**

### **1. Minutes**

The historical and legal record of proposals, reports and decisions by members of an organization is contained in the organization's minutes. Courts give minutes great weight as evidence and auditors depend on the minutes of an organization as proof for authorizations of expenditures (*Standard Code*, p. 198). In general, the *Standard Code* points out that the minutes of an organization are not a record of the discussions held during a meeting. Rather, the minutes are a record of the actions and proceedings that occurred at the meeting. The minutes should record all motions and resolutions, with the identity of the movant, and the disposition of each motion, together with the method of disposition (the *Standard Code*, pp. 200-01). The business transacted at the meeting should be recorded with specificity, as general statements of business conducted are of no value (the *Standard Code*, p. 201).

Reports given during a meeting should be recorded in the minutes with the name of the presenter of the report, any action taken on the report and the location where the report can be found. Important reports may be summarized in the minutes (the *Standard Code*, p. 201).

Under Illinois law, the keeping of minutes of the annual session of the House and of Board and Board committee meetings is a legal requirement. "Each corporation shall ... keep minutes of the proceedings of its members, board of directors and committees having any of the authority of the board of directors..." (805 ILCS 107.75(a)). Further, "[a]ny voting member shall have the right to examine ... the corporation's ... minutes, and to make extracts therefrom, but only for a proper purpose" (805 ILCS 105/107.75(a)).

All approved minutes of the Board and Board standing committees with the exception of the Audit and Compensation Committees, shall be maintained within the office of the Executive Director. Audit Committee minutes shall be maintained by the Division of Legal Affairs, while the minutes of the Compensation Committee shall be maintained by the outside retained counsel of the Committee (*Board Rules*, p. 12).

No minutes of attorney-client sessions of Board meetings are prepared. Instead, the minutes of the non-privileged session of the meeting at which an attorney-client session is held shall state the time that such session was held and shall identify the topic that was discussed (*Board Rules*, p. 12).

Within six working days of a council meeting, the chair or director shall prepare and distribute a report of unofficial actions in accordance with instructions of the Executive Director. It shall also be the duty of the chair or director of each council to record the minutes of all meetings and to send copies thereof to all members, to the Board of Trustees liaison to the council, and to the Executive Director of the Association within 30 days following the last day of the meeting. The minutes shall be approved at the next meeting or by mail vote. Council minutes should be sent to the Board of Trustees immediately following their approval. It shall be the duty of the director of the council to post approved minutes and action items in the members' only section of ADA.org and keep a permanent file of all minutes of the council. Also, in accordance with a 1992 House of Delegates directive, non-confidential summary reports of all ADA council and committee meetings shall be forwarded on a timely basis to all constituent societies (*Standing Rules*, p.12).



## 2. Recordings of Meetings

House of Delegates. Pursuant to the *Bylaws*, the Secretary of the House of Delegates and the Secretary of the Board of Trustees shall serve as the recording officers respectively of the House and BOT and shall be the custodians of their records, and shall cause a record of the proceedings of each to be published as the official transactions of the House and of the Board (*Bylaws*, Chapter V, Section 110Bb and Chapter VII, Section 130Bb, respectively).

Board of Trustees. Under the Board *Rules*, the Executive Director is responsible for electronically recording regular and special non-privileged Board meetings, which are used in the preparation of the minutes. The Executive Director destroys or erases the non-privileged meeting recordings at the conclusion of the next meeting of the House or one year, whichever is longer. Other electronic recording of sessions of the Board or portions thereof, including attorney-client sessions, are not permitted unless authorized by the Board (*Board Rules*, p. 12).

Councils and Commissions. There is no mention of a requirement for the recordation of council and commission meetings in the governance documents reviewed by the Council. Consequently, it appears that there is no requirement for electronic recording of council or committee meetings.

## E. Risk Assessment and Transparency

The governance material reviewed by the Council makes clear that only topics of a “highly sensitive” or “highly confidential” nature should be subject to a closed session where the attendance at and the review of minutes of such sessions are restricted (*House Manual*, p. 14; *Board Rules*, p. 11). The Council envisions that “highly sensitive” or “highly confidential” information that is the proper subject of a closed session would encompass information that (1) is considered by third parties to be private and not generally known, such as individual employee performance or salary information or information disclosed to the Association by a third party that is subject to a confidentiality agreement; or (2) non-public, detailed information concerning aspects of the operation of the Association that would place the Association at a disadvantage if known or which, if divulged, might create reputational risk to the Association.

The risks inherent in the disclosure of information deemed to be covered by the attorney-client privilege are well documented in the governance material reviewed by the Council, as summarized above. The disclosure of privileged information would have the potential to result in greater harm to the Association than the disclosure of highly sensitive or confidential information. Also, as is noted above, the treatment of attorney-client information is governed by legal principles rather than by Association policy.

The Council devoted substantial time to studying the recording, reporting and disclosure policies of discussions, actions and the conduct of business of the governing bodies of the Association and their committees, councils and commissions. As a result of such study, the Council is of the opinion that those policies strike a reasonable balance between the need and the risk of Association members and agencies to receive reports of the actions and conduct of business of the House, the Board and their respective committees, councils and commissions.

## Appendix 4

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### Report on the Referral of Resolution 108H-2010 Regarding Review of Fiduciary Duties of Delegates

**Background:** The Council on Ethics, Bylaws and Judicial Affairs (the Council) received an assignment from the House of Delegates to study and report to the 2011 House of Delegates in regard to Resolution 108H-2010:

**Resolved**, that the Council on Ethics, Bylaws and Judicial Affairs consider and delineate the fiduciary responsibilities and duties of individual delegates to the ADA House of Delegates, and be it further **Resolved**, that the Council be encouraged to consult additional resources including, but not limited to, current delegates, comparable associations and the American Institute of Parliamentarians, and be it further **Resolved**, that a report, including recommended bylaws changes, if necessary, be presented to the 2011 House of Delegates.

This report from the Council provides the analysis requested by the resolution. The report is informational in nature; no action is requested.

**Discussion:** In response to Resolution 108H-2010 the Council researched material prepared by the Association respecting the concept of fiduciary duty. It was discovered that a comprehensive study of the fiduciary responsibilities and obligations imposed upon individuals elected to the position of trustee was completed in December 2010. This study resulted in an educational module being prepared for the Board of Trustees as a part of an eight module educational onboarding process that has recently been commenced.

Because of the comprehensive nature of the work leading up to the preparation of the module reviewed by the Council, and the fact that the module appeared to the Council to have a thorough explanation of the concept of fiduciary duty in the context of the business of the Association, the Council used the Board of Trustees educational module as the primary basis for the delineation of the fiduciary duties owed by individuals elected to the position of delegate to the Association. Use of this resource has the benefit of adding consistency to the discussions of the obligations imposed on members of both governing bodies of the Association—the House of Delegates as the legislative and governing body and Board of Trustees as the managing and administrative body. Secondary sources referenced by the Council during the course of its work on this referral include the ADA *Constitution and Bylaws* and the *2010 Manual of the House of Delegates and Supplemental Information*.

### The Responsibilities of Delegates

#### I. Primary Duties: Care, Loyalty and Obedience

Under the ADA *Bylaws*, the House of Delegates is the “supreme authoritative body” of the association, vested with the power to legislate; determine the policies governing all Association activities; enact, amend and repeal the ADA *Constitution and Bylaws*; adopt and amend the *Principles of Ethics and Code of Professional Conduct*; grant, amend, suspend or revoke charters of constituent societies and, in certain instances, suspend the representation of a constituent society in the House of Delegates; create special Association committees; establish branch Association offices and approve all memorials, resolutions or opinions issued in the name of the Association. Additionally, the House of Delegates has a number of duties, including to elect the elective officers, members of the Board of Trustees and, unless otherwise prescribed in the *Bylaws*, members of councils and commissions; receive and act upon reports from committees of the House of Delegates; adopt an annual Association budget and establish the dues of active members; and serve as the appellate body from decisions from the Council on Ethics, Bylaws and Judicial Affairs, except for those decisions involving the discipline of members of the Association. The holding of these powers and duties by the House of Delegates under the ADA *Bylaws* and general

principles of corporate governance impose three related “fiduciary” legal duties on ADA House of Delegates members (delegates), i.e., care, loyalty and obedience.

A fiduciary is defined as a person who stands in a special relation of trust, confidence or responsibility in his or her obligation to another. As members of the House of Delegates, individual delegates stand in a special relation of trust. A delegate’s breach of fiduciary duty can subject him or her to personal liability.

Delegates’ fiduciary obligations, along with specific illustrations of how these fiduciary obligations apply to delegates fulfilling their duties under the ADA *Bylaws*, are discussed below.

## A. Duty of Care

The duty of care describes the level of competence that is expected of a delegate. Each delegate must fulfill his or her obligations honestly, in good faith, and with the care that an ordinarily prudent person would exercise in a like position and under similar circumstances. The duty of care includes the following:

1. Duty to participate actively: Delegates must do their best to participate in all meetings, to be punctual, and to undertake such work as may reasonably be necessary to complete the duties imposed by the position as delegate. In performing his or her duties, a delegate must exercise independent judgment. For example, delegates should take appropriate steps to become informed about matters that will be brought before the House of Delegates for consideration and must critically review and consider any recommendations or reports on issues that are before the House of Delegates.

As noted in the Introduction to *Manual of the House of Delegates and Supplemental Information* (2010 edition):

At the convention, a delegate learns new facts and listens to the arguments of others from different localities and with differing viewpoints. Frequently, a proposal is changed so completely by amendments adopted at the convention that it is really a different proposal from that originally offered. For these reasons, a delegate should be free to weigh the pros and cons and vote according to what appears to be the wisest course. Therefore, a delegate should understand thoroughly how constituency members feel about the proposals to be voted on but should be trusted to exercise good judgment in voting on measures as they are finally presented for decision.

Only by participating actively in the affairs of the House of Delegates can delegates fulfill these responsibilities effectively.

2. Duty to act in the best interests of the ADA: The *Manual for the House of Delegates and Supplemental Information* (2010 edition) contains the following passage:

*The Standard Code of Parliamentary Procedure* by Alice Sturgis (*Standard Code*), fourth edition, notes that the first duty of a delegate is to vote for what the delegate believes is best for the profession and the Association as a whole. The second duty is to vote for what is best for the particular constituency represented.

Each delegate must vote based exclusively on his or her assessment of what is in the best interests of the ADA, uninfluenced by personal or other considerations. Delegates must be attentive and alert, and inform themselves of all reasonably available information pertaining to any decision which the House of Delegates is called upon to make. They must always act in a manner they reasonably believe to be in the ADA’s best interest. As part of this duty, delegates must familiarize themselves with all items in the agenda book of the House and ask any questions necessary to help them reach informed conclusions. They must not act in unquestioning reliance upon officers, trustees, staff or others, particularly where such reliance is not reasonably justified. However, unless an officer or delegate has knowledge that makes reliance unwarranted, a delegate, in performing his or her duties

to the organization, may rely on written or oral information, opinions, reports, or statements prepared or presented by: (i) officers, trustees or employees of the association with whom the delegate believes in good faith to be reliable and competent in the matters presented; (ii) legal counsel, public accountants, or other persons as to matters which the delegate believes in good faith to be within the person's professional or expert competence; or (iii) a Committee of the House or Board of Trustees on which the delegate does not serve if the delegate believes in good faith that the Committee merits confidence.

The "business judgment rule" is a standard of review used by courts of law when determining whether a delegate has breached his or her fiduciary duties. Courts presume that in making business decisions on behalf of a corporation such as the Association, the volunteer acted on an informed basis, in good faith and in an honest belief that the action taken is in the best interest of the corporation. In other words, no one is expected to be perfect.

The elements of the business judgment rule can be categorized as follows:

1. Business decision: There must be a business decision involving a wrongful act or a conscious decision not to act. The business judgment rule does not offer protection for the failure to act.
2. Disinterestedness: Delegates must be disinterested in the action, which means having no personal gain or self-dealing.
3. Exercise of Due Care: Delegates must make informed decisions after reviewing all of the information available. Delegates must ask for and receive any and all information necessary to make a "well informed" decision. It is the duty of management, including the Board of Trustees, to provide the House of Delegates with all information necessary for informed decision-making.
4. Good Faith: Delegates must have acted with the belief that their decision was in the best interest of the ADA.
5. No Abuse of Discretion: Decisions must be based on reasonable information—rational bases for decisions are needed.

Because courts tend to give deference to a volunteer's business judgment, the question of whether a volunteer violated his or her duty of care usually arises in situations in which a volunteer failed to comply with reasonable procedures for making decisions. Failure to attend meetings, exercise independent judgment on corporate matters, read reports or documents, gather sufficient information with which to act, and seek help on important matters are all circumstances in which a court may conclude that a volunteer did not conform his or her conduct to the duty of care of a reasonably prudent volunteer under the circumstances.

For the foregoing reasons, delegates should be sure to attend meetings, exercise independent judgment and make informed decisions. In discharging their duty of care, delegates are well advised to secure all necessary information before taking actions, including information about the pros and cons of any potential action. This includes information from ADA legal counsel, as appropriate, regarding possible liability.

3. Duty to act in a fiscally responsible manner: Delegates must act prudently in considering the budget of, and expenditures by, the ADA. More generally, delegates must see to it that the ADA is governed and administered in a financially responsible manner.

## B. Duty of Loyalty

The duty of loyalty is a standard of faithfulness. A delegate must give undivided allegiance to the ADA when making decisions affecting the organization and always act in the best interests of the ADA as an entity.

1. Duty to avoid conflicts of interest: A major responsibility of a delegate is the obligation to avoid conflicts of interest. Delegates must not subordinate the interests of the ADA to any personal or financial interest—or to the interests of any other organization or entity. Delegates must make available to the ADA any business opportunity that might benefit the ADA before acting personally on the opportunity. They must not use their positions as delegates to advance, at the expense of the ADA, any personal agenda that they might have. As part of the duty of loyalty, delegates cannot put personal interests above the interests of the ADA and must be sensitive to any interests they may have in any decision to be made by the House of Delegates.

With respect to conflicts of interest, the ADA *Bylaws* and the *Rules* of the Board of Trustees require “[t]hat at all times while serving in such offices or positions, these individuals shall further the interests of the Association as a whole. In addition, they shall avoid:

- a. placing themselves in a position where personal or professional interests may conflict with their duty to this Association;
  - b. using information learned through such office or position for personal gain or advantage; and
  - c. obtaining by a third party an improper gain or advantage.”
2. Disclosure: Pursuant to 99H-2010, ADA delegates will be asked to complete a written disclosure and that they transmit any noted conflicts to the House of Delegates if they have any such relationship that may present a conflict of interest. Also 99H-2010 calls for a conflict of interest statement to be read at the commencement of each meeting of the House of Delegates and that delegates disclose on the floor of the House any relationships that may present a conflict of interest prior to speaking on an issue. Delegates have an ongoing responsibility to promptly report any situation in which a potential conflict of interest may arise. Delegates should be careful to disclose even potential conflicts of interest to the House, and should recuse themselves from deliberation and voting on matters in which they have a personal interest.
  3. The Association Conflict of Interest policy, reprinted in the 2010 *Manual of the House of Delegates and Supplemental Information* states in relevant part that:

While serving in any elective, appointive or employed office or position, the individual shall comply with the conflict of interest policy applicable to his or her office or position, shall complete and file a conflict of interest statement for each year of service, and shall promptly report any situation in which a potential conflict of interest may arise.

4. Confidentiality: Another important part of the duty of loyalty relates to confidential information. A delegate must maintain in confidence whatever information the ADA desires to keep confidential and that it treats as confidential. Delegates must be mindful not to disclose business information of the Association that might put the Association at a commercial, competitive or financial disadvantage. Similarly, delegates must not use confidential information obtained through participation in House of Delegates matters for unfair personal advantage. The best interests of the ADA as an entity must prevail over the interests of any single ADA member or employee.

Communications with ADA attorneys and the attorney-client privilege are discussed separately below.

## C. Duty of Obedience

The duty of obedience requires delegates to act in accordance with the organization’s articles of incorporation, bylaws and other governing documents, as well as all applicable laws and regulations. ADA

delegates should know the purpose of the ADA, be prepared to serve its interests, and adhere to the corporate purpose in all activities and programs.

As stated in the ADA Articles of Incorporation and the ADA *Constitution and Bylaws*, the purpose and object of the ADA is to “encourage the improvement of the health of the public and to promote the art and science of dentistry.” The ADA also has a mission statement: “The ADA is the professional association of dentists that fosters the success of a diverse membership and advances the oral health of the public.” ADA’s vision statement provides that ADA is “To be the recognized leader on oral health.”

In the event of conflicts in any of the governing documents of the Association, the Articles of Incorporation legally controls, followed by the ADA *Constitution* and then the ADA *Bylaws*.

1. Duty to act in a lawful manner: Delegates must vote against any measure that would clearly place the ADA in violation of law and thereby expose the ADA to penalties. Similarly, delegates must, subject to reasonable (i.e., not unquestioning) reliance on the officers, trustees and staff, satisfy themselves that all taxes owed by the ADA are paid and that all applicable laws are followed. Delegates must also make sure that whistle blowers are appropriately protected and that ADA documents are preserved in accordance with governing law and the policies of the ADA. When in doubt about the legal implications of a proposed course of conduct, a delegate should consult with the Chief Legal Counsel of the Association.
2. Adhere to corporate formalities: Part of the duty of obedience includes holding regular annual meetings of the House of Delegates and maintaining books and records. A verbatim transcript of every House of Delegates annual session is prepared. That transcript should accurately reflect House of Delegates’ discussions, as well as actions taken at meetings, and will constitute the official record of the proceedings of the House of Delegates session it reports.
3. Duty to carry out directives of the House of Delegates: Under the ADA *Constitution*, the House of Delegates is the “legislative and governing body” of the Association. Similarly, under the ADA *Bylaws*, the House is the “supreme authoritative body” of the Association. Consequently, subject only to two limited exceptions, the Board of Trustees is required to accept, and to carry out, any specific directive of the House of Delegates – even if the Board of Trustees disagrees with that directive or believes it not to be in the best interests of the ADA. The exceptions are these: (a) if a directive of the House of Delegates is believed to be contrary to the ADA *Constitution and Bylaws*, or (b) if implementation of a directive would be contrary to the obligations imposed on the Board of Trustees under Illinois law to act in a fiscally responsible and legally sound manner. A delegate who believes that the Board may be acting in a contrary manner should consult with the Chief Legal Counsel.

## **II. Attorney-Client Privilege**

A delegate has a fiduciary duty to the ADA to maintain the attorney-client privilege and to ensure that he or she does not do anything that could result in waiver. Delegates must not discuss or otherwise communicate the information shared in privileged communications with others who are not within the “control group” (described below) for that communication. They must also avoid circumstances in which privileged communications may be overheard or otherwise inadvertently disclosed. Any privileged documents, including handwritten or electronic notes of a privileged meeting, must be protected from disclosure to anyone outside of the applicable control group. The best practice is to avoid discussing the subject matter of the attorney-client communication outside the setting in which the communication was made, and to keep privileged documents under lock and key.

### **A. Attorney-Client Privilege Defined**

Delegates may receive communications from attorneys representing the ADA and some of these communications may be protected by the attorney-client privilege. As fiduciaries of the ADA, delegates may also have occasion to seek the advice of legal counsel. In addition, the Association’s legal advisors may provide delegates with legal advice on various matters related to risk exposure. When a

communication is privileged, it is protected from disclosure. For example, if there is a lawsuit, the opposing attorney cannot require delegates or the ADA to turn over privileged documents or to testify about privileged discussions.

To be protected, the communication must have been made for the purpose of securing or providing legal advice or services, must originate with reasonable confidence that it will not be disclosed, and must remain confidential. There has to be the reasonable expectation that the confidentiality and limited disclosure of the information can be maintained. Ordinary business discussions, even about subjects that are confidential, are not covered under attorney-client privilege.

The attorney-client privilege does not automatically protect every discussion where a lawyer happens to be present and it does not protect every document that is prepared by or sent to a lawyer. For the privilege to apply, the communication must be between a member of the ADA's "control group" and an attorney for the ADA who is serving in his or her legal capacity (rather than, say, giving business advice). The "control group" is limited to top decision-makers and certain other individuals who possess critical information pertinent to the issue involved and who advise those top decision-makers.

## **B. Waiver of the Privilege**

If privileged communications or documents do not remain confidential, the privilege can be waived. When the privilege is waived with respect to even a single document or communication, the entire subject matter may lose the protection as well. If the attorney-client privilege is waived, the ADA may be seriously harmed. The ADA could be compelled to publicly disclose the privileged information and the information could be used against the ADA in litigation, which could expose the ADA to the risk of significant financial, reputational, and other harm. A delegate who discloses any attorney-client privileged information could also expose himself or herself, at best, to the inconvenience and expense of being required to participate in depositions or other legal proceedings, and, at worst, to personal liability that may not be subject to indemnification by the ADA.

## **C. House Manual on Attorney-Client Sessions**

The *Manual of the House of Delegates and Supplemental Information* defines an attorney-client session and does not permit actions to be taken during such session. The Manual states:

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

In accordance with the above information, all those participating in an attorney-client session shall refrain from disclosing information about the discussion held during the attorney-client session. In certain cases, a decision may be made to come out of the attorney-client session for purposes of conducting a non-privileged discussion of the same or related subject matter. The difference will be that during the non-privileged session there will be no discussion of any legal advice requested by attendees during the attorney-client session or about any of the legal advice given by legal counsel. It is such requests for legal advice, legal advice given, and discussion of the legal advice during the

attorney-client session that are protected by the privilege and that shall not be disclosed or discussed outside of the attorney-client session.

The Council, having reviewed the governing documents of the Association against the principles of the fiduciary duties owed the Association by delegates, and knowing that procedures to enforce breaches of those fiduciary duties are being proposed in response to other resolutions referred by the 2010 House of Delegates, does not believe that any proposals to revise the *Bylaws* need be made in response to the referral of 108H-2010.



# Council on Government Affairs

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**Neary, Matthew J.**, chair, New York, 2011  
**Weinman, Richard A.**, vice chair, Georgia, 2012  
**Albert, Jeremy M.**, Florida, 2011, *ex officio*\*  
**Bowen, Ronald S.**, Utah, 2013  
**Condrey, James D.**, Texas, 2011  
**Dater, Steven M.**, Michigan, 2012  
**Determan, Amber A.**, South Dakota, 2013  
**Fields, Henry W.**, Ohio, 2013  
**Hall, William M.**, Louisiana, 2014  
**Howard, H. Fred**, Kentucky, 2014  
**Jennings, Mary S.**, Washington, 2014  
**Jernigan, Kim U.**, Florida, 2012  
**Klima, Rodney J.**, Virginia, 2011  
**Lo Monaco, Carmine J.**, New Jersey, 2014  
**Mooney, John J.**, Connecticut, 2012  
**Murray, Rhett L.**, Colorado, 2012, *ex officio*+  
**Ray, Herbert L.**, Pennsylvania, 2013  
**Schinnerer, Donald M.**, California, 2011  
**Testa, Ronald G.**, Illinois, 2012  
**Spangler, Thomas J.**, director

**Meetings:** The Council met January 27-29 and April 14-16, 2011, in Washington, D.C. The Council's third meeting is scheduled for August 25-27, 2011, in Chicago.

**The Strategic Plan of the American Dental Association:** Plan Goal: Provide support to dentists so they may succeed and excel throughout their careers. Ensuring implementation of 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), in a manner that provides support for dentists and their patients is a very high priority for the American Dental Association (ADA) in 2011. Meeting this goal requires a sustained, consistent advocacy effort.

With the assistance of outside counsel, the ADA is spending a great deal of resources monitoring and lobbying implementation of the health care reform law—supporting those provisions consistent with ADA policy, and seeking repeal (and blocking funding) of those provisions that conflict with Association policy. At the time of this writing, Republican members in the House of Representatives are seeking various means of defunding the law, while discussions of "repeal and replace" continue. In the meantime, the Obama Administration continues with implementation, which is further complicated by the looming Medicaid program expansion in 2014 called for in the health care law.

The law contains a number of provisions that we have consistently opposed, including the "*Alternative Dental Health Care Provider Demonstration Projects*" provision, which would allow workforce pilot programs that may lead to non-dentists performing irreversible surgical dental procedures. The ADA is opposing this provision on many fronts, utilizing the Association's grassroots network and aggressively lobbying to defeat proposed funding for the demonstration projects in the 2011 Continuing Resolution. In letters to House and Senate leaders (backed by e-mails from our grassroots dentists), the ADA urged Members of Congress not to fund the demonstration projects for these reasons:

- The existing dental workforce model is a proven delivery system.
- The dentist workforce is growing, as five dental schools have opened since 2000 and over a dozen schools are at varying stages of development.

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

+ American Dental Political Action Committee Co-Chair without the power to vote.

- Dental practices have become more efficient. Today it takes only 88 practices to serve the same number of dental patients as 100 practices during the 1980s.
- There is no evidence to support the economic feasibility of mid-level providers, such as dental therapists who are trained to perform irreversible, surgical procedures.
- Federal funding for oral health programs should focus on fully implementing the prevention and public health infrastructure programs, as education and prevention are the most cost effective ways of minimizing untreated dental disease.

Consistent with the ADA's position, the federal budget funding the government through September 30, 2011, explicitly prohibits funding for the alternative providers demonstration program. However, President Obama's FY 2012 budget proposes almost \$5 million in funding for the alternative providers project. The House of Representatives approved a separate FY 2012 budget that makes no mention of alternative dental providers and the Senate has yet to act. The ADA will continue its advocacy efforts opposing projects allowing non-dentists to perform surgical/irreversible oral procedures.

In addition, the ADA will continue to lobby the workforce issue at the 2011 Washington Leadership Conference (WLC) in May, as the ADA will be promoting the "Breaking Down Barriers to Oral Health for All Americans: the Role of Workforce" document and asking for support of ADA-developed federal legislation, titled the "Breaking Barriers to Oral Health Act of 2011." The draft legislation is intended as a *fiscally responsible* means of empowering constituent and component dental societies to take steps in addressing *some* of the many barriers to oral health. The draft bill is NOT intended as a "fix" for the Medicaid program's shortcomings or an answer to all of the access problems. But given the current budget constraints, it is offered as one means of empowering those nearer to the end user (dental patients) with resources to address some of the barriers. The draft bill provides federal grant money (up to \$10 million per year for five years) for entities providing free dental care to underserved populations (i.e., Mission of Mercy programs) and a separate grant program (up to \$10 million per year for five years) for state or local dental associations or their foundations to form partnerships with other state or local stakeholders to accomplish any of the following goals:

- Improve oral health education and dental disease prevention, or
- Reduce barriers (including low reimbursement and administrative impediments) in a manner that increases dental provider participation in Medicaid and the Children's Health Insurance Program, or
- Make the dental delivery system providing dental services under Medicaid or CHIP more efficient by taking actions necessary to facilitate the establishment of dental homes, or
- Address geographic, language or cultural barriers.

The ADA also has objected to restrictions placed on Flexible Spending Accounts (FSAs) in the new health care law and the Association is on record supporting legislation ("Patients' Freedom to Choose Act," (H.R. 605/S.312)) that would repeal those limitations. This is another issue on the lobbying agenda for the WLC.

As stated last year to the House of Delegates, the health care reform law contains a number of provisions the ADA supported, including: increased funding for public health infrastructure; increased Title VII grant program opportunities for general, pediatric or public health dentists; and funding for the National Health Services Corps loan repayment programs. The ADA supports funding of these programs as the Association strongly believes that education and prevention, coupled with other efforts to increase oral health literacy, would have a positive impact on the public's oral health.

**Summary of Federal Legislative and Regulatory Activity Addressing the Impact of Information Technology on the Practice of Dentistry:** *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 (HHS) to advise the Secretary on the implementation of the provisions of the HITECH Act. As a result, HHS has begun to publish the necessary regulations as required by ARRA and HITECH.

On July 13, 2010, the Centers for Medicare and Medicaid Services (CMS) and the Office of the National Coordinator (ONC) issued the final rules to implement the electronic health records (EHR) incentive program under the HITECH Act. By focusing on the effective use of EHRs with certain capabilities, the HITECH Act makes clear that the adoption of records is not a goal in itself: it is the use of EHRs to achieve health and efficiency goals that matters. In the context of the EHR incentive programs, “demonstrating meaningful use” is the key to receiving the incentive payments. It means meeting a series of objectives that make use of EHRs’ potential and related to the improvement of quality, efficiency and patient safety in the healthcare system through the use of certified EHR technology.

At the same time, the ONC issued the Final Rule on Health Information Technology: Initial Set of Standards, Implementation Specifications, and Certification Criteria for Electronic Health Record. Both the Medicare and Medicaid EHR incentive programs include a requirement that providers must adopt certified EHR technology.

Under the Medicare EHR incentive program, eligible health care providers must adopt and meaningfully use certified EHR technology. Any dentist that participates in Medicare is eligible for up to \$44,000 over five years. The actual reimbursement computation is complicated based on what year the provider begins to be a meaningful user and on the amount of reimbursement for Medicare services provided in that year. There is also a penalty beginning in 2015 in the form of reductions in Medicare payments for Medicare providers who fail to demonstrate meaningful use. Under the Medicaid EHR incentive program, eligible health care providers may first adopt, implement, or upgrade to certified EHR technology in their first year of the program and receive an incentive payment before having to meaningfully use certified EHR technology. The reimbursement under Medicaid for an eligible provider is \$63,750 over six years beginning in 2011. However, to be an eligible provider, a dentist must meet a patient volume threshold of 30% in Medicaid or similar programs. There are no penalties for a provider under Medicaid for either failing to demonstrate meaningful use or for not meeting the patient volume threshold. Also, providers may only qualify for either the Medicare or Medicaid incentives, not for both. Some states have begun to enroll providers in their Medicaid incentive programs.

Currently, the HHS’s HIT Policy Committee is in the process of developing their recommendations to the Office of the National Coordinator for the second phase of the meaningful use criteria as well as possible adjustments to the initial phase one requirements. At the same time, the HHS’s HIT Standards Committee is looking at the standards changes that will be required to implement phase two. The rule making involved will probably begin in the last quarter of 2011 and won’t be finalized until sometime in early 2012.

To date, the only federal legislative initiative in the 112<sup>th</sup> Congress is the introduction of companion bills (S. 643 and H.R. 1187, respectively) entitled the “Fix HIT Act of 2011” by Senator Debbie Stabenow (D-MI) and Representative Adam Kinzinger (R-IL). Both bills amend Medicaid to provide direct incentive payments for establishment of electronic health records under the HITECH provisions to federally qualified health centers and rural health clinics. The bills were referred to the Senate Finance Committee and the House Energy and Commerce Committee. A unique state initiative has begun in Minnesota. Dentists there are now required to send patient prescriptions to pharmacies electronically under a new law that took effect on January 1, 2011. E-prescribing, or the practice of sending prescriptions electronically from the prescriber to the pharmacy, is touted as a convenient, cost-effective measure that increases patient safety by minimizing medication error. Used for years by doctors, hospitals and pharmacies, e-prescribing is relatively new to dentistry.

**Medicaid Block Grants: Federal Legislation:** The following resolution was submitted by the Council on Government Affairs and supported by the Council on Dental Benefit Programs and the Council on Access, Prevention, and Interprofessional Relations. It is consistent with the ADA’s Strategic Plan goal of “Provide support to dentists so they may succeed and excel throughout their careers.”

*Background.* State and federal budget pressures and rising health care costs have re-opened the debate over the federal financing structure of the Medicaid program. Specifically, some lawmakers have expressed support for funding the program as a block grant.

- Currently, the Medicaid program is structured and financed as an entitlement, with the federal government paying a share of states' costs. That share—referred to as the federal medical assistance percentage (FMAP)—is approximately 57%, on average across the states. However, some states receive as little as 50% and others up to 75% of the cost of the Medicaid program from the federal government.
- Under block grant proposals, the federal government would likely pay a fixed dollar amount to the states based on a pre-set formula, and allow states increased flexibility on eligibility, enrollment and benefits.

Overshadowing the block grant discussion are coverage guarantees and expansions passed as part of the new health reform law, which add to the cost of the program.

- Under the maintenance of effort piece of the law, states generally can't make changes to their Medicaid eligibility standards to make them more restrictive than what was in effect for the state when the law was enacted in 2010, although CMS has permitted some waivers to this requirement. The law prevents states from cutting Medicaid eligibility for most adults until 2014 and children until 2019. However, states retain the option of cutting optional services—including adult dental coverage.
- Additionally, in 2014 the health law opens the Medicaid program to nearly all Americans younger than 65 who earn up to 133% of the federal poverty level. Under the current financing system, the federal government will foot the bill for 100% of the expansion through 2016, scaling back to 90% by 2020.

On April 15, 2011, the U.S. House of Representatives passed "The Path to Prosperity: Restoring America's Promise"—the Fiscal Year 2012 Budget Resolution (H Con Res 34) introduced by House Republicans. Among its many funding provisions, the resolution proposes converting the federal share of Medicaid to a block grant to states. President Obama's budget proposal makes adjustments to the current federal matching formulas for Medicaid and the Children's Health Insurance Program but would not convert the Medicaid program into a block grant.

Current ADA policy *Medicaid Block Grants* (*Trans.*1995:651) does require the ADA to take the position that if the block grant concept for funding Medicaid becomes law, a designated portion of the block grant be allocated for dental care. However, the CGA believes the ADA needs policy that clarifies the Association's position regarding Medicaid block grants *before* such grants become law to ensure needed oral health care protection for the underserved population and the dental profession serving that population. The CGA was provided feedback from a number of constituent dental societies and an overwhelming majority of those who responded did not favor block grants as dentistry is likely to suffer under such a situation, especially adult dental. The CGA agrees with that assessment and recommends the following:

**12. Resolved**, that the ADA ensure that adequate funding and safeguards are in place to provide comprehensive oral health care to underserved children and adults concerning legislation that would convert the federal share of Medicaid to a block grant to the states, and be it further **Resolved**, that the ADA opposes the proposed block grant in the event adequate funding and safeguards cannot be assured.

**Federal Emerging Issues and Trends:** Additional federal issues affecting dentistry include antitrust reform, ERISA reform, and Medicaid coverage for the aged, blind and disabled.

*Antitrust Reform.* 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. H.R. 1150, the "Competitive Health Insurance Reform Act of 2011," introduced by Rep. Paul Gosar (R-AZ) would repeal this unfair exemption and restore application of the federal antitrust laws to the business of health insurance to protect competition and consumers. The ADA is seeking support for H.R. 1150 as one of its lobbying issues at the Washington Leadership Conference.

*ERISA Reform.* The ADA is seeking reintroduction of the “Dental Coverage Value and Transparency Act.” This bill 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.

*Medicaid Coverage for the Aged, Blind and Disabled.* The ADA is also seeking reintroduction of the “Special Care Dentistry Act,” which will provide Medicaid dental coverage for the aged, blind and disabled. For the aged, blind, or disabled, oral health services are deemed “optional” by the federal government and most states provide little to no Medicaid coverage. Many of these vulnerable citizen’s mouths are infected with no hope of receiving access to even basic dental care. Appropriate and necessary oral health services for adult aged, blind, and disabled people will help reduce not only Medicaid costs for these populations, but also down-stream Medicare expenditures.

**Emerging Issues and Trends in the States:** Throughout 2011, 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 2012. In addition, the following is a brief synopsis of key activities in the states within the last year.

*Alternative Workforce Models.* As of this writing at least 11 states have seen legislation or organizing to foster alternative dental workforce models. Those states include: Maine, Vermont, New Hampshire, Connecticut, Ohio, Kansas, New Mexico, Michigan, Washington, Oregon, and California. Five of those states are part of the Kellogg Foundation’s efforts to legalize a model similar to the DHAT model (Vermont, Ohio, Kansas, New Mexico and Washington). Three other states have seen the Pew Foundation fostering the effort (Maine, New Hampshire and California). While no measure has become law in 2011 as of this writing, expect pressure and challenges to continue over the next several years.

*Non-Covered Services.* In 2008, dental benefit plans began an aggressive effort to offer or amend contracts with dentists that included a limit on what participating dentists may charge for non-covered services. A few plans had been doing this for some time. Rhode Island enacted the nation’s first law in June 2009 to prevent fee caps on non-covered services (NCS). As of this writing, 41 states have filed an NCS bill in at least one legislative session and 22 of those states have enacted an NCS law (Alaska, Arizona, Arkansas, California, Georgia, Idaho, Iowa, Kansas, Louisiana, Maryland, Mississippi, Nebraska, New Mexico, North Carolina, North Dakota, Oklahoma, Oregon, Rhode Island, South Dakota, Virginia, Washington, Wyoming).

*Medicaid.* With the budget situation being dire at the state level, increased FMAP funding was provided in the stimulus package. However, with increased baseline eligibility for Medicaid within the Affordable Care Act, there has never been more funding pressure on Medicaid dental systems. The confluence of events have crippled adult dental Medicaid programs—where they were in existence—and severely hurt mandatory programs for eligible children. Only a few states provide relatively full dental benefits for adult Medicaid enrollees and several states reduced already slim benefit packages in the last year. For example, South Carolina discontinued dental services for adults. Washington’s governor eliminated all dental services except emergency services, while Arizona eliminated adult dental services. Federal regulations require necessary dental services for children in Medicaid, but do not mandate adequate funding. States have reduced fees paid to dentists on services *required* under Medicaid to help reduce overall costs. Arizona adopted a 5% rate reduction recently. Tennessee is considering a 4% reduction after having already reduced fees paid for restorations. Indiana reduced reimbursements by 5% last year, while making downward adjustments on annual expenditure limits (per person) in their adult dental Medicaid program.

*Dental Hygiene.* State dental associations worked with organized dental hygiene in crafting legislation that would address access to care by expanding the functions those hygienists and in some cases dental

assistants could perform. One such negotiated bill that the New Mexico Dental Association expects the governor to sign will create the first community dental health coordinator (CDHC), allow for the use of expanded-function dental assistants and hygienists, and allow applicants who are licensed to practice dentistry or dental hygiene in another state (or students who are enrolled as dental residents at the University of New Mexico) to obtain a temporary "public-service" license. Other negotiated bills were introduced in Florida to expand the duties of hygienists (pending) and Kansas (failed but will be reintroduced next year), collaborative practice bills passed in Arkansas and South Dakota. Organized dental hygiene, with opposition from state dental associations, attempted to obtain expansion of the functions and lessen supervision by a dentist. These states are grouped by subject: *Expanded Scope* - Arizona, Connecticut, Maine, Massachusetts, Maryland, Missouri, Montana (failed), New York, Oregon and Texas; *Direct Reimbursement* - Maine, Michigan, and Oregon; *Reduced Supervision and Expanded Settings* - Illinois and Nebraska; *Self Regulation* - Massachusetts, New Hampshire and Oregon.

*Electronic Health Records.* The Department of State Government Affairs over the past six months has fielded calls from ADA members wondering how to comply with Electronic Health Records (EHR) requirements of the 2009 American Recovery and Reinvestment Act. Some of the members had received newsletters from software vendors claiming that dentists are mandated to file claims electronically, update their practices with EHR systems, or face a penalty from the federal government. These claims are deceptive; there is no federal mandate for dentists to adopt EHR software, whether they participate in the Medicaid or Medicare systems. Under the law, eligible dentists can qualify for Medicaid incentive payments when they adopt and use certified EHR technologies. But these are merely incentives, not mandates. In order to provide their dentists with timely, accurate information, some state dental societies have created resources to help inform their members about EHR incentive programs and continuing efforts to implement health information exchange initiatives in their states. For example, the Texas Dental Association has run a series of articles in their monthly newsletter that focuses specifically on EHR timelines for compliance and other helpful electronic resources, such as websites, CMS guidebooks, meaningful use for dentists and an EHR online information center.

**Response to Assignments From the 2010 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.

*Additional Federal Advocacy Resources.* Resolution 21H-2010 (*Trans.2010:601*) directs the ADA's Division of Government and Public Affairs to engage the services of at least one additional outside lobbying firm with particular expertise in working with federal agencies that are charged with implementing the new health care law and that the ADA conduct public opinion research, run advocacy advertisements in Capitol Hill publications and employ other related tactics in support of ADA's federal advocacy goals. After issuing a request for proposal and interviewing three firms, the ADA chose to work with Drinker Biddle & Reath, LLP (DBR). DBR is a prominent law and lobby firm, with a 160-year history and nearly 650 attorneys and other professionals. The firm has 12 locations, including large and growing offices in Washington, DC and Chicago, IL. Washington, DC is the location of the firm's Government and Regulatory Affairs Practice Group and Health Team. In addition, the firm has a nationally recognized Health Law Practice group and a Life Sciences Team, which represents the medical device and pharmaceutical industries, practicing before the Food and Drug Administration (FDA).

Some highlights of the work DBR and ADA staff have completed at the time of this writing (early April), as well as areas of projected future activity:

- *Entities Tasked With Creating the Essential Benefit Package for the Exchanges:* The ADA and the American Academy of Pediatric Dentistry (AAPD) submitted joint testimony to the Institute of Medicine (IOM) on March 2 regarding the pediatric dental benefit. The IOM was asked to make recommendations to the Department of Health and Human Services (DHHS). On March 28, ADA, AAPD, and DBR representatives met with staff at the Center for Consumer and Insurance Oversight (CCIO), which is the division tasked with designing the essential benefit package within the DHHS. Follow up communications are ongoing.

- *Medicaid and CHIP Payment and Access Commission (MACPAC)*: MACPAC was created to address payment and access issues in Medicaid and the Children's Health Insurance Program (CHIP). The commission has met twice and a first report was issued in March. Dental was identified as a topic for future discussion. Both ADA and DBR staff met with the executive director of the MACPAC and communications are ongoing.
- *National Health Care Workforce Commission*: The National Health Care Workforce Commission will evaluate and make recommendations for the nation's entire health care workforce, giving it a broad perspective and scope. The commission will make recommendations to Congress, the U.S. Department of Labor and HHS on a broad range of workforce-related topics, including national workforce priorities and goals, current and projected workforce supply, and needs and assessments of current education and training activities. To date, the commission has taken no action but DBR and ADA are closely tracking the commission's activities.
- *Center for Medicare & Medicaid Innovation (CMI)*: The stated purpose of the CMI is to test innovative payment and service delivery models to bring about a reduction in Medicare and Medicaid program expenditures while preserving or enhancing quality of care. DBR and ADA staffs are following the actions of CMI. For the present time, the center's focus is on expanding models with a proven track record of reducing cost and enhancing quality.
- *Comparative Effectiveness Research (PCORI)*: DBR will help the ADA stay up to date on activities of the Agency for Health Care Research and Quality (AHRQ) with efforts focused on comparative effectiveness research that could impact dentistry.
- *Health Information Technology*: Through strong contacts at HHS and within the Office of the National Coordinator for Health IT, DBR will assist the ADA with information on the agency's activities and insight on regulatory and funding opportunities associated with HIT efforts.
- *Food and Drug Administration Activities*: DBR has strong FDA contacts and will help represent the ADA before the agency on pertinent issues as they arise during the year. In fact, very early in our relationship, DBR was instrumental in setting up a meeting with the Director of the FDA's Center for Devices and Radiological Health that facilitated the Association's communicating with FDA officials regarding a potential ban on mercury-containing products, including dental amalgam, in the United Nations Environment Program's (UNEP's) mercury treaty negotiation. Following a conference call between ADA staff and officials from the State Department and the FDA, the State Department modified their position in favor of taking a neutral stance at the UNEP meeting.

*Negotiated Rulemaking Process Regarding a National Pretreatment Standard for Dental Office Wastewater.* Resolution 50H-2010 (*Trans.*2010:602) directs the ADA to engage in negotiated rulemaking with the Environmental Protection Agency (EPA) regarding a national pretreatment standard for dental office wastewater in a manner consistent with the principles stated in the resolution. On September 27, 2010, the EPA announced its intention to issue a proposed rule to mandate the use of amalgam separators in dental offices. The agency's announcement stated, "EPA expects to propose a rule [in 2011] and finalize it in 2012. Dental offices will be able to use existing technology to meet the proposed requirements. Amalgam separators can separate out 95 percent of the mercury normally discharged to the local waste treatment plant." The ADA has met with the EPA to explain its position on a national standard and has also met with other stakeholders in the process. However, no details regarding the rule (such as a phase-in period or exemptions) are known at this time. It is difficult to overstate the overall concern among regulators and lawmakers over matters relating to mercury, in whatever form. This concern, coupled with pressure from state officials, a large separator manufacturer, members of Congress, a potential international mercury treaty and the EPA's own regulation of treatment plant biosolids and mercury levels in surface waters, all increase the pressure for nationwide or state and local separator mandates. Ten states and a number of municipalities already require the use of separators.

*Maximum Fees for Non-Covered Services.* Resolution 79H-2010 (*Trans.*2010:615) states that the ADA oppose any third-party contract provisions that establish fee limits for non-covered services, and that the ADA pursue federal legislation to prohibit federally regulated plans from applying such provisions and encourage constituent societies to work for passage of similar state legislation. Regarding federal legislation, as stated above, the ADA is seeking reintroduction of the "Dental Coverage Value and Transparency Act." This bill would, among other things, prohibit all health plans that offer dental benefits from dictating fees for procedures that the plan does not cover. The ADA's Department of State

Government Affairs is working very closely with constituent dental societies to facilitate passage of state legislation. Rhode Island enacted the nation's first law to prevent a fee cap on non-covered services in June 2009. Thirty states filed a bill similar to Rhode Island's in 2010 and, as of this writing; 22 filed or re-filed a bill in 2011. Of these states, a total of 19 have enacted a law to prevent limits on non-covered service fees (Alaska, Arizona, Arkansas, California, Idaho, Iowa, Kansas, Louisiana, Mississippi, Nebraska, North Carolina, North Dakota, Oklahoma, Oregon, Rhode Island, South Dakota, Virginia, Washington, Wyoming).

*ADA Support of Repeal of Health Care Reform Legislation.* Resolution 100H-2010 (*Trans.*2010:626) requires the ADA to make advocating for changes in the health care law that deviate from current ADA policy a legislative and regulatory priority and requires the Council on Government Affairs (CGA) to monitor the new rules and changes to the health reform law and report to the Board of Trustees and the House of Delegates on those issues that may significantly affect ADA members. Within the "Strategic Plan of the American Dental Association" section of this report and in the response above to Resolution 21H-2010, the CGA has provided a good deal of information on key activities concerning implementation of the new health care reform law. This topic is on the agenda for each CGA meeting and aspects of the law and its implementation are topics of frequent communications between the CGA and ADA staff between meetings. A comprehensive table of health care reform implementation activities is also available to all on the ADA web page at <http://www.ada.org/2389.aspx>.

**Acknowledgments:** The Council on Government Affairs announces the addition of the following new members: Dr. William Hall, Louisiana; Dr. H. Fred Howard, Kentucky; Dr. Mary Jennings, Washington; and Dr. Carmine Lo Monaco, New Jersey.

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. Matthew Neary, New York; Dr. James Condrey, Texas; Dr. Rodney Klima, Virginia; and Dr. Donald Schinnerer, California.

The Council would also like to acknowledge the guidance and very valuable insights provided by its Trustee-Liaison and the District 1 trustee, Dr. Robert A. Faiella.

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## Summary of Resolutions

**12. Resolved,** that the ADA ensure that adequate funding and safeguards are in place to provide comprehensive oral health care to underserved children and adults concerning legislation that would convert the federal share of Medicaid to a block grant to the states, and be it further **Resolved,** that the ADA opposes the proposed block grant in the event adequate funding and safeguards cannot be assured.



# Council on Members Insurance and Retirement Programs

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**Cassat, D. Douglas**, California, 2011, chair  
**Fink, Steven R.**, New Jersey, 2012, vice chair  
**Abshire, Philip M.**, New Mexico, 2011  
**Coleman, Robert A.**, Michigan, 2014  
**Dodge, Jeffrey E.**, Rhode Island, 2013  
**Dorris, George B., Jr.**, Florida, 2012  
**Eisenhart, Craig A.**, Pennsylvania, 2012  
**Gerber, C. Richard**, West Virginia, 2011  
**Hettinger, Richard F.**, Iowa, 2014  
**Imburgia, Louis A.**, Illinois, 2011  
**Jilek, Spencer S.**, Washington, 2012  
**Paumier, Thomas M.**, Ohio, 2014  
**Rashall, Gregory W.**, Texas, 2013  
**Rawls, Douglas S.**, South Carolina, 2013  
**Rosenbaum, George F.**, Nevada, 2013  
**Unkenholz, Eric**, South Dakota, *ex officio*\*  
**Weinberger, Mark J.**, New York, 2012  
**Yarbrough, L. Wayne**, Alabama, 2014  
**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 insurance and endorsed retirement programs, and (b) aiding dentists in the management of their personal and professional risks through educational activities, informational programs and services.

**Purpose of Members Insurance and Retirement Programs:** The members 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 ADA's membership recruitment and retention effort. Surveys have consistently shown these programs to be among the most highly valued member benefits.

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 New Dentist Committee and the American Student Dental Association.

**The Strategic Plan of the American Dental Association:** Through all of its activities, the Council supports the ADA's Strategic Plan goals to ensure that every member achieves a personally desired state of financial well-being and economic stability. These activities include oversight of the members' insurance and retirement savings plans; monitoring trends in the dental professional liability market; the sponsorship of seminars on dental risk management and retirement saving; and providing extensive content areas on ADA.org which focus on insurance, financial planning and risk management.

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

## ADA Members Group Insurance Programs

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The four ADA members' group insurance programs are underwritten and administered by the Great-West Life and Annuity Insurance Company (Great-West Life). The programs are marketed, without the use of agents, by direct mail and other advertising, as well as through ADA.org.

The Council oversees the administration and marketing of these programs, and 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, providing they have a financial impact of less than 5% of an insurance program's assets.

The four member group insurance programs are as follows<sup>1</sup>:

- The life insurance program consists of the *Term Life Plan*, providing up to \$3 million in coverage to a member, a maximum of \$750,000 for the member's spouse, and \$10,000 for eligible dependent children; the *Term Plus* (universal life) *Plan*, available to members only, provides up to \$3 million in coverage; and the *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 \$15,000 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 student is unable to continue his/her professional studies.
- The *Office Overhead Expense Plan* will reimburse an insured member for up to \$25,000 in monthly business expenses when he/she is totally or partially disabled from his/her 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.

**Key Results for 2010:** The Council is pleased to report that each of the members' insurance programs is 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 4% as compared to 3% in the prior year. The volume of life insurance in force grew to more than \$34 billion. The volume of insurance in force under the Income Protection and Office Overhead Expense Plans grew nearly 6% to a combined total of nearly \$184 million in monthly benefits. The total assets of the insurance plans are now approximately \$677 million.

During the year, more than \$85 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 following table.

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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.

Program	2006	2007	2008	2009	2010
Member Term Life <sup>2</sup>	57,950	57,428	55,143	55,171	55,128
Spouse Term Life	20,252	19,755	19,364	19,259	19,104
Child Term Life <sup>3</sup>	8,381	8,144	7,961	7,764	7,618
Student Term Life	9,860	9,684	11,362	12,344	12,930
Term Plus Plan	1,882	1,765	1,694	1,629	1,577
Income Protection	17,867	17,732	17,596	17,667	17,355
Student Disability	540	754	872	1,114	6,410
Overhead Expense	8,600	8,534	8,467	8,420	8,309
MedCASH	5,715	5,340	5,101	4,851	4,612

The demographics of the participants in the insurance plans reflect those of the general membership. The average age of ADA active members is 55, while the average age of participants in the Term Life Plan is 52 years, the average Income Protection Plan participant is 54 years old and the average Overhead Expense Plan participant is 55 years old. The average age of MedCASH Plan participants is 61 years.

**Non-Contributory Insurance Plans for Student Members:** To reinvigorate growth in the member insurance plans, the Council is strengthening the student insurance plans as a “feeder system” for sales to practicing dentists. Since 1981, the Student Life Insurance Plan has been offered on a non-contributory basis wherein the insurance is provided free to student members. The cost of the Student Plan is funded by the participants in the Life Insurance Program for member dentists. Upon graduation, the insured student has the option to continue the insurance on a premium paying basis. The Council anticipates that this will result in a steady flow of new, young participants to the Term Life Plan, thus helping maintain its financial strength over the long-term. Moreover, it will increase membership recruitment and retention opportunities for the ADA.

In 2010, the Council approved a proposal to offer the Student Disability Insurance Plan on a non-contributory basis. The cost of the Student Disability Plan will be funded by participants in the Income Protection Plan and the Office Overhead Expense Plan. Upon graduation, insured students will be guaranteed the right to convert their Student Plan coverage to a \$2,000 monthly benefit under the Income Protection Plan and a \$2,000 monthly benefit under the Office Overhead Expense Plan.

The non-contributory Student Disability Plan was introduced in the fall of 2010. The Council is pleased to report that there has been a very satisfactory response by student members. As of December 31, 2010, there were 6,410 participants as compared to 1,144 at the end of 2009. The Council believes the enhanced Student Disability Insurance Plan will lead to higher levels of participation by young dentists in the Income Protection Plan and Office Overhead Expense Plan in future years, thus helping to maintain the long-term financial stability of these plans.

**Financial Strength of Insurance Plans:** Based upon an examination of claim experience, assets and reserve requirements, the Council believes that the insurance plans are 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.

<sup>2</sup> In 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 following table shows premium credits for each plan during the past year and those scheduled for 2011.

Program	Payment Date	Credit
Life Insurance Program	January 1, 2010	50%
	July 1, 2010	50%
	January 1, 2011	55%
	July 1, 2011	55%
Income Protection Plan	May 1, 2010	38%
	November 1, 2010	38%
	May 1, 2011	42%
	November 1, 2011	42%
Office Overhead Expense Plan	February 1, 2010	56%
	August 1, 2010	56%
	February 1, 2011	60%
	August 1, 2011	60%
MedCASH Plan	April 1, 2010	35%
	October 1, 2010	35%
	April 1, 2011	40%
	October 1, 2011	40%

**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 10 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

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.

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, 2010, the expense charge was .52% (52 basis points). For the one-year period beginning May 1, 2011, the expense charge will be .50% (50 basis points). This charge will be assessed daily at .50% / 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.

**Payments From AXA Equitable:** To offset its expenses in endorsing the retirement programs, the Association receives payments from AXA Equitable. The payment for expenses relating to the Members Retirement Program is based upon the assets held in the program as well as the number of participants. The payment 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. In 2010, these payments totaled \$497,064. The Company funds the payments to the Association from the program expense charge. The Board of Trustees has used the payments from AXA Equitable to fund the portion of the Council's budget which is not reimbursed by the members' insurance programs. Any payments which exceed this budget allocation represent general revenue to the Association. In 2010, this revenue amounted to \$292,113.

**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>4</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 2010, 5,198 members were participating in the ADA-endorsed Members Retirement Program. There were 13,523 additional participants consisting of dental office employees, surviving spouses and the staff of 31 constituent and component dental societies. The most popular plan among employers is the Safe Harbor 401(k) Plan. In 2010, this type of plan represented almost all of the new plans established under the program.

**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.

Members Retirement Program Assets as of December 31, 2010 <sup>5</sup>		
	Year-End Assets	Percent of Total
Target 2015 Allocation	\$ 44,621,045.80	3.07%
Target 2025 Allocation	\$ 48,187,177.57	3.32%
Target 2035 Allocation	\$ 17,834,742.29	1.23%
Target 2045 Allocation	\$ 4,966,743.15	0.34%
AXA Conservative-Plus Allocation	\$ 38,181,369.49	2.63%
AXA Moderate Allocation	\$ 321,602,394.48	22.13%
AXA Moderate-Plus Allocation	\$ 81,760,349.85	5.63%
AXA Aggressive Allocation	\$ 32,099,675.40	2.21%
Eq/Large Cap Value Plus	\$ 10,244,374.38	0.71%
Eq/Davis New York Venture	\$ 14,797,753.91	1.02%

<sup>4</sup> Deposits to the Guaranteed Rate Accounts are held in the general account of the AXA Equitable Life Insurance Company.

<sup>5</sup> As reported by AXA Equitable, *ADA Members Retirement Program Status Report December 31, 2010*, presented on March 24, 2011.

Eq/Equity 500 Index	\$ 78,403,341.37	5.40%
Eq/JPMorgan Value Opportunities	\$ 22,272,334.73	1.53%
Eq/Large Cap Growth Plus	\$ 37,848,746.00	2.60%
Eq/T. Rowe Price Growth Stock	\$ 39,065,214.79	2.69%
Eq/AllianceBernstein Small Cap Growth	\$ 35,397,238.86	2.44%
Eq/Gamco Small Company Value	\$ 35,832,030.50	2.47%
Eq/Small Company Index	\$ 17,454,542.45	1.20%
Eq/Mid Cap Index	\$ 15,061,857.77	1.04%
Eq/Mid Cap Value Plus	\$ 10,505,549.46	0.72%
Eq/Morgan Stanley Mid Cap Growth <sup>6</sup>	\$ 41,789,023.85	2.88%
Eq/International Core Plus	\$ 40,698,785.47	2.80%
Eq/Templeton Global Equity	\$ 30,893,324.05	2.13%
Eq/Global Multi-Sector Equity	\$ 37,655,062.86	2.59%
Eq/Core Bond Index	\$ 32,953,526.53	2.27%
Multimanager Multi-Sector Bond	\$ 13,359,131.08	0.92%
Money Market Guarantee	\$ 307,464,513.12	21.16%
3-Year And 5-Year Weekly Gras	\$ 42,083,925.98	2.90%
<b>Total Assets</b>	<b>\$1,453,033,775.18</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, 2010, there were 1,720 participants in the ADA-endorsed IRA; and their assets were invested as follows:

<b>ADA-Endorsed IRA Program Assets as of December 31, 2010<sup>7</sup></b>		
	<b>Year-End Assets</b>	<b>Percent of Total</b>
1-Year and 3-Year Weekly Gras	\$ 5,809,965	7.92%
Eq/Money Market	\$ 11,500,175	15.69%
Eq/AllianceBernstein Common Stock	\$ 18,868,172	25.74%
Eq/AllianceBernstein Government Bond Index	\$ 2,268,611	3.09%
AXA Moderate Allocation Portfolio	\$ 13,798,450	18.82%
Multi-Manager Multi-Sector Bond	\$ 808,817	1.10%
Multi-Manager Aggressive Equity	\$ 1,790,132	2.44%
Eq/Large Cap Value Plus	\$ 4,087,355	5.57%
Eq/Equity 500 Index	\$ 4,590,763	6.26%
Multimanager Small Cap Value	\$ 2,307,344	3.15%
Eq/Large Cap Growth Plus	\$ 1,511,206	2.06%
Eq/Blackrock International Value	\$ 881,985	1.20%
Multimanager Technology	\$ 1,436,503	1.96%
Eq/Capital Guardian Research	\$ 459,977	0.63%
Eq/AllianceBernstein	\$ 3,197,267	4.36%
<b>Total</b>	<b>\$ 73,316,722</b>	<b>100.00%</b>

<sup>6</sup> Name change from EQ/Van Kampen Mid Cap Growth effective May 1, 2010.

<sup>7</sup> As reported by AXA Equitable, *ADA Members Retirement Program Status Report December 31, 2010*, presented on March 24, 2011.

## **Risk Management Activities**

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**Meetings With Dental Professional Liability Insurers:** The Council conducts environmental scans of trends in the dental professional liability market, with respect to the incidence, severity and causes of malpractice allegations as well as with respect to competition among companies that insure dentists. In the past year, the Council met with two professional liability insurance companies, the Medical Protective Insurance Company and the ProAssurance Corporation, to discuss market conditions, claim trends, clinical risk management educational programs and resources available to members.

## **Acknowledgements**

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**Personnel:** The Council acknowledges with appreciation the significant contributions made by its members who will complete their terms in 2011. They are: Dr. Philip Abshire, Dr. D. Douglas Cassat, Dr. C. Richard Gerber and Dr. Louis Imburgia. Through diligence, expertise and sound judgment, they have helped the Council make significant improvements to the members' insurance and retirement programs over the past four years. This has advanced the ADA Strategic Plan and increased the value of these programs as economic benefits of membership. The Council also thanks Dr. S. Jerry Long for his service as its Liaison to the Board of Trustees and the guidance he offered.

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

## Council on Membership

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**Hughson-Otte, Virginia**, California, 2011, chair  
**Rosenthal, Nancy**, Pennsylvania, 2012, vice chair  
**Bainbridge, Jean E.**, Texas, 2013  
**Bauman, Mark A.**, New York, 2013  
**Card, Rex B.**, North Carolina, 2011  
**Cassidy, Kevin M.**, Kansas, 2014  
**Christy, Todd R.**, Michigan, 2011  
**Goad, Jamie Dale**, New Mexico, 2013  
**Kelly, Thomas**, Ohio, 2014  
**Martin, William F., III**, Maryland, 2011  
**Moore, T. Delton**, Mississippi, 2012  
**Ogata, Randall H.**, Washington, 2014  
**Poteet, Sara T.**, Texas, *ex officio*\*  
**Rich, Jonathan**, Kentucky, 2012  
**Thomsen, Brett**, Nebraska, 2012  
**Vouras, Lisa**, Massachusetts, 2012  
**Yonan, Kenneth**, Illinois, 2013  
**Zuknick, Stephen**, Florida, 2014  
**Rauchenecker, Steve**, director  
**Bronson, Liz**, manager

**Summary:** As the lead agency responsible for membership policy and success, the ADA Council on Membership recognizes the following:

- The membership market continues to grow at a rate that is outpacing tripartite membership growth. The result has been a steady decrease in membership market share over time.
- The dental landscape is shifting. The pending retirements of those who comprise the ADA's historically loyal membership base will occur over the next 10 to 15 years. The ranks of U.S. dentists, particularly among new graduates, will continue to grow. Concurrently, the overall dentist population will expand to include more women and ethnically diverse dentists. Even the traditional dental office business model is beginning to change as new dentists choose between starting or acquiring solo or small group practices versus becoming employed by a large group practice in order to minimize their risk and repay excessive debt loads.
- ADA is working to further establish its tripartite value proposition for future generations of dentists, while it maintains its historical value that has been so effective to those ADA members that are nearing the stage where they will complete their dental careers. To that end, the Council has set its own agendas, and sought to partner with other agencies, in order to maximize opportunities to develop and demonstrate greater relevance in the transitioning marketplace.
- Based upon the Council on Membership's vision and staff effort, the tripartite collaborative marketing approach has succeeded in developing truly collaborative working relationships with all tripartite dental societies, particularly with those in the 18 constituent dental societies where approximately 80% of the membership growth opportunity exists. The result has been nearly full participation by dental societies in national membership campaigns that offer specific tripartite value and messaging.
- The Membership Program for Growth, an expansion of the tripartite collaborative marketing approach, provides the ability to test effective membership approaches and then replicate those identified as successes in other areas of the country. Eighty initial resource requests have been submitted to date seeking approximately \$950,000 in funding through the program. Using funds allocated through Resolution 48H-2010, a total of \$500,000 is expected to be awarded to a variety of dental societies in June. More information about this program will be included in the Council on Membership's supplemental report following its June meeting.

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



The remainder of this document details the specific efforts lead by the Council on Membership that support the initiatives described above.

**Reaching Membership Goals Through Tripartite Collaboration and Enhanced Resources:** Out of all the professional associations in the United States, the American Dental Association enjoys a healthy membership participation rate and a unique tripartite structure. The future of the ADA is dependent upon maintaining these strengths, both by continuing to deliver member value and by effectively working at all three levels of the tripartite to demonstrate and communicate that value. The Council is committed to increasing ADA member value while controlling cost to the Association and to the member. The Council is focused on expanding the ways member value is communicated by utilizing collaborative tripartite messaging, the Dental Society Resources website and preparing for the launch of new ADA knowledge management software.

The Council has done this over the past membership year through a variety of ways, such as:

- Developing and implementing the marketing collaborative expansion, subsequently named Membership Program for Growth (MPG);
- Working with constituent societies one-on-one to create strategic recruitment and retention plans;
- Expanding utilization of the MC<sup>2</sup>: Membership Contact and Connections program. (MC<sup>2</sup> provides tools, resources, training and consultation to constituent societies, component societies and MC<sup>2</sup> volunteers to support their membership outreach. Utilizing a variety of resources, this outreach strategy focuses on energizing membership efforts, engaging volunteers in new ways, enlarging outreach networks, expanding membership contacts, and enticing prospective members to join the tripartite);
- Working with component societies in tandem with constituent societies to mainstream tripartite membership outreach; and
- Working with other agencies, such as the Council on ADA Sessions, the Council on Communications, the Council on Dental Benefit Programs, the Council on Dental Education and Licensure, and the Council on Ethics, Bylaws and Judicial Affairs to address a variety of topics with the potential to increase member value.

In addition, the Council on Membership continues to further ADA's efforts to grow membership through a number of methods, including:

- Conducting annual member and nonmember research to identify membership opportunities and trends among these groups;
- Creating customizable member value campaigns for constituent and component societies geared toward specific target markets throughout the year;
- Implementing a new "Signing Day" event to assist the tripartite with student conversion;
- Receiving a 97% overall satisfaction rating from constituent and component societies based upon their MC<sup>2</sup> program experiences working with ADA staff; and
- Supporting constituent and component societies with one-on-one consultative recruitment and retention activities through 26 site visits in 2010.

In addition to focusing on membership growth, despite the tough economy, the Council on Membership continues to focus and encourage constituent and component dental societies to focus on gains in membership market share by creating new and innovative programs to promote membership value while providing resources where needed to maximize membership opportunities.

**The Strategic Plan of the American Dental Association:** The Council has actively incorporated aspects of the Association's 2011-2014 Strategic Plan into the planning process and projects. The Council uses the plan as its guide for priority setting for resource allocation including money, people and time. In addition to presentations from Dr. Edward Vigna, the Council's Board of Trustee liaison and Dr. Kathleen O'Loughlin, ADA's executive director to help guide the Council's efforts, the Council has devoted significant time at each of its 2011 meetings to ensure their decision-making has been made within the context the ADA's environmental assessment and supports ADA's four strategic goals.

**Membership Outreach Update:** “MC<sup>2</sup>: Membership Contact and Connections” is an evolution in approach to how the ADA recruits and retains its members. Utilizing all available resources, this membership growth and outreach strategy reinforces the ADA brand, delivers consistent tripartite recruitment and retention messages, and assists dental societies by providing cost-effective resources and expertise that reinforces member value at all three tripartite levels. New marketing materials and the roll-out of new membership growth resources have continued to be popular among constituent and component dental societies.

*Marketing Collaborative.* During 2010, a number of activities were conducted to prepare constituents for participation in the marketing collaborative approach:

1. Results from the fall 2009 collaborative pilot effort were reviewed by the Council at its February meeting.
2. Curriculum was developed for the 2010 ADA Annual Conference on Membership Recruitment and Retention.
3. Demonstrations of web-to-print as well as training on the collaborative approach were provided at the 2010 ADA Annual Conference on Membership Recruitment and Retention.
4. This same curriculum was provided via a series of webinars to individuals who could not attend the Conference.
5. Outreach managers continued to work individually with states throughout the year to ensure an understanding of and encourage participation in each of the marketing collaborative campaigns.
6. Resolution 48H-2010 Expansion of the Tripartite Marketing Collaborative Program was approved by the House of Delegates in October of 2010 expanding the marketing collaborative, subsequently named the Membership Program for Growth (MPG).

*2010 Marketing Collaborative Rollout.* Three collaborative membership campaigns were made available to the tripartite dental societies in 2010.

1. Reinstatement Campaign (for tripartite members who were members as of December 31, 2009, but had not paid their 2010 dues)
2. Half-Year Dues Campaign (for dentists eligible for tripartite membership who were not members in 2009 or 2010 and joined after July 1)
3. Retention Campaign (for 2010 member dentists)

Based upon the experience gained through the pilot program, the first two campaigns—reinstatement and half-year dues—engaged constituent societies in customizing the look, feel and copy of the membership marketing pieces that were used. In addition, the Fall Member Value Campaign provided constituent dental societies with a variety of complementary touch points to reach existing members to reinforce the value of membership. These touch points included direct mail, dues bill stuffers and e-mail blasts.

Early adoption of the marketing collaborative approach was a key success factor in 2010 and measured by constituent participation in the program. Overall, results were very positive, with more than 44 constituent dental societies participating in each of the three campaigns offered. Of the 47 that did participate overall, more than 30 constituents provided customized copy that tailored the messaging of the material to their state’s membership value proposition. In addition, for the first 2011 marketing collaborative campaign that promotes the New Dentist strategic promotional incentive 49 of the 53 state societies participated.

### 2010 Reinstatement Campaign Dental Society Participation

Template	Customized Copy	Used Default Copy	Total Participation	Opted Out
Postcard	31	13	44	9

### 2010 Half-Year Dues Campaign Dental Society Participation

Template	Customized Copy	Used Default Copy	Total Participation	Opted Out
Brochure and Postcard	32	15	47	6

### 2010 Retention/Member Value Campaign Dental Society Participation

Template	Customized Copy	Used Default Copy	Total Participation	Opted Out
ADPAC Buckslip	20	NA	20	NA
Member Value Buckslip	21	NA	27	NA
Letter	17	30	47	6
Brochure	15	32	47	6
Eblast	15	32	47	6
Postcard	14	33	47	6
AD	6	NA	6	NA

During 2011, three major membership marketing campaigns are being conducted through the marketing collaborative approach. The campaigns include a New Dentist Recruitment campaign promoting the strategic promotional incentive, a half-year dues campaign, and a Quarter-Year \$0 Dues promotion campaign. Additional marketing collateral templates are being created to help state and local societies conduct ad hoc promotions and campaigns in addition to the three major campaigns noted.

ADA Membership Outreach staff continues to work very closely with constituent staff to ensure involvement in the campaigns at all levels within the tripartite. Four web-based training webinars were offered in 2010 to inform constituent dental society staff about MC<sup>2</sup>, the marketing collaborative approach, the three national campaigns, additional blank marketing templates and to train them on the web-to-print process. A web-to-print training guide was also provided to states as a follow-up to their initial instruction.

Additional webinars will be held in 2011 to provide constituent staff with guidance and assistance for the 2011 National Campaigns. Curriculum at the 2011 ADA Annual Conference on Membership Recruitment and Retention also included information about these campaigns and further expansion of the program.

**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 30, 2011, of the 305 nonmember attendees who took advantage of the nonmember reduced rate at the 2010 ADA annual session in Orlando, 28 have joined the ADA including 15 who are pending renewals for 2011. In 2009,

258 nonmember dentists took advantage of the one-time reduced nonmember rate to attend the 2009 ADA annual session and as of end-of-year 2010, 34 of them had joined the Association.

**Membership Research:** The 2010 Council on Membership Annual Report noted a number of studies that were in process at the time. Updated information on this membership research is outlined below.

*Student/New Dentist Quantitative Web Survey.* Member junior and senior dental students and dentists in the first five years following dental school graduation were surveyed in the fourth quarter of 2011, with over 1,600 responses. Selected findings include:

- Respondents indicated that the number one factor which attracted them to dentistry was the opportunity for a flexible lifestyle and time with family, followed by the opportunity to provide patient care and help others.
- The top three reasons for membership were: support my profession, stay up-to-date on the profession, and voice of organized dentistry.
- Respondents selected up to three advocacy priorities from a list of 10; the top three included protecting the autonomy of the dental profession, educating the public on the importance of oral health care, and maintaining the dentist as the leader of the oral health care team.
- Currently, this group of young practitioners had a wide variety of primary occupations, from dental students and resident to military or other federal service, associate or employee in a community health center, private practice or corporate practice. When asked what they expected their occupation to be in 2020, 22% expected to be in solo practice, 52% a practice owner/partner, 7% an associate in a dentist-owned practice, 1% employed in a corporate practice, 3% dental faculty, 4% in the military or federal services, and 7% said they would have a “combination” occupation.

*Federal Dental Service (FDS) Membership Needs and Opinions.* A web survey was completed among member and nonmember federal dentists, with about 500 completed surveys. FDS members indicate that supporting their profession (81%) is the most important reason they are members, followed by supporting the ADA’s advocacy goals (42%) and staying up-to-date with news within their profession (53%). The majority of respondents (58%) stated that the ADA’s efforts on behalf of federal dentists had a large or moderate impact on their decision to join, renew or reinstate their membership. Although the response rate among nonmembers was fairly low, it was of interest that the majority of members had not been deployed to a combat zone, while a majority of nonmembers had been. The number one reason cited for nonmembership was “I forgot to renew.”

*Affiliate Membership Web Surveys.* The ADA undertook Web surveys among new and lapsed affiliate members—non-U.S. dentists who practice outside the United States—in 2010. The purpose of the survey was to assess the motivation for ADA membership, the value of the member benefits, key professional issues, needs and opinions, as well as the reason for nonrenewal. Overall, the surveys yielded some interesting information, including the top four reasons this target market cited for joining: 1) Access ADA publications, 2) Enhance their professional credibility, 3) Gain access to online continuing education, and 4) Support their profession.

*Diversity Qualitative.* A total of 48 panelists were recruited for a three-part research panel to gain qualitative perspectives on the American Dental Association. One half of the panelists were comprised of ADA members and the other half of nonmembers. Four sub-segments of dentists were targeted: Caucasian, Black/African-American, Hispanic/Latino, and Asian-American dentists. Selected findings:

- In general, nonmember dentists indicated that they were members of some dental organization, and many ADA members are members of other organizations, as well. The ethnic dental organizations have a strong presence, even among those who do not currently belong.
- When asked what issues are most important to dentists, dental reimbursement and the oral health-overall health connection were top of mind. Scope of practice and practice management issues were also frequently mentioned.
- Overall, dentists see the ADA as an advocate, educator, and small-business supporter. There was variability among the different subgroups regarding emphasis.

- When asked what the ADA should focus on, African-American and Asian dentists tended to mention advocacy; Hispanic dentists mentioned advocacy, practice success, and greater diversity among the membership; and Caucasian dentists emphasized access to care and leadership development.
- There is an opportunity for the ADA to increase its professional relevance to all subgroups and to communicate member value to both members and nonmembers.

The Council on Membership also has an ambitious membership research agenda in 2011. Planned activities, current status, and selected results are provided below.

*Informal Faculty Focus Group.* The Council requested staff facilitate an informal focus group of faculty members in cooperation with the American Association of Dental Boards at its meeting in early April. Ten dental faculty dentists, including nine members and one nonmember, participated. Selected findings:

- In general, these highly involved faculty members seemed to have positive attitudes toward the ADA, although the ADA is not the primary membership organization for any of them.
- Many of their priorities are ADA priorities as well, and it appears that these faculty members may not have a good understanding of the specifics of ADA activities. Their focus is on student/school needs as well as helping underserved populations above other professional needs.
- Tangible benefits are not a membership motivator for this group.
- Finally, faculty may experience membership overload and have pressure to belong to a number of organizations besides the ADA.

*Nonmember Quantitative.* This project builds upon the 2010 Diversity/Nonmember qualitative study. It seeks to quantify needs and opinions of nonmember dentists specific to their membership and participation in organized dentistry. This study is currently in process and a completion date of August 2011 is anticipated.

*Critical Issues Qualitative.* A series of focus groups is planned (suburban Chicago, Tempe, AZ, and online) to identify current and emerging profession and practice issues of importance to the profession. Focus group findings are expected to be delivered by June 1, 2011.

*Online Membership Panel.* This new approach to member feedback is a pilot with the ADA Survey Center. A panel of dentists that reflect the overall make-up of the ADA membership is in development with an up-front commitment to complete multiple, short surveys over the course of the year. Benefits are expected to include increased engagement and response rate, while allowing for more frequent and timely web surveys and minimizing survey fatigue across the membership. A series of short web surveys are expected to build off the Critical Issues Qualitative study. The first survey is expected to be in the field by June 1, 2011.

*Urban Issues Qualitative.* Previous research in urban areas provided useful nonmember information; this follow-up qualitative study will examine issues and perceptions among lower-income dentists in urban areas, with a goal of assessing issues related to race and ethnicity vs. income and/or patient population. Focus groups are planned in May 2011 with two groups each in Detroit, Philadelphia, and Houston. The report is anticipated by mid-June, 2011.

*Group Practice Impact Quantitative.* This quantitative, paper-and-pencil survey is a follow-up to Health Policy Resource Center (HPRC) study regarding growth in group practices. The goal is to quantify impact of practice setting on perception of the value of membership. This study will build on diversity qualitative, nonmember quantitative and critical issues research. This report is anticipated for fall 2011.

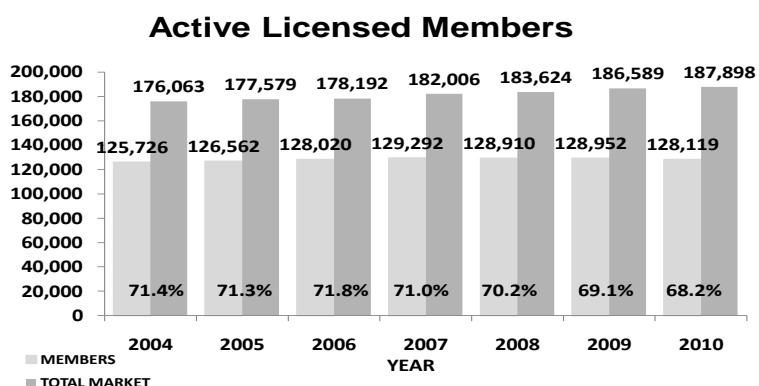
*Tripartite Member Value Web Survey.* This short web survey of members will address the member value of the tripartite overall and each level, as well as utilization of member benefits, products and resources offered at each level. This survey will be conducted in June.

*Nonrenew Web Survey.* This brief survey of 2010 members who do not renew in 2011 will be conducted in July 2011, to assess reasons for lapsed membership.

*Annual Loyalty Metrics.* This survey is conducted annually at the direction of the Council on Membership and provides annual reporting/trending on key metrics including loyalty composite score, and may include a few additional questions on related topics. This survey is planned for October 2011.

**Membership Market Share:** At end-of-year 2010, the ADA's membership market share among active licensed dentists decreased by nine tenths of a percentage point to 68.2% from end-of-year 2009 (Table 1). There was a decrease of 157 members in all membership categories and a decrease of 733 in the number of active licensed members, from 128,952 to 128,119. The total market of active, licensed dentists grew by 1,309 in 2010 compared to an increase in the market of 2,965 in 2009.

**Table 1. ADA Market Share**



The ADA continues to be challenged to increase the number of active licensed members. Because the market size is growing at a faster rate than the membership, ADA market share has dropped. Table 2 illustrates that between 1993 and 2010, active membership has grown by almost 12,000 dentists. During that same period, the market has grown by over 31,000 dentists. The result is a decrease in membership market share from 74.3% to 68.2% since 1993. 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.

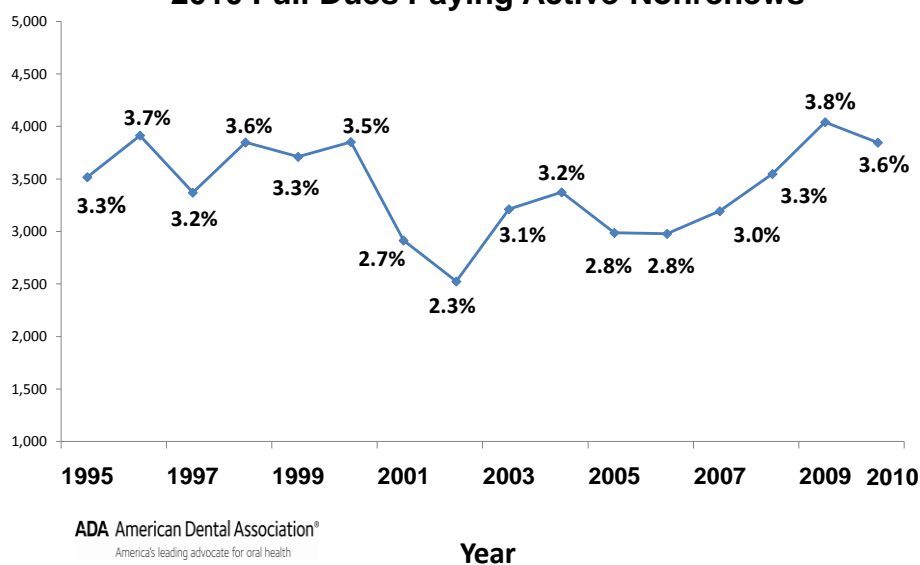
A membership goal of 129,028 active licensed members has been set in ADA's 2011 Operational Plan. This number has been shared with the Board and with Council Chairs. Achieving the 2010 membership goal, while factoring in an expected increase in market size of 2,000 active licensed dentists, it is anticipated that ADA's market share will be between 67% and 68% at the end of 2011.

Despite the weak economic climate, more active licensed members renewed their membership in 2010 than in 2009. The active nonrenew percentage declined two tenths of a percentage point from 3.8% to 3.6% at year end. There were 3,846 full dues active nonrenewals in 2010 compared to 4,041 full dues active nonrenewals in 2009, a decrease of 195. Table 3 shows the percent of full-dues-paying active non-renewing members from 1995 through 2010. However, it should be noted that the percent of member dentists who pay full dues has declined from 85% of active members to 75% of active members during the same time period.

**Table 2. Membership Growth and Market Share From 1993–2010**

Year	Active Licensed Members	Change From Previous Year	Total Market of Active Licensed Dentists	Change From Previous Year	Market Share %	Change From Previous Year
2010	128,119	-733	187,898	1,309	68.2%	-0.9%
2009	128,952	42	186,589	2,965	69.1%	-1.1%
2008	128,910	-382	183,624	1,618	70.2%	-0.8%
2007	129,292	1,272	182,006	3,814	71.0%	-0.8%
2006	128,020	1,458	178,192	613	71.8%	0.5%
2005	126,562	836	177,579	1,516	71.3%	-0.1%
2004	125,726	2,581	176,063	2,538	71.4%	0.4%
2003	123,145	2,039	173,525	1,467	71.0%	0.6%
2002	121,106	3,828	172,058	5,447	70.4%	0.0%
2001	117,278	685	166,611	1,058	70.4%	0.0%
2000	116,593	-2,414	165,553	-1,044	70.4%	-1.0%
1999	119,007	-312	166,597	-483	71.4%	0.0%
1998	119,319	-465	167,080	2,140	71.4%	-1.2%
1997	119,784	928	164,940	1,918	72.6%	-0.3%
1996	118,856	1,289	163,022	2,939	72.9%	-0.5%
1995	117,567	2,139	160,083	3,012	73.4%	-0.1%
1994	115,428	-1,061	157,071	333	73.5%	-0.8%
1993	116,489	—	156,738	—	74.3%	—

Source: End-of-Year ADA Active Licensed Market Share Reports.

**Table 3.****2010 Full Dues Paying Active Nonrenews**

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, non-U.S.-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 2009 Vs. Year-End 2010  
Members By Target Market for Active Licensed Dentists**

Target Group	Increase/ Decrease in 2010 Members	2009 Membership Market Share Percentage	2010 Membership Market Share Percentage	Increase/ Decrease in Market Percentage Points 2009/2010	Increase/ Decrease in Market 2008/2009
<b>Women Dentists</b>	592	62.4	61.8	-.6	1,416
<b>All Faculty (Full-Time and Part-Time)</b>	168	72.1	72.0	-.1	244
<b>Full-Time Faculty</b>	-173	68.4	67.3	-1.1	-188
<b>General Practitioners</b>	-1200	66.3	65.4	-.9	261
<b>Specialists</b>	367	80.5	79.3	-1.2	1,048
<b>Federal Dental Service</b>	-90	61.5	58.3	-3.2	103
<b>Non-U.S. Trained Dentists</b>	-58	50.4	49.8	-.6	-3
<b>Minority Dentists</b>	164	54.0	53.6	-.4	524
<b>New Dentists</b>	-546	68.4	67.4	-1.0	-177

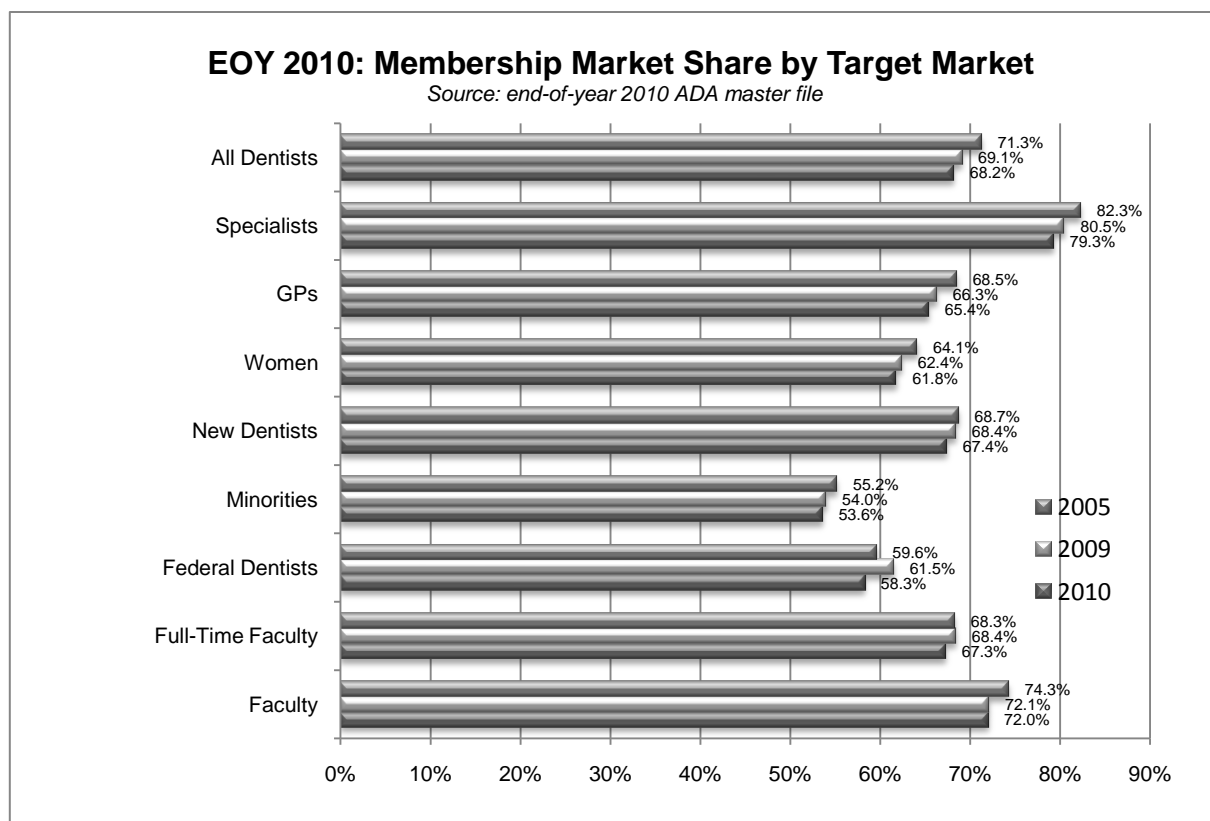
Source: 2010 ADA Dentist Masterfile.

Note: Target Markets overlap and should not be added together.

**End-of-Year 2010 Target Market Membership Statistics:** As noted in Table 5, the overall membership market share dropped by nine-tenths of a percent between end-of-year 2009 and the end of 2010, and this decrease is reflected in all target markets. Overall, the largest membership market share declines were in the federal services and specialists. Table 5 shows end-of-year market share compared to prior year (2009) and five years ago (2005). In general, membership market share was higher in 2005 compared to 2009 and 2010, with the exception of FDS and full-time faculty in 2009.



Table 5.



**ADA Direct Membership Marketing:** The Council on Membership's 2010–2012 Membership Marketing Plan outlines membership recruitment and retention initiatives for both tripartite and direct membership. In 2010, in support of Membership Outreach goals, direct marketing contact included the following:

- 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)
- Nonmember federal dentists
- Non-practicing dentists
- Full-time and part-time faculty
- Graduate students

**Tripartite Membership.** The ADA supports tripartite recruitment through a variety of direct mail recruitment and retention communications. Leads or applications received are transmitted to the constituent dental societies for processing and appropriate follow-up. Three membership campaigns per year are conducted through the Marketing Collaborative, offering constituent societies the opportunity to customize messaging for their state's recipients through the web-to-print tool. Campaigns undertaken collaboratively include:

- A *reinstatement campaign* was conducted in the spring of 2010 before ADA membership cut-off, but after the March 31 cut-off date that many constituent societies use. The campaign was implemented as a reminder for dentists to renew their membership. Constituent societies had an opportunity to customize copy with state-level benefit information. Of the 8,241 nonrenews that

were included in this campaign, 3,214 (39%) renewed their membership by the member cutoff on July 12, 2010.

- The *2010 half-year recruitment campaign* targeted nonmember dentists eligible for the 50% prorated dues at the half-year mark. A total of 783 of the dentists joined as tripartite members at the half-year rate in 2010. (This campaign will occur in 2011 as a direct national ADA campaign, featuring targeted messaging to women, African-American, Hispanic and non-U.S.-trained dentists as follow-up to an earlier campaign to some of these target markets.)
- The final marketing collaborative campaign of 2010 focused on the *retention* of tripartite members in 2011. The goal was to positively affect retention rates by reinforcing the value of the tripartite and its services and resources, and to increase the number of members who renew their membership by April 2011. As of April 30, 2011, comparison of pending tripartite members to the same time period in 2010 reveals a slight decrease in “pending” dues payments. A variety of promotional pieces were used, including PDF ads, brochures/direct mailers, electronic communications and dues stuffers for states to include with their fall invoice mailings.
- The first marketing collaborative campaign for 2011 focused on the *Strategic Promotional Incentive (SPI)*, as permitted through the ADA Bylaws Chapter I, Section 20Ac. In 2010, the ADA Board of Trustees approved a 2011 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 SPI for 2011 was implemented through the marketing collaborative program and targeted nonmember dentists five to 10 years out of dental school (or the classes of 2001 to 2006). This campaign provided an opportunity for states to customize copy on a number of pieces, including a teaser postcard, a direct package and an e-mail. Additional promotions included a call-out in the March issue of *New Dentist News* which mailed as a bonus issue to nonmembers. As of April 30, of the 7,300 eligible dentists, 366 had become ADA members (excluding those who joined as graduate students), for an approximate 5% response rate to date.

The ADA also undertakes recruitment campaigns at the national level. Those undertaken in the fall and winter of 2010 include:

- The ADA and many state and local dental societies offer *\$0 quarter-year dues* in order to recruit nonmember dentists to join in the final three months of the membership year. A total of 567 dentists joined at the \$0 rate; the ADA monitors renewal rates among this group and as of May 1, 53% had paid their 2011 dues. (The 2011 quarter-year dues campaign will be implemented through the marketing collaborative, providing constituent societies with an opportunity to customize copy to increase overall campaign response, and will be undertaken in September 2011.)
- The ADA has undertaken an annual lapsed member calling campaign every fall; this was completed in the fall of 2010 for 2009 tripartite members who let their membership lapse. A total of 4,863 lapsed members were targeted and 14% renewed by end of year. As anticipated, an additional 10% have been reinstated in 2011. Overall, reinstatement for dentists contacted compared to those not contacted demonstrates the effectiveness of the calling program, with reinstatement levels for those contacted at 25.8% compared to those not contacted at 19.6%. Through the Marketing Collaborative Expansion, the ADA will conduct a collaborative outbound calling program much earlier in 2011, with calls slated to begin at the end of May and be completed by the end of July. After the member cutoff and once all calls have been completed through the lapsed member calling program, the ADA will conduct an electronic survey of all 2011 nonrenews to help learn more about their reasons for not renewing.
- Under-represented groups will be scheduled to receive additional membership recruitment and retention messages in 2011 in hopes of increasing the diversity of new members and to enhance the retention rate for current members.

*Diverse (Minority) Dentists.* While the ADA is America’s most diverse dental association, including dentists of all racial/ethnic backgrounds, occupations and practice settings, some subgroups are unrepresented in membership. While the profession is becoming more diverse, membership participation for dentists of diverse background continues to lag significantly behind white dentists, particularly for

African-American and Hispanic dentists. With racial and ethnic background information being self-reported, the ADA database includes a large number of dentists of unknown background, half of whom are new dentists. The ADA will continue to gather this information through the Distribution of Dentists survey, which goes to one-third of the ADA database annually. Overall, the market share of known ethnic/diverse dentists is 53.6%; there has been a steady decrease from 61.7% in 1993. The 2010 membership market share was 42.9% for African-American dentists, 48.0% for Hispanic dentists, and 59.6% for Asian dentists, with a white dentist market share of 75.6%.

In 2010 the ADA conducted research on diversity and, as follow-up in 2011, will conduct qualitative research related to issues associated with nonmember dentists in urban areas. The 2011 nonmember quantitative survey will oversample minority dentists to provide insight as well. Other activities that occurred in 2010 that may have a future impact on membership include the 2010 National Summit on Diversity in Dentistry, as well as the public apology from the ADA that was related to past membership practices, leadership positions within the tripartite, and a commitment of collaboration to the profession and the public.

The 2010-12 ADA Membership Marketing Plan includes specific outreach to nonmember dentists in under-represented target markets, including a direct mail campaign, targeted communications in the 2011 half-year dues campaign, and retention communications to help increase the renewal rate within this market segment.

*Non-U.S.-Trained Dentists.* The number of non-U.S. dentists who come to the United States to practice is growing; between 2003 and 2010, active licensed non-U.S.-trained dentists grew by 25% (increasing in real numbers during the period from 8,222 to 10,292). About half of these dentists maintain ADA membership. About 81% of non-U.S. trained dentists are general practitioners, and 19% are specialists; the gender breakdown is 60% men, 40% women. More than half of non-U.S.-trained dentists (52%) practice in California, while 9% practice in New York. The racial and ethnic background of dentists in this group varies, and the ADA does not have race or ethnicity information for a significant percentage of the group. These potential members are included in all outreach, including those initiatives targeted to under-represented segments. Non-U.S.-trained dentists will be over-sampled in the 2011 nonmember research for additional insight.

*Recent Graduates.* With the opening of new dental schools and increased size of dental school graduating classes, the new dentist market has grown in size in recent years. Continued 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. Overall, new dentist market share is strong and the market share gap is smaller than it has ever been (68.2% for members overall and 67.4% for new dentists). However, conversion of dental students to active membership upon graduation is an ongoing challenge; conversion for the class of 2009 at end-of-year 2010 was down slightly over previous years. Encouraging continuous membership in this target market will continue to be a focus. Expanded conversion initiatives in 2011 will serve to help this effort, including National Signing Day, a spring conversion drive and a conversion campaign, which will be implemented through the marketing collaborative.

*Federal Dentists.* The overall FDS market share of active, licensed dentists at end-of-year 2010 was 58.3%, down slightly from 2009 when market share was 61.5%. The total number of members (including both active duty and transition year) decreased by 90 dentists and the overall market increased by 103 dentists. It is important to note the FDS Membership Office no longer reconciles its records with every branch of service. As a result, there are very likely nonmember dentists who are no longer in service who were counted in the total market at year end, which would reduce the market share for federal service dentists. A number of ongoing and new tactics to collect this data are planned for implementation in 2011.

Looking at active duty dentists alone, the end-of-year 2009 market share at 57.5% was a decrease over end-of-year 2009 at 60.2%. There was an increase in the number of active duty dentists in 2009, with 165 more dentists serving. The number of "transition year" members—those who maintain direct

ADA membership in the year following their separation from active duty—decreased from 148 to 86, likely related to the retention of dentists in the military.

A web survey of member and nonmember federal service dentists was completed in 2010. Federal dentists continue to tell the ADA that supporting their profession (81%) is the most important reason they are members, followed by supporting the ADA's advocacy goals (42%) and staying up-to-date with news within their profession (53%). The majority of respondents (58%) stated that the ADA's efforts on behalf of federal dentists had a large or moderate impact on their decision to join, renew or reinstate their membership.

*Graduate Students.* Nonmember graduate students received a total of two recruitment mailings and follow-up e-communications in 2010. 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 the low \$30 dues rate. By end-of-year 2010, a total of 3,072 dentists had paid the \$30 graduate student rate, a decrease of 15 graduate student members from end-of-year 2009, when graduate student membership was 3,087 (Table 6).

**Table 6. Graduate Student Membership**

	<b>Members at End-of-Year 2010</b>	<b>Percent</b>	<b>Members at End-of-Year 2009</b>	<b>Percent</b>
<b>Direct</b>	1,484	48%	2,002	65%
<b>Tripartite</b>	1,325	43%	819	26%
<b>Federal</b>	263	9%	266	9%
<b>Total</b>	<b>3,072</b>		<b>3,087</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* in 2010. In 2011, a staff editorial group will be formed to help generate more meaningful content for this publication. Additionally, a Graduate Student Advisory Group is in the process of being formed; the group will meet informally twice a year via conference call. The group will provide volunteer opportunities and serve to take the pulse of particular issues affecting graduate students. It will consist of members from both general practice and specialty programs, along with participation from residency program directors and ADA staff.

The Reduced-Dues Program continues to appeal to dental school graduates who enter a graduate program or residency following graduation or within their first few years out of school. The program 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 near the half year mark and again in the fall. 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 to promote the importance of continuous membership as it relates to eligibility in the Reduced-Dues Program. As of April 30, 2011, a total of 2,156 dentists have paid graduate student membership rates, 75 more than had paid graduate student dues at the same time last year. In addition to the three renewal mailings received by graduate students, a multiple touch-point e-mail retention campaign is underway in 2011.

*Nonpracticing Dentists.* As of April 30, a total of 55 non-practicing dentist members had paid 2011 dues (compared to 63 members at end-of-year 2010 and 54 who were paid members as of April 30, 2010). There are close to 5,000 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 will receive a recruitment mailing in May 2011.

*Affiliate Membership (Non-U.S. dentists practicing outside the United States).* Affiliate members 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 generally access member benefits online, with access to *The Journal of the American Dental Association*, the *Professional Product Review* and other resources on ADA.org. As of April 30, 2011, there were 2,006 affiliate members. Of these, 1,594 paid \$75 and 412 paid \$12. This compares to 1,696 affiliate members as of April 30, 2010, and 2,434 as of December 31, 2010.

Surveys conducted in 2010 of new and lapsed affiliate members to identify reasons for joining, perceptions of member value, and reasons for nonrenewal will be continued in 2011. Overall, the surveys yielded some interesting information, including the top four reasons this target market cited for joining: 1) Access ADA publications, 2) Enhance their professional credibility, 3) Gain access to online continuing education, and 4) Support their profession.

A total of three renewal mailings have been completed to affiliate members for 2011 year and an electronic retention campaign has been added to help increase the retention rate. A check on affiliate member renewals on April 30, 2011, reveals a 15.4% increase in the renewal rate over the same time in 2010.

**Dental Student Outreach and Conversion:** The ADA Office of Student Affairs prepares an annual Student Membership Marketing Plan for the Council on Membership's review and approval. The American Student Dental Association (ASDA) and the ADA have dual membership; ASDA collects \$5 in ADA student dues from each ASDA/ADA student member.

The ADA Office of Student Affairs (OSA) coordinates outreach to dental students, provides resources to the tripartite and works closely with the American Student Dental Association to recruit and serve student members. Outreach includes informational resources including the seasonal mailers, *Dental Student Loan Repayment Programs & Resources*, *Understanding Licensure* guidebook and its companion piece *The Patient's Guide to the Clinical Licensure Exam*, electronic communications, and issues of interest to dental students available on ADA.org, such as ergonomic health and applying to advanced education programs.

*Student Block Grant Program.* The Office of Student Affairs manages the Student Block Grant program, which provides reimbursement to constituent dental societies of up to \$3,000 per school for outreach initiatives. Constituent societies with dental schools that have total enrollment over 500 were eligible for additional funding: 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. Appropriate documentation and receipts outlining the activities must accompany all requests to be eligible for funding.

During the 2010 calendar year, the OSA processed reimbursements for a reported 187 total programs with estimated 20,000 student contacts, and the \$175,000 budget was fully utilized. The societies held a mix of cost-effective programming (pizza lunch and learns, exam breaks and breakfasts) as well as more expensive events (receptions, dinners, trips to sporting events or meetings) with an average cost per student of \$8.74. As in previous years, few of the programs were new initiatives; most are ongoing activities that had been conducted in previous years.

The program remains unchanged for 2011 and, as seen in previous years, only a few societies have submitted reimbursement requests through April 30, 2011.

*Student Market Share.* The ADA tracks student market share by school on a monthly basis and benchmarks on July 1 each year, reflecting the academic year cycle. Again in 2010, a strong percentage of students joined and renewed as student members of ASDA and the ADA. Table 7 reflects the market

share for the 2009-2010 academic year reported July 1, 2010. In addition, the ADA reports a total of 12 international dental student members at the end of 2010.

**Table 7. 2009–2010 Dental Student Market Share**

Class Level	Member	Market Share	Nonmember	Market Share	Total Market
Freshmen	4,440	86.6%	686	13.4%	5,126
Sophomore	4,264	84.6%	774	15.4%	5,036
Junior	4,071	83.4%	812	16.6%	4,883
Senior	4,160	82.3%	895	17.7%	5,055
<b>Total</b>	<b>16,935</b>	<b>84.3%</b>	<b>3,167</b>	<b>15.7%</b>	<b>20,102</b>

*Conversion.* The dental student conversion rate—the percentage of new dental school graduates who become ADA members the following year—is a key metric for the ADA. 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 2009 at end-of-year 2010, the conversion rate is 63.5%. This is a decrease of 2.3 percentage points when compared to the class of 2008 at end-of-year 2009; the conversion rate was 65.8%.

Conversion for the class of 2010 is well underway. More than 38% of the class of 2010 provided post-graduation practice plans and subsequently received a membership brochure and application. This represents a 4% increase compared to the class of 2009 for this same type of request. Information about the class of 2010 continues to be collected. A total of 53% of new graduate members were transferred to an appropriate constituent society by the end of 2010. Of these 2,438 new graduates, 1,650 (67.6%) transferred to tripartite dental societies, 616 (25.2%) to direct graduate student membership, 169 (7%) to federal services, and three (.12%) to direct ADA membership.

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. There will be continued communication with the class of 2010 and the final numbers for conversion of this group will be established on December 31, 2011.

*Class of 2011.* As of May 1, 2011, the class of 2011 is still in school, but the ADA has undertaken several initiatives designed to increase conversion to active membership for this group. The first initiative was the ASDA Conversion Drive, a chapter-level financial incentive to increase responses to the ADA's "Where Are You Going?" mailing that gathers updated contact information and post-graduation practice plans. Data shows that graduates who complete the form have a higher likelihood of joining the ADA. The first year was very successful, with a total of 38 ASDA chapters participating in the Conversion Drive. The OSA received a total of 1,392 "Where Are You Going?" forms as a result of the drive and 23% came in online and 77% were received by mail. The ADA will send subsequent "Where Are You Going?" mailings to graduates who did not respond after the close of the incentive this spring and summer. All graduates who complete the form receive the appropriate membership application. A general mailing to those who do not provide information will be completed in the fall.

Also new, the ADA kicked off its first National Signing Day in February 2011. Signing Day was a designated time period when constituent dental societies encouraged fourth-year students to apply for membership with the ADA or Tripartite. Signing Day Season was a fun way for dental schools, state and local societies, and ASDA chapters to focus on the transition to active membership. The Signing Day goal was for new graduates to "sign up" for membership during the Signing Season, between February 1

and April 30. The ADA provided a Signing Day kit to all constituent societies to facilitate the event. An estimated 15 to 20 Signing Day events took place in 2011.

### **Response to Assignments From the 2010 House of Delegates:**

*2011 Membership Related Market Research Activities.* The 2010 House of Delegates adopted the following resolution put forth by the Council on membership regarding funding for research projects:

**41H-2010. Resolved**, that funding for the Council on Membership's research projects on critical issues in dentistry, urban market needs and group dental practice needs to be reinstated to the amount of \$62,000 for the 2011 budget year.

In response to the House of Delegates action to increase the funding for membership research, the Council included critical issues, urban issues, and group practice research into its agenda. A full research update is included in this annual report.

*Funding of Student Block Grant Program.* The following resolution submitted by the Council on Membership was adopted at the 2011 House:

**47H-2010. Resolved**, that the funding for the Student Block Grant Program for the 2011 budget year be maintained at its 2009 utilization level of \$169,000.

The reinstatement of the block grant funds was completed and communicated to eligible constituent societies. An update on the student block grant program is included in this annual report; societies have until December 31, 2011, to submit expense reimbursement requests.

*Expansion of the Tripartite Marketing Collaborative Program.* The following resolution submitted by the Council on Membership was adopted:

**48H-2010. Resolved**, that the 2010 House of Delegates approve funding in the amount of \$500,000 for the purpose of expanding the Tripartite Marketing Collaborative Approach to positively impact tripartite membership in those areas and among those market segments that offer the greatest opportunity.

To date, the Council has received 80 applications with a total of \$958,313.83 requested for resources.

*Humanitarian Membership Category.* The House of Delegates referred Resolution 115H-2010 to the Council on Membership for further review and update to bylaws language if deemed appropriate by the Council. The resolution states:

**115H-2010. Resolved**, that the Council on Membership consider a new category of membership for dentists that engage in full-time international humanitarian relief and have been active members in good standing for at least five years immediately before leaving the country, and be it further **Resolved**, that for purposes of determining eligibility for life membership, years as a member in this humanitarian category will be considered the same as active members, and be it further **Resolved**, that, if appropriate, bylaws language be developed and submitted to the 2011 House of Delegates for consideration.

The Council studied the past usage of the charitable practice waiver and discovered that based upon the historic number of members who have taken advantage of the charitable organization practitioner dues waiver, it is not expected that more than 60 dentists would belong to the humanitarian membership category annually. It could be anticipated that since there is a current waiver, there is no need to create a membership category just for active members providing humanitarian services.

The Council then discussed Resolution 115H-2010 and the proposed requirements for a Humanitarian membership category, the Council has drafted a change in *Bylaws* language and will be voting on the

updated language at its June 2011 meeting then submitting a proposed resolution in its supplemental annual report.

*Faculty Membership Pilot Projects.* The 2010 House of Delegates assigned the Council to monitor progress of various faculty membership program pilot projects via the following resolution:

**117H-2010. Resolved,** that the Council on Membership monitor the progress of any pilot projects for faculty recruitment and retention programs from the states of Alabama, Washington and other states that may have similar programs, and be it further

**Resolved,** that the Council on Membership report its findings and results of these pilot projects and any recommendations to the 2011 or 2012 House of Delegates.

The Council polled the constituent dental societies regarding the types of recruitment and retention programs they have for faculty members. A total of 29 constituent societies responded.

Dental societies with dental schools that responded as having programs in place for faculty recruitment and retention were Missouri, Oregon, Washington, Alabama, Georgia, Nevada, Michigan, Massachusetts, Wisconsin and California.

The following societies report offering a 50% dues reduction for full-time dental school faculty members at the state level: California, Missouri, Washington, Alabama, Georgia and Nevada. In addition, there is a matching 50% dues reduction at the component level in Missouri, Washington, Alabama and Georgia. Oregon only charges \$25 for faculty dues, and the component where the dental school is (Multnomah Dental Society) offers a 75% discount for full-time faculty.

The Council will continue to monitor the progress of these programs and report to the House in 2012. The Council also reported to the Board of Trustees that the ADA offer a strategic promotional incentive to full-time faculty nonmembers of a 50% dues reduction in 2012. The Council will also report the status of this incentive in its 2012 Annual Report.

*Study of the Active Life Member Category.* The 2010 House of Delegates referred the following resolution to the Council for further study:

**125H-2010. Resolved,** that the Council on Membership study the active life member category to determine whether active life members should pay 50% of dues until the age of 72 when dues will then be the same as retired life members.

At its February 2011 meeting, the Council on Membership studied the Active Life Membership category at length. Currently, there are 4,618 active life members who are age 72 and over. For the 2010 membership year, these members paid \$1,138,611.50 in dues to the ADA. Only a small amount of these members received dues waivers for the 2010 year. There were two on charitable organization practitioner waivers (\$0.00), 23 on a 75% dues waiver (\$63) and 57 on a full dues waiver. There were 26 active life members who refused the active life dues rate and paid full dues.

In response to the study directed by Resolution 125H-2010, the Council on Membership studied the life membership requirements and impact on dues revenue and recommends that no *ADA Bylaws* changes be made to the age, years or dues requirements for Active Life members at this time.

**Meetings:** The Council met at the ADA Headquarters Building on February 18-19, 2011, and will meet again on June 10-11, 2010. Dr. Edward Vigna, trustee, Tenth District, serves as the Board of Trustees' liaison to the Council.

**Personnel:** At the close of the 2011 annual session, the terms of four highly regarded members of the Council will end: Dr. Virginia Hughson-Otte, 2007-2011, who served as the chair of the Council for 2010-2011; Dr. Rex B. Card, 2007-2011; Dr. Todd Christy, 2007-2011; and Dr. William F. Martin, III, 2007-



2011. The Council wishes to acknowledge these individuals for their strong and thoughtful leadership and for the many contributions they have made during their years on the Council.

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

# Joint Commission on National Dental Examinations

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**Spielman, Andrew**, New York, 2011, chair, American Dental Education Association  
**Conard, George D., Jr.**, West Virginia, 2011, vice chair, American Association of Dental Boards  
**Byrne, B. Ellen**, Virginia, 2012, American Dental Education Association  
**Carlile, Richard**, Virginia, 2011, American Student Dental Association  
**Donahue, Jeri Ann**, Wyoming, 2013, American Association of Dental Boards  
**Glass, Birgit J.**, Texas, 2013, American Dental Education Association  
**Grzesikowski, Tamara J.**, Florida, 2014, American Dental Hygienists' Association  
**Peterson, Lorin D.**, Washington, 2014, American Dental Association  
**Podruch, LeeAnn**, Wisconsin, 2014, American Association of Dental Boards  
**Radack, Stephen T., III**, Pennsylvania, 2011, American Dental Association  
**Shampaine, Guy**, Maryland, 2013, American Association of Dental Boards  
**Shannon, Kelley**, Maryland, 2014, Public Member  
**Sill, J. Stephen**, Nevada, 2012, American Association of Dental Boards  
**Trager, Peter S.**, Georgia, 2013, American Dental Association  
**Trinca, Samuel A.**, Louisiana, 2012, American Association of Dental Boards  
**Neumann, Laura M.**, interim 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 6, 2011. Dr. A.J. Smith, First Vice President, served as the Board of Trustees' liaison to the Joint Commission. 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 5, 2011. The fourth standing committee of the Joint Commission, the Committee on Research and Development, met on February 18, 2011.

**Summary of the 2011 National Dental Examiners' Advisory Forum:** The Joint Commission hosted the National Dental Examiners' Advisory Forum on Monday, April 4, 2011. 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, an update on the proposed integrated written National Board Dental Examination, a report on examination trends, and updates on test administration and JCNDE policy changes. Attendees also had an opportunity to view a new JCNDE video on prevention of cheating.

**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 involved in the second year of a five-year project to develop and administer a single comprehensive examination, which would ultimately supplant the present two-part examination program. The JCNDE has developed a communications plan to inform state boards, candidates, educational programs and other stakeholders of the status of the project and will provide opportunities for feedback and comment.

### Trends in the Number of Examination Candidates and Pass Rates:

**Part I:** Table 1 presents the numbers and failure rates by candidate status over the 10-year period beginning in 2001 for Part I National Board Dental Examination. As shown, the number of first-time candidates from accredited programs taking Part I was relatively stable from 2001 to 2005. From 2006 to 2007, the number fell from a 10-year high of 5,094 to a 10-year low of 4,179. (Please note, effective 2007, Part I became a comprehensive examination and was no longer administered in four sections based on subject matter.) From 2008 to 2010, the number increased annually from 4,697 to 4,923. The total number of candidates from non-accredited programs taking Part I decreased from 5,237 in 2001 to 2,316 in 2010.

The total number of first-time candidates and repeaters from accredited and non-accredited programs fell from 10,125 in 2001 to 7,701 in 2010. This shows an overall decrease of 2,424 candidates taking Part I, or 23.94%. Please note, effective 2010, candidates who have passed Part I may not retake the examination unless required by a state board or relevant regulatory agency.

The failure rate for Part I increased slightly during the early years, and then tended to be lower in recent years, with the lowest rate shown for 2007, i.e., 3.5%. The failure rates for candidates from non-accredited programs were relatively higher.

**Table 1.\* Numbers and Failure Rates for First-Time and Repeating Candidates  
Part I**

Accredited					Non-Accredited				Total	
Year	First-Time		Repeating		First-Time		Repeating		First-Time and Repeating	
	Number	% Failing	Number	% Failing	Number	% Failing	Number	% Failing	Number	% Failing
2001	4,296	8.2	592	32.4	2,730	57.8	2,507	71.4	10,125	38.6
2002	4,423	10.5	667	36.3	2,618	58.3	2,833	73.0	10,541	40.8
2003	4,679	9.7	751	33.7	1,812	59.2	2,349	73.3	9,591	36.5
2004	4,598	10.0	545	29.7	1,109	51.0	1,470	61.2	7,722	27.0
2005	4,685	13.4	771	27.6	1,156	42.4	1,366	52.0	7,978	25.6
2006	5,094	7.8	831	21.9	1,408	39.4	1,417	37.6	8,750	20.1
2007	4,179	3.5	240	28.3	1,240	32.5	820	45.1	6,479	15.3
2008	4,697	7.4	418	31.8	1,652	39.5	1,227	42.9	7,994	20.8
2009	4,881	5.3	615	22.3	1,684	38.5	1,635	35.3	8,815	18.4
2010	4,923	5.3	462	29.4	1,218	38.6	1,098	44.3	7,701	17.5

*\*From 2001 to 2006, the failure rates included any candidate who failed all of Part I or any area in Part I. Effective 2007, Part I became comprehensive, the failure rate was computed based upon candidates who failed the entire Part I examination.*

**Part II:** Table 2 presents the numbers and failure rates by candidate status over the 10-year period beginning in 2001 for Part II National Board Dental Examination. As shown, the number of first-time candidates from accredited programs taking Part II has been stable at just under 5,000. The greatest number was reached in 2010, i.e., 4,945. The total number of candidates from non-accredited programs taking Part II decreased from 2,063 in 2001 to 1,092 in 2010. Comparing 2001 with 2010 shows an

overall increase of 369 first-time candidates and repeaters from accredited and non-accredited programs taking Part II, or 5.4%.

Concerning Part II failure rates, the Joint Commission recognized that the performance of candidates showed an increase in the failure rate from 2008 to 2009. The Joint Commission reviewed the processes and protocols associated with the development of the versions of Part II, standard-setting activities conducted in 2008, and scoring. Based on its investigation of the validity evidence relating to Part II, including the standard setting process, the Joint Commission found that the standard-setting and scoring processes were appropriate. This included consideration of additional information, such as research on the reliability and accuracy of scoring, trend data on the performance of U.S. and Canadian students on the Canadian National Dental Examinations and research on the application of the 2009 standard to the 2008 examination results.

As part of the overall validation process, staff continued to conduct analyses in 2010, including audits, quality control, and monitoring candidate performance on a weekly basis. It is noted that the failure rate for Part II decreased from 13.7% in 2009 to 10.6% in 2010 for first-time candidates from accredited programs.

**Table 2. Numbers and Failure Rates for First-Time and Repeating Candidates  
Part II**

Accredited					Non-Accredited				Total	
Year	First-Time		Repeating		First-Time		Repeating		First-Time and Repeating	
	Number	% Failing	Number	% Failing	Number	% Failing	Number	% Failing	Number	% Failing
2001	4,226	7.0	533	36.6	1,356	26.7	707	58.7	6,822	18.6
2002	4,226	7.2	591	31.0	1,649	33.8	798	54.9	7,264	20.4
2003	4,124	8.0	542	32.1	1,255	33.3	860	58.5	6,781	21.0
2004	4,200	7.3	593	29.5	810	33.2	475	62.7	6,078	17.3
2005	4,042	4.7	487	25.9	641	27.9	380	56.3	5,576	12.9
2006	3,775	6.0	417	32.6	564	30.9	286	55.9	5,041	13.8
2007	4,464	6.4	405	26.2	755	26.9	337	55.2	5,961	13.1
2008	4,721	5.3	438	30.8	760	23.4	318	58.2	6,237	12.0
2009	4,726	13.7	584	47.6	631	43.4	334	73.4	6,275	23.0
2010	4,945	10.6	1,154	20.1	701	38.9	391	54.0	7,191	17.2

**Dental Hygiene:** Table 3 presents the numbers and failure rates by candidate status over the 10-year period beginning in 2001 for the National Board Dental Hygiene Examination. As shown, the number of first-time candidates from accredited programs taking the examination increased from 5,810 in 2001 to 6,828 in 2010. The total number of candidates from non-accredited programs taking the examination was relatively small compared to the total number of candidates from accredited programs. Comparing 2001 with 2010 shows an overall increase of 485 first-time candidates and repeaters from accredited and non-accredited programs taking the National Board Dental Hygiene examination, or 6.88%.

In general, the failure rates were stable while the lower failure rates were shown for 2009 and 2010. The failure rates for candidates from non-accredited programs were relatively higher.

**Table 3. Numbers and Failure Rates for First-Time and Repeating Candidates  
Dental Hygiene**

Accredited					Non-Accredited				Total	
Year	First-Time		Repeating		First-Time		Repeating		First-Time and Repeating	
	Number	% Failing	Number	% Failing	Number	% Failing	Number	% Failing	Number	% Failing
2001	5,810	5.8	732	49.5	322	56.2	182	63.2	7,046	14.1
2002	5,821	6.5	830	56.1	358	65.1	269	78.1	7,278	17.7
2003	5,890	5.0	735	62.6	349	67.3	292	77.4	7,266	16.7
2004	6,065	5.0	803	61.6	263	66.2	284	70.8	7,415	15.8
2005	6,136	5.6	805	57.3	237	63.3	312	77.6	7,490	16.0
2006	6,395	6.4	818	54.8	260	63.5	314	70.4	7,787	16.0
2007	6,680	4.0	569	49.2	252	50.4	239	76.2	7,740	11.0
2008	6,770	5.0	637	57.1	222	57.2	230	78.3	7,859	12.8
2009	6,708	4.2	351	55.0	170	31.8	115	72.2	7,344	8.3
2010	6,828	3.8	421	47.5	212	23.1	70	65.7	7,531	7.4

**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 26 dental hygiene test constructors to another one-year term and selected 20 new dental and two new dental hygiene test constructors.

**Research and Development Activities:** The Joint Commission plans to conduct a practice analysis as part of the validation of the NBDE Part II examination. The process recommended by the Committee on Research and Development includes: (1) adoption of the concept and content of revised, consolidated clinical competencies which define the domain of entry-level dental practice; (2) a description of the survey instrument with defined rating scales; (3) the methodology which includes the procedure for online delivery of the survey, survey design and sample selection; and (4) other phases in the validation process, including data collection and analysis and convening an ad hoc review Committee to link the practice analysis outcomes with Part II content elements.

At its April 2011 meeting, the Joint Commission reviewed and approved a list of 65 revised, consolidated competencies of the New General Dentist that define the domain of dentistry, as well as the proposed survey instrument and methodology, including the procedure of delivery of the online survey and the design and description of selecting the sample. The survey will be conducted during the second and third quarter of 2011, and results and recommendations from the study will be presented to the Joint Commission at its 2012 meeting. The results will also be used by the JCNDE's Committee on an Integrated Examination to support the development of the new, integrated National Board Dental Examination.

**Standard-Setting for the National Board Dental Hygiene Examination:** In September 2010, the Joint Commission conducted a standard-setting exercise for the National Board Dental Hygiene Examination. A panel of 11 members, including dental and dental hygiene practitioners and educators representing all

major geographic regions of the U.S. participated in the activity. The standard-setting activities were conducted using a widely accepted criterion-referenced approach, the Objective Standard Setting Method, to set the standard on the March 2009 edition of the NBDHE. Results from outcome assessment of the standard-setting activities and research on the application of the new standard to the previous examination results provide validity evidence relating to the new standard for the National Board Dental Hygiene Examination.

**Implementation of New Score Reporting Policy:** In 2010, the Joint Commission determined that it would report examination results in a pass/fail format and that numerical scores would no longer be reported beginning January 1, 2012. To accommodate the new score reporting policy, the Joint Commission adopted revised language for the new score report formats for the National Board Dental and Dental Hygiene Examinations as follows:

*Candidate has achieved a standard score of 75 or higher on the [name of test] and has therefore successfully completed requirements for the National Board Certificate.*

*Candidate has achieved a standard score below 75 on the [name of test] and is required to repeat the examination.*

Additional language will be incorporated as appropriate for the intended recipient, e.g., candidate, state board, or educational program.

The Joint Commission also approved the following language to be suggested to state boards that may need to update their statutes as a result of this change:

*Prior to issuance of a license, a dental or dental hygiene applicant shall successfully complete the National Board Dental Examinations or the National Board Dental Hygiene Examination by achieving a standard score of 75 or higher, where 75 is designated as the minimum passing standard score by the Joint Commission on National Dental Examinations.*

**Revisions to National Board Examination Regulations:** At its April 2011 meeting, the Joint Commission adopted several revisions to the Examination Regulations for the NBDE Parts I and II and the NBDHE. Two changes impact candidate eligibility to test. First, beginning January 2012, candidates for the NBDE Part I, Part II, and NBDHE will be limited to successful completion of an examination within five years of testing or five examination attempts, whichever comes first. A second change in eligibility requirements relates to the amount of time a candidate is eligible to test following submission and approval of an application. Effective January 2012, candidates will be eligible to test for six months, rather than 12 months, from the date on their eligibility letter. The original 12-month eligibility period was set in relation to print-format examinations administered two or three times per year. The Joint Commission determined that such a long eligibility period is no longer necessary with the availability of computer-based testing on a continuous basis almost every day of the year.

The Joint Commission adopted a new policy directing that a complete history of scores shall be transmitted to state boards of dentistry or other entities requested to receive scores. Previously, only the most recent score was reported and the Joint Commission determined that state boards should have more information regarding candidate history and performance. This policy becomes effective January 1, 2012.

The Joint Commission also added a statement to the Examination Regulations to codify the policy prohibiting candidates from taking the test to practice. Candidates who test for the purpose of obtaining an advanced look at examination content will have their scores reported and will be required to wait one year to retest. Additional revisions clarify potential JCNDHE actions that may be taken as a result of a rule or regulation violation.

Effective January 2012, the following new policy will be implemented: If it is determined that a candidate engaged in irregular behavior, information regarding this determination becomes a part of the

candidate's National Board record. In its sole discretion, the JCNDE may elect to send a summary report documenting the incident, with a brief statement provided by the candidate immediately following the decision by the JCNDE to report, to legitimately interested parties, including all persons or agencies to which the candidate has instructed that scores be sent, both presently and in the future.

The Joint Commission will disseminate information regarding these policy additions and revisions to all stakeholder groups. The information will be posted on the JCNDE website and included in the 2012 candidate Guides.

**Chair and Vice Chair for 2011-2012:** The Joint Commission elected Dr. Peter Trager as the Joint Commission's chair and Dr. J. Stephen Sill as vice chair for the 2011-2012 term.

**Acknowledgments:** The Joint Commission acknowledges with appreciation the contributions made by Dr. Andrew Spielman, Dr. George D. Conard, Jr., Dr. Stephen T. Radack, III, and Mr. Richard Carlile who complete their terms on the Joint Commission this year. The Joint Commission also acknowledges the support of its Board of Trustees liaison, Dr. A.J. Smith.

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

## Council on Scientific Affairs

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**Hellstein, John W.**, Iowa, 2012, chair  
**Wright, J. Timothy**, North Carolina, 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  
**Harrel, Stephen K.**, Texas, 2013  
**Michalowicz, Bryan S.**, Minnesota, 2014  
**Noraian, Kirk W.**, Illinois, 2014  
**Novy, Brian B.**, California, 2014  
**Salierno, Christopher J.**, New York, *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  
**Truelove, Edmond L.**, Washington, 2014  
**Whitaker, Steven B.**, Arkansas, 2013  
**Zentz, Ronald R.**, senior director

**The Strategic Plan of the American Dental Association:** The Council's programs are closely aligned to the ADA Strategic Plan: 2011-14, and support member dentists through the advancement of dental science and the development of evidence-based oral health resources. These programs are central to the Council's mission to serve "the public, the dental profession and other health professions as the primary source of timely, relevant and emerging information on the science of dentistry and promotion of oral health." To fulfill this mission, the Council serves to facilitate communication between ADA members, the dental science community and ADA leadership. In this role, the Council on Scientific Affairs (CSA) has established strong collaborations across the dental and medical community through liaison relationships with government agencies, academia, research groups, health care associations, practice-based research networks, military dental research groups, industry and others.

The Council is committed to fulfilling the Strategic Plan's goals of serving as "the trusted resource for oral health information," and providing "support to dentists so they may succeed and excel throughout their careers." Also in support of the Strategic Plan, the Council strives to "ensure that the ADA is a financially stable organization" by operating in a fiscally responsible manner when prioritizing scientific programs and developing budgetary proposals to address the evolving needs of the profession.

Each year, the Council holds strategic planning sessions to set measurable goals focused on providing continued leadership and member value in a range of programs, including: evidence-based dentistry (EBD); the ADA Seal of Acceptance Program; the *ADA Professional Product Review*; the development of Council reports, statements and guidelines, and evidence-based clinical recommendations; and science policy recommendations for the ADA House of Delegates. The Council facilitates the development and distribution of dental science resources, collaboratively addresses key scientific issues with other organizations, and promotes evidence-based dental practice, education and research. Along with CSA's continuous monitoring of emerging issues in dentistry, the Council also commonly responds to scientific questions from dentists and organizations, pursuant to its *Bylaws* duty to "serve as the primary resource for scientific inquiries from the public and the profession."

The 2010 House of Delegates supported the Council's recommended changes to the CSA *Bylaws* duties. The updates were proposed to ensure that CSA's duties remain current and appropriately reflect

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



the profession's needs related to dental science and research. As a result, the Council is integrating the following updated *Bylaws* duties in 2011:

- *Updating the ADA Research Agenda Biennially Rather Than Annually.* This *Bylaws* amendment aims to provide a more consistent focus for the Research Agenda and assist with ADA advocacy for increased research and funding support for priority dental research goals. Since even short-term research programs take time to conduct, revising the Research Agenda biennially is appropriate and a more efficient use of limited resources. This updated *Bylaws* duty also addresses financial considerations by directing CSA to “propose an appropriate budget for studies that are recommended by the Council to be conducted by the ADA.” The Council also plans to consider several strategic issues related to the Research Agenda in 2011 in an effort to increase and measure the Agenda's impact.
- *Guiding and Assisting the ADA Center for EBD.* Building on CSA's history of service as lead agency for initiatives in evidence-based dentistry (EBD), the Council is directed by the updated *Bylaws* duties to “guide, assist and collaborate with the ADA Center for Evidence-Based Dentistry.” The 2011 House of Delegates will be asked to consider and approve a recommendation to transfer oversight of the ADA's EBD initiatives to a standing subcommittee of CSA with representation from other ADA agencies. Pending approval by the 2011 House of Delegates, this CSA subcommittee would collaborate with the EBD Center and other ADA agencies to support the advancement of evidence-based dental practice and provide input on other appropriate science and research topics (e.g., ADA Research Agenda).
- *Standards Development Focusing on Dental Products.* The Council's role in dental standards development was updated to focus primarily on dental products, and dental informatics standards that were designated to fall under the purview of the Council on Dental Practice (CDP). The Council's expertise has historically focused on national and international standardization programs for dental products. There will continue to be “gray areas” with overlapping responsibilities for both councils, but CSA will work closely with CDP and others to ensure that ADA member needs are addressed.

These revised *Bylaws* duties underscore the Council's commitment to evidence-based practice, the dental research agenda, strong collaborations with internal and external groups, and the coordination of standards programs. This year, the Council has started to actively integrate recommendations from mega-issue/strategic discussions and the 2010 CSA self-assessment. These recommendations include:

- Considering ways to identify and expand funding for ADA Research Agenda goals;
- Improving on the Council's work as an information clearinghouse through: more frequent review and updates of Council statements and reports; encouraging and supporting other agencies' goals on EBD; and supporting revitalization of the ADA Seal of Acceptance Program;
- Considering strategies to strengthen CSA collaborations with dental education-focused agencies (current collaborations include work on EBD programs, the *ADA Professional Product Review*, and research careers, among others); and
- Develop online continuing education courses in collaboration with the EBD Center and the ADA Center for Lifelong Learning.

The Council recognizes that although its scope and responsibilities are broad, it is critical to align and continually reassess CSA activities in light of the Association's strategic and operational plans. Financial discipline is required with all ADA operations, programs and activities, and the Council would like to assure the House that it will remain vigilant in this area to prioritize activities and weigh the allocation of ADA funds, staff time and other resources carefully.

**Response to Assignments From 2010 House of Delegates:** In 2011, the Council addressed the following resolutions from the 2010 House of Delegates:

*Evidence-Based Guidelines on Antibiotic Prophylaxis for Dental Patients With Total Joint Replacements (Resolution 27H-2010).* Resolution 27H-2010 recommended that the ADA and the American Academy of Orthopaedic Surgeons (AAOS) “continue to update the guidelines on evidence-

based use of antibiotic prophylaxis for dental patients with total joint replacements.” Further, Resolution 27H-2010 requested that the ADA “endeavor to appoint at least one [American Association of Oral and Maxillofacial Surgeons] AAOMS representative within its ADA appointees,” and “ensure that the workgroup’s discussion includes the consideration of the importance of a pre-joint replacement dental evaluation.” These directives have been fulfilled and are detailed below.

The ADA/AAOS workgroup tasked with developing evidence-based guidelines on antibiotic prophylaxis prior to dental procedures for patients with orthopedic implants met in Rosemont, IL, on November 19-20, 2010. Eight ADA member dentists were appointed to the workgroup, representing four ADA councils (Council on Scientific Affairs, Council on Dental Education and Licensure, Council on Dental Practice, Council on Dental Benefit Programs) and AAOMS. The other 13 workgroup members included orthopedic surgeons, pathologists, and infectious disease specialists. At the introductory meeting, the workgroup identified key questions relevant to developing the guidelines. Questions about how optimal oral health would affect patients with orthopedic implants have also been included. After a search strategy was developed based on the key questions, 2,972 studies were identified and 1,099 were recalled. ADA and AAOS staff are in the process of analyzing these studies.

The next workgroup meeting is scheduled for October 15-16, 2011, in Rosemont, IL. At the October 2011 meeting, the group is expected to finalize a preliminary draft of the guidelines document. The document would then be circulated for internal review, and followed by external peer review. Pending completion of the internal and external review process for the draft guidelines, the Council anticipates considering the proposed guidance document for review and approval in spring 2012.

*Health Screening Program Funding (Resolution 71H-2010).* In accordance with Resolution 71H-2010, which provided funding support for the 2011 Health Screening Program (HSP), the Council plans to offer a full range of proposed screening tests at the 2011 HSP in Las Vegas. Collaborations have been arranged with external researchers to offer the following: point-of-service, rapid fingerstick blood and salivary diagnostic tests; head/neck examinations; type 2 diabetes screening; and carpal tunnel syndrome evaluations. Collaboration with the Council on Dental Practice’s Dentist Well-Being Advisory Committee is also underway for 2011. The 2011 HSP will serve as a useful forum for CDP’s research and continuing education activities related to dentist well-being, including range-of-motion and other ergonomic evaluations.

The Council’s HSP subcommittee will work with staff and stakeholder organizations to refine the HSP’s research initiatives for the 2011 annual session and beyond. The Council discussed ways to expand and enhance HSP research collaborations, including prospective studies and health assessments of HSP’s occupational cohort of dental practitioners. A final proposal will be evaluated by the Council in July 2011.

*Medication-Induced Xerostomia (Resolution 101H-2010 and Resolution 45-2009).* The Council reported to the 2010 House of Delegates on CSA’s activities related to a referred resolution, 45-2009, which proposed that ADA encourage the Food and Drug Administration (FDA) to require warning labels for medications that cause dry mouth and a resultant increased risk of tooth decay. The Council considered ways to address member dentists’ concerns about drug-induced dry mouth within the FDA’s regulatory framework and with existing ADA resources as reported in 2010. One activity initiated by CSA was to collaborate with the FDA Office of Public Information to develop content for the FDA public website on drug-induced dry mouth. Although delayed due to resource issues, on May 9, 2011, the FDA posted a new Consumer Update entitled “Dry Mouth? Don’t Delay Treatment” on the FDA’s Consumer Health Information page ([www.fda.gov/consumer](http://www.fda.gov/consumer)). This Consumer Update is freely accessible to the public, and can be distributed by dental professionals to patients as needed.

Also in 2010, the House of Delegates adopted Resolution 101H-2010 which directed ADA to encourage the FDA to require warning labels for medications that cause dry mouth and an elevated risk of dental caries or other potential complications that should be discussed with a dentist.

As lead reporting agency for Resolution 101H-2010, CSA prepared a draft letter that encourages the FDA to require medications that are commonly associated with moderate-to-severe dry mouth

(xerostomia) to carry warning-label information advising consumers of the oral complications associated with reduced salivary flow. The final letter was developed with input from the ADA Washington Office, the Council on Government Affairs and the ADA Division of Legal Affairs. In April 2011, the approved letter was sent to FDA under the signatures of the ADA president and executive director. *ADA News* prepared an announcement regarding the letter (<http://www.ada.org/news/5750.aspx>), which is available on the Advocacy page on ADA.org: [http://dev.ada.org/sections/newsAndEvents/pdfs/ltr\\_dry\\_mouth\\_110427.pdf](http://dev.ada.org/sections/newsAndEvents/pdfs/ltr_dry_mouth_110427.pdf). Any further actions taken by FDA on this matter will be communicated to members through appropriate ADA media.

In addition, a Council collaboration with the *Pharmacist's Letter* resulted in publication of a professional update on drug-induced dry mouth in the October 2010 issues of both *Pharmacist's Letter* and *Prescriber's Letter*. Although the complete content is available only to subscribers of these publications (primarily pharmacists and physicians), an overview of this information is available on the *Prescriber's Letter* website ([prescribersletter.therapeuticresearch.com](http://prescribersletter.therapeuticresearch.com)).

This year, the Council also worked with the ADA Division of Communications to develop an ADA press release on medication-induced xerostomia for national news outlets. These ADA agencies requested the support of the following organizations to increase the reach and impact of the information: the American Pharmacists Association, the American Geriatrics Society, the Academy of General Dentistry and the American Academy of Periodontology. The press release is undergoing review by the collaborating organizations, and it will be disseminated online via several distribution channels in summer 2011.

*Regular Comprehensive Policy Review (Resolution 111H-2010)*. The Council and staff are collaborating with the Board and other ADA agencies to implement the 2010 House of Delegates adopted Resolution 111H-2010, which directs that ADA policies be reviewed every three years. The Council will be ready to implement this directive according to the Board of Trustees' timetable.

## Evidence-Based Dentistry

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**ADA Center for Evidence-Based Dentistry:** The ADA Center for Evidence-Based Dentistry ("EBD Center") was established in 2007, and serves to assist practitioners and improve the oral health of the public by collaborating with other interested parties to:

- Enhance the evidence base and its integration in clinical practice;
- Appraise and disseminate the best available scientific evidence on oral health care; and
- Help practitioners understand and apply the best available evidence in their clinical decision-making.

The ADA's *Bylaws* direct the Council to "guide, assist and collaborate with the EBD Center." Primary activities of the EBD Center in 2011 are highlighted in the sections below.

*EBD Website.* Funded by a grant to the ADA Foundation from the National Institute of Dental and Craniofacial Research to develop an EBD website (grant number G08 LM008956), the Center's EBD website was launched on March 10, 2009. In the original grant proposal, the ADA committed to maintain this website after the grant expired, which occurred on March 31, 2011.

Through a collaborative effort of volunteers, the EBD Center, the Information Technology department and the ADA Library, the EBD website is thriving and serving the needs of the profession and the public. The EBD website has exceeded expectations for its first two years of operation, based on number of visitors and other website metrics. The website contains a database of over 1,600 systematic reviews, 109 critical summaries of systematic reviews prepared by ADA-trained evidence reviewers, and links to many external sources of information that enable a clinician to more easily access and incorporate evidence into the decision-making process.

The EBD website has also been expanded to include a patient-focused section with plain-language summaries of the systematic reviews. Additionally, a mobile version of the EBD website, <http://mobile.ebd.ada.org>, is now available that is designed to be accessible from a variety of smartphones. The Council on Communications was involved in quantitative analysis of the plain-language summaries via surveys conducted at the council members' dental practices. The EBD Center also developed a future vision for the website, which includes the use of online tools that allow for self-directed search, appraisal and analysis of data.

*Fourth EBD Champions Conference.* Launched in 2008, the EBD Champions Conference has been a highly successful program that recruits and trains practitioners to be local professional community leaders on EBD implementation. Previously funded by a grant from Procter & Gamble, the 2011 conference is now funded by the ADA, and will be held on July 28-30, 2011. The conference agenda focuses on implementing EBD in practice, utilizing EBD resources developed by the ADA, and disseminating evidence-based information to dental care providers and patients.

For the 2012 EBD Champions Conference, the ADA Center for EBD was awarded a grant for \$50,000 from the Agency for Healthcare Research and Quality. The grant will provide partial funding for the conference, with other costs already planned in the 2012 Center budget. A requirement of this grant is that the 2012 conference must be open to non-members and allied dental professionals.

*ADA/Forsyth EBD Course.* The ADA Center for EBD and the Forsyth Institute have collaborated to offer two successful weeklong EBD courses in Cambridge, Massachusetts. The courses were taught by faculty from the ADA, the Forsyth Institute, and the Oxford Centre for Evidence-Based Dentistry. The 2010 course drew 30 participants, who were educated on critical appraisal of systematic reviews and clinical studies, online citation management and more.

The 2011 ADA/Forsyth EBD course will be held on September 19-23 at the Forsyth Institute in Cambridge, MA. This innovative course is open to health care professionals worldwide, with ADA members receiving a 20% discount. Course tuition covers 100% of the ADA's and Forsyth's direct expenses and part of the indirect expenses. A small-conference grant application has been submitted to AHRQ, which, if awarded, would enable ADA and Forsyth to reduce the cost of course tuition, making it more affordable and attractive to dentists.

*EBD Courses at the 2010 ADA Annual Session.* Three EBD courses sponsored by an educational grant from Procter & Gamble were held at the 2010 annual session. Two of the courses were identical computer workshops titled "Practical Ways to Search for Evidence," which provided instruction on conducting online literature searches using PubMed, the EBD website and the Cochrane Library. The third EBD course, titled "The Role of Evidence in Dental Practice," was taught by Dr. Janet Clarkson, University of Dundee and Cochrane Oral Health. Unfortunately, all three courses were significantly undersubscribed and will not be offered in 2011.

*ADA Evidence Reviewer Program.* This program was launched a few years ago to recruit and train dentists to write critical summaries of systematic reviews for the EBD website. Participation in this program includes attendance at a two-day training workshop. Three workshops were held in 2010 at the following locations: Temple University (January), New York University (March) and ADA Headquarters (August). The workshops held at the dental schools were funded by an Administrative Supplement grant available through the American Recovery & Reinvestment Act. Two additional workshops are planned for 2011: Boston University (June) and University of Kentucky (October).

*Evidence-Based Clinical Recommendations.* Three sets of evidence-based clinical recommendations were recently published in *The Journal of the American Dental Association (JADA)* (issue listed parenthetically): oral cancer (May 2010), fluoride supplements (December 2010) and fluoride and infant formula (January 2011). Multiple communication strategies were used to disseminate the recommendations, including ADA News articles, electronic newsletters and posting on ADA.org and the EBD website (<http://ebd.ada.org>). Chairside guides for all of the clinical recommendations have been developed and are available on the EBD website.

Clinical recommendations that are currently under development will address: antibiotic prophylaxis for dental patients with total joint replacement (in cooperation with the American Association of Orthopaedic Surgeons); non-fluoride caries-preventive agents (in cooperation with the Centers for Disease Control and Prevention); a revision of the topical fluoride clinical recommendations that were last published in 2006; and periodontal disease. It is anticipated that the non-fluoride caries-preventive agent recommendations will be completed in 2011 and submitted to *JADA* for publication consideration.

Over the past few years, the Council developed an ADA Clinical Recommendations Handbook that describes the objective, transparent processes that are followed in the course of developing evidence-based clinical recommendations for the profession. The Council also developed a handbook entitled "Criteria for Disseminating Evidence-Based Guidelines Developed by External Agencies." This handbook describes criteria to assess whether recommendations developed by other agencies follow the key principles of EBD. Both handbooks were approved by the Council at its March 2011 meeting and are posted on the EBD website.

*Cochrane Library Subscription.* In 2010, the ADA Library secured a subscription to the Cochrane Library for all ADA members, as proposed by the House of Delegates per Resolution 46H-2008. The license allowed for one year of access to the Cochrane Library for all ADA members at a cost of \$33,000. Over the first year of the subscription, there were 1,152 online sessions, approximately 300 of which were ADA staff. The ADA's current subscription to the Cochrane Library was renegotiated at a discounted rate of \$16,500, and it is effective through January 31, 2012.

*EBD Advisory Committee Recommendation to Reassign Committee Duties to CSA.* At its February 2011 meeting, the ADA Advisory Committee on Evidence-Based Dentistry adopted a resolution recommending that the committee's role be reassigned to CSA to facilitate active communication between the Council and other ADA agencies on EBD and related scientific or research topics. The Council supported this recommendation from the EBD Advisory Committee. Pending approval by the 2011 House of Delegates, the Council would plan to expand the scope of a new standing subcommittee beyond EBD to include interagency input on other appropriate science and research topics, such as the ADA Research Agenda and emerging issues.

## Scientific Information and Research

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**Dental Management of Patients Receiving Oral Bisphosphonate Therapy:** At its March 2011 meeting, the Council approved an updated report entitled "Antiresorptive Agent-Induced Osteonecrosis of the Jaw: Oral Health Management of Patients on Medications for the Prevention and Treatment of Osteoporosis." The report notes that there are new antiresorptive agents (not bisphosphonates) approved by the FDA for the treatment of osteoporosis that are also associated with osteonecrosis of the jaw (ONJ). Therefore, the CSA report title was revised to focus on antiresorptive agent-induced ONJ, which is intended to encompass oral bisphosphonate-associated/induced ONJ cases, as well as cases associated with the use of other antiresorptive therapies. The report will be submitted to *JADA* for publication consideration, together with a "For the Dental Patient" page on the topic.

**Open Clinical and Science Forums at Annual Session:** In partnership with the Council on ADA Sessions and *The Journal of the American Dental Association* (*JADA*), the Council presented three Open Clinical and Science Forums at the 2010 ADA annual session on fluoride, oral cancer, and cone beam computed tomography (CBCT). Each forum brought together clinicians, scientists, industry representatives and opinion leaders to consider controversial and emerging issues related to key clinical topics. The forums drew over 2,000 attendees, and the discussions were moderated by Dr. Michael Glick, *JADA* editor, and Dr. Daniel Meyer, senior vice president, Science/Professional Affairs. This successful program will continue at the 2011 annual session in Las Vegas.

**CSA Reports and Statements:** As a scientific content provider for *JADA*, ADA.org and other ADA media, the Council develops articles for the profession, position statements, critical (evidence-based) summaries

of systematic reviews, and other resources. In this role, the Council serves as an information clearinghouse to support the profession's needs and the public interest.

The Council collaborated this year with the EBD Center to complete evidence-based clinical recommendations on three key clinical topics: oral cancer, dietary fluoride supplements for caries prevention, and fluoride intake from infant formula. The Council also prepared the following reports and statements for the profession, which are available at ADA.org and other media outlets:

- *Tooth Whitening.* In response to a 2008 House of Delegates resolution, the Council developed a report entitled, "*Tooth Whitening/Bleaching: Treatment Considerations for Dentists and Their Patients*," which was disseminated to constituent societies in September 2009 and posted on ADA.org. The Council recently updated the tooth whitening report to consider new literature and other information, and the report was disseminated to constituent societies in April 2011. A link to the document can be found under the "Tooth Whitening" section of the ADA Positions, Policies & Statements page on ADA.org. The revisions do not affect the substance and overall findings of the original 2009 report. The revised report was also submitted to the Food and Drug Administration (FDA) since the original report was included as part of the ADA's petition to request that FDA establish an appropriate regulatory classification for tooth whitening/bleaching preparations that act by chemical means to lighten tooth color.
- *Literature Review—Dental Amalgam Fillings and Health Effects:* The Council approved an updated literature review addressing dental amalgam restorative materials and health effects in September 2010, and posted it on ADA.org.
- *Updated Council Statement on Bisphenol A and Dental Materials.* The Council approved an update to CSA's Statement on Bisphenol A (BPA) and Dental Materials, which was posted online at: <http://www.ada.org/1766.aspx>. The Council's revised statement incorporates information from the U.S. Food and Drug Administration on BPA that was posted online in 2010.

To enhance Council communications and interprofessional relations, Dr. John Hellstein, Council chair, authored an editorial on current CSA activities and programs, which was featured in the January 2011 *Dimensions of Dental Hygiene*. The editorial was developed to promote CSA's resources and programs to dental hygienists, especially information about the ADA Seal of Acceptance Program's evaluations of over-the-counter dental products for safety and effectiveness.

Council staff have also continued to help dentists answer patients' questions on dental science issues by developing "Science in the News" articles for ADA.org ([www.ada.org/goto/sciencenews](http://www.ada.org/goto/sciencenews)). In recent months, "Science in the News" provided coverage and analysis on:

- The U.S. Department of Health and Human Services' January 2011 proposal to update its recommendation for optimal fluoride level in community drinking water for caries prevention; and
- An evaluation in the journal *Pediatrics* on exposure to bisphenol A from dental sealants and composites.

Member dentists are encouraged to e-mail feedback on the Council's online information to [science@ada.org](mailto:science@ada.org)

**ADA Guide to Dental Therapeutics:** The Council is proceeding with scientific oversight and collaboration on development of the sixth (2012) edition of the *ADA Guide to Dental Therapeutics*. Negotiations to identify and contract with a business partner are in process, and a CSA-established editorial panel has advised the editor on ways to improve the readability of the book while decreasing its overall size. The Council also advised on authors for the sixth edition, and ways in which appropriate ADA and Council statements, evidence-based clinical recommendations and other dental therapeutic resources can be integrated into the publication. The editor reports on progress twice a year to the Council, with the next update due in July 2011.

**2010-2011 ADA Research Agenda:** The Council is charged with responsibility for developing a 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 2010-2011 ADA Research Agenda is available online at: <http://www.ada.org/532.aspx> and features a targeted list of four primary goals and corresponding objectives of importance for dentistry.

As described in the Strategic Plan section above, the Research Agenda will now be updated biennially. The two-year cycle is expected to bolster ADA lobbying efforts to provide stronger advocacy for dental research funding on Capitol Hill, while also providing more time to promote funding and research on specific agenda topics before the next update is completed.

As recommended in the CSA's 2010 self-assessment, the Council is pursuing a collaborative process in 2011 to help identify advocacy, promotional and funding opportunities for the Research Agenda. One primary goal is to identify ways in which the impact of the Research Agenda can be measured in order to track and maximize the benefits of this activity for patients and the profession. A report on this work will be presented at the November 2011 Council meeting.

**New Science E-Publication:** In fall 2010, the Council worked in collaboration with the ADA Division of Communications and Marketing to develop a monthly "Science & Technology" electronic publication, which is sent to all ADA members with e-mail addresses. The "e-pub" highlights current news related to dental science information, the ADA Center for Evidence-Based Dentistry, the ADA Seal of Acceptance Program, the *ADA Professional Product Review*, and standards and guidelines.

The first "Science & Technology" e-publication debuted in November 2010, and included a feature on the ADA/AAOS collaboration to develop guidelines for antibiotic prophylaxis for patients with orthopedic implants undergoing dental procedures. As of this reporting, six e-publications have been developed to update ADA members on news of importance to dentistry from the Food and Drug Administration, the Center for Disease Control and Prevention, and the U.S. Environmental Protection Agency, plus a science "question of the month."

**Caries Classification System:** In 2008, the Council hosted a two-day international stakeholder conference to develop consensus on a new caries classification system (CCS). There is growing demand for a classification system that will: facilitate documentation of the caries disease process by stage, activity and location; allow for patient-centered management of caries; encourage treatment of early/reversible lesions; and allow for tracking lesion progression over time. The G.V. Black classification system is a static restoration classification system that does not adequately describe the dynamic caries disease process.

The project is complex and far-reaching in its potential impact on the dental profession. Implementation of a new system of this scope will require extensive coordination and cooperation among numerous internal and external stakeholders, including academia, industry, research and dental practitioners. The Council assessed progress on this project in fall 2010, and approved an updated project plan and targets for 2010-2011. Due to activities underway and soon to be initiated, the Council will provide further details on this project in a supplemental report to the 2011 House of Delegates.

**Information Technology Update:** Resolution B-115-2004 (*Trans.*2004:272) directs ADA councils to summarize programs, projects, or policies related to the impact of information technology (IT) on dental practice. Technological advancements over the past two decades have introduced significant change to the world of clinical practice. Dental lasers, radiographic imaging (including cone beam computed tomography and digital imaging generally), digital impressions and computer-assisted design and manufacturing techniques are notable examples.

In the April 2011 *ADA Professional Product Review*, the editor of the *Review*, Dr. David Sarrett, describes digital impression technologies as "the future of impression-making," providing impressions that can be "transmitted to the dentist's laboratory of choice and used for traditional laboratory fabrication of indirect fixed restorations." Along with digital impressions, modern technologies such as electronic dental charts, cone beam volumetric images, and practice management software are transforming dental

practice operations and enabling improved coordination of image data transfer between dental practices and dental labs.

Further, the Council has been active both in standards development, and in adoption, implementation, and certification efforts for digital technology hardware and software. The Council is working to engage many involved stakeholders, including practicing dentists, vendors and third-party payers, to ensure the functionality, usability, and interoperability of digital dental technologies, particularly in the area of electronic health records and digital radiographic imaging. Through recent meetings on digital imaging, including CBCT, the Council is developing a strategic, collaborative approach to CBCT usage that involves all stakeholders and focuses on education, patient safety, development of clinical guidance and standards.

Lastly, the Council aims to help dentists in the ongoing transition toward improved access to online information. As an example, the Association's EBD website now offers a mobile version (<http://mobile.ebd.ada.org>) that provides smartphone users with access to the site. This expanded access to EBD information was developed to assist dentists with accessing and using evidence-based information on the go, and at the point of care in clinical settings.

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### Review of Association Policies

The Council reviews existing ADA policies and recommends updates or rescissions as appropriate. Pending implementation of the Board of Trustees' timetable and protocol for the new ADA policy review process (per Resolution 111H-2010), the Council conducted sunset review of an ADA policy related to the Seal of Acceptance Program, as addressed in the following section.

**ADA Policy on Use of Approved Materials in New Techniques and Products:** At its March 2011 meeting, the Council reviewed a 1977 ADA policy on the Use of Approved Materials in New Techniques and Products, which reads:

**Resolved**, that the use of American Dental Association approved materials in new techniques and products does not constitute approval of such techniques and/or end products by the Association.

The Council determined that the policy's use of the term "approved" is not current as it relates to the Seal of Acceptance Program, which uses the term "Accepted" or "ADA-Accepted" to identify products that meet the Seal Program's evaluation criteria for safety and effectiveness. The Council also agreed that the phrase "techniques and/or end products" refers to professional dental products and related clinical techniques. Given the discontinuation of the Seal Program for professional materials and products, and implementation of professional product evaluation through the *ADA Professional Product Review*, the Council supported submitting a proposal to the 2011 House of Delegates that recommends rescission of the 1977 ADA policy. The Council also considered updating the 1977 policy rather than proposing it for rescission, but the Council learned that issues of this nature are effectively managed via written communication from the ADA Division of Legal Affairs to the offending individual, business or organization.

In accordance with the ADA Strategic Plan goal to "be the trusted resource for oral health information that will help people be good stewards of their own oral health," the following resolution is presented for the House's consideration:

**13. Resolved**, that the ADA policy statement entitled Use of Approved Materials in New Techniques and Products (*Trans.* 1977:939) be rescinded.



## Product Evaluations and Evaluation Criteria

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**Professional Product Evaluation Program:** The Council develops the *ADA Professional Product Review*™ (*Review*) as a quarterly publication, which is mailed with *JADA* to ADA members and subscribers. The April 2011 *Review* was the twentieth issue published since the program began in 2006. Since then, 53 product categories and topics have been featured in the *Review*, ranging from bonding agents to digital impression systems. The following sections outline recent developments and future plans for the *ADA Professional Product Review*.

**Dental Therapeutics.** In October 2010, the *Review* began publishing a series of dental therapeutics articles that address issues related to medications used in dental practice and related topics of interest to clinicians. The first feature was called “Great Question! Glad You Asked That,” and presented information in a question-and-answer format. The dental therapeutics feature in the January 2011 *Review* addressed questions related to antiplatelet drugs, and the April 2011 issue examined OraVerse for reversal of soft-tissue local anesthesia. Additional topics related to dental therapeutics will be featured in upcoming issues.

**Product Forum.** In recent years, the Council has sponsored a Product Forum in conjunction with the *ADA Professional Product Review*, which is held in the ADA Pavilion at the Association’s annual meeting. For the 2011 Product Forum, plans are underway to provide an educational display and slide presentation on amalgam separators. The Council supported featuring this product category as a timely topic for clinicians who may face local, state, and possibly national requirements to install the equipment. Results from ADA laboratory evaluations and a 2010 web-based member survey on amalgam separators will appear with additional information in a future issue of the *Review*.

In addition, results from the 2010 Product Forum on dental loupes will be presented in the July 2011 *Review*. This Product Forum was held at the 2010 annual session in Orlando, where over 160 dentists participated in the Product Forum’s hands-on demonstration that examined magnification, lenses, working angle and other product characteristics.

**Clinical Evaluations With External Collaborators.** In 2010-2011, the *Review* completed its first research collaboration with two dental schools (University of Maryland and University of the Pacific) on the Cadent iTero digital impression system. This pilot research program with two dental schools obtained clinically relevant data on the Cadent iTero system, and findings from the evaluation were featured in the April 2011 *Review*.

In 2011, the *Review* is conducting additional collaborations with dental schools and research organizations, including evaluations of four digital shade matching systems at Virginia Commonwealth University and University of the Pacific dental schools. With CSA’s support, the *Review* is also collaborating with other research groups, such as the U.S. Department of Veterans Affairs Practice-Based Research Network (VA Dentists Engaged in Research, or VADER), which will evaluate disposable dental handpieces for a future issue of the *Review*. The Council also recommended that the *Review* pursue the following clinical evaluations in 2011:

- Evaluating various clinical techniques for composite resin restorations; and
- Investigating the efficacy of resin-based composite/curing light combinations on resin conversion.

**Newsletter Distribution.** At its March 2011 meeting, the Council recommended having the *Review* continue as a print publication while also exploring the potential for enhancing the print version with online media, such as links to videos and other resources as well as a user-friendly searchable component for product categories and products. The Council will continue to promote maintaining the *Review*’s quality and integrity as a valued print publication and significant ADA member benefit.

**Editor Appointment.** Also in March 2011, the Council supported extending the contract for the *Review*’s current editor, Dr. David Sarrett of Virginia Commonwealth University, for an additional three-year term, effective July 2011.

*ADA Clinical Evaluators Panel.* As of April 2011, over 2,200 member dentists are serving on the ADA Clinical Evaluators (ACE) Panel, a volunteer group of ADA members who contribute clinical feedback for the quarterly *Review*. ACE Panel members suggest professional products they would like to see evaluated, and report their experiences with the professional products they use in clinical practice. There are several ongoing promotional efforts to attract additional participants, including promotions in the new "Science & Technology" e-publication. Individuals seeking additional information can contact the *Review* by e-mail at [pprcinical@ada.org](mailto:pprcinical@ada.org).

**ADA Seal of Acceptance Program for Over-the-Counter Products:** The Council is firmly committed to, and continues to work towards, revitalizing the ADA Seal of Acceptance Program. The program remains a vital information link between ADA, dental professionals and the public. The awareness and impact of the Seal make it one of ADA's key programs to meet its strategic goal to help the public "be good stewards of their own oral health."

Awareness and impact of the Seal Program is supported by the results of three recent consumer, dental professional and industry surveys. The surveys showed that the Seal Program remains widely recognized and trusted by these audiences, and that it provides a valuable service to the general public. These surveys also showed that information provided by the dental professional is the most credible channel for conveying oral health information to consumers. Eighty-nine percent of consumers surveyed were likely to purchase a product recommended by their dentist or hygienist.

By leveraging existing resources in tight financial times, the Council and staff worked in collaboration with other ADA agencies in 2011 to pursue a number of revitalization activities at little or no cost to the ADA, including the following promotional activities. These activities are a good start to the plans described below as part of a 2012 budget decision package.

*Detailed Information on Accepted Products.* Greatly enhanced over the past year, the Seal Program website (<http://www.ada.org/sealprogramproducts.aspx>) now offers detailed information on each of the over 300 ADA-Accepted oral care products available over-the-counter. Consumers and dental professionals can look up individual products or compare attributes of products, and then use this information when making product purchase decisions. The ADA Division of Information Technology, the Departments of Marketing and Electronic Media, and the Division of Communications assisted the Council in this project.

*New Seal Program Product Categories.* The Council has actively investigated expansion into new Seal product categories in 2010-2011. As a result, three new categories were added to the program:

- Products for the cessation of smoking and use of smokeless tobacco;
- Bottled water with fluoride; and
- Devices to help prevent tooth damage from bruxism.

The Council looks forward to reviewing product submissions in these categories in the near future.

*Seal Program Publicity.* With assistance from the Division of Communications, the Seal Program generated positive publicity and favorable news coverage in the following media:

- Articles by Dr. Dennis Engel, ADA Ninth District Trustee, in the Michigan and Wisconsin Dental Association journals (February and March 2011 issues) titled, "ADA's Stamp of Approval." The article concludes: "We need the Seal Program because we are a science-based organization and we care for the well-being of our patients."
- Guest editorial on the ADA Council on Scientific Affairs by Dr. John W. Hellstein, CSA chair, which was published in the January 2011 *Dimensions of Dental Hygiene*. According to the editorial, "[t]he ADA Seal provides dentists, dental hygienists and consumers with information on safe and effective (OTC) dental materials, devices and therapeutic agents. Dentists and dental hygienists are encouraged to recommend OTC dental products that carry the ADA Seal of Acceptance."

- A February 23, 2011, *Wall Street Journal* article titled, “Whitens, Brightens and Confuses,” which includes the following quote from Dr. Ada Cooper (consumer advisor for the ADA): “Just make sure it has fluoride and has the American Dental Association Seal. The ADA Seal tells you that the product has been tested, that it is effective in doing what it says it’s going to do, and has the right mix of ingredients.” The article was subsequently picked up by Time/CNN online.
- Segment on CBS News’ *Early Show*, which included the following quote from Dr. Nancy Rosen, a New York City dentist: “The ADA’s Seal of Acceptance means that the product has met ADA criteria for safety and effectiveness, and that packaging and advertising claims are scientifically supported.”

The Seal Program also received positive coverage in other publications and news media, including:

- Two textbooks for dental hygienists/assistants: *Clinical Practice of the Dental Hygienist*, 11<sup>th</sup> edition, and *Modern Dental Assisting*;
- Article in the Kroger’s magazine titled *Caring for Your Smile*, which was mailed, along with product coupons, to about 500,000 Kroger customers who have previously purchased oral care products; and
- ADA Seal Promotions in the West Virginia State Journal, the Oral-B website, and in the ParentDish.com blog.

*Pilot Seal Program Marketing Plan for 2012.* The goal of this CSA initiative is to strengthen consumer demand for Seal products and drive more manufacturers to seek the ADA Seal on more over-the-counter (OTC) oral health products. Increased participation by manufacturers in the Seal Program would expand the number of ADA-Accepted products available in the consumer marketplace that have been shown to meet the rigorous ADA criteria for safety and effectiveness.

Based on the survey results mentioned previously, the Council recommends that the most credible and cost-effective channel to influence consumer behavior is to market the Seal Program directly to the ADA membership and to dental hygienists in their practices. The plan would ensure that the Seal of Acceptance remains the primary way most consumers relate to the ADA. With regard to the dental industry, a recent survey revealed that a primary reason for declining participation by OTC oral care companies is that the ADA Seal has “lost its luster.” By this, the manufacturers noted that the ADA has not been promoting the Seal Program to consumers and to industry, which has diminished public awareness of the Seal of Acceptance.

While the Seal Program’s revitalization and promotional activities over the past year within the existing budget are an important start, the Council continues to recommend that a more meaningful and significant impact for revitalizing the Seal Program can be achieved through additional financial support from the 2011 House of Delegates. To that end, a comprehensive Seal Program marketing plan has been prepared for consideration in the 2012 budgeting process.

The Council continues to pursue low/no-cost activities similar to 2010-2011 in order to continue to build momentum. Although these Seal Program promotions were relatively successful in their reach and impact, the Council believes that additional funding is needed to strengthen the impact and drive results.

*Mega-Issue Discussion on Criteria Used for Awarding the Seal of Acceptance.* As part of its ongoing efforts to revitalize the Seal of Acceptance Program, the Council held a mega-issue discussion in March 2011 about the guidelines it uses to evaluate dental product submissions for the Seal. The Council’s evaluation criteria for awarding the Seal of Acceptance, as explained in the guidelines, are developed to be scientifically sound and appropriate for the product category while also maintaining fairness and objectivity. The Council is also considering the types of effectiveness claims that are important to review for Seal products, so that dentists and consumers are provided the accurate information they need to make informed decisions when choosing the oral care products. After development by a CSA subcommittee, the full Council will again consider this issue at its July 2011 meeting.

**Standards Activities:** The *Bylaws* direct the Council on Scientific Affairs to coordinate 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 2010 House of Delegates approved an amendment to CSA *Bylaws* duty "c," which directs CSA to "[e]ncourage 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" (underlined text added). The amendment formalizes the Council's role of oversight for the ADA's dental product standards program. A similar amendment to the Council on Dental Practice's *Bylaws* duties formalizes CDP's role in oversight of the ADA's dental informatics standards program.

In 2010-2011, the Council worked with standards committees on projects in newer technology areas such as CAD/CAM and cone-beam computed tomography, and coordination of joint activities on these technologies with the ADA Standards Committee on Dental Informatics.

*ADA SCDP.* In 2010, the Department of Standards successfully completed its audit by the American National Standards Institute (ANSI) and its procedures were re-accredited by ANSI. The ADA SCDP currently has over 90 projects registered with the ANSI. In 2010-2011, the Council and SCDP approved the following new work projects: Dental Cartridge Syringes, Interfaces for Dental CAD/CAM Systems, CAD/CAM Implant Abutments and Accuracy of CAD/CAM SLA Models. To date, the U.S. Food and Drug Administration has recognized some 60 ANSI/ADA specifications for use in the FDA's premarket evaluation of dental products.

During 2010-2011, the SCDP and U.S. TAG held their annual meetings on March 2, 2010, in Washington, DC, and on March 15, 2011, in San Diego. A strategic planning session was held at the 2010 meeting to consider "challenges and new opportunities," and specific goals were identified to ensure the continued relevance and sustainability of the dental standards program. It was generally agreed that the most significant challenge facing the standards program today is the rapid rate of emergence for new technologies in dentistry. Some emerging technologies that need to be addressed by standards include CAD/CAM and other digital and automation technologies. Another challenge is the sustainability of SCDP's business model for dental standards in light of the difficulties of recruiting new volunteers and securing sustainable funding for SCDP activities. In developing a strategic plan to meet these challenges, the SCDP first needs to find ways to increase the involvement of the major stakeholders: industry, academia, government and military.

*ISO/TC106.* Through the Council, the ADA sponsors U.S. participation in ISO/TC106, Dentistry, as Secretariat of the U.S. Technical Advisory Groups. 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 ADA positions on standardization issues to this international organization. The 2010 meeting of ISO/TC106 Dentistry was held from September 27 to October 2, 2010, in Rio de Janeiro.

The 2011 ISO/TC106 Meeting, co-hosted by the ADA and the Dental Trade Alliance, will be held September 18-24, 2011, in Phoenix, AZ. Forty-three working group and plenary meetings are scheduled, and more than 300 delegates from ISO/TC106's 24 member countries are expected to attend.

*Outside Standards Committees.* External organizations develop standards that can affect the dental profession in such areas 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. The ADA's 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 2010-2011, ADA representatives nominated by CSA participated in 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).

**Guidelines Development:** In product categories without established ADA standards, the Council develops Acceptance Program guidelines as criteria for dental product evaluation. Although the Council has phased out the Seal of Acceptance 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 effectiveness of professional products for the *ADA Professional Product Review*.

As of spring 2011, the Council has completed or is developing Acceptance Program guidelines in some 50 product areas. In 2010-2011, the Council revised or completed guidelines for tobacco cessation products, chemotherapeutic agents to arrest or control periodontitis, and bottled water with fluoride. Acceptance Program guidelines are also under development or revision on adjunctive dental therapies, cleansers for removable appliances, and determination of effectiveness in product evaluation.

**Emerging Issues and Trends:** The Council continuously monitors and evaluates emerging issues with respect to its *Bylaws* duties, member needs and the ADA Strategic Plan: 2011-2014. The Council identifies issues and related trends through several communication channels: member inquiries to the ADA Division of Science; CSA's mega-issue discussions and strategic planning sessions on programs and objectives; ADA scanning reports; and collaboration with external stakeholders and internal ADA agencies.

Past emerging issues of lasting importance are now reviewed more frequently as CSA has implemented a three-year review cycle for Council statements and reports. In 2011, the Council's review priorities for updating CSA reports and statements include: resources available to members on medical emergencies in the dental office (note: completed as of spring 2011); and updating previous CSA reports on the following: xerostomia, antibiotic resistance, endosseous implant technologies, antibiotic premedication for orthopedic joints and implants, updated recommendations for managing patients receiving oral bisphosphonate therapy; and patient selection for dental radiographs (information on last three topics included in "Response to Assignments From 2010 House of Delegates" and "Scientific Information" sections of this report).

In parallel with the last item on dental radiographs, the Council is also initiating work to develop clinical guidance on CBCT. This work on dental radiographs and CBCT will involve a number of internal and external stakeholders with a focus on indications and radiation safety. The Council's related activities in collaboration with the ADA Center for EBD on evidence-based clinical recommendation topics are addressed in this report under the section titled Evidence-Based Dentistry.

The area of dental product standards is an ongoing and ever-changing area for emerging issues as new products and technologies are commercialized. Several initiatives on CBCT are underway in this area, and serve as a perfect contemporary example of the crossover between professional products, equipment and dental informatics standards.

The Council maintains strong ties in sharing information with other professional organizations, government agencies, academia, military dental researchers, industry and groups such as dental practice-based research networks (PBRNs). These relationships are integral for maintaining CSA's liaison role for the profession by staying abreast of changes in various scientific fields while also serving as an important mechanism to identify emerging issues.

**Meetings:** The Council on Scientific Affairs (CSA) met on November 8-10, 2010, and March 21-23, 2011, at ADA Headquarters in Chicago. The Council's third meeting of the 2010-2011 term will be held on July 11-13, 2011.

Dr. Dennis W. Engel, Ninth District trustee, served as the Board of Trustees' liaison to the Council. Dr. Jonathan D. Shenkin participated as liaison from the ADA Council on Communications, and Dr. Christopher Salierno as *ex officio* representative from the ADA New Dentist Committee. Ms. Christina Wiggins of Nova Southeastern University College of Dental Medicine also attended and participated as representative of the American Student Dental Association.

**Personnel:** In 2010-2011, Dr. John Hellstein served as Council chair and Dr. J. Timothy Wright as vice chair. In fall 2010, the Council welcomed four new members: Dr. Bryan Michalowicz, Dr. Kirk Noraian, Dr. Brian Novy and Dr. Edmond Truelove. The 2011 annual session will mark the completion of terms of service for the following members: Dr. Steven Armstrong, Dr. Robert Buhite, Dr. John Burgess and Dr. George Taylor, III. The Council acknowledges their exemplary service to the Association and the profession.

In May 2011, CSA member Dr. Martha Somerman resigned from the Council following her appointment as director of the National Institute of Dental and Craniofacial Research, effective August 29, 2011. The Council has requested that the ADA President name a replacement CSA member according to the *Standing Rules for Councils and Commissions*. The new Council member will serve for the remainder of Dr. Somerman's term, and will not be eligible for re-appointment since half of the term remains.

### Summary of Resolutions

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**13. Resolved,** that the ADA policy statement entitled Use of Approved Materials in New Techniques and Products (*Trans.*1977:939) be rescinded.

# ADA Research Institute

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**Zeller, Gregory G.**, senior director, Research and Laboratories

In past years, this report was submitted to the House as the report of the ADA Foundation Research Institute. In December 2010, the ADA Foundation (ADAF) Board of Directors voted to transfer the Research Institute (RI) to the ADA as part of the ADAF's reassessment of its program priorities. The transfer involved no significant assets and only one major program, the Health Screening Program.

In February 2011, the ADA Board of Trustees accepted transfer of the Research Institute to the ADA and directed that the RI be housed in the Division of Science. The Board further directed the Science division, in cooperation with other appropriate ADA agencies, to develop a business plan for the future of the Research Institute with an appropriate budget for presentation to the Board in December 2011. Work on the business plan is underway. Some initial concepts are outlined below.

**Health Screening Program (HSP):** The ADA House of Delegates authorized \$350,000 to underwrite the 2011 Health Screening Program and encouraged the appropriate agencies to pursue corporate funding to offset as much of the expense as possible. Fundraising is underway, spearheaded by ADA Corporate Relations and Strategic Alliances. To date, commitments have been received totaling \$192,000 in cash and additional in-kind support. Cash support includes a grant of \$107,000 from the ADA Foundation. The 2011 HSP is being planned as a forum for research, education, the introduction of new technologies (saliva diagnostics) and to provide a superb member experience. A number of new screenings will be introduced that reflect the changing demographics of the study population. Because of overwhelming interest in the program, appointments are available to member dentists when they register online for the ADA session. One-half hour appointments are available on October 10-12 from 7:00 am until 11:30 am. Members and others can participate as walk-ins October 10-12 from noon until 3:00 pm. All trustees and delegates are encouraged to participate.

**Concepts for the Future of the Research Institute:** The Research Institute was, historically, the sister agency to the Paffenbarger Research Center under the auspices of the ADA Foundation. At one time, the RI engaged in significant grant-funded research in Chicago. Over the years, funding declined, until only the Health Screening Program, funded through unrestricted corporate grants, remained as a major RI activity. ADA scientists, though, have continued to contribute their expertise to research on emerging issues of critical importance to the dental profession in collaboration with other researchers. A recent example is the collaboration on lead in dental crowns with the Paffenbarger Research Center completed in 2010. However, even this type of activity has been constrained by the lack of staff resources.

The vision for the future of the Research Institute is to rebuild its grant-funded capacity to conduct research, development, and education activities that advance the science of oral health for the profession and the public. The revitalized Research Institute might serve the following functions:

- Offer the capability to receive unrestricted grants and funds;
- Serve as an intermediary body to assure that funds received are appropriately unrestricted and handled in accordance with proper financial procedures;
- Serve as an unbiased intermediary referee to assure that the content and scientific approach of Research Institute projects is fair, balanced, and not improperly influenced by funding sources;
- Offer the capability to enter into financial agreements for development of projects with external entities that meet the requirements of all parties involved;
- Offer the capability to provide grants from Research Institute funds to external entities; and
- Build funds beyond the direct expenses associated with project costs in order to defray RI operating expenses or to fund RI operational goals.

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

## Notes



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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., (ADABEL) has been a wholly owned subsidiary of the American Dental Association (ADA or Association). ADABEL's primary mission is to enhance the value of Association membership by providing a broad range of endorsed products and services from industry leading providers. ADABEL endorses best-in-category products and services useful to ADA member dentists in their businesses (the Program) which typically features special benefits, discounted pricing and increased customer service levels. In return, ADABEL receives a service fee for providing marketing services, program management and other services. ADA also receives significant non-dues revenue in the form of royalty income from licensing its name and list to the endorsed providers in the Program. In addition, many of the state dental societies often co-endorse specific products and services and receive a share of program revenue.

For 2010, ADABEL'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. Transitioning the credit card provider in late 2009 and early 2010 from Citibank to U.S. Bank.
3. Continuing the wind down of operations of ADA Intelligent Dental Marketing ("ADAidm").

**Products:** In 2010, the Program included 13 products and services from 11 vendors:

- Credit Card—U.S. Bank
- Credit Card Processing—Chase Paymentech LP
- Patient Financing—CareCredit LLC
- Practice Financing & Commercial Real Estate—Wells Fargo
- Payroll 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

No new products or services were launched in 2010. However, U.S. Bank, which contributes approximately 50% of Program revenue, converted the existing portfolio of credit card customers in April and May of 2010.

**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 website at [www.adabusinessresources.com](http://www.adabusinessresources.com).

In 2010, product inquiries increased by more than 14%, driven by increased usage of the ADABEL electronic channels. In 2011, ADABEL has updated the electronic publication and direct mail formats, respectively, increasing opportunities for products and providers to be featured in each channel, a key to generating more leads.

**State Dental Society Endorsements:** State dental societies may choose to co-endorse products and services and share in ADA's royalty revenue through a license agreement. In 2010, 37 state dental

societies endorsed one or more products in the *ADA Business Resources* program. In 2010, more than \$488,000 in royalties was paid by the ADA to state dental societies, the majority of which is contributed by the endorsements of the credit card with U.S. Bank and patient financing with CareCredit LLC.

**Revenue<sup>1</sup>:** A total of \$5,478,295 in combined revenue was earned in 2010 as a result of both service fees to ADABEI from the Program and royalties to ADA from endorsed providers in the Program—this was 1.7% above the budget of \$5,385,311. The ADA received royalties of \$2,732,014 (approximately 50% of this revenue stream). ADABEI received \$2,746,281 in service fees.

Since the majority of products in the Program are credit based (credit cards, practice financing, patient financing), overall revenue was initially impacted by the global economic downturn, but recovered in the second half of 2010.

In addition, ADABEI was also able to reduce core business expenses to compensate for some of the early revenue shortfalls and ADABEI's 2010 Pre-Tax Income was positive by \$569,428, exceeding the net income goal by 24%.

In June 2010, ADABEI declared a dividend payment of \$536,050 to the ADA. This amount was equal to the ADA's 2010 budget deficit that was approved by the 2009 House of Delegates in order to provide level funding. ADABEI could not, however, direct the dividend to the ADA Reserve Fund, but only that the funds be returned to the Shareholder (the ADA).

The second half of 2010 showed signs of improvement and economic conditions in 2011 have continued to trend positively with expected favorable impact on ADABEI results. Therefore, the 2011 ADABEI budget was built to show modest growth.

Through March 2011, a total of \$1,255,343 was earned by ADABEI from Program service fees and by ADA from royalties from Program endorsed providers—4.0% more than the targeted budget of \$1,206,899. The primary drivers are the financially related products, including, credit card, practice financing and patient financing.

Solid revenue growth should allow the ADA to receive \$2,985,104 in royalty income from the endorsed providers in 2011, which is \$238,823 or 9% more than 2010.

**ADA Intelligent Dental Marketing LLC (ADAidm):** By 2010, all operations had ceased and all refunds processed. In 2010, sales of assets (i.e., proprietary software, computer equipment) totaled just over \$60,000.

Throughout 2010, an analysis of ADA member renewal rates was conducted to determine the membership impact, if any, of winding down ADAidm operations. According to the ADA Data Warehouse, ADAidm customers renewed at rates (96%) slightly ahead of overall membership (94%).

In 2011, the 2008 and 2009 audits have been completed and the only remaining open ADAidm matter is to finalize ADAidm's 2008 and 2009 tax returns.

**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. As a result, 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. In 2010, ADABEI also hired a consultant to evaluate "best practices" of for-profit subsidiaries of not-for-profit organizations.

At its December 2010 meeting, the ADA Board of Trustees passed a resolution, reconstituting the ADABEI Board of Directors, with five members as follows:

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<sup>1</sup> Revenue data is unaudited and subject to change.

- three ADA members at large members
- one member of the ADA Board of Trustees (appointed by the ADA President)
- one independent director

Dr. Gist, on behalf of the ADA Board of Trustees, sent out a call for qualified candidates in March 2011, followed by communications from Dr. O'Loughlin and Dr. Robert Faiella. Candidates have been screened and continue to be interviewed.

At the July 2011 ADA Board of Trustees meeting, a recommendation report will be given to the ADA Board who will review it and then elect the new ADABEI Board.

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

# Notes

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# ADA Foundation

# Notes



# ADA Foundation

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**Whiston, David A.**, Virginia, 2012, president  
**Ellwein, Orin**, South Dakota, 2011, director, vice president, Grants & Programs  
**Rethman, Michael P.**, Hawaii, 2014, director, vice president, Scientific Research  
**Simms, Richard A.**, California, 2012, director, vice president, Development & Fundraising  
**Szarzynski, Ronald**, Minnesota, director, 2014, vice president, Finance  
**Chibe, Paul D.**, Illinois, director, 2014  
**Fletcher, Kent W.**, Quebec, 2011, director  
**Garcia, Ernest J., Jr.**, California, 2011, director  
**Gounardes, Steven**, New York, 2014, director  
**Grover, Jane S.**, Michigan, 2012, director  
**Hopkins, Sheila**, New York, 2011, director  
**Niessen, Linda C.**, Texas, 2011, director  
**Norman, Charles H.**, North Carolina, 2012, director  
**Rouse, Leo E.**, Maryland, 2011, director  
**Seago, Donald L.**, Mississippi, 2013, director  
**Smith, Charles L.**, West Virginia, 2013, director  
**Sullivan, Timothy J.**, Wisconsin, 2012, director  
**Thompson, R. Wayne**, Kansas, 2011, director  
**Walker, Lewis C.**, Florida, 2011, director  
**Zarkowski, Pamela**, Michigan, 2014, director  
**Beutler, Jeffery**, interim chief executive officer  
**Murphy, Emmett P.**, interim chief financial officer  
**Czarnecki, Robert N.**, director, administration  
**Jasek, Jane F.**, director, programs

## **Paffenbarger Research Center, Gaithersburg, Maryland**

**Schumacher, Gary E.**, associate director, chief research scientist, clinical research  
**Carey, Clifton M.**, director, independent research and grant administration  
**Bowen, Rafael L.**, distinguished scientist  
**Chow, Laurence C.**, assistant director and chief research scientist, dental chemistry  
**Skrtic, Drago**, interim chief research scientist, polymer chemistry  
**Vogel, Gerald L.**, chief research scientist, dental cariology

## **Governance and Administration**

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Since the last ADA Foundation (ADAF or Foundation) Annual Report, the ADAF has taken the following actions.

**Corrective Action Plan:** The Foundation has undergone a self-evaluation in response to the KPMG Report. Various aspects of this assessment are described elsewhere in this report. A comprehensive Corrective Action Plan (CAP) responsive to the issues raised by KPMG is in process. The CAP is targeted for completion by August 1, 2011, at which time it will be provided to the ADAF Board of Directors for review and approval.

### **ADAF Governance Initiatives:**

- To better serve the Foundation, the ADAF developed new bylaws, which the American Dental Association (ADA) as sole member approved.
- Developed and launched an implementation plan for all aspects of the new bylaws.
- Fully constituted the six Foundation standing committees, including the Executive Committee, the Governance/Board Development/Nominating Committee, the Finance Committee, the Scientific Research Committee, the Program Committee, and the Fundraising/Development Committee.

The committees are comprised of ADAF Board members and additional non-ADAF board members serve as advisors to the committees.

- Worked with KPMG, ADA Subsidiary Accounting and ADAF Legal counsel to update all state charitable fundraising registrations and initiated outsourcing the registration process to a national company specializing in state registration processes for fundraising entities for the purpose of improving efficiency and decreasing cost.
- Completed, reviewed and submitted amended 2007, 2008, and 2009 IRS Form-990s as well as state charitable registration filings for 2007 through 2009.
- In response to a letter received from the U.S. Department of Health and Human Services (HHS) about the Foundation's 2009 A-133 Audit (audit of government grants), the Foundation developed and submitted a response and corrective action plan, which was accepted and approved by HHS in April 2011 subject to implementation of all items set forth in the Foundation's response.

#### **ADAF Executive Management Initiatives:**

- Initiated a strategic planning process that creates strategic alignment of the vision, mission-purpose, goals, annual operational plan and budget, and staffing; metrics will be specific and measurable, and will serve to inform the ADAF Board of Directors of progress made in furthering the ADAF mission.
- Developed a historically based budget for 2011 that will provide the information necessary to identify the *true cost of all ADAF programs and activities* and will be a critical piece of the cost/benefit portion of the Program Evaluation Process. This step has lead to a strategic, cost-specific, program-based, future ADAF budgeting process for 2012 and beyond.
- Approved the ADA-ADAF Services agreement, with regularly scheduled internal meetings to assess effectiveness and success.
- Initiated separate ADA-ADAF agreements where one organization is providing services to the other. These agreements delineate the roles and responsibilities of each organization and insure that costs are properly tracked.

#### **Human Resource Initiatives:**

- Initiated a search for an executive director, including contracting with a professional search firm. An individual has been selected to serve in this role with a starting date of July 5, 2011.
- Initiated a search for the senior director–Paffenbarger Research Center, including contracting with a professional search firm and the creation of a search committee composed of oral health research leaders with a target of selecting the candidate by July 1, 2011, and having the person in place by September 1, 2011.
- Eliminated three unfunded (no research grants) positions at Paffenbarger Research Center and initiated an ongoing review of all grant-supported positions within PRC to strategically and tactically align performance measurements.

#### **Grant and Program Initiatives:**

- Developed a Board-approved, objective Program Evaluation Process (PEP) that has been *rigorously* applied to all existing programs to ensure compliance with standards, governmental requirements and the ADAF mission.
- Standardized ADAF grant-making processes and forms, and created model program profiles.
- Agreed to the movement of all Give Kids A Smile (GKAS) programmatic activities to the ADA and agreed to continue to house and manage the GKAS fund in support of mission-related activities.
- Assumed responsibility for some mission-appropriate programs that were once operated by ADA, and agreed to serve in a grant-making role for other funds restricted or designated to support ADA-operated programs that align with the ADAF mission.
- Approved in concept the Relief Grant Program Rules designed to improve the way the Relief Grant Program is currently operated. Due to appropriate concerns raised by constituent societies and others, the ADAF has committed to a longer comment period and to publish a request for proposals to perform a needs assessment to clearly identify the extent and type of needs to be

addressed by this program prior to making further changes. (The Relief Grant Program Rules are addressed in more detail later in this document.)

**Strategic Framework:** The ADAF Board of Directors approved a new strategic framework that will drive all future Foundation planning and activities. The new ADAF Mission and Vision are:

**Mission:** *To improve human well being through improved oral health.*

**Supporting Pillars—C.A.R.E.:** The ADAF advances its mission by focusing its programmatic and grant-making efforts and resources on four programmatic pillars: *Charitable Assistance, Access to Care, Research and Education.*

**Vision:** *All people experience optimal oral health.*

## Fundraising

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At its June 1, 2011 meeting, the ADA Foundation Board voted to rescind the 2010 ADAF fundraising moratorium and empowered the ADAF Executive Committee to approve and initiate the commencement of fundraising at such time after the Correction Action Plan (CAP) is approved by the ADAF Board. The resumption of fundraising is subject to certain additional conditions including, but not limited to, the Executive Committee being satisfied that all essential elements of the CAP are operational, including strategic alignment of fundraising and implementation of controls and procedures to track both contributed funds and all related expenses. The Board anticipates resumption of Foundation fundraising efforts no later than the 2011 ADA annual session.

## Grants and Programs

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**ADAF Program Evaluation Process Launched:** In early 2011, the Program Committee developed a Program Evaluation Process (PEP). The ADAF Board approved the PEP in March 2011 as its program review protocol. As a result of rigorous application of this process, the ADAF has reduced the number of programmatic activities, which are all mission-driven. The PEP will be used with all potential future programs and applied in the episodic review of all ADAF programs and grants. Table 1 includes a summary of the programmatic changes.

**Table 1. ADA Foundation  
Summary of Program-Related Board Actions Since June 2010**

Program/Funds	Number of Programs/Funds Prior to September 3, 2010	Board Directed Changes on and After September 3, 2010	Number of Programs/Funds in 2011
Total Ongoing	42		19
Transferred		4	
Suspended		2	
Discontinued		17	
Total of All Programs/Funds	42	23	19

The PEP serves to guide the Board and staff in determining the appropriateness of programmatic activities, including direct-control programs, scholarships, awards, grants and fellowships. The steps for determining programmatic appropriateness are well documented as best practices for foundations and not-for-profit organizations. As summarized in Table 2, the ADAF PEP process is designed to enhance current and future program analysis to support informed decision-making.

**Table 2. ADA Foundation  
Program Evaluation Process (PEP) Action Steps**

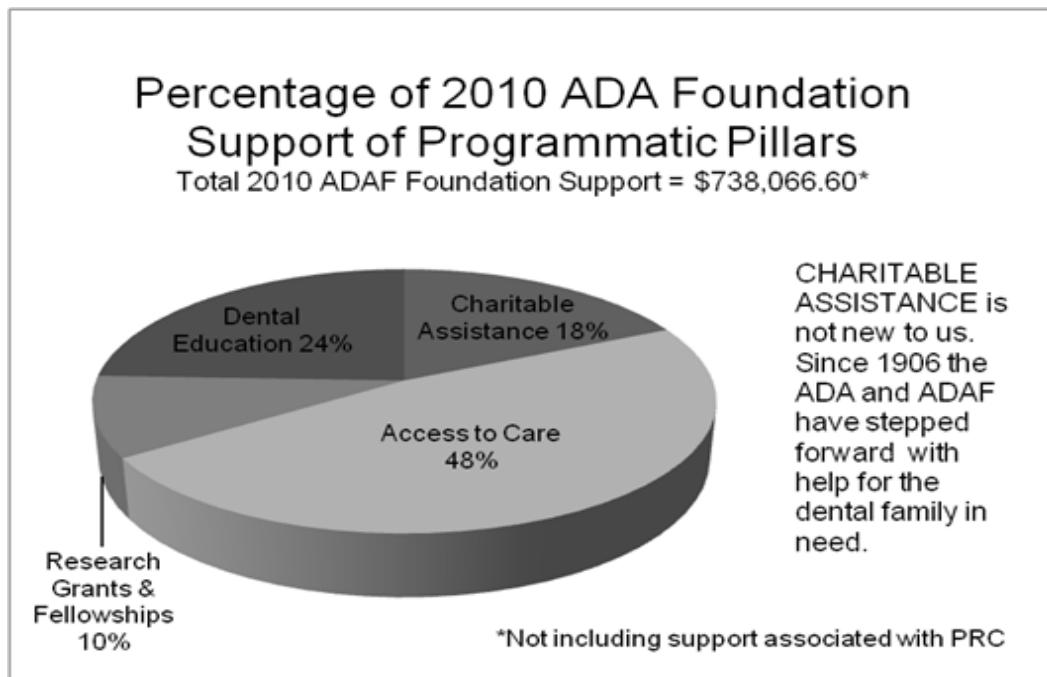
Action Step	Description of Activity
1	Identify new or existing program to review.
2	Check compliance with laws and regulations.
3	Perform S.W.O.T. Analysis: Evaluate strengths, weaknesses, opportunities and threats.
4	Based on SWOT analysis findings, determine need for further analysis.
5	If further analysis is necessary, determine whether funds/resources exist for further analysis.
6	Perform a cost-benefit analysis.
7	Program Committee develops recommendation.
8	Board considers Program Committee's recommendation and takes action.

**Change in ADAF Business Model:** Based on a desire to operate more efficiently and to focus on what the Foundation does best, the ADAF Executive Committee considered a change in the current ADAF business model. In part, this model includes a plan to officially shift from program operation to a more fully active grant-making or grant-management model; this model also requires assessing fees associated with grant management, something that the ADAF has not done in the past, due in part to the fact that the ADA has underwritten most of the ADAF and PRC administrative and overhead costs through an annual grant and the provision of other in-kind services to the Foundation. Under this new model, the ADAF will continue to use the PEP to assess proposed and existing charitable initiatives, proactively fundraise for those initiatives, and then offer larger and more sustainable grant opportunities. The ADAF hopes to focus its efforts by targeting fundraising that will support areas of need and by issuing requests for proposals for grants that support worthwhile initiatives.

*The Foundation, therefore, intends to make enduring and noteworthy changes in improving oral health that will also serve to inspire current and future donors.*

The overarching goal of the newly recast ADA Foundation is to create a tangible path whereby individual donors can positively advance the ADAF mission and goals through the four programmatic pillars of the Foundation. Every donor will be recognized as a partner in advancing human well-being by advancing improved oral health. By supporting research efforts at PRC and through Foundation research grants, ADA members are provided a unique opportunity to become co-researchers and co-creators of new knowledge—sharing in the fruits of scientific advancement and evidence-based dentistry. Chart 1 demonstrates the array of disbursements for grants, awards, scholarships and fellowships within each of the four programmatic pillars plus the Paffenbarger Research Center (PRC) during 2010. Every donor is invested in these endeavors by their support of the ADAF.

**Chart 1. Total Disbursement of Grants, Awards and Scholarships  
by Percentage of 2010 ADAF Support of Programmatic Pillars**



**Give Kids A Smile Funds and Grant Management:** The ADAF will continue to receive individual and corporate donations for its Give Kids A Smile (GKAS) Fund. The ADA will manage all GKAS programmatic activities and will be eligible to receive grants from the ADAF in support of GKAS activities aligned with the ADAF's mission. Consistent with past practices, GKAS grants may also be made available to other qualified individuals and organizations.

**Relief Grant Program Review:** Dentistry's Relief Grant Program has existed since 1906. The program operates under rules approved by the ADAF Board in 2004 and amended in 2009 (available at [www.adafoundation.org](http://www.adafoundation.org)). Through this charitable program, financial assistance has been granted to low-income dentists and/or their family members because a debilitating medical condition or injury resulted in their being unable to meet basic living expenses even while accessing social services at all levels of government. The assistance is designed to be a helping hand, with provisions for emergency as well as regular relief grants to needy applicants.

Over \$11 million is available for relief grant-making at the national and state levels. The ADAF Relief Fund balance as of April 30, 2011, was \$5.8 million, while the combined state Relief Fund balances reported to ADAF for fiscal year 2009 equaled \$5.7 million. Entitlement benefits—such as nutrition assistance, home repair services, transportation assistance, energy bill discounts and care giving services—are universally available from state and local aging service networks via the Older Americans Act.

In August 2008, the ADA Foundation Board of Directors initiated a review of the Relief Grant Program, believing a new operational model was needed. A national task force comprised of constituent society, ADA and ADAF representatives met in September 2009 and developed a new Relief Grant Program operational model currently under review.

Draft proposed rules were developed and circulated to 20 constituent societies with relief grantees in February 2010. A March 4, 2010, conference call was held and the 20 states were invited to provide feedback to the ADAF. Seven constituent societies responded. In February 2011, the ADAF Relief and

Disaster Grant Review Committee (Review Committee) reviewed the comments received from constituent dental societies. The Review Committee appreciates the concerns raised by the constituent societies and urged continued dialogue.

To that end, the ADAF scheduled meetings with constituent society executive directors in May, July and during annual session 2011 to receive feedback on draft proposed Relief Grant Program rules. In addition, the ADAF is determining the financial resources needed to perform an assessment of the Relief Grant Program, including, but not limited to, the population of potential beneficiaries across the country.

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### **Paffenbarger Research Center**

The Paffenbarger Research Center (PRC), which is located on the campus of the National Institute of Standards and Technology (NIST) in Gaithersburg, Maryland, is a significant programmatic activity of the ADAF. PRC receives funding through the American Dental Association's (ADA) annual grant to the Foundation, from National Institutes of Health (NIH) grants, from industry support and grants, and from service contracts with NIST. NIST also provides PRC with substantial in-kind support. PRC generates significant royalty income to support future PRC research and education-related activities. The licensing of patented inventions ensuing from scientific research at the PRC has resulted in 30 products currently available to practicing dentists and one toothpaste available to the public.

PRC scientists conduct basic, applied and translational studies in clinical research, dental chemistry, polymer chemistry and dental cariology. Research projects further the scientific mission of the ADA Foundation, and also respond to some critical issues identified by the Association's Council on Scientific Affairs. In the past year, PRC scientists published or had accepted 36 peer-reviewed manuscripts and abstracts, including a special issue of the *Journal of Research of the National Institute of Standards and Technology* that featured the current research (11 articles) of the PRC's Dr. Laurence Chow and the calcium phosphate chemistry group. The work of the PRC resulted in the issuance of three new United States patents in the last year. The researchers made 24 scientific presentations and lectures at scientific meetings or for dental continuing education, including invited talks both nationally and internationally to ADA affiliate societies, universities, academies, study clubs and other organizations. Twelve PRC researchers and associates presented their data at the 2011 International Association for Dental Research meeting in San Diego, California. Abstracts of PRC research presentations and publications, as well as reprints of published articles and manuscripts presented at scientific meetings, are available from PRC on request. Descriptions of the ongoing research projects are available on the ADAF website at <http://www.ada.org/2919.aspx>.

**The PRC Supports the Foundation's Mission:** The PRC advances public oral health through basic and applied research and more specifically through the development of improved dental materials and treatment technologies. Several examples of how PRC directly supports the Foundation's mission are:

- *Public Presence*—by responding to critical issues identified by the ADA Division of Science and the Council on Scientific Affairs (CSA) and through direct participation in national and international standards setting organizations. PRC researchers assisted the CSA to promote chewing gum guidelines and develop a standard reference gum through a proposed chewing gum research project. PRC hosts the Dental Students' Conference on Research, which is sponsored by the ADA Foundation and industry (Johnson & Johnson). Publicity about PRC is often supported by the National Institute of Standards and Technology public relations office.
- *Data and Information*—by researching issues that have direct impact on practice and public health, and the publication and dissemination of these research results. PRC serves the practitioner, the patient and manufacturers through involvement in and support of the national and international standards process. PRC researchers serve as an ISO subcommittee secretary (dental implants), an ISO subcommittee vice chair (dental products), a working group convener and experts on working groups.
- *Education and Transfer of Knowledge*—by providing quality continuing education programs for dental and oral health professionals. Topics discussed include dental materials, caries

mechanisms and caries management for the at-risk dental patient, fluoride therapies, and re-mineralization therapy via calcium and phosphate applications. The PRC hosted the 46<sup>th</sup> annual Dental Students' Conference on Research by providing lectures and tour stops that highlight areas of research interest and application to evidence-based practice.

- *Recruiting Future Researchers*—by communicating PRC accomplishments directly to interested professionals through programs, presentations, and the public media. This includes, for example, press releases on PRC tooth re-mineralization technology, amorphous calcium phosphate, presentations to state dental associations and local societies, and publication of a compact disc highlighting PRC accomplishments. The compact disc is available by contacting Gretchen Duppins (301-975-6806) or by written request at: Paffenbarger Research Center, NIST, 100 Bureau Drive, Stop 8546, Gaithersburg, MD 20899-8546. The PRC research highlights are also accessible online at the ADA website: (<http://www.ada.org/2919.aspx>).

**Plan to Reinvigorate PRC:** In 2008, the PRC prepared a self-study for a committee of external reviewers that was commissioned to examine the scope, scientific program, operational aspects and funding of the Paffenbarger Research Center. The findings of the report were presented to the ADA Board of Trustees, which referred them to the Council on Scientific Affairs (CSA) to develop recommendations with an action plan and milestones. PRC staff worked with the CSA subcommittee that developed the report on the future of PRC that was adopted by the full Council and submitted to the Board of Trustees in April 2009. The Board of Trustees forwarded a modified version of CSA's report and recommendations to the 2009 House of Delegates for the House's information (Board Report 11).

A workgroup was appointed to begin implementation of priority actions needed to reinvigorate PRC's operations and research programs. The workgroup, originally created by the ADA Board, was subsequently transferred to the auspices of the ADA Foundation. Over the past year, the ADA Foundation has undergone reorganization and the PRC remains an integral part of the Foundation. The ADAF Board of Directors provides high-level oversight through a newly created vice president of Scientific Research position and a Scientific Research Committee. The next step of the plan to reinvigorate PRC was to aggressively seek a permanent director, a position that has been vacant for nearly five years. A search committee was created and a search firm was utilized to identify more than 100 candidates with qualifications suitable to be the director. After weekly teleconference meetings, the committee chose several candidates who were interviewed in April 2011 with the goal of making a selection by June 2011 and having a qualified individual in place by September 1, 2011.

Concerted efforts to establish a new vision and mission for the PRC, along with new scientific directions, will be implemented once the new director is onboard. In addition to building on current PRC strengths, future emphasis will include tissue engineering and the study, development and use of antimicrobial dental materials to inhibit biofilms and dental caries.

#### **Critical Issues Research and Standards:**

- *Dental erosion.* PRC researchers are examining the effects of tooth whitening (bleaching) agents and dental erosion caused by beverages such as sports drinks, soft drinks and wine. Procedures developed would be incorporated into ANSI/ADA specifications as well as in International Standards.
- *Zinc in denture adhesives.* PRC scientists have planned experiments to measure the amount of zinc in denture adhesives as well as measurement of the amount of zinc released. This will aid in developing a performance standard.
- *Chewing gum guidelines for ADA Seal acceptance.* PRC scientists developed a proposal including a clinical research protocol to add clarity to the ADA Chewing Gum Guidelines and to verify a standard reference chewing gum. The research project would be funded by chewing gum manufacturers through the ADA Council on Scientific Affairs.

**Dental Chemistry:** Progress continues on PRC-developed calcium phosphate bone cements with experiments currently being conducted to applications for bone repair, endodontic procedures and ridge augmentation. A new, dual-paste, auto-mixed cement is undergoing intensive developmental work. PRC

scientists have synthesized the first alkaline pH calcium phosphate cement that forms fluorapatite as the main product. The material is being evaluated for antimicrobial and root canal sealing properties at the University of Maryland Baltimore College of Dental Surgery, and for non-resorptive properties using a rabbit model at Nihon University School of Dentistry, in Tokyo, Japan. Experiments to assess the efficacy of nano calcium fluoride particles in an oral rinse are continuing. In a collaborative effort with the University of Maryland Baltimore College of Dental Surgery, the materials are being used as sources of calcium, phosphate and fluoride ions released in smart restorative materials research. A newly discovered fluoride-calcium-phosphate complex is being studied for applications in fluoride rinses, dentifrices, gels and varnishes. Additional work has focused on incorporating calcium into fluoride prophylaxis pastes and varnishes, which produces improved tooth fluoride uptake by these applications. In a collaborative study with the National Institute of Environmental Health Sciences (NIEHS), one of the institutes of the NIH, calcified specimens from patients suffering from juvenile dermatomyositis have been examined by Fourier transform infrared microspectroscopy and x-ray diffraction to determine their composition. Analysis of the results is progressing.

A research project supported in part by the U.S.-Egypt Science and Technology Joint Fund, and in collaboration with the Egyptian National Research Centre, provides PRC with a \$30,000 grant to work jointly with Egyptian scientists. The goals of the Joint Fund are to strengthen the scientific and technological capabilities of both the United States and Egypt, and to broaden and expand relations between the scientific and technical communities. Preparations are being made for an Egyptian scientist to work up to three months at the PRC to create nano calcium fluoride powders for drug delivery systems. This collaboration permits the PRC to investigate new avenues of research.

**Dental Cariology:** A clinical research project, funded from a grant from the Wm. Wrigley Jr. Company was begun to evaluate the therapeutic nature of chewing gums. Gum will be formulated to release calcium and phosphate to determine its ability to prevent caries. Studies will also determine the remineralizing potential of therapeutic-releasing chewing gums compared to traditional sugar-free chewing gum. PRC laboratory techniques have attracted the interest of commercial manufacturers with resulting collaborative research. A new commercially available anti-caries varnish that contains both fluoride and amorphous calcium phosphate (ACP), which is a PRC-licensed remineralizing technology, was launched. The use of ACP as a filler in a resin matrix is part of the ongoing "smart composite" research, and the current focus is on the effect of the size of the ACP particles. A study to evaluate the performance of ACP fillers in root canal sealers is ongoing and will continue through most of calendar year 2011. Additional goals for the Cariology group include development of international standards for assessing the abrasiveness of dentifrices and for assessing the erosive capacity of oral rinses. Studies to determine the amount of fluoride that is necessary to provide therapeutic efficacy are underway. These studies use a novel laboratory mouth model, and will begin validating the results in a clinical study.

The PRC recently received grant funding from the National Institute of Dental and Craniofacial Research (NIDCR) to investigate the relationship of dental plaque biofilms and resin composite restorative materials and their interaction that could lead to secondary caries. The research will focus primarily on mutans streptococci in an *in vitro* mouth model reactor as the biofilm forms on teeth that are restored with commercial resin composites. The goals of this four-year research project will help us to better understand the mechanisms of secondary caries formation and then help to discover resin composites that might counteract the effects of the bacterial acidic challenge.

**Polymer Chemistry:** The PRC named Drago Skrtic, PhD, the interim chief research scientist of the Polymer Chemistry program, temporarily filling a position that had been vacant for one year. A patent application for a remineralizing dental composite material based upon calcium phosphate nano fillers is currently under review. Extensive experiments and evaluation on the *in vitro* remineralization of artificial caries lesions in comparison to natural lesions has recently been completed. Experiments were performed to determine the mechanical and physical properties of resin composites modified with silane oligomeric comonomers. It has been shown that these comonomers are able to reduce polymerization shrinkage stress in composite restorative materials. Studies involving development of a new adhesive resin formulation based on newly synthesized monomer derivatives continue. Initial bond strength tests for bonding a composite material to dentin were encouraging. Research is continuing into new resin



composite filler schemes that would include elliptical particles and fillers based upon nano-clays. Basic research on scaffold materials and the effects of size and structure of the scaffold for optimized cell attachment has been started.

**Clinical Research:** Clinical studies involving human subjects are ongoing to evaluate the therapeutic nature of chewing gums in terms of their ability to form intraoral reservoirs of calcium and phosphate. Clinical studies have been initiated to assess the effectiveness of a re-mineralizing chewing gum and a mouth-rinse, both of which contain a fluoride calcium phosphate complex. The PRC has been active in assisting the Division of Science in the review of chewing gum guidelines for the ADA Seal of Acceptance program. PRC conducted its third annual Dental Fractography Workshop, co-sponsored by the ADA Foundation, NIST, Zeiss and 3M. Past courses were filled to capacity with a class of international dental researchers and the 2011 course is sold out. Discussions have begun to develop research collaborations with dental schools to provide a larger volunteer base for clinical trials.

## Financial Update

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In April 2011, the ADA Board of Trustees and the ADA Budget and Finance Committee tabled discussion of the ADA Foundation grant request until the June meetings of both deliberative bodies and pending the receipt of additional information. The ADA Board, on behalf of the Member, requested that the ADA Foundation prepare a multi-year budget projection and provide clear rationale and justification as part of its annual request to ADA for support in the form of a grant to the Foundation. Specifically, the Member requested that the Foundation apply a zero-based budgeting process to develop a budget that:

- aligns with its strategic plan
- reflects actual costs
- addresses the re-starting of purposeful fundraising
- moves toward the goal of financial independence
- reduces financial dependency on the ADA
- represents the degree of financial support needed to permit the Foundation to operate efficiently, to re-tool its operations, and to move forward in a meaningful and strategic way

The ADA BOT also requested assurance that:

- its grant to the Foundation will be used for the intended purpose(s)
- systems are in place to protect the donor's intended purpose of the funds
- the Paffenbarger Research Center remains viable
- the ADAF has the competency to manage the PRC over time
- strategic planning for PRC included a thorough risk/benefit assessment

**Rationale for Support:** The value proposition of the ADAF to the ADA, its members and other donors is multi-dimensional and provides essential relevance to all donors.

- The Foundation provides a tax-advantaged avenue for individual donors and corporate sponsors to accomplish together what they could not otherwise accomplish alone. As a 501(c)(3) charitable organization, the ADAF does what a 501(c)(6) cannot do alone.
- The Foundation provides the structure and process for managing funds that are created and restricted for a specific purpose, which frees the donor from the due diligence requirement of managing the fund, including multi-budget-year funding of programmatic initiatives.
- Individual and collective financial support of oral health and dental research through the ADAF and its research component, the PRC, allows individual donors to transcend the physical limits of their clinical practice and become co-researchers and co-creators of new knowledge, products, services, systems, processes, techniques, and equipment that improve societal oral health. In addition, these fruits of basic and translational research make possible evidence-based clinical practice.

- Societal demographics are rapidly changing. New and future oral health practitioners will demand a profession that sees “what is possible and says why not?” The charitable work and research focus of the Foundation is a very tangible example of how the members of the oral health communities accomplish together that which they could not accomplish alone.
- The ADAF five-year budget projections establish a path that will allow the ADA to foster the Foundation’s financial independence and provide a method for monitoring progress on this shared goal. It is projected that in five years, the Foundation will at a minimum decrease its dependency on the ADA grant by 46% and the ADA grant as a percentage of total ADAF expenses will be reduced from 45% to 19% in the same period of time.
- The Foundation provides a unique opportunity for professional colleagues to advance oral health through charitable works that extend their commitment beyond their personal operatories, offices and homes.

**Budgeting Process:** The Foundation has developed a five-year budget projection utilizing a zero-based budgeting process; this process was driven by the Foundation’s strategic plan and included budget projections based on the resources needed to accomplish the goals and objectives specifically and strategically designed to advance the Foundation’s mission and goals. The budget was *zeroed-out* for 2012 and beyond; the new budget was built upon the projected costs of implementing associated annual work plans, including fundraising, programmatic, administrative, human resource and other overhead costs. In addition, future revenue was forecast based on currently available data on the fundraising potential within and among the ADAF communities of interest. Based on this revenue forecast, the Foundation is projected to decrease its financial dependency on the ADA by at least 46% in five years, including a 17% and 20% reduction in 2012 and 2013, respectively. (See Table 3.) The five-year projection also includes an assumption that all revenue and expense ratios meet appropriate standards in 2012 and exceed industry standards in each subsequent year.

**Table 3. Five-Year Budget Projections and Related ADA Grant Impact**

Parameter	2011	2012	2013	2014	2015	2016
Total ADA Grant	3,560,247	2,966,402	2,375,639	2,207,013	2,116,142	1,932,338
Incremental Decrease (\$)	NA	593,845	590,763	168,626	90,871	183,804
Incremental Decrease (%)	NA	17%	20%	7%	4%	9%
Cumulative Decrease (\$)	NA	593,845	1,184,608	1,353,234	1,444,105	1,627,909
Cumulative Decrease (%)	NA	17%	33%	38%	41%	46%
% of Total ADAF Expense	45%	34%	26%	23%	21%	19%

The ADAF anticipates preparing a five-year rolling budget projection each year, adjusting for annual investment income, fundraising and other environmental factors, while still operating within industry financial standards. The current budget also anticipates additional ADAF participation by committing \$500,000.00 from reserves each year from at least 2013-2016 to be applied to the re-engineering and rebuilding of the PRC to become an international leader in oral health and dental research.

**Commitment and Stewardship:** The ADAF is committed to assuring the ADA and all current and potential donors that it will meet or exceed all industry standards in managing the Foundation’s assets and programs. As described earlier, the ADAF will assure that expenses are in line with national standards by building the standards into the budgeting process so that the ADAF Finance Committee, staff and Board will all be able to monitor these expenses on at least a quarterly basis to assure compliance or make adjustments as needed.

As described in earlier communiqués with the ADA BOT, the Foundation is moving toward a grant-making model and away from operating direct-benefit programs. This approach is more efficient and

allows the Foundation to have better control over the programmatic and associated overhead costs. Under this model, grant agreements will be required and are standardized so that all grant recipients will be held accountable to use the grants for the purposes intended and will be required to submit to the Foundation a report verifying that the funds were expensed as intended. In addition, the Board or the Development Committee will be required to officially accept funds that are given to the Foundation. When funds are given for a specific purpose and the Foundation is asked to manage the funds, a grant or fund management agreement between the ADAF and the prospective donor will be required to codify the donor's explicit purpose for the fund, the cost of managing the fund (management fee) and the Foundation's responsibility in managing the fund, including any reporting requirements.

The ADAF has established a Program Evaluation Process (PEP) that is a robust process for evaluating all existing and potential future programs to assure that all programs are compliant in every way required. In addition, the formulas included in the PEP process also allow the Foundation to *assess the true cost of every program*, including direct, indirect and overhead expenses. This information will allow the Program Committee, staff and Board to make informed decisions about the programs; ensure appropriate reporting of all associated programmatic costs; maintain expense ratios in line with industry standards; and identify accurate and strategic fundraising goals.

The ADAF Board of Directors also initiated a nationwide search for a new Foundation executive director in January 2011. This process has led to the selection of a highly qualified individual who will officially assume this role on July 5, 2011.

**Paffenbarger Research Center:** The Paffenbarger Research Center (PRC) is the largest asset currently housed within the ADAF. As the single largest programmatic activity within the ADA Foundation, it is the mainstay of the programmatic research pillar that advances the Foundation's mission to improve well being through improved oral health. The PRC fills a mission critical role through the creation of new knowledge, products, systems, processes and equipment, and by providing leadership in the oral health and dental research communities.

As the sole Member of the Foundation, the ADA through its Board of Trustees and executive director, rightfully expressed its interest in the operation, management, financing and future of the PRC. After thorough review of the 2008 PRC Self-Assessment and the recommendations from the 2009 PRC External Review Panel and the 2009 CSA Review Panel, the ADAF agreed with the report that the PRC is extremely valuable and viable. Because of the mission critical role of the PRC and of research activity in general, the ADAF Board of Directors revised the ADAF Bylaws to include a Scientific Research Committee that will be populated with research specialists and others who will help provide the necessary oversight, mentorship and recommendations to assure a clear vision and successful future for the PRC. Subsequently, the Foundation classified the PRC as a high-priority program and initiated a high level of activity to adopt many of the recommendations from the report. The potential for the PRC is best described by the following quote in the final report from the chair of the PRC Director Search Committee, Dominick P. DePaola, DDS, PhD, Associate Dean-Academic Affairs, Nova Southeastern University, College of Dental Medicine, Fort Lauderdale, Florida.

"In my considered opinion, the ADAF has the opportunity to secure a truly innovative, creative, scientifically sound leader to restore the PRC to its prominent role as an acknowledged leader in oral health science."—Dr. Dominick P. DePaola

The ADAF took two immediate additional actions. First, the Foundation authorized an executive search to fill the PRC director position as soon as possible to assure appropriate leadership in the re-engineering of the PRC in support of the ADAF mission in the area of oral health and dental research. Second, the Foundation contracted with a finance and management consultant to serve in the interim role as the PRC business manager tasked with: identifying and improving all business processes and financial systems; identifying the key responsibilities for this position and the qualifications of the individual needed to make this position effective in managing PRC business processes and financial systems; managing these activities on an interim basis until the PRC director is in place and able to recruit and hire an individual qualified for this position; and to help with the orientation of the new business manager and ensure a

smooth transition for the PRC director and business manager. Both of these positions are included in the five-year budget projections.

**Conclusion:** The ADAF Board of Directors appreciates the ongoing strong support of the ADA House of Delegates, the Board of Trustees, members and staff. The ADAF Board is committed to leading the Foundation to the highest level of professionalism and success. In addition to establishing a new strategic framework and new business model, the ADAF has initiated the necessary steps to assure the successful re-engineering of the PRC and commits to moving it toward a new level of recognition among the international oral health and dental research communities.

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

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## 2010 Referred Resolutions

# Notes

# 2010 Referred Resolutions

2010 Resolutions Referred to the 2011 House of Delegates

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## Seventh Trustee District

### Amendment of the ADA *Bylaws*: Setting the Dues of Active Members

The following resolution was adopted by the Seventh Trustee District and submitted on September 24, 2010, by Mr. Douglas Bush, executive director, Indiana Dental Association.

**Background:** Chapter V, Section 130, of the ADA *Bylaws* states that the House of Delegates is to establish the dues of active members by a two-thirds affirmative vote of the delegates present and voting.

This policy has generated considerable disorganization and confusion at recent House meetings. This is due to the fact that the Annual Budget and resolutions creating a financial impact, can be approved with a simple majority vote of 50%, while adoption of the dues necessary to fund the proposal requires a two-thirds vote. An impasse is created when a resolution achieves a 50% vote, but falls short of the two-thirds vote required for funding.

This conflict can be remedied by: 1) Increasing the percentage of votes required to approve both the Annual Budget and any resolutions calling for an appropriation of funds; and 2) Decreasing the percentage of votes required to set the Association's annual dues.

The North Dakota Dental Association has submitted two resolutions to the 2010 House that would raise the percentage of votes required to approve the Annual Budget (Resolution 62) and to pass a resolution calling for appropriation of funds (Resolution 61) to three-fifths (60%). The Seventh Trustee District supports these resolutions and the ADA Board of Trustees has recommended the House of Delegates vote "yes" on these two resolutions.

To further address the issue, the Seventh Trustee District is submitting the following resolution that proposes lowering the vote required to set the ADA dues for Active Members to the same three-fifths (60%) majority. This amendment to the *Bylaws* changes the procedure for setting dues and requires 90 days written notice to the House. Therefore, the Seventh District wishes to present this resolution to the 2010 House, with the intention to carry over to the 2011 House for a vote.\*

Therefore be it

### Resolution

**105-2010. Resolved**, that Chapter V, Section 130A.d of the ADA *Bylaws* be amended as follows:

APPROVAL OF THE DUES OF ACTIVE MEMBERS. The dues of active members of this Association shall be established by the House of Delegates as the last item of business at each annual session. The resolution to establish the dues of active members for the following year shall be proposed at each annual session by the Board of Trustees in conformity with Chapter VII, Section 100F of these Bylaws, may be amended to any amount and/or reconsidered by the House of Delegates until a resolution establishing the dues of active members is adopted by a sixty percent (60%) ~~three-fifths (3/5)~~ ~~two-thirds (2/3)~~ affirmative vote of the delegates present and voting.

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\* Note: The 2010 Standing Committee on Constitution and Bylaws editorially revised this resolution. The resolution as presented reflects this editorial change.

### **Special Committee on Financial Affairs**

#### **Amendment of the ADA *Constitution* Regarding Audit Responsibilities**

The following resolution was adopted by the Special Committee on Financial Affairs and transmitted on September 20, 2010, by Dr. Ronald P. Lemmo, Committee Chair.

**Background:** After the Special Committee meeting of September 10, 2010, and after the Board voted to recommend the formation of the Council on Financial Affairs, an issue was raised about a potential conflict with the *Constitution*.

Industry standards and best practices recommend that organizations like the ADA have an independent Audit Committee. The Special Committee believes that this independence is best achieved by transferring the Audit function to the House of Delegates. This requires that the *Constitution* be changed to remove the Audit function from the Board, and establish the Audit Committee as a committee of the House under the new Council on Financial Affairs.

In an effort to resolve the Constitutional issue that was raised, and to allow the work of the Special Committee to be in front of the House of Delegates, the following resolution is being proposed.

#### **Resolution**

**114-2010. Resolved,** that ARTICLE IV, *Section 20*, of the ADA *Constitution* be amended as follows (new language underscored):

*Section 20. ADMINISTRATIVE BODY:* The administrative body of this Association with the exception of audit responsibilities 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*.



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## Appendix

## Notes

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<b>Res. 8</b>	<i>Reports:96</i>	<b>Council on Dental Education and Licensure</b> Amendment of the Policy Statement on Continuing Dental Education
<b>Res. 9</b>	<i>Reports:138</i>	<b>Council on Ethics, Bylaws and Judicial Affairs</b> Amendment of the ADA <i>Bylaws</i> Regarding Nominations of Elective Officers (Speaker of the House of Delegates)
<b>Res. 10</b>	<i>Reports:141</i>	<b>Council on Ethics, Bylaws and Judicial Affairs</b> Amendment to ADA <i>Code</i> , Section 2 – Principle: Nonmaleficence
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## 2010 Resolutions Referred to the 2011 House of Delegates

<b>Res. 105-2010</b>	<i>Reports:247</i>	<b>Seventh Trustee District</b> Amendment of the ADA <i>Bylaws</i> : Setting the Dues of Active Members
<b>Res. 114-2010</b>	<i>Reports:248</i>	<b>Special Committee on Financial Affairs</b> Amendment of the ADA <i>Constitution</i> Regarding Audit Responsibilities